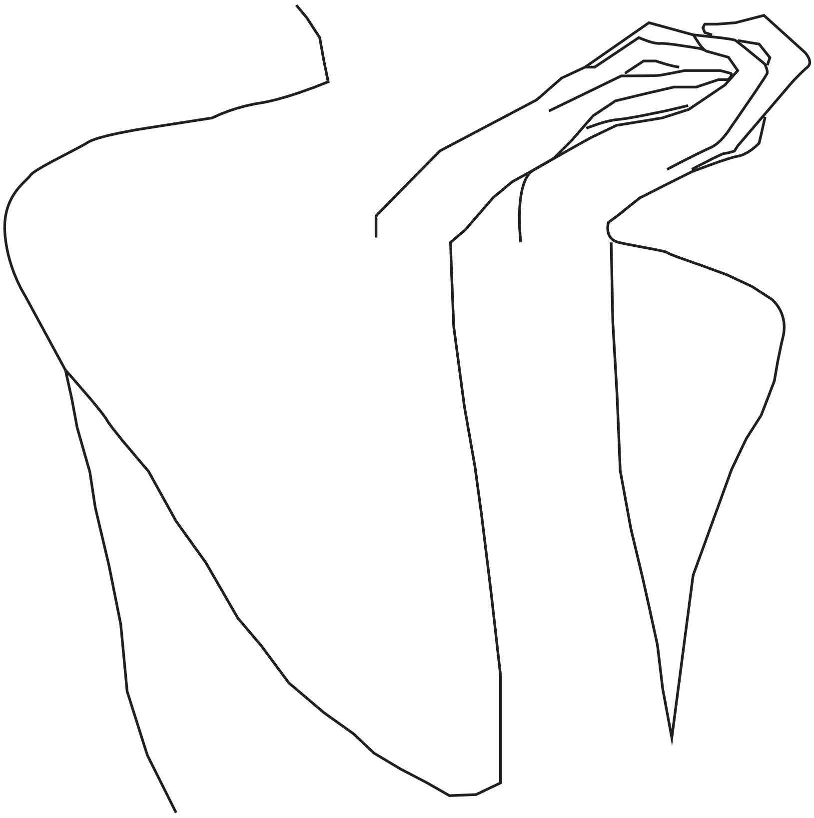

What Is Normal, What Is Healthy?
A Comparative Study of Anorexia Nervosa Through the Lens of Autobiographical Illness Narratives

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Preface

The A-Word. That was the title for a personal essay I wrote for a creative writing course during my BA, nearly three years ago now. At the time, I was a few months into my treatment programme for anorexia nervosa and had, in those summer months of writing character descriptions, plot twists and short stories, suddenly decided to write about the most intimate part of my life for the final assignment. Naturally, I was nervous. After all, someone would have to *read and grade* the thing, meaning that my secret would be 'found out' and evaluated. Yet I do remember that once I had handed in my portfolio, a feeling came upon me that I had not felt in a very long time: the teensiest tiny sense of pride. I had managed to put into words how I felt as a recovering anorexic, and I was not even disgruntled with the result. Writing that essay was quite a turning point for me. Even though I would be in treatment for another two years, and would relapse from time to time too, the act of sitting down and thinking and writing about what was at that point my main occupation in life, was incredibly valuable. I learned a lot, not just through reading texts about anorexia for research, but also through re-writing my many drafts. A lot has changed since then, but as I read through the essay I still recognise many of the feelings I attempted to express. I still feel very strongly that the stigma around anorexia is damaging for those who live with it. I still feel that the word anorexia, as a category or label, does not do justice to those directly associated with it. I still believe that anorexia is more than a stereotype. I still feel that raising awareness about anorexia is necessary to counter stigma and prejudice. And I still believe that taking consideration of people with personal experience with anorexia is paramount to doing that responsibly.

Three years on and I have envisioned another personal project: to write my MA thesis about the lived experience of anorexia nervosa. But this time, I am interested in the experiences of others. After all, I have hardly been the only one. To the contrary, in fact: anorexia has been described as a recent epidemic (see, for example, Gordon 151-161). And even though this description is based on data of people diagnosed with the same illness, their experiences are bound to be completely different, as anorexia manifests itself in highly individual ways. That is, at least, my starting point for this research project, which will centre on the variety of lived experiences of anorexia, the ways in which these interact with the several discourses (academic and societal) on the illness and the hegemonic medical model, and what this ultimately means for our common understanding of anorexia.

The incorporation of narratives of people with (a history of) anorexia in research is not new: in fact, I shall be referring to various types of research that use interviews with or survey responses from (recovered/recovering) anorexics as their primary data source (e.g. Orbach, Tierney 2001, Easter, Fox et al., Garret 1998). However, even though anorexia memoirs and fictional accounts of the illness have been emerging in great numbers and have become a genre in their own right, these narrative accounts have not yet been considered proper research material for discussions of anorexia within academia. This is quite surprising, because they have so much to offer (Power et al. 40). There are, of course, constraints in using autobiographies to investigate the lived experience of anorexia: there are slippery elements to it, such as the notions of truth and memory (Power et al. 40, Smith & Watson 22-28, Hawkins 225). I do wonder, however, if this outweighs its benefits in comparison to those of interviews and survey responses; after all, as I have myself experienced, there are succinct differences between telling your story ‘spontaneously’ to another person, answering questions online, and taking the time to reflect on the illness experience and its effect on your life. I seriously doubt if the last is actually a less reliable source of information. This is not to say that processes such as selecting, editing, restructuring and polishing should not be accounted for, but I do think that anorexia memoirs deserve more attention. So I have selected three memoirs that will take centre stage in this research project, and I intend to show their strengths.

Introduction

- “Induce a coma, hook her up to an IV, put her on a feeding tube and give her another chance.”
- “I will never ever understand why so many people who said they loved her still let her die.”

Emma Caris wanted to live. So much so, in fact, that through filming or allowing the filming of the last stages of her anorexia nervosa, she tried to find the strength and motivation to recover. She wanted to use this footage for a documentary about anorexia that was meant to raise awareness: depending on the outcome of her treatment, she wanted to either give hope of recovery or caution a warning. Unfortunately, it became the latter, as she passed away at age 18 after over six years of treatment. Although her recovery attempt ended tragically, her wish did come true: Jessica Villerius was approached to make a documentary about Emma’s life with anorexia and her recovery process. This documentary, aptly titled *Emma Wil Leven (Emma Wants to Live)*, aired on Dutch television in November 2016. In it, Villerius brings together interviews she held with Emma’s parents, best friends, pediatrician, and other counsellors and carers. These are mixed with Emma’s autobiographical footage, in which she reflects on her anorexia and treatment, which she nearly always does in a cheerful way. Her hope of recovery and jokes about her difficulty getting better are, perhaps surprisingly, the lightest parts of the documentary, and provide a break from the sorrow that underlies most of the interviews.

The documentary caused quite a lot of uproar, both in the Netherlands and abroad, as the statements cited above reveal: they are just two responses to the English version of the documentary found on the Amazon website as part of reviews, and make apparent the fierce reactions it caused in viewers. In the Netherlands especially, Emma’s story came as a shock to many people, and a review of the documentary made the front page of one of the country’s national newspapers (the *Volkskrant*). It also occasioned a ‘special’ on one of the largest national television channels (NPO3) in which both the documentary and anorexia in general were elaborately discussed. Interestingly, this special used Emma’s illness experience as a springboard to understand anorexia, looking at it from a pedagogical perspective: Emma’s story was taken as exemplary and used to see what could be learned from her experience and that of the people she loved, with the aim to come to some sort of tentative conclusion of why anorexia is so difficult to treat. In this way, Emma’s story became the warning she had wanted it to be in case of her early death, as the media attention that followed the documentary and television special focused primarily on how dangerous anorexia can be and how recovery, even though very difficult, should at all times be attempted. Through Emma's documentary, anorexia was suddenly given much more attention, and her story reportedly even shocked some anorexics into a try at recovery; the Human Concern foundation, where Emma was last treated, received a disproportionate number of applicants in the weeks after the documentary was broadcast (Oosterom).

Something else that was given much attention in the *Volkskrant* review, the television special and the international online reviews was the termination of Emma's treatment at such a young age. As her pediatrician explains in the documentary, she and her medical team were facing 'the devil's dilemma' when Emma, still underaged, was put under judicial authorisation and made to undergo force-feeding and forced bedrest, which Emma absolutely abhorred, as her best friends confide to Villerius. Emma's reluctance was difficult for the medical team, but they did not want to let her die on their watch and therefore proceeded. When consecutive years of forced treatment did not work, however, Emma was discharged from the hospital and granted her wish: to go to Portugal and undergo treatment at Human Concern, a Dutch eating disorder organisation that works with 'ervaringsdeskundigen' (loosely translated as experience experts) who have themselves suffered and recovered from an eating disorder and use this experience to facilitate treatment and psychological support. The footage of Emma's time there is touching; she is cared for with so much love and devotion, which inspires in her a strong desire for life and recovery. She is also, however, visibly deteriorating, and in the end, this decline in health is fatal.

The comments from the Amazon reviews quoted at the beginning of this introduction reveal a dominant sentiment in viewers when finishing the documentary: an incomprehension at the doctors' and parents' decision to grant Emma's wish and stop forced treatment, for, as the first comment makes clear, then she would have had another chance whereas now, following the second comment, she has just been left to die. It is perhaps no wonder that the documentary raised ethical questions such as this one. After all, as Emma's pediatrician also indicates, the medical team's decision to forego forced treatment can be considered controversial, especially in the case of a young girl. Yet this in itself also produces questions. For example, what does this controversy say about how anorexia is understood in society? What does this tell us about conceptions of mental illness generally? What role do cultural representations of anorexia play in the construction of the societal understanding of the illness? And how do underlying notions such as health, illness, normalcy and difference manifest itself in such a public debate?

It is this latter set of questions that I am interested in because, although I understand the general sentiment regarding Emma's forced treatment and its termination, I do believe there is more to it than that she was simply 'left to die.' An additional ethical difficulty in watching the documentary is that even though Emma shot footage of herself during her recovery, it was only after her death that Villerius was approached to make the documentary. Hence, the documentary tells Emma's life story but she is not able to speak for herself, which complicates the interpretation of her illness experience. This in turn makes a comprehensive understanding of anorexia and its treatment methods difficult. After all, the viewer comes to know about Emma's anorexia mainly through images and descriptions of other people and only occasionally through her own voice. Then again, as the comments quoted above show, it is questionable whether a more autobiographical narrative in the documentary would have made a significant difference; Emma's mind is considered to be in a defunctive state, and she herself incapable of making responsible decisions regarding her health and well-being. This sweepingly declares Emma to lack any form of rationality and eliminates her agency. How, then, to navigate among these varied positions? How to interpret cultural representations of anorexia such as *Emma Wil Leven*, and how to understand the underlying notions that enable such interpretations?

In this research project, I will attempt to make some sense of these ambiguities surrounding anorexia and its representation in cultural artifacts, investigating the different theoretical frameworks in which it is understood and situating these interpretations and explanations of the illness in the larger fields of disability studies and mental illness studies. I will then relate these theoretical understandings to the representation of the lived experience of anorexia in three different autobiographical illness narratives (memoirs) written by recovered/recovering anorexics. Due to the difficulty of the recovery process from anorexia, and due to the contestation that surrounds the notion of recovery within disability and mental illness theory, I cannot classify these memoirs easily as written by 'recovered' or 'recovering' anorexics. Hence, I have used the construction 'recovered/recovering', as it is only in the third chapter that I will be able to address this issue adequately. The memoirs will be analysed by using autobiography theory and be considered within the discourse of the illness narrative in order to do justice to their literariness and to ensure responsible readings that take into account this literariness as an important interpretive factor.

The anorexia narrative has become quite an elaborate genre. One of the earliest and most famous renderings of anorexia is the fictional *The Best Little Girl in the World*, a young adult novel published in 1978 and written by the American psychotherapist Steven Levenkron. It received quite a lot of attention, especially after Levenkron's most notable client, the singer Karen Carpenter, died of complications from her anorexia in 1983. Hers was one of the earliest well-known celebrity cases of fatal anorexia and brought the illness to the fore in Western society. In terms of (auto-)biography, the genre has certainly expanded. A search of the Waterstones UK website for 'anorexia' filtered for 'biography/true stories' yields 32 results. A similar search on Goodreads produces even higher numbers: 30 anorexia 'stories,' 11 anorexia memoirs and 2 anorexia autobiographies. Featuring most prominently in these searches are *Brave Girl Eating* by Harriet Brown, *Wasted* by Marya Hornbacher and *An Apple a Day* by Emma Woolf. A Goodreads search for young adult eating disorder fiction comes up with 132 literary works. Of the latter category, *Wintergirls* by Laurie Halse Anderson has the highest score and is most widely read, even though it has been reviewed as highly triggering by people with eating disorders. Most of the books that come up during these searches have been published relatively recently; in the 2000s and 2010s. Of this substantial and ever increasing collection, I have chosen three memoirs that I believe will provide the most insightful accounts with regard to the aims of my research project. It should be noted that all three were written by well-educated white women from Western and English-speaking countries (the US and the UK), which means they do not represent the ethnic, class and gender diversity of anorexia sufferers. I have selected them because even though these three authors approach the same illness very differently, they all combine personal experience with (academic) research; this way, they can be compared in how they interact with the various theoretical frameworks, as well as in their individual ways of narrating their stories and conceptualising anorexia.

The earliest memoir I will discuss is Marya Hornbacher's *Wasted* (1998), which was highly successful upon publication, nominated for a Pulitzer Prize, and which is still considered a canonical work within eating disorder literature (which my Goodreads search corroborates). It was written in a US context, published when she was only 23, and covers Hornbachers' experience with anorexia and bulimia from a very young age. In her memoir, she relates the story of her life while actively engaging with various theoretical discourses on anorexia (primarily psychological and feminist). Hornbacher has undergone extensive treatment for her anorexia; she has been "hospitalized six times, institutionalized once, had endless hours of therapy, been tested and observed and diagnosed and pigeonholed and poked and prodded and fed and weighed for so long that [she had] begun to feel like a laboratory rat" (Hornbacher 3). She therefore has quite a lot to say about institutionalised processes of recovery. She also explores in great detail how her eating disorders gradually took shape, what their possible source(s) might be, how she experienced treatment, and how she feels about herself now. Significantly, while Hornbacher was still in recovery while writing *Wasted*, a reissued version came out in 2014 with a new afterword in which she elaborates on the possibility of a full recovery and her own route back to health. This makes for an interesting contrast with the way in which her memoir initially ended, namely on a rather negative note.

Kelsey Osgood's *How to Disappear Completely: On Modern Anorexia* (2013) was similarly written in a US context, yet over a decade later, which reveals compelling cultural shifts when compared to *Wasted* even though many similarities remain. Osgood's memoir is technically an autobiographical narrative of her experience with anorexia, yet it has essayistic tendencies: while drawing on personal experience, she openly critiques the anorexia memoirs published before hers (*Wasted* among them). Her aim from the outset is to write a narrative that does not trigger any (recovering) anorexics or anyone prone to develop the illness - her major criticism of many other memoirs is that they can be used as 'guidebooks' for anorexia - and inform any reader of the dangerous and 'contagious' nature of some of the earlier autobiographical writings. She therefore refrains from mentioning her weight at varying stages of the illness, as well as her eating habits and other rituals she carried out while anorexic. She also discusses the cultural romanticisation of anorexia, the emergence of 'wannarexia' and the pro-anorexia subcultures that have emerged in online spaces.

Emma Woolf's *An Apple A Day* (2012), finally, came into being after her column in *The Times*, in which she was tracking her recovery process, became popular. She was still in recovery while writing her memoir, which is illustrated by her ambivalence towards the process. Her recovery was prompted by her wish for a baby and her happiness in a new relationship. Nevertheless, apart from a supportive family and boyfriend and a weekly appointment with a psychiatrist, Woolf undertook her own recovery, completely free from hospitalisation, force-feeding, therapy or other treatment methods. In her memoir, Woolf pays significant attention to the biomedical model of anorexia and the illness' possibly genetic roots, while also crediting the feminist model which emphasises the contradictory beauty ideals and the focus on thinness that many women (feel they must) aspire to. Woolf writes her memoir in a UK context, and around the same time as Osgood's memoir and Hornbacher's new afterword came out.

A comparison between these three memoirs should be fruitful: all three authors have had very different experiences with anorexia, both in terms of the cause and onset of the illness and in their respective choices of treatment and stances towards recovery. Their approaches to anorexia therefore interact very differently with the academic research that has been conducted in the fields of disability studies, mental illness and anorexia, even though they share certain outlooks and feelings too. This should create a variety of illness narratives, which overlap but which do have distinguishable features and representational strategies.

My main point of interest in analysing these case studies will be the question of how the lived experience of anorexia nervosa is illustrated in different autobiographical illness narratives by recovered/recovering anorexics, and to what extent and in what way these works comply with or subvert the medicalised discourse on anorexia and disability. I will attempt to answer this throughout my readings of the memoirs by means of three more specific questions: In what ways are the notions of health and normalcy on the one hand and illness and deviance/disability on the other conceptualised in the memoirs? How are mental illness in general and anorexia specifically conceived of in the works? And how do the narrators illustrate their diagnosis, the various types of treatment they have undergone, and their eventual recovery process? I hope to be able to clearly delineate how the various theoretical approaches to disability, mental illness and anorexia can inform one another which, ideally, produces a more inclusive framework for thinking about concepts that underlie these three fields (such as normalcy, health, illness and recovery). This simultaneously enables me to approach the memoirs in a more comprehensive way. I also aim to illustrate how understandings of anorexia might be enriched and made more intelligible by taking note of autobiographical illness narratives of (former) sufferers.

As mentioned before, I will combine disability theory and several explanatory models of anorexia with theorisations of autobiography and the illness narrative. The starting point for my delineation of the field of disability studies will be the idea of the norm. Lennard J. Davis traces the history of this term to around 1840 (3), and links it to the emerging interest in statistics and eugenics in the 18th and 19th centuries (6). In a similarly historic vein, Vic Finkelstein relates "the increasing dominance of large-scale manufacture" (12) in early industrial society to the importance of normativity and the normal body. The creation of the norm simultaneously brought into being deviance, difference and disability (Davis 7). This scientific, biogenetic approach to difference is called into question by the currently dominant social model of disability within disability studies, which sees the problem in “the way that normalcy is constructed to create the ‘problem’ of the disabled person” (Davis 3) as “the meaning of disability is determined by the way our society is organised” (Finkelstein 11); hence, “[t]he primary object of critique is the body of knowledge and practices which constitute disability as an asocial and apolitical condition of lack and inability” (Titchkosky 2000: 214). However, the medical model of disability still holds sway in society at large (Titchkosky 2003: 162), placing the ‘problem’ within the body of the disabled person; in “the body gone wrong” (Titchkosky 2000: 198). There is, however, an almost unilateral focus within this field on the physical body and, thereby, on physical disabilities, leaving mental illnesses out of the picture. Although they are classified as disabilities, which allows welfare states to provide services to all who need them under one homogenised category, mental illnesses are distinguished as different, both by those with (physical and mental) disabilities and societally (Beresford 2000: 169). The social model of disability, which sees disability as a construct, can function as a bridge between the two (Beresford 2000: 170).

A further complication arises when addressing anorexia specifically; just as mental illness is considered the odd one out in disability studies, so anorexia (or eating disorders generally) occupies an ambiguous place within the category of mental illness (O’Hara and Smith 45). This may have to do with the two types of stigma that Michele M. Easter outlines with regard to eating disorders: the first is the stigma surrounding disability and mental illness in general, which can be considered in the traditional sociological sense of a “mark” that “[taints]” an individual’s identity (Goffman 131) due to its deviance from the norm, whereas the second is a “’volitional stigma’” (Easter 1409) which “involves the ‘trivialization’ of eating disorders as behavioral choices rather than serious mental illnesses” (1409). This latter type of stigma makes it difficult to place anorexia smoothly in the category of mental illness, and, in addition, “negatively impacts patient care” (O’Hara and Smith 45) as well as attributes a significant amount of responsibility to the anorexic, who is in effect blamed for her/his condition (Crisafulli et al. 333).

Separately from disability/mental illness studies, there are four main explanatory models of anorexia – biomedical, psychosocial, sociocultural and feminist. The biomedical model, still hegemonic in health care practice, is based on the diagnostic criteria of anorexia as stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which include “persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape. The individual maintains a body weight that is below a minimally normal level for age, sex, developmental trajectory, and physical health" (APA). Within this model, there are a range of physical symptoms (such as BMI) that are required in order to meet these diagnostic criteria. Anorexia is considered a disease with a biological cause which can therefore be cured. The treatment emphasises a normalisation of the emaciated body and consists mainly of an increased food intake in order to gain weight. The psychosocial model, on the other hand, does away with the idea of anorexia as a problem within the patient's body and stresses psychological underpinnings such as developing sexuality or difficult family dynamics (e.g. Bruch; Berg et al.), leaving the treatment method largely the same but adding a more empathetic approach. The sociocultural model similarly focuses on anorexia as lying outside the patient's body, placing the root of the problem in the almost obsessive focus in Western society on thinness, which is aggravated by the media, and the resulting boom in dietary practices (e.g. Gordon 153-4): this model sees disordered eating practices as existing in a continuum, with "the clinically identified cases representing the extreme end" (Gordon 154). The feminist model, finally, builds on the psychosocial and sociocultural models but emphasises the meaningful underpinnings of thinness in Western society and relates this to women's subjugation to patriarchal norms (e.g Bordo 1993; Malson 1998; Orbach 1985), considering anorexia to be "an extremely complicated response to a confusing social role" (Orbach 1985: 129).

The hegemony of the medical model in health care practice results, among other things, in the "[depersonalization]" (Hawkins 2000: 223) of the patient and her/his story, which, according to Anne Hunsaker Hawkins, explains (in part) the relatively recent birth of the illness narrative in the Western hemisphere, as it provides patients with the agency denied them by the medical system (2000: 223): by writing illness narratives, patients can take back control over their life story and express this story through their own linguistic means. An important feature of the illness narrative is the possibility to create a "world of illness" (Radley 779), which enables this narrative to be not just a story about illness but also a window into the experience of living in/with an ill body or mind; the illness narrative often provides an alternative perspective on concepts such as health and illness. As a recent literary phenomenon, the illness narrative provides important insights for the comparison between the three memoirs I have chosen, as it foregrounds the relationship between narration, healing and the self within the context of illness and disability, thereby enabling me to analyse the narration of lived illness experience.

I will use autobiography theory in order to more fully explore the texts themselves and their readings as phenomena imbued with meaning. This way, I can analyse the memoirs not just as illness narratives, but also as what they are technically classified as: autobiographies, or life writings. Central to theorising life writing is the idea that "subjects [...] write simultaneously from externalized and internal points of view, taking themselves as both subject and object [...]" (Smith and Watson 5). This distinction should be kept in mind, as it affects the truth value ascribed to autobiographies; it emphasises that even though the works may be written with the best intentions and most scrupulous memory recollection, it is nonetheless a mediated experience. An important aspect to this is the slippery nature of narrated memory, as this is "an interpretation of a past that can never be fully recovered" (Smith and Watson 22). In addition, autobiographies are written with an audience in mind, and thus "life narrators address readers whom they want to persuade of their version of experience" (Smith and Watson 7). The relationship between author and reader is perhaps best captured in the notion of the "autobiographical pact" (Lejeune 14) which stipulates that the author's name on the title page and the protagonist of the autobiography are the same person. If this is the case, "we read differently and assess the narrative as making truth claims of a sort that are suspended in fictional forms [...]" (Smith and Watson 11), because "autobiographical narrators are expected to remain faithful to their personal memory archives" (ibid., 12). This faithfulness "can be neither fully verified nor fully discredited" (Smith and Watson 16) and invites theories of stigmatisation of mental illness when addressing the anorexia memoirs specifically: can these memoirs be easily placed within the category of autobiography or illness narrative, given that the state of mind of the author can be called into question by the reader? And does this entail a different responsibility for the authors' authenticity, due to the taboo nature of their subject and, by extension, their selves?

In theorising disability, I will be working primarily with the social model within this field, thinking through concepts such as the norm/normativity/normalcy, difference, illness, disability and health. Tanya Titchkosky's work, especially, will be useful when addressing the phenomenology of disability and the relationship between disability/illness and the self (as in her *Disability, Self and Society*), as well as the way in which disability manifests itself through textual mediation (as in her *Reading and Writing Disability Differently*). Working out of this general social framework, I will discuss how mental illness and (physical) disability differ, especially in how they are stigmatised, and how they are, or can be considered, similar. Michel Foucault's *Madness & Civilization* can then aid me in placing the gradual stigmatisation of mental illness in Western society in a historical framework.

Of the explanatory models of anorexia, I will especially employ the sociological and cultural-feminist readings; the former primarily in the understanding of Catherine Garrett and the latter mostly through Susan Bordo's and Susie Orbach's work. I will also discuss a more controversial and recent explanatory model; the pro-ana, or pro-anorexia, model, which has been discussed in various fields but most comprehensively in the work of Karen Dias and Nick Fox. In addition, I will use Joan Jacobs Brumberg's outline of the history of anorexia in her *Fasting Girls* in order to provide a wider framework in which to interpret the illness. Apart from the memoirs, I shall also be making use of various types of research (sociological, literary, feminist, nursing) that have been written by people with a history of anorexia and who often, even if just in a few words, mention this history in their work. It should be noted up front that I in no way mean to discount or minimise research or knowledge about anorexia that has not been written by someone with personal experience with the illness. In fact, some of the works that have been instrumental in shaping my view of anorexia and that I will be using throughout this thesis have been written this way. However, I do believe that knowledge produced by former anorexics, academic or not, is necessary in order to adequately form an understanding of the illness.

In my discussion of illness narratives I will primarily employ the work of Thomas G. Couser, Anne Hunsaker Hawkins and Alan Radley, as they outline in detail how this genre came into being and identify its characteristic features. In relation to the anorexia memoirs specifically, I will elaborate on Catherine Garrett's argument that autobiography is central in understanding anorexia and recovery. For my theoretical framework on autobiography, I will mainly use Sidonie Smith and Julia Watson's delineation of the core concepts they have identified for autobiographical writing: memory, experience, identity, space, embodiment and agency (21-22). I will use these ideas to think about the relation between illness narrative and autobiography and the way in which notions such as a liveable (and narratable) life and truth may vary within these related but different frameworks.

My thesis consists of three main parts. The first is a delineation of the state of the art, or rather: states of the arts, as I will be combining theories and concepts from the fields of disability studies, mental illness, anorexia and autobiography/the illness narrative, all of which are also highly diverse themselves. In outlining my framework, I hope to provide a clear foundation for the analysis of the memoirs and, consequently, the answering of my research questions. The second chapter will focus on the notions of illness and diagnosis as they are illustrated and conceptualised in the memoirs. In this part, I will look at the representations of the lived experiences of Hornbacher, Osgood and Woolf and relate them to various theoretical concepts. In the third and final part I will focus on the ways in which recovery is conceptualised and represented in the memoirs, and to what extent these narrated personal experiences challenge medical interpretations of health and recovery. In this chapter I will also address the structural organisation of the memoirs and larger narrative questions (such as narrative intent), as recovery and narration are intricately related. By structuring my thesis in this way, I can cover the entire illness experience in a somewhat chronological order.

Finally, I should briefly address my use of terminology. Some writers, like Hornbacher, use anorexic as an adjective to describe "a type of behavior" (2) and use anoretic as a noun for "a person diagnosed with anorexia" (2), which, technically, is the proper way of distinguishing the behaviour from the person. However, I will not be making the same distinction, as hers is one of the very few works in my corpus that does this consistently. Hence, for efficiency's sake, I will use anorexic for both, as this seems to be the custom in more recent writing and theory, but will make clear each time how it is meant. I have also described anorexia as an illness, which, for now, I will continue to do, but I do intend to complicate this equation when outlining my theoretical framework.

Ideally, comparing the memoirs and situating them in a diverse theoretical framework will make (at least a bit) more understandable what it means when a person lives or has lived with anorexia, what this illness experience entails for their sense of self, what the autobiographical narration of anorexia says about how the illness is understood by (former) anorexics themselves and what we can learn from this. In addition, I hope that through my analysis of these cultural representations, I can begin to uncover some of the underlying structures that determine how anorexia, or (mental) illness generally, is perceived. That is, what it means to speak of a normal or healthy body, and where the dividing line between ill and not-ill, normal and abnormal, is situated at the moment in time when these memoirs were written (and read).

Theoretical Concerns: How to Understand Anorexia and Its Lived Experience?

In their memoirs, Marya Hornbacher, Kelsey Osgood and Emma Woolf all put forward various ways in which to understand anorexia as it is lived or has been lived by them in their day-to-day life. These testimonies to illness both conform to and challenge general ideas about anorexia that have been thought up over many years and in various fields. In order to show to what extent these authors have produced subversive autobiographical illness narratives, I will first outline some principal concepts and ideas propagated by theorists working on disability, mental illness or eating disorders, and then delineate critical notions regarding autobiography and the illness narrative that will aid me, in the two consequent chapters, in reading these memoirs with a focus on representations of illness, diagnosis and recovery.

Disability Studies: An Investigation into Normalcy and Difference

In the introduction to *The Disability Studies Reader* (2013), Lennard J. Davis writes that "[t]o understand the disabled body, one must return to the concept of the norm, the normal body" (1). This sounds simple; after all, what could be more straightforward than the normal? As Davis moves on to show, however, the idea of the norm has not always been around, as is often assumed, but is rather a product of the emerging interest in statistics in the nineteenth century, the first recorded use of the term dating to around 1840 (ibid). This sudden development in statistics was related to the upcoming ideas in the eighteenth and nineteenth centuries about "nationality, race, gender, criminality, sexual orientation, and so on" (ibid). There was a need to map the population "into standard and nonstandard subpopulations" (3) for, in light of the advent of industrialisation, the working force had to be measured in terms of fitness for work (a feature not determined solely by physical traits, as the socially constructed categories listed earlier show). This relation between normality and the rise of industrial societies can be traced back to Vic Finkelstein's work, in which he argues that "the increasing dominance of large-scale manufacture" (12) occasioned a rise in industrialised work places which meant that buildings, equipment and technology, as well as public transport systems were constructed on the basis of the standard subpopulation; on the normal/normative body (ibid). Finkelstein stipulates that with the normal body as measure for employment suitability, the unemployed were categorised as either "infirm" or "indolent" (ibid). This categorical distinction required "diagnostic experts (doctors)" (13), who in distinguishing the infirm from the indolent initiated the practice of "classifying and interpreting disability in medical terms" (ibid). This medical, depersonalising process is similar to what Michel Foucault outlines in his history of mental illness within Western society, and to what Peter Beresford characterises as the major criticism voiced by the psychiatric survivor movement, as I shall discuss later in this chapter.

The statistical roots of this classification process carried the implication that the majority of the population was conceived of as the norm in the shape of the bell curve. Every extreme on this curve was considered deviant (Davis 3), which created "the 'problem' of the disabled person" (1). Davis explains that this scientific approach to the human body resulted in that the body of "the average man" (2) became "a physically average and a morally average construct" (ibid). This combination of a normalised physique and morality made the average body "paradoxically a kind of ideal, a position devoutly to be wished" (ibid). The dogma of the norm or normal, then, seems to spring from this history in which the norm and the ideal are intimately linked and, effectively, inseparable. This was reinforced through the rise of eugenic philosophy and its aim "to norm the non-standard" (3) through the eradication of difference and by constructing a hegemonic image of the average body. This hegemony of normalcy, Davis emphasises, maintains its power due to the continual emphasis on the normal in everyday life, which simultaneously demeans or marginalises deviations from the norm on a daily basis (12).

These two historical perspectives on the norm exemplify a key feature within the social model of disability studies, namely that normalcy (and, by extension, disability) is a social construction. This is an important insight, because the dogma of the norm generally comes with a substantial stigma for the deviant: in his work on stigma, Erving Goffman contrasts the general population, the "normals" (132), with the not-normals, who are stigmatised. This results in the social fact that an abnormal person is now "reduced in our minds from a whole and usual person to a tainted, discounted one" (131) and that effectively, this person is dehumanised (132). This equation of the normal with the human and of the abnormal or disabled with the non-human can result in "varieties of discrimination through which we effectively, if often unthinkingly, reduce his [the disabled person's] life chances" (ibid). In this way, when receiving the label 'disability', part of a person's life narrative is presupposed by her/his environment, which is due to the historical associations of disability with lack or deficiency. A reversal of such associations requires a shift in language use when discussing disability, both in self-representations of different embodiment and in cultural representations more generally.

The stigmatisation of disabled people is not limited to practices of discrimination and lessened social, economic and professional opportunities. As Jenny Morris makes clear in *Pride Against Prejudice* (1991), a perhaps more serious concern for disabled people is "the internalisation of *their* values about *our* lives" (13; original emphasis) that follows stigmatising practices, which can damage a disabled person's ideas about her/himself and other disabled people (13; see also Titchkosky and Michalko 135). Moreover, the "stigmatizable attributes" (Coleman 141) of a society may vary depending on the social context. In this way, like the normal, whatever is considered abnormal and prone to stigma can change over time and differ across cultures (ibid). This again underscores that rather than inherently 'off' or 'wrong', the disabled person is subjected to cultural and societal values which determine whether or not he or she falls outside of the standard subpopulation.

In this way, the idea that "the meaning of disability is determined by the way our society is organised" (Finkelstein 11) is central to the social model of disability studies. In this model, the attention is explicitly pulled away from the individual disabled body and is refocused instead on precisely those societal practices which stigmatise disabled people as different. That is to say, it is the social response to disability and the stigma that surrounds it that are essentially disabling; more so than the impairment or disease that the disabled person lives with (Garland-Thomson 1567). These stigmatising practices are not limited to overt and explicit discrimination, such as those described by Goffman. Rather, it is the "taken-for-granted" notions that underlie the distinction between normal and abnormal and the manifestation of this dividing line in everyday life that are truly problematic (Titchkosky 2003; 17, 172, 214).

Tanya Titchkosky points out that the societal focus on the normal has to do with a form of pragmatism, which is based on the assumption that "disabled people are best understood as measurable objects of limit and lack" (2003: 56). This measurability is derived from the field of medicine - as Finkelstein's and Davis's historical accounts make apparent - which similarly conceives of the disabled body as a calculated sum of certain deficiencies or absences. This biologically based pragmatism pervades societal structures and the direct environment in which disabled people live their lives. Titchkosky observes that the social environment is generally designed for normal bodies, which creates a version of the disabled person as "unintended and unexpected" (2003: 121). At the same time, the notion of normalcy is hardly ever questioned or investigated (ibid., 123). Because of this, even movements against discrimination, which “frame equality as sameness” (Gedge 233) might thereby (unthinkingly) “applaud or even impose conformity” (ibid). Illness narratives form a good example of challenges to this generally unquestioned normalcy, particularly in their subversion of the able-ist language that is common in medical discourse (e.g. the ‘indolent’ and ‘infirm’ in Finkelstein’s historical account).

The practice of conceiving disability as a problem of the disabled individual, a problem, moreover, that is located “*in* bodies that have gone wrong” (Titchkosky 2003: 17, original emphasis), is all too present still. The social creation of the impeached disabled body leads Titchkosky and Rod Michalko to write that “[d]isability is not only a problem that some of us have, we are also *the* problem that others have” (134; original emphasis). This statement makes understandable Morris’ description of internalised negative feelings about disability: the relation between ‘normals’ and ‘not-normals’ is unbalanced, as having a ‘flawed body’ is equated with being a ‘flawed person’. This is because disability is interpreted as “essential inferiority” rather than “human variation” (Garland-Thomson 1567). Moreover, the long-standing influence of the medical field on the disabled body has meant that disability has generally been considered in need of a (medical) solution. This implies disability is an undesirable position, which stems from the common conception of disability as “personal tragedy” (Titchkosky 2003: 213) - a circumstance that can only be defeated by sheer human willpower.

The narrative of disability as tragedy does two things at once: it both obscures the fact that disability is the fate of every aging body (Titchkosky 2000: 216) and it makes explicit the extent to which general conceptions of disability rely on the Cartesian mind/body distinction and the dominant power of the former over the latter. This rule of the mind in the tragedy narrative is corroborated by the medical discourse on disability, which is similarly based on the idea that bright minds in the field of medicine can remedy any bodily complaints people might have (and that such solutions are always welcome). In this way, both the ill or disabled person and her/his body are disregarded, as they are not considered (equally) knowledgeable. Alternative narratives, which represent the ‘different’ body as valid and intelligent, can expose this marginalisation and the stigma that underlies it.

In such cases when medical solutions are insufficient, as is the case with instances of permanent disability, a popular solution is “normalisation which takes shape through remedial treatments such as rehabilitation, special education [...]” (Titchkosky and Michalko 133). Although this is certainly a modernised version, it is still reminiscent of the eugenic project of norming the substandard: the imperative to be normal or to appear so still holds sway. This latter option, a feigned normalcy, is often put into practice in the form of 'passing'. Titchkosky explains that in the case of invisible disabilities, no connection is made by outsiders between the identification as disabled and the person that is perceived: passing entails "the performing of an identity in regards to which a person has no taken-for-granted connection" (2003: 170). This is based, in turn, on an unspoken societal 'taken-for-granted' expectation: "that you are who you appear to be" (Titchkosky 2003: 172). Thus, performing a clearly demarcated identity is a strong societal requirement, the success of which is judged generally by means of first impressions of the physical body. Should the body deviate from the norm, then it 'appears to be' disabled and is equated with a disabled (flawed) person. If not, any made or perceived connection to disability will be considered odd, or questionable. This also makes understandable the appeal of passing as normal: when successful, it can mean a serious improvement in social position and participation opportunities (Titchkosky 2001: 134). Passing exemplifies, to my mind, what Peter Beresford describes as the internalisation of medical discourse and the general representation of disability as unwanted (of which more later).

The commonly reiterated dynamic between disability as problem and the process of solution-seeking reinforces the idea that disability is not part of a person's embodied experience but that, rather, it is "an add-on" (Titchkosky 2007, 9). This empties the experience of disability of any personal, social, historical or political meaning (ibid., 38) and it effectively means that "[d]isability is thus conceived of as the problem-background against which the figure of individuality is achieved" (Titchkosky and Michalko 139). This latter process ushers forth the common "overcoming narrative" (Titchkosky 2007: 179-201), which is based on the idea of disability as lack, vulnerability and essentially unwanted: as something that must, if at all possible, be overcome. This is a primary object of critique within the social model of disability studies and its aim to move away from essentialised and biologically based conceptions of identity, as in this model the focus is redirected to the interrelationality between and among people which determines the meaning of disability in society at large. Apart from being interrelational, this meaning-making process is also intertextual; the societal understanding of disability is largely constituted through texts, which often make use of able-ist values.

As a discord exists between textually and interrelationally mediated interpretations of disability and the embodied experience of being disabled, the disabled self is left in a position of “between-ness” (Titchkosky 2007: 215). This is why cultural representations that disrupt able-ist constructions of normalcy, health and illness are necessary; as the rise in illness narratives (which I will later elaborate) makes clear, the need for alternative interpretations and linguistic means that better reflect different/disabled embodiment is great. Titchkosky, as well as Morris (11-2), are exemplary in this regard, as in their theoretical work they both emphasise the importance of taking into account and valuing precisely this disabled embodiment, thereby deviating a little from the traditional social model in disability studies. Rather than focusing entirely on the socially constructed notions that dominate societal understandings of disability, they underscore the danger of the practical implication of this completely social explanation, namely, the forgetting or diminishing of disability as a different lived bodily and embodied experience. Their texts, as well as other (cultural, theoretical) representations that argue for this emphasis on lived experience and embodiment, are therefore vital in trying to bring about a shift in the language that is used when discussing disability.

Conceptualisations of Mental Illness//Difference/Distress (And the Problem of Wording)

Within disability studies, there is a general emphasis on physical disabilities. Titchkosky argues that because of this, invisible disabilities, many of which are mental illnesses, often come with the requirement of providing proof of a disabling condition (2001: 132). This entails “the reconfiguration of diverse experiences into a single organized category of identity” (ibid): if society cannot essentialise your identity on the basis of the perception of your disabled body, then you must do so yourself, since you are not who you appear to be. This practice has roots in the field of medicine, which similarly attempts to find physical proof of disability, be it physical or mental, in order to establish a diagnosis and form of treatment.

In *Madness & Civilization* (1965), Michel Foucault revisits the contemporary relationship between mental illness and medicine, tracing the history of the stigmatisation of madness to the disappearance of leprosy in medieval Europe, when many lazar houses were shut down, only to be occupied a few hundred years later by “[p]oor vagabonds, criminals, and ‘deranged minds’ [...]” (7). The confinement of the mad began at an increasingly large scale in the seventeenth century (39), initially for the cheap labour force they provided (46). Medicine first entered the realm of madness for the practice of curing, as madness was considered an error in ethics and was therefore subjected to the “operation of purification” (162). When this idea of a fault in ethical behaviour slowly shifted to “the single notion of guilt” (176), purification was transformed into “moral punishment” (ibid), for which the doctor, now the beacon of morality, was responsible (186). This development went hand in hand with the emergence of psychiatry, which would replace the “[p]hysical therapeutics” that were common before (182). Psychiatrists were to bring madmen to awareness of their own madness (264), which they did through observation (247-8), estranging the madman from himself. Observation would similarly enable diagnosis, or classification (250). Foucault emphasises that the interaction between medicine and the madman was not “a dialogue” (ibid) but rather “language without response” (251), preconditioned by the silencing of the madman (x-xi). This one-directional use of language transformed what was formerly “repression” into “authority” (ibid) within the walls of the asylum, the latter belonging exclusively to the medical practitioner. Madness thus became “a minority status” (252), as it was always subordinated to the reason of the man of medicine. Hence, “[t]he asylum of the age of positivism [...] is a juridical space where one is accused, judged, and condemned” (269). The idea of judgment, in the form of diagnosis, became so pervasive that a “medical certificate” (270) was eventually necessary for admittance to asylums. The increasing influence of medicine left its mark on the relationship between doctor and patient, too: the former would become authoritative because of his knowledge rather than because of his morality and reason and the latter would “[accept] entirely and in advance all his prestige” (275). This process would invite medical knowledge to determine the nature of mental illness (277), and reinforce the depersonalising process of diagnosis described earlier by Davis and Finkelstein.

Today, mental illness and physical disability are accommodated by the general category of disability in the administration of welfare states. Yet there are meaningful disparities between the two. One is the way in which they are societally conceived. In his research on social responses to and knowledge of mental and physical disabilities, Kristian Pollock found that among the participants in his survey, the ‘invisibility’ of mental illness was an important basis for distinction (which Titchkosky also points out when discussing the need for providing proof). As a consequence, “[...] mental illness was often thought to be unnecessary, and avoidable through sufficient effort or will” (Pollock 55). This is in line with the overcoming narrative and the strong societal hold on the mind/body distinction, which places a substantial weight on human willpower in the face of disabling conditions. As Pollock makes clear, mental illness is perceived as a failure or absence of this willpower, which implies a weakness in the person suffering from it. In fact, his respondents even characterise this individual weakness as typical of “a certain ‘type’ of person who [is] susceptible” (57). In addition, due to the invisibility of most mental illnesses there is a sense of distrust, if not in the existence of the illness then in the severity of its disablement (56). This is tied to the idea that whereas physical disability is often characterised by the tragedy narrative, mental illnesses are often perceived to be “motivated” (ibid). This carries the implication that the mentally ill person can be held accountable and, effectively, that a difficult recovery process does not always engender sympathy, as mental illness is considered at least partly ‘your own fault’. Pollock argues that it is the relation made between weakness and a certain “loss of control” (60) that is responsible for the majority of the stigma that still surrounds mental illness, and, as Donna Reeve points out, these stigmatising practices are more frequent and severe compared to those experienced by most other disability groups (Reeve 25). This can influence the potential publishing and reading of autobiographies about mental illness, as their authors may be considered unreliable, unsympathetic, or difficult to identify with.

The arguments made by Titchkosky, Foucault and Pollock reveal the pervasive tendency to medicalise (physical and mental) disability and society’s general distrust if the disability is a mental illness, especially in the absence of tangible proof. This combination of medicalisation and proof-providing can explain some of the terminology that is most common today, as well as some resistance within the field of mental illness studies against this wording. The psychiatric survivor movement is most articulate in this regard: a serious concern for those involved is the repudiation of “medical concepts of their distress” (McWade et al., 306) for they do not think of themselves as “psychologically impaired” (ibid). This criticism is primarily aimed at the fact that mental health care is still largely based on medical conceptions of illness and health, which the pervasiveness of the term mental *illness* underscores. These medicalised interpretations of individual symptoms “[are] based on a deficit model, which presumes the pathology and inadequacy of ‘the mentally ill’ and which conceptualises their thoughts, emotions, perceptions and behaviours as wrong and defective” (Beresford 2002: 582). This, as Pollock’s argument also reveals, is a consequence of the stigma clinging to mental illness, and it is more all-encompassing than that of physical disability: all aspects of a person’s self are questioned because the mind, which is generally considered superior to the body, is now seen as defective. In cases of self-representation, this can complicate the establishment of an autobiographical subject that is considered reliable, both as protagonist and as narrator.

The mental health care system and its services are in turn criticised for medicalising individuals and severely limiting their human rights (Beresford 2002: 582): the survivor element within this movement stems from the traumatic nature of the experiences of some of those who have received mental health care. In order to counter the medicalisation of individual symptoms, a range of new terms has emerged, such as "'mental health', 'mental health issues' and people with 'mental health problems'" (ibid., 581), but, Peter Beresford emphasises, the negative associations of difference remain (ibid). This tendency is so pervasive that those who are mentally 'ill' often internalise the medicalised discourse and therefore have a hard time interpreting their experiences as other than a result of "faulty genes or chemical imbalances" (Beresford and Wilson 543). Consequently, "[i]deas of *blame, shame, inferiority* and *defect* weigh heavily [...] on the identities of mental health service users/survivors" (ibid; original emphasis). Due to this medicalisation, moreover, the medical and psychiatric narrative of mental illness is hegemonic, leaving any counternarratives "not heard, overwritten, silenced, or even erased [...]" (Russo and Beresford 153), even though these alternative narratives showcase how lived experience can be a useful source of knowledge (ibid, 54). As this knowledge is still marginalised in academia, there does appear to be a window here for autobiographically structured cultural representations to pave the way in making this knowledge more readily accessible. However, due to the internalisation of medical discourse, narrators of such autobiographies may experience themselves as different and therefore have trouble unearthing an 'authentic', non-medicalised self to take centre stage in the narrative.

Another source for feelings of shame and blame is the fear of permanent disability: that with the diagnosis of mental illness, normality ends forever. The internalisation of societal oppression is especially detrimental because it is "insidious and difficult to counter because it largely acts at an unconscious level" (Reeve 25). The effect is two-fold: it both injures a person's sense and value of self as well as often increases feelings of anxiety (ibid). The medicalised and essentialised approach to mental distress and the emergence of the psychiatric survivor movement show just how narrow the conception of normalcy can be in the face of human variation, how strong the hold of it is in society and health care, and how painfully this may be experienced (which is also made abundantly clear in the memoirs by Hornbacher, Osgood and Woolf). This reveals, in turn, both how mental illness is not easily classified as disability (or illness, for that matter), and how those diagnosed with a mental illness may not want to be labeled disabled in the first place. At the heart of this matter seems to be a question of language, as these terms come with certain associations that are difficult to shed, and so alternative illness narratives may well opt for a radical shift in linguistic means as a representational strategy for portraying an illness experience.

Theoretical Conceptualisations of Anorexia Nervosa (as (Mental) Illness)

Anorexia as a symptom - lack or loss of appetite - has a longstanding history, primarily as a secondary symptom to numerous illnesses that affect the appetite or the ability to eat. As a primary symptom - unattached to a (biological) illness - the first recorded instances of anorexia in the form of food refusal occurred in the European Middle Ages, and primarily among women of religious disposition. In effect, "prolonged fasting was considered a female miracle" (Brumber 43), as these women claimed they stayed alive through other, godly means of sustenance. The exertion of restraint on the appetite and the practice of fasting had a particular resonance within Catholicism during the years between 1200 and 1500, as "control of appetite was linked to piety and belief; through fasting, the medieval ascetic strove for perfection in the eyes of her God" (ibid., 48). As such, Catherine of Siena, for example, was declared a saint. This form of anorexia was later, during the scientific upsurge in the seventeenth and eighteenth centuries, dually labeled "anorexia mirabilis (miraculously inspired loss of appetite)" and "inedia prodigiosa (a great starvation)" (ibid., 44). This diagnostic practice coincided with a shift that Joan Jacobs Brumberg characterises as a repositioning of anorexia from "sainthood" to "patienthood" (48), as by the end of the Middle Ages, asceticism was no longer seen as a female miracle but rather, "was increasingly cast as demoniacal, heretical, and even insane" (49).

The rise of the medical profession and this substantial shift in how prolonged abstinence was interpreted by physicians - as impossible, contradicting scientific fact - caused a considerable change in how later 'fasting girls' were treated. Rather than revered as holy, food-refusing young women were now put under intense scrutiny as scepticism of food miracles increased, occasioning "around-the-clock investigations conducted not only by clergymen but by civil magistrates, physicians, dukes, bishops, even kings" (49-50). This had a double purpose: the skeptics had to either prove that the woman's claim to abstinence was false, or that the anorexia was a symptom of a biological illness and thus equally unholy (52). The medicalisation of anorexia went hand in hand with the creation of treatment methods and etiology theories, the latter of which were focused primarily on connections between anorexia and other illnesses, female hysteria being the main diagnosis to which anorexia was linked as a symptom (92). In addition, the increasing emphasis on a normal body, from which the anorexic body deviated, stimulated scientists to formulate ideas about ideal body weight and food intake, which in the beginning of the twentieth century initiated the now familiar practices of matching weight to height (BMI) (231) and measuring nutritional value (calorie counting) (234). Significantly, this scientific approach to the body was intricately linked to women: as those responsible for the health and well-being of their husbands and children, women were the first to actively engage in measuring meals and the body, which was considered a great (moral) duty (235). This historical delineation also shows a reinforced impulse to establish a new form of normalcy and health, which, similar to its construction in the nineteenth century, uses medical tools.

The early form of contemporary anorexia - anorexia nervosa - emerged in the 1870s. Anorexic patients around this time were different from the medieval ascetics or fasting girls, as “[t]he sitophobe [...] claimed no special powers” (Brumberg 106). In addition, these sitophobes were exclusively young, middle-class women (108). This led William Gull to formulate the first diagnosis of anorexia nervosa, which “implied a moral or mental aberration rooted in the nervous system but exacerbated by the patient’s age, her mode of life, or both” (ibid., 111) Significantly, this meant a move away from anorexia as a symptom of an organic illness - a medical problem - and placed emphasis on the mental aspects of the condition (123), even though the treatment method still focussed on the material body and thus consisted of gaining weight through increased food intake (154). A French contemporary of Gull, Ernest-Charles Lasègue, was similarly interpreting anorexia anew but, with a background in psychology, he emphasised the relation between the development of the illness and “a broad set of frustrations that we would link with the transition to adulthood: inappropriate romantic expectations, blocked educational or social opportunities, struggles with parents” (ibid., 127). Apart from a regimen of increased food intake, Lasègue also recommended treating the fasting girl away from parental influences (154). This psychological approach, although still influential, has over time been complemented with social and cultural interpretations, as I will elaborate later in this chapter.

There is now a general consensus that the anorexia’s etiology is multifactorial; that medical (genetic) and environmental (psychological, cultural, social) factors play a role in a person’s susceptibility to develop the illness. This consensus does not extend to the general public, however. A poll which was commissioned by the National Eating Disorders Association (NEDA) in 2005 revealed that among an American adult population, the three main causes of eating disorders were considered to be "dieting (66%), the media (64%) and families (52%)" (O'Hara and Smith 44); all environmental. This corresponds to the finding that "respondents often feel that ED[1] patients 'could pull themselves together' (35%) and 'are to blame' for the condition (33%)" (ibid). Anorexia is thus not understood as a "medical condition with complex causes" (ibid). This is due to the dual stigma attached to eating disorders. The first is that of mental illness generally, such as described by Pollock, which centres on invisibility and a perceived weakness and loss of control. The second is a "volitional stigma" which stems from "AN/BN[2] being interpreted as an ongoing voluntary behavioral choice rather than as a mental illness" (Easter 1409). The idea that anorexia is a choice is also dually explained: it stems from the assumption that anorexics "behave as they do, because they are morally bad (vain, conformist, greedy for attention), and/or because eating disorders must not be so bad" (ibid). This latter assumption again underscores the fragility of mental illness' place within disability, as the severity of anorexia is clearly weighed here against the accompanying 'benefit' of being thin and is thus considered a motivated choice (something that disability is never considered to be).

This dual stigma seems to have been internalised, as anorexics consider themselves both responsible and not for their condition (Easter 1414). A proposed solution for the misconception of anorexia as behavioral choice has been to more openly communicate the physical aspects of the illness, as a 2008 study found that the emphasis on physical rather than environmental causes in communication to lay audiences can dramatically decrease volitional stigma and reduce the responsibility ascribed to the anorexic (Crisafulli et al. 337). This could simultaneously bring to light anorexia's physical ramifications, which might allow the illness to fit more easily within the category of disability, which it is classified as bureaucratically. However, as Stephanie Tierney has found in her patient-based study, the forged relationship between anorexia and disability based on physical symptoms is not without complications. Although certainly beneficial with regard to the volitional stigma and in aiding less 'conventional' patients (i.e. not young white middle-class women) to seek treatment, participants in her study expressed drawbacks, too: "self-defining as disabled was regarded as limiting one's life opportunities [...] using this term could impinge on their relationships,

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[1] ED is short for eating disorder.
[2] AN is short for anorexia nervosa; BN is short for bulimia nervosa.

changing people's views on them, positioning them as weak and vulnerable, or could jeopardise their career" (Tierney 2001:752). Moreover, opting to self-classify as disabled in order to receive benefits may not be considered a credible claim in the (not exceptional) case that "a person has a 'normal' body, but 'anorexic' thoughts" (ibid). When this occurs, even the (self-) diagnosis of anorexia or mental illness may be questioned, as the emaciated body is generally considered a trademark of anorexia and a slightly less bony frame may therefore be considered quite regular, given the societal preoccupation with body shape regulation. Moreover, an emphasis on the possible genetic causes of anorexia could increase the general stigma attached to mental illnesses and enable genetic essentialism.

The 'standardisation' of the emaciated frame as a marker of anorexia does not only occur societally, but also, and much more intensely, within anorexic 'communities'. In Eating Disorder Units (EDUs), for example, the group dynamic is often highly competitive and admittance with a relatively 'normal' body weight can result in feelings of exclusion (Segal 21). Jacqueline Segal conceptualises this as a "hierarchy" (ibid., 23), which is based on body weight, degree of emaciation, number of hospitalisations, history of force-feeding and so on, thus ranking each anorexic on the basis of their 'status'. This can result in a reversal of sorts, where admittance for recovery from anorexia can (and quite often does) result in further emaciation and illness (ibid., 34), strengthening anorexic thoughts and thereby decreasing the chance of a timely recovery (I will elaborate on this in my discussion of the memoirs). The idea of recovery in the context of anorexia is therefore not straightforward, as it stands quite apart from treatment, with which recovery from an illness usually begins. This also puts forward the question of whether the underlying conceptualisations of health and illness which these treatment forms deploy are accurate, or sufficient, as their inefficacy demonstrates a general misunderstanding of anorexia's illness experience. Segal proposes listening to those who underwent or are undergoing treatment at EDUs in order to reconceptualise recovery and emphasises the importance of autobiographical narratives in kick-starting such rethinking (3).

Within the academic (bio)medical model, there is still a heavy emphasis on physical determinants in anorexia's etiology. This focus on genetics may be due to the general ineffectiveness of treatments for anorexic patients (as highlighted by Segal), which occasions high relapse rates and a high mortality rate; anorexia has the highest mortality of all psychiatric disorders (Bergen et al., 397; Greenblatt and Delane 2). Attempts at locating a physical determinant are often aimed at improving treatment through extended knowledge of the neurological disturbances that are considered to be at the heart of anorexia's etiology.

Another motivation is the belief that the heritability of anorexia is very high (Greenblatt and Delane 6), which would also benefit from a genetic explanation and its accompanying possible cures. This biomedical approach still influences the field of psychiatry, which is now considered the authority on eating disorders, as the historical outline by Brumberg reveals. The American Psychiatric Association, producer and publisher of the widely used Diagnostic and Statistical Manual of Psychiatric Disorders (DSM), for example still prioritises weight gain through increased food intake over psychiatric treatment (Yager et al., 17), as the latter is only considered helpful once the patient has "improved mood, enhanced cognitive functioning, and clearer thought processes" (ibid.) due to nutrition; "[o]nce malnutrition has been *corrected*" (ibid; added emphasis). The phrasing here hints at the idea of a form of irrationality due to starvation, which is in line with Pollock's outline of the stigma of mental illness and which can marginalise illness narratives about psychiatric distress, as well as their authors. In the case of extremely reluctant and/or emaciated patients, the correction of malnutrition takes place through force-feeding. As it is such as invasive procedure, the appointed clinician is advised to take into account ethical and legal dimensions, the family's view and "the wishes of *competent* patients [...] intervening respectfully with patients whose judgment is severely impaired by their psychiatric disorders when such interventions are likely to have beneficial results" (ibid., 15-6; added emphasis). In the documentary *Emma Wil Leven*, discussed in the introduction, Emma was clearly not considered a competent patient in the way it is understood here, as force-feeding and forced bedrest were authorised despite her reluctance. Moreover, as Segal's observation of treatment as conducive to the formation of hierarchies underscores, force-feeding does not necessarily have a positive effect on the psychological dimension to anorexia; it may in fact only exacerbate it or traumatise the patient, making any physical improvements in terms of weight gain temporary at best.

The DSM is the most authoritative handbook for diagnosing psychiatric disorders. In outlining the requirements for diagnosing anorexia nervosa, there is similarly a focus on physical, or medicalised, aspects of the illness. The three main criteria are:

> [r]estriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health [...] Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight [...] Disturbance in the way in which one's body weight or shape is experienced, undue influence of

> body weight or shape on self-evaluation, or persistent lack of recognition in the seriousness of the current low body weight. (APA)

Apart from these requirements, the clinician must specify whether the patient is suffering from the restrictive type or the binge-eating/purging type and what the severity of the illness is at the moment of diagnosis, which is measured by means of the body mass index (BMI) (ibid). In general, anorexics can thus be diagnosed through measurable traits, both physical and mental; either in numbers, such as BMI, or relatively, in to what extent their eating behaviour and body image perception deviate from the norm. The success of recovery is similarly measured through weight gain and adapted ('corrected') behaviour.

The psychosocial model shifts the emphasis from the individual anorexic body to the social context, and to the family unit in particular. The cause of anorexia is therefore not considered to be physical, and curable through medical solution, but psychological, and formed in childhood. For this reason, psychosocial studies place much more emphasis on the patient's perspective. A 2002 patient-based study found that over a third of their participants considered dysfunctional family dynamics to be an important contributing factor to the development of their anorexia (Tozzi et al. 148). This was expressed variously as "poor parental care/childhood deprivation, parental overcontrol, poor relationship with parents, pervasive family tensions/fights, and emotional abuse" (ibid). As this model acknowledges the multifactorial etiology of anorexia, these family dysfunctions are placed within a larger social context. As the patients in the 2002 study also indicate, other perceived contributors were considered to be dieting or weight loss and stress (ibid), which often (although not always) also had causes outside the family. The incorporation of stress and anxiety in this model is often linked to personality traits considered typical of anorexic patients, such as "excessive needs for control, perfectionism, excessive needs for approval and emotional sensitivity" (Berg 37), which, in turn, contribute to an explanation of the anorexic psychology. Other causes of stress considered viable within this model are "[p]recipitating factors or stressful life events" which spark the anorexia and turn it into "a way of coping with trauma, change, conflict and developmental challenges" (ibid., 29). In addition to personal difficulties (e.g. dysfunctional family relationships or developing sexuality), credit is given to the physical ramifications of dieting, irregular eating and starving (ibid), and the often accompanying "disturbances in size awareness" (Bruch 89): this "denial of thinness" (ibid) also causes significant stress and amplifies the anorexia. Taken together, these factors "entrech the individual in the eating disorder" (Berg 29). In terms of treatment, this model still focuses on weight gain but the emphasis on psychotherapy is far heavier than in the biomedical model. In addition, the psychological treatment is more varied, involving individual and creative therapy with the purpose of constructing "a realistic body-image concept" (Bruch 90), and family therapy, as the family is considered a primary source of support for the anorexic patient, aiming at creating a thorough and empathetic understanding in the family members so that outpatient treatment has a better chance at being successful.

The sociocultural model acknowledges, like the other models, the multifactorial nature of anorexia, yet it stresses the contemporary cultural setting as an important factor. This model is the first to preoccupy itself with explanations of why anorexia is most prevalent among women (even though cases of anorexia in men are increasingly documented and studied, too). Most frequently mentioned is the contemporary beauty ideal, which from the 1960s onwards has revered ever thinner female bodies; more athletic, more toned, less curvy - more Moss, less Monroe. As Brumberg's historical account illustrates, women were, from the early decades of the twentieth century, linked to the practice of controlling the body and food intake, and this duty seems to have expanded in the post-war period: exercising, dieting and cosmetic surgery are increasingly popular solutions for attaining or maintaining a certain body shape, and the publicly reinforced thinness ideal seems to affect (adolescent) women disproportionately (Gordon 152). Dieting and a focus on thinness are thus considered strong indications of a vulnerability for anorexia. The commonality of "the relentless pursuit of thinness" (Schwartz et al., 20) in society at large is linked to the accompanying "revulsion for obesity and excessive eating" (ibid., 23) in post-war Western societies which, in turn, was enabled by the periods' growing affluence (Gordon 158). The exorbitant growth in bodily control through dietary practices and exercise regimes has been magnified by the "increasing number of often sensationalized descriptions of eating disorders in the mass media" (ibid). The growing recognition that the cultural environment from the 1960s onwards and its slenderness ideal have a part to play in anorexia's etiology and increased prevalence has also made a mark in diagnostic practices: in 1979, David M. Garner and Paul E. Garfinkel published their Eating Attitudes Test (EAT), a self-assessment test for determining an individual's eating behaviours and perceived body image, which was developed in order to incorporate the cultural interpretations of anorexia into the diagnostic model. However, the sociocultural components are mostly acknowledged to be more of a "*final common pathway* of a number of etiological factors" (Schwartz et al., 27; original emphasis), which may partly determine the illness' onset and explain its recent high prevalence but which are not the sole cause of developing anorexia. Treatment within this model is similar to that in other models, emphasising weight gain and psychotherapy.

Embedded within the sociocultural model is the feminist model, which has taken up varying standpoints with regard to anorexia. A relatively common conception of the illness is that of a protest; a power struggle waged on the site of the female body. Susie Orbach compares the contemporary anorexic to the British suffragette, linking them through the notion of the hunger strike. Although both are political, the anorexic cannot, unlike the suffragette, conceptualise her protest in any way other than through physical struggle; she cannot "articulate the basis of her cause" (1993: 85). Nevertheless, this cause can be placed within the larger protest waged in the body politic. The anorexic protest can, in this argument, be approached from two complementing viewpoints. Firstly, the position of women in Western society has been shaken during the "backlash against women and women's liberation" (ibid., xx) that accompanied the rewards of emancipatory efforts. Orbach argues that the price for these new opportunities, for "being allowed to enter the world outside the home" (ibid., xxii), has been "a continuing obsession with the body" (ibid). This process has been fuelled by consumerism, which has similarly focused on women's bodies as "very much both *commodity* and *object* for them in the world" (ibid., 85; original emphasis). Moving into the world is thus predicated on the "acceptability" (ibid) of the female body, which has resulted in feelings of non-entitlement in women who try to enter the newly accessible professional sphere. In this way, anorexia is not about appearance but about "achievement" (ibid., 91). Secondly, Orbach stresses the socio-psychological meanings underlying this obsessive body control and lack of self-worth in women, in which thinness equals a lack of female "neediness" (ibid) and fatness an abundance of it, as well as "the guilt associated with the satisfaction of those needs" (ibid). In this way, anorexia can be considered either as submitting fully to the patriarchal beauty ideal or as resisting it completely. In her gendered reading of the emaciated anorexic body, Helen Malson has used "its discursive construction as androgynous or boyish" (114) to illustrate how the anorexic can similarly be considered subversive; how through the "boyish female body" she can "signify a liberation from oppressive patriarchal gender (im)positions" (ibid). This is reinforced through "the amenorrhea-ic body" (116), or the non-menstruating body, that anorexia often produces after a certain degree of emaciation has taken place. This reading construes the anorexic body as "non-feminine" (117).

Susan Bordo takes a different approach, borrowing from the sociocultural model the idea of a continuum of disordered eating practices and emphasising that even though anorexia nervosa is a serious mental illness, the anorexic is not “the victim of a unique and ‘bizarre’ pathology, but [...] the bearer of very distressing tidings about our culture” (60). She argues that the medicalised concept of Body Image Distortion Syndrome (BIDS) as a “visuo-spatial problem” (55), generally considered an important marker of anorexia (as the DSM criteria show), is not a fruitful measuring tool, as the majority of women in Western societies are dissatisfied with their bodies and opt, at varying points in their lives, for reducing their form through either dieting or exercising (57). Hence, “the anorectic does not ‘misperceive’ her body; rather, she has learned all too well the dominant cultural standards of *how* to perceive” (ibid; original emphasis). In this way, anorexia is not an eating *disorder* per se, as the notion of disordered eating is questioned through a revaluation of ‘normal’ eating behaviour among women. Bordo locates the source of the dominant standards of beauty and eating in general cultural imagery, consumed through advertising, television, books and magazines which often reinforce the slenderness ideal and its associated (masculine) notions of discipline, liberation, strength and control. For her, then, anorexia is neither protest nor disease pur sang, as it is the interaction between culture and the individual gendered body that she considers to be the central issue. In this way, she considers the development of “psychopathologies” to be “the crystallization of much that is wrong” (141) with the culture in which they emerge, rather than deviations from the norm.

Abigail Bray offers a critique of the sociocultural approach to anorexia as stemming from the slenderness ideal and the latter’s hegemonic presence in most forms of media. She uses the term “eating/reading disorder” (421) to designate the conception of media consumption as “[facilitating] autophagy” (ibid), arguing that such a direct causal effect does not take place and that, moreover, the assumption that it does configures both anorexics and ‘normal’ women with body image issues into “weak-minded, docile bodies” (420). The idea of the eating/reading disorder is not corroborated by all sociocultural theorists, as the concept of a final common pathway makes clear. Yet Bray’s argument does contribute to a more critical interpretation of the sociocultural model’s conception of media consumption, as she emphasises, I think rightly, that a too facile jump from the increasingly strong thinness ideal to the recent high prevalence of anorexia is easily made, and has serious implications.

The most recent and controversial explanatory model is the pro-anorexia model, which is based on the pro-ana movement that has emerged in online spaces over the past few decades. Integral to this model is that “anorexia is perceived as a symptom of a more deep-seated life disturbance” (Fox et al. 954) and that it “contributes to a sense-of-self” (ibid). On online pro-ana forums, anorexics commonly share their progress in losing weight and post “thinspiration” (ibid., 955); pictures of thin bodies that the forum users can aspire to. These websites are often used either as dieting guidebooks (by users who may not necessarily suffer from or develop anorexia nervosa) or “as a means of supporting individuals with a disease” (ibid., 957). Although the pro-ana movement has been highly criticised, resulting in the censoring and forced removal of many of the websites, new ones keep emerging, and it has been suggested that the presence of these online communities may be integral to those forum users for whom “anorexia [can] not be simply discarded at will like a diet” as “it [is] symptomatic of underlying pain and a need to exercise control” (ibid., 958). From this viewpoint, the pro-ana community can become “a refuge for anorectics” (ibid., 959) as, in the anonymity of online spaces, anorexics can share their personal troubles. The primary goal of pro-ana communities is considered to be, by its users, “the safe management of a dangerous condition” (ibid). The reasoning that underlies the pro-ana model is that “if anorexia is a response to social and emotional difficulties, and one that enables individuals to cope, then it makes no sense to ‘cure’ this coping mechanism” (ibid., 963). It thus questions the notion of recovery as logically following ‘illness’, as well as the latter’s connotations when considered in light of the enabling aspects of a coping mechanism.

Karen Dias argues that from a feminist perspective, the pro-ana forum can be considered “a safe space” (40). She argues that “[t]he stigma and shame that come with both diagnostic labeling and society’s misunderstanding of eating ‘disorders’ contribute to women’s need to find creative ways to connect and find support” (ibid., 32) and the anonymity of cyberspace lends itself to this well. The coming out for a very private illness in a relatively public space underscores this need to find a sympathetic ear which, as studies on stigma and social prejudice have shown, is difficult to find for the anorexic. Dias therefore advances a reconsideration of the general vilification in the media of pro-ana website owners, who are often “blamed for causing and promoting a ‘deadly disease’” (ibid., 36) (the first of which is, in the light of Bray’s ‘eating/reading disorders’, unconvincing). Deborah Pollack, although acknowledging the positive potential pro-ana websites offer, does express concern about the possible romanticisation of “pro-eating disorder websites as political statements” (249), thereby enabling the image of the anorexic as “symbolic martyr” (ibid).

The Autobiographical Illness Narrative and the Narration of Anorexia

Illness narratives are, like those who author them, generally marginalised (Couser 1997: 6), even though the genre itself is expanding. This growth can be credited to two developments. Firstly, the ”general valorization of mind over body in Western culture” (ibid., 4) has gone hand in hand with the felt need to control the body and the concomitant widespread nature of practices such as dieting and exercising. At the same time, due to improved living conditions in the Western world, “we now tend to consider health as normative and illness as a condition to be corrected, rarely to be simply accepted” (Hawkins 2000: 223). Within this cultural-historical context, illness and disability become “not so much inevitable natural phenomena but [...] unexpected and perhaps disastrous events” (Couser 1997: 9), something the medicalisation of difference has reinforced. This conception of illness as an interruption of life has made the writing of illness narratives an increasingly practiced activity. Secondly, the medicalisation of individual symptoms has initiated depersonalising practices of diagnosis (as outlined by Foucault, Finkelstein and Beresford). That is to say, treatment methods “necessarily [involve] a sort of narrative collaboration between doctor and patient” (ibid,. 10) in which the patient presents the doctor with his or her medical history which the latter then interprets in the form of a diagnosis that will determine “prescription, treatment, and prognosis” (ibid). Effectively, then, “doctors may both reinterpret patient’s pasts and literally pre-script their futures” (ibid) and thereby “[reconfigure] the sick person’s illness as the patient’s disease” (ibid).

This reconfiguration through reinterpretation is based on and validated through a certain use of language, which Foucault already pays attention to when he talks of the silencing of the madman and the authority of the physician due to knowledge (which is expressed through language in a unidirectional ‘conversation’). Sidonie Smith and Julia Watson argue that this linguistic exchange affects the subject whom it regards - i.e. the ‘patient’ - and so they write: “through the ‘discourse’ of medical institutions [...] people learn to understand themselves - ‘experience’ themselves - as ‘patients’ in need of healing or as ‘diseased’ or ‘insufficient’ bodies in need of surgical intervention and repair” (32). Although similar to Morris’ as well as Beresford and Wilson’s arguments, which focus on the internalisation of stigma, Smith and Watson place more emphasis on the fact that people experience themselves through language, that “experience is discursive” (ibid), and that this determines what kinds of identities people in turn develop and create. That is to say, "[e]xperience [...] is the very process through which a person becomes a certain kind of subject owning certain identities in the social realm" (31). In describing this discursivity in a medical setting, they thus point to the way in which doctors choose language for their patients, thereby ascribing certain identities to them. This deprives patients of expressing and experiencing themselves through their own linguistic means. In this way, the individual aspect to the illness experience is emptied to make room for a previously determined general set of criteria that now define the ill or disabled subject. This depersonalisation has stimulated some to write illness narratives, as this enables them to interpret their illness experience on their own terms and to take control over their life narrative.

Because life writings primarily base themselves on personal memories, the writing process is generally characterised by the act of remembering. In the case of illness narratives, the remembered experiences will most often be those of the period(s) of illness, although they may also include contextualising memories of periods before or after falling ill. In addition, "imaginative acts of remembering always intersect with such rhetorical acts as assertion, justification, judgment, conviction, and interrogation" (Smith & Watson 7). Thus, the memories that are related in autobiographical writing are carefully selected and are part of an argument of some sort; not in the essayistic sense of the term, but rather in that the author addresses the reader in a way that is meant to "persuade [him/her] of their version of experience" (ibid). In order for the reader to suspend disbelief, then, the writer of the autobiography is presumed to employ her/his memory in an accurate and trustworthy manner, thereby in a way 'guaranteeing' that the memories that are narrated are authentic and have actually happened to the narrator. Implicated in this presumption is that the life writer adheres to the "autobiographical pact" (Lejeune 14), which stipulates that the author, narrator and narrated subject are one and the same person. This pact, or 'contract', between reader and writer (and publishing house), is of an ethical nature and lends the narrative a truth value that allows the reader to assume that what is narrated is genuine (Smith and Watson 11).

In order to strengthen their narrative argument, life writers may opt for the incorporation of other sources of knowledge, too; biographical information, for example, which takes memories and ideas from acquaintances as its source, or more general material, such as statistics or theoretical concepts. Through the use of these various types of knowledge, they can contextualise their own memories and at the same time use a representational strategy that can be considered less 'subjective'; that is to say, they can let themselves be represented through the perspective and linguistic means of others, rather than rely solely on self-representation. In this way, they can be considered “multiply vulnerable” (ibid 58), namely “to their own opaqueness, to their relationality to others, and to the norms through which they tell of themselves” (ibid). The autobiographical ‘I’ is, because of this vulnerability, not an independent entity but rather relational and entwined with the stories of others.

The idea of an authentic autobiographical work can be troubled by the conception of memory as somewhat of a slippery notion; remembering is not a straightforward practice, and this may be especially so when writing an illness narrative about an illness or disability that affects the ability to remember (either entirely or certain periods in life). Moreover, “narrated memory is an interpretation of a past that can never be fully recovered” (ibid., 22). Thus, memories in autobiography cannot be read as factual information, as they are always coloured by circumstances which characterise the moment of writing (and reading). In this interrelationality, they are “situated association” (ibid., 24), and so they, and the past they encapsulate, are constantly changing, subject to equally shifting experiences of the present. This explains the use of rhetorical strategies and lays bare the fluidity of the identity of the autobiographical subject. This subject does not precede experience; rather, as argued earlier, experience - in its discursivity and malleability - forms (or enables the forming of) identity, which is an equally shapeshifting notion. Smith and Watson conclude that “there is no coherent ‘self’ that predates stories about identity, about ‘who’ one is. Nor is there a unified, stable, immutable self that can remember everything that has happened in the past” (61). This reveals how the self that is narrating and narrated is closely bound to the process of narration; the telling of the story and the construction of an identity cannot be separated. In this narrative process, the autobiographical subject is thus fluid and may take up personal but also culturally available identity structures that are “intersectional” rather than “additive” (42). Moreover, due to these multiple identity constructs, which are similarly indistinguishable and relational, there are “competing versions of personhood” (103) that may appear at strategic points in the narrative to fulfil a certain function. For example, in shifting from the “‘I-then’ to the ‘I-now’” (72), the autobiographical subject can show the capacity for self-reflection and simultaneously characterise a change in identity configuration. The same goes for differentiations made among “[t]he ‘real’ or historical ‘I’; the narrating ‘I’” and the ideological ‘I’” (ibid), which similarly require the autobiographical narrator to take up a meta-position and reflect on the narrated life, self and this process itself. It should be noted that the idea of indistinguishable, intersectional selves can complicate the writing and narration of illness narratives that have internalised a medical master narrative, as this demands an active remembering and reinterpreting of past experiences and a re-stating of these experiences in language that has similarly been revisited and re-imbued with personal meaning.

Just as the autobiographical subject has multiple intersectional identities, so too she/he is “multiple embodied” (ibid., 50). That is to say, this subject may variously inhabit “the body as a neurochemical system; [...] the anatomical body; [...] the ‘imaginary body’ that ‘reflects social and familial beliefs about the body’” and the “sociopolitical body” (ibid) within one narrative. In the case of illness narratives, especially, the way the body figures in various forms of embodiment can uncover some of the relations that are brought into being when a particular body enters a particular space. In this way, the figure of the body can be employed as the bearer of knowledge which has been gained through experience. Smith and Watson conceptualise this relation between the body, experience and knowledge as follows: “[...] the body is a site of autobiographical knowledge because memory itself is embodied. And life narrative is a site of embodied knowledge [...] because autobiographical narrators are embodied subjects” (49). Through centralising the body, life writers of illness narratives can thus create a “[site] of agentic narration” (54) in which they, employing their different embodiment as a source of knowledge (production), interact with cultural interpretations of the normal and deviant body, thereby creating an alternative framework in which to understand illness or disability.

This idea of the body as a site of knowledge is also a principal element in Thomas G. Couser’s conceptualisation of the “nobody memoir” (2012: 2), which is an autobiographical narrative centred on the experience of a different embodiment; it is about “what it’s like to have or to *be*, to live in or *as*, a particular body [...] that is usually odd or anomalous” (ibid; original emphasis). The rise in nobody memoirs has coincided with the general ‘memoir boom’ but its growth has not, Couser underscores, been recognised as such by publishers or book reviewers (ibid), which gives the ‘nobody’ in this conceptualisation a painfully literal meaning. He relates this marginalisation of illness narratives to the stigmatisation of the disabled body and notes that this can profoundly influence the success and potential readership of illness or disability memoirs (2012: 2). He does concede, however, that the rise in illness narratives overall signals the topic’s increasing prevalence (ibid., 3), which, as I argued before, seems due to the growing need for alternative interpretations of disabled embodiment, which question hegemonic conceptions of health, illness and disability and which value personal experience as knowledge. The overall marginalisation of illness narratives can also be related to the fact that “remembering has a politics” (Smith & Watson

24), as not everyone is warranted the ‘right’ to remember or forget, either on an individual or collective level. Moreover, when stigmatising practices with regard to disability and illness are internalised, Couser argues, “stigma serves to silence the stigmatized” (2012:12), effectively preventing some individuals from writing about their experiences because they conceive of their lives as unworthy of being the subject of a book. In this way, the writing (and publishing) of an autobiographical illness narrative can be considered a political act, for, Couser emphasises, this is “a matter of speaking *for* as well as speaking *about*” (2012: 7; original emphasis), given that not all of those living with a similar disability or illness may be in a position to speak up and vouch for alternative ways of understanding and talking about difference. In this sense, when life writing becomes a way of speaking on behalf of others, too, the autobiographical subject is even more interrelationally connected, and can therefore also be considered exceptionally vulnerable.

The relationship between author and reader that is brought into being once an illness narrative is published (and read) can occasion “a ‘lived ethics of bodies’” (Radley 779), as the reader as embodied being is invited to enter the lived experience of the (previously) ill body of the author through a narrative account. The author thereby does more than recount his illness experience, as “a ‘world of illness’” (ibid) is created through the depiction of the (period of) life with illness as inherently an “[exemplification] of a way of living” (ibid). In this way, through exemplifying rather than explaining an experience, “illness accounts are always more than ‘stories about’: they are also ways of ‘seeing as’” (ibid., 791). Significantly, upon entering this narrativised world, the reader must reposition her/himself in relation to notions such as health or illness, as these texts often demand a move away from the hegemonic, able-ist constructions of these terms (ibid). This can be understood through the conceptualisation of the body of the author as a site of embodied autobiographical knowledge. The resulting reader-writer relationship - which requires affective immersion in the text and the willingness to reconceptualise these taken-for-granted constructs - can enable the recognition of deficiencies in common understandings of disability. This is especially so when the illness narratives “contradict and serve to overturn ‘master narratives’” (Ridgway 336), such as the dominant psychiatric narrative that is challenged by testimonies of psychiatric system survivors.

In reinterpreting the illness experience and placing it in one’s individual life story, the self must be understood as malleable and reconstructed throughout the rethinking of the narrative, as the writing process and the life on which it centres are not easily separable but rather feed into each other, and as the past that is remembered is not a stable, coherent unity but rather is continually being reshaped. As recovery from mental illness generally involves this reconfiguration of the self primarily through a reconsideration of mental states, Couser has argued that "[t]he effects of disease on identity and self-perception may be most fundamental and troubling in the case of mental illness" (1997: 13) - the recovery process being often of long duration and high complexity, especially since the self has a more ambiguous position in relation to the illness than in the case of physical disability and illness. This can be complicated when the (language of a) grand medical narrative has been internalised (as Beresford and Wilson have shown) or when an individual has been given a medical life narrative at the expense of a personal, experiential one (through depersonalisation in diagnostic practices, for example).

Illness narratives come in many shapes and sizes. Within Arthur Frank's typography, the most common one is the quest narrative, which does not (like the restitution narrative) centre on a straightforward and successful route to health, nor (like the chaos narrative) focus on chronic disability, but rather "meets suffering head on" (Frank 2013: 115). Within the quest narrative, the illness or disability is accepted and the narrative "[seeks] to *use* it" (ibid; original emphasis). The nature of the quest itself may remain ambiguous for the sufferer, but "is defined by the ill person's belief that something is to be gained through the experience" (ibid). These three narratives primarily identify different illness trajectories. Anne Hunsaker Hawkins offers a different construction, based on the narrator's desire to convey a certain message. She distinguishes between a) the didactic pathography, which is inspired by the desire to inform and help others; b) the angry pathography, which expresses the inadequacy of the medical system (often centring on its depersonalising approach); c) the alternative pathography, similar to the angry pathography but aimed at discovering different forms of treatment rather than denouncing existing practices; and d) the ecopathography, which relates the author's illness experience to a wider context of "environmental, political, or cultural problems" (1999: 128-9). Although Frank and Hawkins conceptualise the illness narrative differently and with distinctive categories, their typographies may in reality overlap. Apart from types of illness narratives, several pervasive metaphors within this genre can be identified that not only imbue the illness with meaning but that also function as "dynamic constructs that actually shape and 'in form' the experience" (Hawkins 2000: 230). Hawkins lists as the most common metaphors for illness that of a journey, a battle, "the paradigm of death and rebirth" and "'healthy-mindedness'" (ibid., 233), the use of which in a narrative can reveal how the notions of illness and health (and recovery) are experienced and conceptualised.

Pertaining purely to illness/recovery narratives of anorexics, Merav Shohet offers another categorical distinction. She conceives of recovery as a “psychological and interactionally discursive reframing of past, present, and imagined future selves, collaboratively authored by the self-starver and her clinicians and/or other relational partners” (346). In the ‘full recovery’ (FR) genre, this process is completed, “depicting a break from a former relatively incapacitated self and a transformation to a self more capable of handling life’s contingencies” (ibid). Conversely, the ‘struggling to recover’ (SR) genre is characterised by these past, present and future selves as being “narrated as continuous and conflicted versions of an ambivalent person who is sometimes cast as an agent of her life, while other times remaining an experiencing patient” (ibid). In stressing the interrelationality central to recovery, Shohet deviates from the linear temporal trajectory that explicitly or implicitly structures the illness narrative typographies elaborated above, as she wants to acknowledge that the FR genre is not available to everyone and that this is (at least in part) due to the type of narrative the individual anorexic “coconstructs with and tells to others as well as herself” (ibid., 347). Through challenging the understanding of recovery as a linear process, she similarly adheres to the idea of past, present and future as merging in the writing process of an autobiographical narrative. She thereby acknowledges that through remembering and reinterpreting the past, new identity constructions can be established which may in turn alter the life narrative as a whole (in that way enabling conceptions of recovery).

Catherine Garrett has also written extensively on recovery from anorexia and has pointed out that even though “the stories of ‘recovery’ and ‘anorexia’ are inseparable” (47), hardly any writing - be it medical, cultural or sociological - has credited recovery with due importance; focus is virtually always placed on anorexia’s etiology or symptoms. The same goes for media representations of anorexia: these similarly focus on the “horror of the experience” (185). Hence, she emphasises the need for recovery stories and describes how these stories are often born out of a close connection between the construction of an autobiographical narrative and the recovery process. Her understanding of recovery, formed through interviews with anorexics, as well as those who have recovered or are recovering, and drawing on her own experience, is based on the idea that “[a]n eating disorder is [...] an extreme form of desire; a spiritual craving expressed through the body” (17). This spiritual aspect, combined with the common conception of anorexics as carrying out ‘ritualistic’ behaviours, has prompted Garrett to conceptualise anorexia and recovery as part of the same rite of passage, aimed at the (re-)creation of an identity (102). In this ritual, anorexia "is the separation phase in the initiation of the individual into full selfhood; a chaotic, liminal period" (ibid), in which the disordered eating practices are ritualistic attempts of self-transformation (ibid). The anorexic period is characterised by the body/mind dichotomy (148), experienced as impurity and purity respectively (128). The body must be disciplined through the abstinence of certain foods and through exercise, both aimed at purification.

This negative anorexic rite is complemented by a positive rite, recovery, which, with its own rituals, "is the reconnecting part [...] when the individual returns to the community, strengthened through suffering" (ibid., 103). Significantly, thinking about anorexia and recovery as being part of the same process of self-transformation and (re-)discovery rejects the medical notion of anorexia as an illness that has to be overcome or cured. Rather, it considers it "a spiritual journey in its own right" (ibid., 108) which therefore cannot be divided into a period of 'sickness' and a subsequent (unitary, lasting) restoration to 'health' manifested in weight gain and 'normal' eating: the anorexic and recovery period are intricately entwined and magnify each other. Moreover, the idea of 'normal' eating such as it is propagated in clinical settings is rejected by Garrett's participants, and the notion of normality questioned (ibid., 67). In this conception of anorexia as ritualistic rite, a quest for selfhood, Garrett also enables "the possibility that, for some rare individuals, self-starvation and death can be another way of being" (ibid., 108), acknowledging, as does Shohet, that the 'tools' for recovery are not available to all anorexics, and that recovery is not always wanted (ibid., 187).

Those who have recovered, who have thus gone through both rites, are most articulate and coherent in their reflections on their eating disorder as they have actively re-constructed their life narratives and reshaped the role of anorexia within this story. Looking back, Garrett's recovered patients regarded their anorexic period as "a vital part of their ongoing transformation" and therefore felt appreciative for having gone through it all, even though it had been difficult (61). They considered it a fruitful episode in their lives "rather than a period of developmental stagnation; they recognize that their behaviour was self-protective, not self-destructive" (ibid). Anorexia is thus conceived of as a coping mechanism and recovery the reconfiguration of this mechanism into "other, less damaging ways of dealing with past hurts" (85). To Garrett, these recovery stories attest to the fact that the process of constructing an autobiographical narrative is a process centred on imbuing one's life with meaning when looking at it retrospectively (ibid., 33). In this way, the past, present and future are reconfigured, as well as the subjects' sense of identity (ibid., 36). Garrett thus considers the creation of an illness narrative to be integral to the healing process.

Another vital element to recovery that her participants put forward is the revisiting of the mind/body split; rather than seeing the mind as pure and authoritative, "bodily, metaphorical, poetic ways of knowing" (177) must be taken into account so that the dualism is surpassed, enabling a growth in a sense of embodiment and appreciation of the body (150). This simultaneously allows the body to become a site of autobiographical knowledge, of embodied memory, which can aid in constructing an illness narrative. The embodied self that is developed in the recovery period relies in turn on a reconnection with other people and nature (71). In this conceptualisation of recovery as part of a construction of selfhood, the positive rite is a continual process that never really ends, and is therefore not measurable in terms of completion or success (67), an interpretation that defies those of the other explanatory models. This is due to the fact that "it is always subject to reinterpretation" (ibid., 38), which is also why Garrett emphasises the importance of narrative and storytelling. After all, "our very experience is understood in our storytelling" (ibid., 39).

Looking Ahead

What becomes clear in many of these arguments and conceptualisations is that our current understanding of disability, illness, and anorexia is not well-rounded; that it lacks an inclusivity of knowledge. Moreover, understanding something such as anorexia fully is impossible; it is an embodied experience that, even for one individual, continually changes. How then to remedy this tendency to somehow always generalise, essentialise, depersonalise (or at least to make a start)? As I have proposed in my introduction and throughout this chapter, I believe the answer lies in taking seriously autobiographical illness narratives that, in centralising the body as a site of (autobiographical) knowledge, subvert common understandings of what it means to live with different embodiment, and what it means to write it, too. In the next chapter, I will attempt to unearth some of the elements that make up this 'anorexic' embodiment in the period of illness and place these self-representations in a larger framework of disability, mental illness and the illness narrative. Hopefully, this will show that autobiographical illness narratives can indeed enable a better understanding of anorexia, and that the ways in which they do so are meaningful.

Illness & Diagnosis: A Chicken & Egg Story

Hornbacher's *Wasted* (1998), Osgood's *How to Disappear Completely* (2013) and Woolf's *An Apple a Day* (2012) represent the lived experience of anorexia in very different ways. In this chapter, I will look at how the period of illness and the experience of being diagnosed are portrayed. It is difficult, in the case of anorexia at least, to definitively draw a line between illness and diagnosis. One complication is the ancient chicken and egg story: which comes first? A common understanding of illness is of course that, being diagnosable, it pre-exists the diagnosis. On the other hand, in terms of, for example, medical statistics, only those who are diagnosed are considered to be ill. Another complicating factor is the influence of diagnosis on the person who is diagnosed. As Thomas G. Couser has noted, a doctor's interpretation of a person's medical history and current symptoms, which leads to a diagnosis, effectively transforms "the sick person's illness" to "the patient's disease" (10). Apart from the impact this may have on a person's future treatment, the allotment of a patient status can occasion an emotional, psychological effect which can in turn impact the illness experience. Such a psychological reaction also follows the diagnosis of anorexia, as the memoirs by Hornbacher, Osgood and Woolf make apparent, and the ways in which this response is expressed are meaningful in forming an understanding of the illness experience of anorexia pre- and post-diagnosis.

I have identified several principal representational strategies that are used in the memoirs to characterise the onset, development and diagnosis of anorexia. In the first section, I will look at the individual ways in which Hornbacher, Osgood and Woolf conceive of the onset of their anorexia, a development they all contextualise through interacting with the various explanatory models of the illness which I outlined in the previous chapter. In the second section, I will turn to the general symptomatology of anorexia and look at how the authors conceptualise their physical and psychological complaints. Finally, I will explore the ways in which the illness experiences are described in the memoirs and the influence of diagnosis during this period of illness, while also looking at how descriptions of the general symptoms function as figures or representation and persuasion in the narrative.

The Beginnings of Anorexia: On Onsets and Etiologies

In their engagement with the theoretical explanatory models, Hornbacher, Osgood and Woolf show to what extent their experiences with anorexia can be explained by the ideas these models have propagated. Through this interrogation of ideas - a rhetorical act - they effectively assert their own views on anorexia's etiology.

Hornbacher, to start with, notes that she always had an 'abnormal' relationship with her body and food (12-3) and that from the age of four, she "realized that [she] simply would not do. [Her] body, being solid, was too much" (15-6). This dissatisfaction with her body would grow steadily and result, at age six, in a life plan for the future: "To get thin. To be great. To get out." (35). From very early on, then, Hornbacher had the desire to change her body shape. Yet when she develops bulimia at age nine, this is not a conscious effort to lose weight but a curiosity for "what would happen" (9), an interest in "the limits of [her] own self" (206). She argues that, as she had just reached puberty, this sudden lapse to bulimia does, retrospectively, make sense: the development of her body, "which [she] felt unruly to begin with" and which "without warning [...] began to 'bloom'" (40), transformed her body dissatisfaction into "a full-blown, constant obsession" (41). As bulimia takes its toll on her mental and physical health, Hornbacher begins to isolate herself and at age 13, anorexia becomes "[her] Big Idea, [her] bid for independence, identity, freedom, saviour" (68-9). This idea of anorexia as a means to a new identity construction is an important drive for her in developing the illness; she wants to transform her personality through becoming anorexic, ridding herself of the body she despises and becoming "pure mind" (108). This desired identity, significantly, is one of sickness: she wants to become anorexic because "[she] [is] on a mission to be another sort of person [...] whose passions [are] ascetic" (107).

In Hornbacher's view, a few factors have played a determining role in the onset of her anorexia. One is her family, which occasioned emotional chaos in her childhood that in turn prompted her to develop an "elaborate self-protective [system]" (21) which took the shape of an eating disorder. She remarks that this "is not uncommon for young children" who need "to give themselves a sense of control over their surroundings" (20). Aligning herself with (unspecified) others here, she portrays her eating disorder as a coping-mechanism that is part of a continuum of self-protective systems available to children. She thereby both verifies her experience and subverts the understanding of anorexia as an exceptional circumstance. Yet despite contextualising (in part) her illness' onset in childhood and family insecurities, thereby deploying ideas from within the psychosocial model, she is also critical of traditional psychosocial theory and its generalising assumptions, such as the idea that anorexia is formed in controlling and rigid family structures, which she disagrees with. In moving away from these ideas, Hornbacher inserts phrases such as “often the shrinks assume [...]” (68) or “the shrinks seemed absolutely convinced [....]” (25), thereby clearly demarcating where her experiences and ideas deviate from this theory as well as pointing out, in a slightly ironic manner, the stereotypical nature these theoretical ideas generally rely on. In this way, she actively resists representation of herself through ‘the shrinks’ (an abstract but seemingly unified entity) and instead relies on examples from her own life to make her case. Given the impact that ‘shrinks’ and doctors have had in her period of illness, through diagnosing her or determining her treatment for example, this reversal of power in her narrative can be considered an act of agentic narration that serves to return to her the control over her life narrative.

More so than a certain family dynamic, Hornbacher sees her cultural surroundings as a significant “culprit” (6) in her development of and vulnerability to anorexia, as in her culture, “thinnes is associated with wealth, upward mobility, success” (46) and is thus seen as a form of self-regulation. Consequently, “Becoming a Woman means becoming someone dissociated from, and spiteful toward, her body” (52), as this body has wants and needs that are (experienced as) going directly against the cultural mandate of being thin. This is reminiscent of the feminist model, and Susie Orbach’s argument in particular, in which the (overall) female preoccupation with the body is similarly linked to an attempt at control and success, despite its accompanying sense of disembodiment, and in which the physical thin body is less significant than what it represents and symbolises in society at large - namely, the masculine notions of discipline and strength, and its concomitant lack of female neediness. The influence of this cultural imagery and ideology begins when Hornbacher is only nine and confronted with various forms of pop culture which emphasise body shape and control (44), and when she reads Steven Levenkron’s *The Best Little Girl in the World* (1978), the main character of which inspires her to become anorexic (43). This is strengthened at boarding school, where she realises that virtually all girls obsess over their weight and that all conversations revolve around food and weight loss. Therefore, “longing stares followed the ones who were visibly anorexic” (102); a generally felt romanticisation which spurred her individually on to eat less. Both the larger cultural environment and her immediate surroundings, then, were conducive to her eating disorder. In line with the feminist model she argues that her anorexic body, if a means to anything, was “both an apology for being a woman and a twisted attempt to prove that a woman can be as good as a man” (229). In this feminist characterisation of anorexia she also goes against the psychological interpretation of it as a way of halting sexual and physical development and as a longing for the safety of childhood. Rather, this "Freudian analysis" (ibid) should be revisited, as she deems it more plausible, within the scope of her life, to consider anorexia and the emaciated body as an attempt "to demonstrate - badly, ineffectively, narcissistically - a total independence from the helpless state of childhood" (ibid). This interpretation of the anorexic body as subversive is in line with Helen Malson's gendered reading of this body as going against patriarchal gender constructions. However, whereas Malson characterises the anorexic, "amenorrhea-ic" (Malson 116) body as androgynous and non-feminine, Hornbacher does not equate its emaciation and (temporary) infertility with a lack or loss of femininity or womanhood.

Writing and publishing *Wasted* can thus be considered a political act, as she openly challenges the cultural standards dominant in her youth (the 80s and early 90s) that contributed to the development of her eating disorder. Her memoir can in this regard be classified as what Anne Hunsaker Hawkins has termed an 'ecopathography,' as Hornbacher explicitly situates her illness' etiology in a larger cultural and political context. She also recognises that she exhibits certain personality traits considered typical of anorexics - perfectionism, competitiveness, intelligence, as well as "diametrical" (237) thinking - and leaves open the possibility that before the onset of bulimia, she already "had some preexisting depression and/or anxiety disorder and/or mania" (37), thereby enabling a discussion of the biomedical model, albeit in a more limited way. Hornbacher engages, then, with all explanatory models to some extent - with the exception of the pro-ana model - but primarily employs feminist and psychosocial ideas, either to explain and contextualise her experiences (as is the case with the former) or to reveal a contrast with her own life (as is the case with the latter). In combining her personal experiences and memories with ideas from other sources, both academic and other, she strengthens her narrative argument (which I will outline in more detail in the next chapter).

The onset of Osgood's anorexia can similarly be traced back to when she was quite young. From an early age, Osgood was fascinated by stories about mental illness and, as she felt "decidedly unglamorous" (Osgood 19) and "[m]ediocre" (21), she soon developed a desire to become institutionalised; to become "a professional patient" (18). With the onset of puberty, feeling "awkward in [her] body and [her] persona" (19), she concluded that she was fat and needed to become thin. Significantly, she does not consider losing weight in a healthy way, for rather than having "a body that 'looked good'" (22), she wants to become "repulsively thin" (ibid). She opts, from the outset of her quest to thinness, for anorexia as a strategy, as "[she] didn't think of anorexia as a disease [...] but rather as the most logical progression of self-control" (ibid). As in Hornbacher's narrative, Osgood also considers anorexia a means to the construction of a new identity; a means to achieve something other than her self-perceived mediocrity or normality (ibid). Interestingly, this idealised image of anorexia as "dieting perfected " (ibid) and an opportunity to transform the self is strengthened when, shortly after deciding to become anorexic, she reads Hornbacher's *Wasted*. Hornbacher becomes her "hero, [her] near-impossible ideal of self-denial" (24), and she begins to copy the anorexic behaviours described in the memoir.

Osgood's main argument in interacting with cultural and theoretical ideas is therefore that "[a]norexia is contagious" (26), as she has observed over the years that she was not the only one who used anorexia memoirs and information booklets as "instruction manuals" (ibid); that, to the contrary, many people, "both eating disordered and not" (ibid) do this, either as a means to diet or to develop full-blown anorexia. She is adamant about the significant role cultural representations play in the development of eating-disordered behaviour in people, driving young girls to anorexia, and thereby resists Abigail Bray's criticism of this role as determining in her conceptualisation of the eating/reading disorder; according to Osgood, there *is* a causal link. She writes: "'But it couldn't have been that simple,' one might protest. Oh, but it was. It was a specific moment, too [...] I felt suddenly that I didn't belong anywhere [....] I looked down at my stomach. It protruded. I sucked it in [...]" (19). Significantly, Osgood seems to anticipate a certain reaction to her argument, as she incorporates what resembles a miniature dialogue between her and a potential reader/listener. In this way, Osgood (as narrator) shows that she is aware of the fact that she is arguing about something that is generally quite contested (as the widely varying explanatory models in the previous chapter corroborate). She does express certainty, however - in her brief but telling 'Oh, but it was.' - that her experience as it is described here should be taken at face-value.

In conceptualising anorexia as contagious, the cultural romanticisation of thinness and of the anorexic body figure as significant culprits in Osgood's etiology hypothesis, which is in line with Richard Gordon's cultural argument on the sensationalising of eating disorders in the media. Through the exploration of the relatively recent phenomenon 'wannarexia', Osgood highlights the pressure on people, especially young girls, to be thin. She admits, "with a good deal of shame" (102), that at age 13 she was a wannarexic herself, desperately wanting to be "not just thin, not bikini-ready, but *sick*, visibly malnourished" (103; original emphasis).

As in Hornbacher's case, there is a strong desire to attain an identity of illness, but in Osgood's cultural environment this has been given a name and has become an increasingly popular trend. In this way, her memoir, too, can be categorised as an 'ecopathography', as Osgood problematises the relationship between her development of anorexia and her cultural climate. In this larger argument, she not only incorporates the pervasive thinness ideology but also the language used when discussing anorexia, which she considers to be perpetuating the illness' popularity as it is "a linguistic stone's throw from beatific" (49).

In revisiting the onset of her anorexia, then, Osgood emphasises her vulnerability - and, by extension, that of other young girls - to triggering material in cultural representations. She therefore critiques not only *Wasted*, but also Lauren Greenfield's well-known *Thin* (both the film and the book), Levenkron's *The Best Little Girl in the World*, and even the acclaimed collection *Going Hungry*, edited by Kate Taylor, with contributions of eighteen esteemed writers with a history of eating-disordered behaviour. At the heart of her criticism is that these works perpetuate, in one way or another, the mythical aura that surrounds anorexia and that through their use of language or (in Greenfield's case) images, they obscure the severity of anorexia as an illness and serious medical problem. She questions the overt and implicit associations made between thinness as graceful and anorexia as spiritual suffering, for example, and reminds her readers that many cultural representations, such as *Thin*, depict "stock characters" (144) that complicate a proper understanding of anorexia both for a lay audience and for interested (and vulnerable) eating-disordered readers (ibid). In trying to create an alternative understanding of anorexia and an awareness in her readers, I would argue that Osgood's memoir can also be read as a didactic pathography; the message she is trying to convey is clearly aimed at informing others of knowledge she gained experientially (I will elaborate on this in chapter 3).

In addition to these cultural representations, Osgood discusses the online pro-ana movement, which she calls "a kind of nebulous death cult" (89) and which has grown explosively since the days when she was a wannarexic. However, she does acknowledge, reluctantly following the pro-ana argument, that due to the competitiveness at the heart of anorexia, pro-ana sites do not generally encourage others to engage in similar behaviour; after all, "the fewer people striving for thinness, the fewer opponents you have to worry about" (ibid). She concedes that they do not necessarily dissuade visitors either, but that direct stimulation rarely, if at all, occurs. Because this competition is so strongly experienced among anorexics generally, she is equally sceptical about the degree to which actual bonding can take place on forums (91), thereby questioning the feminist argument within the pro-ana model that vouches for these websites as safe spaces where anorexics can voice their opinions and express their feelings anonymously.

In Osgood's narrative, then, the cultural environment - which enabled her wannarexia and her anorexia - and her personality - which predisposed her to transform her self into one of illness - are the main reasons she considers as contributing to her anorexia's onset. She does engage with the psychosocial model and its argument that the predisposition to develop anorexia is formed in childhood, within the family unit, but argues critically: "Even as we've moved away from reliance on the idea of refrigerator moms and oedipal complexes, we still believe that the seeds of sadness are sown in childhood, and these giants of our youth, then, must play large roles in our developing [...] mental instabilities" (42). To her mind, and as her language use and slightly mocking tone also suggest, this reasoning is generic and outdated and does not apply to her (this strategy resembles Hornbacher's). Rather, she points to her own personality as deviating significantly from those of her parents and siblings; hers being "morbid, self-indulgent, and incessantly reflective" and her family's being "even-keeled, well-adjusted, and happy" (ibid) and identifies this disparity as a significant factor; not her family itself.

The onset of Woolf's anorexia is radically different as contrary to Hornbacher and Osgood, she never actively sought out anorexia. Moreover, whereas Hornbacher and Osgood were relatively young when they turned to anorexia (13 and 14 respectively), Woolf became anorexic at 19, when she was already at university. She describes the break-up of her first serious relationship with her old flame Laurie as the most immediate spark to develop anorexia, as she "despised [herself] for getting rejected, so punishment was the next logical step" (87). This strong reaction to her heartache can be explained, she argues, by her personality: she does not deal well with rejection, taking it personally and assuming it is "a judgment on [herself]" (75). She considers this "fundamental lack of self-belief" (87) in moments of failure to have been conducive to developing anorexia, as she condemned herself for the rejection of the break-up and "turned the pain inwards" (ibid). Consequently, "[s]tarving was a way of coping with the pain [she] felt, and a way of controlling [herself]" (ibid). Interestingly, her sudden turn towards starvation happened simultaneously with a first conception of herself as "[t]oo talkative, too emotional, too fleshy. In short, too fat" (ibid). Woolf explains that she never, before the break-up, considered herself in such terms as she was and is “genuinely a confident person” (73). In addition, the cultural and familial environment in which she grew up did not lend itself to these kinds of insecurities. Although she is adamant about the impossibility of the contemporary beauty ideal set for women and the troubling relationship many women nowadays have with their bodies and appetites (62-4) - thereby adhering to the feminist model - she is also clear about the fact that compared to her late teens, “it seems a different world” (81). She did not feel the pressure to be thin or a particular kind of beautiful, and is quick to point out that she does not remember being alone in this: “I don’t remember anyone skipping lunch, getting super-thin or over-exercising; I don’t remember any anorexic talk” (ibid). Hence, compared to Hornbacher or Osgood, the cultural pressures are vastly different; virtually non-existent.

Woolf also emphasises that she had a happy childhood and adolescence and that she was always close to her family. For her, then, the primary reason for developing anorexia is her personality, and this conviction grows stronger throughout her memoir. She engages quite actively with the biomedical model, exploring the chemical imbalances in the brain as well as the possibly genetic nature of anorexia and its potential link to autism. This is fuelled by a belief that “[her] brain is wired differently” (125) than that of other people. In her discussion of the preliminary findings of the Ravello Profile - a test for measuring neurological functioning in anorexia nervosa - she conceives of the possibly genetic susceptibility to anorexia as comforting. In her words: “I’ve always sensed - however unscientifically - that something is broken inside my head. Now I know I’m not going crazy, that anorexia really is a brain disease” (236). Significantly, although relying on scientific evidence in her argument, she also reveals here a more intuitive and embodied knowledge which she appears to disregard but which matches her findings; this use of verifying material is quite important in her argument, as it lends her a sense of credibility (as I will elaborate in chapter 3). Woolf goes on to argue that this medical and genetic side to anorexia relieves the anorexic of being blamed for the disease and that it effaces the notion of anorexia as “selfish, silly, female concerns” (ibid) - in other words, reducing the volitional stigma proposed by Michele Easter. The change in attitude of the general public with regard to this volitional stigma and the biomedical explanation of anorexia has been measured (see Crisafulli et al.) and is indeed positive in that it shifts the blame from the anorexic to his/her brain. However, as Stephanie Tierney has shown, many anorexics in her study expressed fear of genetic essentialism if this medical understanding were to become widespread. Woolf’s determination to convey an understanding of anorexia as more than a ‘selfish female concern’ through questioning stigma reveals a political, even activist aim in her writing of the memoir, which I will discuss in more detail in the next chapter.

All in all, Woolf's conceptualisation of anorexia places more emphasis on the medical understanding of mental illness, as the role attributed to neurological determinants is comparatively larger than in the other two memoirs. Apart from taking up feminist and biomedical ideas, Woolf also pays tribute to larger cultural interpretations of anorexia, reminiscent of those described by Joan Jacobs Brumberg, that tie anorexia to a sense of purity and control. Woolf writes: "I'd confessed an element of distaste for flesh-and-blood femaleness, the voluptuousness of pregnancy, the unpredictability of childbirth and motherhood. My private world, my pristine flat, my runner's body, is controllable, contained and neat" (220). Once the illness kicked off, then, Woolf's attachment to it grew, and she began to place certain values on it that contributed to its growing hold on her.

A Closer Look: What Is Illness, and What Is Anorexia?

The idea of physical symptoms as unambiguously different from psychological symptoms - and thereby requiring different cures or treatments - is inadequate for theorising and creating an understanding of anorexia. In fact, the relationality between and among symptoms is used as a way to illustrate parts of the illness experience, particularly in the memoirs by Hornbacher and Woolf. In describing the effects of malnutrition on her physical body, Hornbacher recounts "[growing] fur, what is technically called lanugo" (109) when she was underweight and starving herself in the colder months of the year. She explains: "Your body grows it when you're not taking in enough calories to create internal heat [...] I grew fur on my belly, my ribs, the small of my back, my cheeks [...]" (ibid). Although she writes, clearly retrospectively, that she "began to look a bit haunted" (ibid), at the time, she liked her lanugo: "I felt like a small bear" (ibid), she writes, as she moves on to describe how the physical changes her body was undergoing made her feel like a successful anorexic, an identity that, as mentioned earlier, she very much aspired to (109-110). This 'physical symptom', then, directly affects her anorexic mindset, which in turn can affect the well-being of her physical body again (and so this constant interchange between mind and body can go on). Hornbacher also writes that during her final relapse, she became so malnourished that she lost the ability to read: "Starvation eventually hits the brain. First it eats all your fat. Then it eats your exoskeletal muscles. Then it eats your internal organs, one of which is the brain" (257). As in her description of growing lanugo, she produces a biological argument, which I interpret as emphasising the part to anorexia that is a physical illness that affects the state of the material body, thereby signalling to the reader that despite the stigma that surrounds anorexia, it is a serious medical problem. The loss of her mental faculties truly shocks Hornbacher, especially as it disables her professionally and thereby eliminates her primary distraction from hunger. This in- (or dis-)ability makes her feel like a failure, "a lazy brat" (ibid), and the self-destructive behaviour that follows makes her conclude that "[she] might be, forever and ever amen, a Crazy Person" (273). Here, again, the physically disabling aspects to anorexia do not leave her psychological state unaffected. Another example of this interrelationality between mind and body is described by Woolf in her discussion of amenorrhoea (absence of menstruation). In outlining her previous, half-hearted recovery attempts, Woolf notes that the return of her period would occasion extreme anxiety and an almost immediate relapse into starvation and anorexic behaviours (Woolf 227). Hence, the physical symptom amenorrhoea signifies, as lanugo does for Hornbacher, a sense of success in her anorexia. Significantly, in both of these cases the symptom is a medically identified marker of anorexia (see APA).

In an inverted way, from more of a recovery perspective, Osgood describes a set of physical symptoms which occurred after her second relapse, when her doctors "discovered that [her] body was, to put it generously, totally fucked" (147) as "[her] blood pressure was erratic, [her] metabolism the speed of someone comatose" (153), occasioning frequent blackouts. This physical damage is unprecedented in her experience with anorexia, and she reflects on this as follows: "I hadn't expected to get so sick, to feel so consistently physically awful. I had begun this particular anorexic quest in a routinely sentimental, dramatic fashion and ended it with a detachment the likes of which I couldn't fathom until months afterward [...]" (150). Interestingly, she does not, up until that particular relapse, take into account the possibility that her body might be seriously affected by anorexia. This is corroborated by her conception of anorexia as 'dieting perfected' rather than an illness. By using a form of flash-forwarding at the end of this passage, she invites the reader to envision a point further in time at which this detachment between her and the world, and her and her body, can finally be grasped. Through this hint at a future, 'months afterward', she stresses the gravity of this disconnection, measured through its long-lasting aftermath.

Hence, the illness experience of anorexia is both physical and psychological, and the general separation between mental and physical illness, and by extension between mind and body, is thus neither helpful nor accurate. This is best exemplified in descriptions of the anorexic voice, which is the most prominent ‘psychological’ or ‘psychologically experienced’ symptom and which figures as a primary representational strategy in the memoirs. Sarah Williams and Marie Reid found that the emergence of this voice is what their participants considered crucial in separating ‘normal’ dieting from an eating disorder such as anorexia (807). They write: “During this switchover, participants experienced a split between their self and their disorder, which was experienced as a ‘battle’ between two minds or two separate voices” (ibid). This anorexic voice is in turn conceived as “a critical, illogical and irrational entity that battled against and controlled their rational true self” (ibid). This sense of an external but internalised controlling entity can be found, for example, in Woolf’s description of anorexia as “an illness which takes on a life of its own, feeding on itself as you starve [...] a voice in your head which never, *ever* shuts up” (15; original emphasis). Notably, she puts forward the idea of anorexia as a parasite, which underscores how the need for control that her anorexia began with turned out to be unsustainable, as her description figures her as passive and the voice as active; as holding all the cards, subjecting her to its will. Moreover, she describes this voice as *feeding off* her body. Although this may seem primarily metaphorical, there is no denying that this takes on a literal meaning as well: as Woolf makes abundantly clear throughout her memoir, the anorexic voice was constantly present and pestered her with thoughts about eating as sinful and greedy (98-9). This makes food something to be avoided at all costs, and eating a distressing practice: Woolf vividly describes the voice as “shouting with each forkful [...]: greedy, greedy” (99) and as “this shrieking-mad anorexic goading you with every mouthful” (100). And as the voice keeps reprimanding her for eating, Woolf keeps eating less, which, in turn, strengthens her anorexic mindset and gives the anorexic voice more power: she writes that “every extra ounce makes an incredible difference to your state of mind and your well-being” (94). Moreover, the incessant comments of the anorexic voice when she eats make eating with others extremely difficult for her; this is a ramification that profoundly influences her social and professional life, thereby isolating her further. Here, again, there is a kind of circularity of symptoms, where physiological and psychological changes exacerbate each other.

Osgood also reflects on the anorexic voice, which in her memoir is primarily referred to as Ana, and explains its power as follows: “Ana knows exactly what to say because she’s inside one’s cranium, privy to all the necessary information. She [...] is aware when your priorities and aesthetics change [...] Anorexia is malleable, a folkloric shapeshifter, constantly adapting, acquiring new vocabulary, new tricks” (87-8). Due to its adaptability, the anorexic voice was able to constantly push Osgood to lose more weight: even when she thought she'd reached the edge, the lowest point, "it would tiptoe beside [her] and whisper snidely in [her] ear: *Perhaps go a bit further… just to be sure*" (201 original emphasis). In this way, the voice can endanger the anorexic, in the sense that it overrules any survival instinct he or she may initially have when approaching a physical and/or mental breakdown. However, apart from being versatile and intimately familiar with her psychological disposition, the anorexic voice is also a companion, which is why Osgood would listen to Ana rather than ignore her. The participants in the study by Stephanie Tierney and John Fox corroborate this feeling when they describe "how the voice gradually entered their life when they felt particularly vulnerable. It arrived with a plethora of endearing qualities; it was a source of comfort, a distraction from other problems and from painful emotions [...]" (246). The anorexic voice is thus initially friendly, even loving, and is considered a genuinely comforting presence. It is only later, Osgood reflects, that she realised "that this companion was downright evil" (201).

This friendly side to the anorexic voice is likely the reason that Hornbacher conceptualises anorexia as a lover, an external entity that is nevertheless very close to her. She writes: "The sickness occupies your every thought, breathes like a lover at your ear [...] You will never find a lover so careful, so attentive, so unconditionally present and concerned only with you" (125). Even though she, too, describes the anorexic voice as driving her to a dangerously low weight, and a dangerously ill physical state, this positive side remains. Moreover, due to this conception of the voice as friendly and well-meaning, these lows in her health instigate a sense of achievement rather than shock in her. For example, she describes passing out in class and tricking the school nurses into believing that she just has the flu, and recalls: "I remember being utterly, utterly pleased with myself" (129). In this way, the anorexic voice as psychological symptom is inextricably entwined with the physical body and its well-being, and vice versa.

This sense of the anorexic voice as friendly and/or inciting a sense of achievement can be explained through the conceptualisation of anorexia as addiction, which is also mentioned by all three authors. Woolf deploys this comparison most exhaustively and argues that "the longer you starve, the more addicted you become to hunger, that clean empty high" (53). She explains this as follows: "It fills me with endorphins, adrenaline; it gives me a pure, healthy feeling, a buzz, a sense of achievement, a sense of control. The hunger is the drug. Forget cocaine, forget Ecstasy, this is the best high I've ever known" (ibid). This high accounts for her sense of hunger as strengthening instead of weakening, and paves the way for Woolf's explanation of why anorexics are able to starve themselves for extended periods of time: “Logically, hunger should make you feel weak and listless, right? Not so with anorexia: the mania has always driven me to run faster, cycle further, stay up later, read more, eat less. The longer you do it, the more you realise that anorexics are superhuman” (ibid). (This addictive element, as I shall discuss in the next chapter, also plays an important role in Woolf’s recovery.) The use of the present tense in these two descriptions indicates that at this stage in her writing process, at least, Woolf is still anorexic; still starving herself and experiencing this high, thereby conforming to Merav Shohet’s SR (struggling to recover) narrative as she can be seen here as an ‘experiencing patient’. Thus, although drawing on very personal feelings for her narrative, she does not base herself so much on memories as she does on ongoing emotions and attitudes. Significantly, she relates the idea of addiction to the anorexic voice, too: “It’s an addiction and a compulsion, a brain disorder and a crutch, your best friend and worst enemy, a fight between body and soul” (15). For Woolf, anorexia takes on all these different guises, and she paints a picture of being both comfortable in her anorexic identity, with the anorexic voice to cheer her on, and of being ill, fighting an internal battle on a daily basis. I would argue that all these conceptualisations of anorexia as they appear to her at varying stages of her illness point to a state of perpetual contradiction. Moreover, Woolf employs the metaphor of anorexia as a fight here, which Hawkins has characterised as a prominent image in many illness narratives, and which seems to signify Woolf’s search for a way to navigate these seemingly opposing and conflicting elements.

In a somewhat more biological way, Osgood also describes the endorphin production upon starvation, “which can make a person feel good and which can become pleasurable and emotionally addictive without discrimination” (94). Thus, the physical sensations of the starving body need not be understood in only painful or negative terms and, given the idea of anorexia as a coping mechanism, this addiction may be especially powerful when the high it produces is aimed at effacing more emotional symptoms, such as feelings of trauma or other inner difficulties. Hornbacher similarly considers eating disorders to be addictions and mentions both the adrenaline high and “the heightened intensity of experience that eating disorders initially induce” (105). The result, she argues, is that “[y]our sense of power is very, very intense” (ibid), which can be related to hunger as an achievement that is encouraged by the anorexic voice. In her argument this description figures more as a warning, as she stresses that like any addiction, “the longer you do it, the more you need to achieve that original high” (106). Consequently, the psychological stimulation and its physical effects enable the anorexia to become more severe, which often happens without the anorexic being aware of it (105). This idea of anorexia as addiction is not new. Brumberg works with a "dependency-addiction model" (Brumberg 41), already established within psychiatry, which also highlights "the psychological and the physiological effects of starvation" (ibid., 33). Similarly, Catherine Garrett writes that some of her participants spoke of their anorexia as an addiction, and notes other similarities: "addictions are means of dealing with psychic pain [...] they involve habitual behaviour which alters the individual's psychological and physical state; they [...] eventually come to feel right and they are characteristically denied by those who suffer from them" (Garrett 51). Thus, Hornbacher, Osgood and Woolf have incorporated a pre-existing model into their own interpretation of anorexia which highlights the joint physical and psychological symptoms of starvation.

A final 'psychological symptom' is the feeling of disembodiment, or the desire to become disembodied. This is also mentioned by all three authors, albeit to varying degrees. Woolf is very articulate about this when she writes: "My experience of anorexia is of a profound disconnect between my body and my mind" (16). This sense of detachment is in her case related to anorexia as a form of self-punishment which is aimed primarily at eradicating anything that might feel or appear "weak and needy" (55) as this is "linked to the fear of becoming fat and greedy" (ibid). Hence, any bodily needs, including not only food, rest and comfort but also, for example, physical consolation through hugs are incompatible with Woolf's conception of herself as undeserving (ibid). Thus, the body is considered inferior to the mind and perceived as completely separate. Nevertheless, her physical body experiences intensely the consequences of this psychological symptom - which is, of course, Woolf's intention - but also, more importantly, this symptom circles back to her mental health again - which seems unintentional - in that she isolates herself further and keeps other people at a distance (ibid).

Hornbacher also writes about experiencing a split between mind and body, but from a different viewpoint. She describes the shift in body perception that was concomitant with her conversion from bulimia to anorexia as follows: "I had no patience for my body. I wanted it to go away" (107-8). As she conceptualises her body as something easily disposable, and as she had no "sense of physical integrity" (108) to function as a "self-protective mechanism in the psyche that will dissuade the brain from truly dangerous activity" (ibid), her body hatred could grow unconditionally: "You stop seeing your body as your own, as something valuable [...] You begin seeing it instead as an undesirable appendage, a wart you need to remove" (ibid). This devalorisation of the body in combination with the anorexic voice can expedite the development of anorexia and can make recovery a difficult process (as I will elaborate in the next chapter). Here, again, the desire - formed in the ‘mind’ - to diminish the body will as a matter of course have an acute effect on this body, this ‘wart’ that will slowly grow smaller, thereby influencing the state of mind of the anorexic through malnutrition. Osgood, finally, is less vocal about her sense of disembodiment but does express a strong desire, during her onset and development of anorexia, to get rid of her body (24) and mentions, en passant and through implication, that when she is hospitalised for the second time she does not feel either embodied or even human (158); her body does appear to be, as it is for Woolf and Hornbacher, an undesirable external thing that must, if possible, be done away with.

On Representations of The Illness Experience and Diagnosis of Anorexia

Hornbacher, Osgood and Woolf characterise their illness experiences and their memories of being diagnosed in various ways, although they share some representational strategies to portray the progression of their anorexia.

To start again with Hornbacher, she writes that her transformation from bulimia to anorexia can be distinguished by the emergence of the anorexic voice: “[...] the sharp hiss of one voice that started out softly, as though below layers of moss, or flesh, and gradually became so loud it drowned out everything else: *Thinner*, it said. *You’ve got to get thinner*” (69; original emphasis). This voice functions as a constant presence of her anorexia, and carries on until well into her recovery (as I shall elaborate later). The drive to become thinner is strengthened by the competitive atmosphere on her school campus, which sparked a desire in her to “[pull] ahead of the pack” (116). Significantly, she does not realise, at this point, that she is already exhibiting eating-disordered behaviour, even when it is pointed out to her. She describes a lunch scene in the school cafeteria as follows: “No one else was eating normally either, so who were they to talk?” (ibid). Through restating her logic at the time, she underscores the divide between normal and abnormal by literally asking the reader who was correct in this scenario - even though the slightly ironic tone of this question already suggests an answer.

Upon her first admission to the hospital, Hornbacher is diagnosed with bulimia with anorexic features (142), which means, effectively, that her required food intake and weight gain are relatively low compared to that of the anorexic patients. Thus, she describes this first hospitalisation as “divine,” “a grand buffet” and “seventh heaven” (150-1). These words appear to have been chosen for their paradoxical and hyperbolic effect, revealing treatment (at least that time) to have been highly ineffective and subverting any common understanding of recovery as unquestionably desired at the time of treatment. They also stand in stark contrast to her description of the heavy medical restrictions imposed on patients on the Eating Disorders Unit (EDU), which include being watched during strictly timed bathroom breaks and a ban on any caffeinated products (146-7). She argues that this hospital admission was sensational because "there is nothing so wonderfully conducive to eating disorders as treatment" (145) as her life in the hospital came to "[revolve] around meals" (151). This strengthened her anorexic mindset and made her more passionate about becoming ill.

Moreover, the atmosphere on the EDU was highly competitive, far more so than at school. Hence, when she realises that she is not among the skinniest of patients, she feels deeply ashamed because she "[is] not *visibly* sick, the very *picture* of sick" (153; original emphasis) and therefore does not "warrant the coveted title of Anoretic" (ibid). It becomes clear to her, at this point, that although she has an 'easy time' at the unit due to her diagnosis with bulimia, she wants to be diagnosed with anorexia instead; she wants the 'glory' that she associates with it. The practice of diagnosis, then, is highly influential in her life, as it both effects her treatment plan and induces her to become sicker. Moreover, treatment worsened her anorexia - which, she emphasises, happens to many hospitalised anorexics (158) - and turned the hospital into "a haven" (ibid); she writes that when she was discharged, she would yearn for this "Eden" because "[i]t was as close to death [....] as [she] thought [she] could come. Life stops. Time stops. You become a case, a study, a curiosity, a problem, a sickness, a child" (158-9). She points here to a process of medicalisation that relieves her of the responsibility to be herself, or to be anyone for that matter, and this clearly speaks to her on a profound level. Significantly, she uses here a shift in personal pronoun, starting out with memories of her own old beliefs and then moving on to a more general perspective that indicates that this process of medicalisation, albeit personal in her narrative, is a larger phenomenon, which happens to other people, too, upon entering a medical setting.

When Hornbacher first relapses after her initial discharge, her approach to starvation starts to change; rather than forcing herself to starve, as she did before, she now begins to rely on feeling empty, and instead of aiming to lose weight, she is now "exploring the extent of hunger" (167). This internalisation of motivation in turn strengthens her idea of anorexia as an identity and as something "completely [her] own" (168), thereby seeming reminiscent of a growing addiction to anorexia. After two brief successive hospitalisations, Hornbacher is transferred to a treatment centre for children, due to her uncooperative behaviour at the EDU. As she is one of only two anorexics in this treatment centre, the rest of the patients being diagnosed with other psychiatric disorders, there is no competitive atmosphere and neither is there any focus on weight or food. Instead, Hornbacher is required to break psychological barriers and to connect with others. Her time in this treatment centre will inspire her to seriously consider recovery for the first time since her anorexia's onset, as her anorexic mindset is not stimulated by her surroundings. The broad approach of this treatment is also apparent in her diagnosis of this admission: rather than being diagnosed with one particular disorder, she is classified in physical terms - "Life-threatening weight loss. Laxative abuse. Orthostasis [...]" (186) - , in psychosocial terms - "Enmeshed father-daughter relationship. Detached mother [...]" (ibid) - , and in psychological terms - "Fear of abandonment. Fear of intimacy [...]" (ibid). This broad diagnosis makes apparent the limited scope of the label anorexia; clearly, Hornbacher's life can be understood - albeit narrowed down, nonetheless - in more detailed terms. The language used in practices of diagnosis is thus highly influential in determining treatment. Moreover, as this experience with treatment prompts her to attempt a first try at recovery, it can also be argued that through being diagnosed in these more varied terms, Hornbacher also *experiences* herself in terms other than the narrow label 'anorexic'; as Smith and Watson have argued, experience is discursive and the way in which people experience themselves through language affects the way in which they conceive of themselves and their identity constructs. Thus, through talking and thinking about herself in different terms, she may also conceptualise her self differently; not in terms of illness, but in terms of who she might be as a person.

When she is discharged, Hornbacher slowly slips back into anorexic habits. She is already underweight when she starts her first semester at university, but her increasingly shrinking food intake results in quick and serious malnourishment. I would argue that in this final relapse, her depiction of what Radley has termed a 'world of illness' is the most vivid - despite the narration of other stages of her period of illness being equally descriptive. Her primary representational strategies in creating this world, this way of anorexia as 'seeing as' rather than a 'story about', are her elaborations on her food rituals at the time and her body-obsession. A scene that is most distinctive with regard to the former is her rendition of eating a small yogurt at a yogurt shop:

> When five minutes had passed, I would start to skim my yogurt. Try this at

> home, kids, it's great fun. You take the edge of your spoon and run it over the top of the yogurt, being careful to get only the melted part. Then let the yogurt drip off until there's only a tiny sheen on the spoon. Lick it - wait, be careful [...] the sheen should last at least four or five licks, and you have to lick the back of the spoon first, then turn the spoon over and lick the front, with the tip of your tongue. Then set the yogurt aside again. (255)

I cannot capture the sheer specificity of this scene, as it covers nearly an entire page, but this excerpt already shows Hornbacher's extreme attention to detail. A few things stand out. Firstly, she employs again a shift in personal pronouns; in this passage, she only names herself at the very start, after which she moves on to what may be assumed is a direct address to her readers. Secondly, this address can be read, as Osgood has probably done, as an instruction for anorexic eating behaviour. The tone of this passage is ironic, as her 'try this at home kids' seems to underscore, and so I would not ascribe Hornbacher the direct and motivated stimulation or encouragement of wannarexics, yet this description can undeniably be read as a 'how to.' Finally, the restraint she imposes on herself and her incredibly strict rule system are exemplified here; the 'wait, be careful' may be directed to her readers, but can alternatively be read as a reiteration of the anorexic voice, which is present (and dominantly so) in an eating-scene such as this one (of which there are many more). Hence, 'seeing as' an anorexic at this stage of her illness can be interpreted as a complete submission to the anorexic voice. In this way, Hornbacher requires of her readers a complete turnaround with regard to the notions of normalcy and deviance and, more specifically, good and bad: in order to become fully immersed in her narrative argument, the reader must listen equally carefully to the anorexic voice and conceive of her strict food rituals as 'good' and healthy, ways of achieving thinness, whereas non-disordered eating must be considered bad and unhealthy, as it is associated with neediness and greed.

The anorexic voice is also an important drive behind her body obsession. She vividly describes a scene of intense body scrutiny as follows: "When the small voice in my head would not stop hissing, I'd [...] go to the mirror [...] and look at the gaps. Pressing my legs together as hard as I could, I'd look at the gaps between my calves and thighs [...] I looked at the way the side of my ass sank in toward the hipbone" (252-3). Significantly, this process of observation and measurement would go on until "[she] was satisfied that [...] [her] body had stayed within its spatial confines and had not encroached" (ibid). The way in which she describes this body as ‘not encroached’ illustrates just how severe her sense of disembodiment is; she is completely disconnected from her body and although aware that she is stuck with it, as this routine check makes clear, an expansion in size would feel like an invasion of her self. Moreover, the sense that the anorexic voice is ‘hissing’ gives the scene a somewhat ominous feel, as if Hornbacher would be in real danger if she did not get up and check the boundaries of her body. In this passage, too, she exemplifies rather than explains her illness experience, thereby creating the body-obsession aspect to her world of illness. The ‘seeing as’ is here, significantly, ‘seeing as’ the anorexic voice; Hornbacher seems completely submissive to its demands and bereft of agency.

At this point in her illness narrative, when the anorexic voice has effectively overpowered her, Hornbacher is nearing a crossroads, which she describes vividly as a shift in her perception of anorexia that becomes noticeable to her when, preparing a meal in the university cafeteria, she hears a classmate say: “Jesus, I wish she would just fucking *eat*” (262; original emphasis). She reflects on this comment: “All along, part of the point of disappearing was to disappear visibly, to wear my thinness like a badge of courage [...] But then, it pissed me off. Something had changed. I didn’t want to be seen anymore” (ibid). The shift she describes here exemplifies her breaking point, as well as a shift in different worlds of illness: at this stage, Hornbacher no longer entertains the notion of anorexia as glamorous and does not associate it with an identity to be proud of. Rather, she expresses a sense of shame, of feeling different and of being lonely and trapped in her illness. Hence, her way of ‘seeing as’, her anorexic thoughts, change in this moment, and Hornbacher explicitly notifies her readers of this, preparing her narrative for a final fall, after which her recovery begins.

Osgood’s narrative best exemplifies the ambiguity of the illness/diagnosis (and illness/treatment) divide. She is called into the doctor’s office after a friend notified the school counsellor of her strange eating behaviours, which she lied about. Significantly, Osgood anticipates the doctor’s attempt to steer questions towards anorexic eating and responds affirmatively, lying about her eating habits and occasional binges. She wonders later: “Did I withhold the truth because I was ashamed of it, which would be pathologically predictable, or because I wanted so desperately the pure and singular diagnosis of anorexia?” (48). This shows just how ‘coveted’ (to use Hornbacher’s words) the diagnosis of anorexia can be. However, Osgood is diagnosed as “a ‘mild case’” (83), which exacerbates her anorexic mindset because, she explains: “To label an anorexic ‘not that bad’ is to call him or her 'normal,' which is to say not sick at all, which is to say fat" (83-4). This reasoning displays a way of anorexic 'seeing as' and contributes to Osgood's creation of a world of illness: she considers the diagnosis of anorexia to be desirable only when it comes with a certain medical gravity; the label alone does not suffice. In this way, she requires the reader to reconsider the label anorexia as a marker of illness and instead to take this label seriously only when the illness has been explicitly characterised as severe. Thus, as in Hornbacher's case, the language that is used in diagnostic practices has the power to influence the patient profoundly, as this addition of 'mildness' affects how Osgood experiences herself; namely in terms of insufficiency and unworthiness.

Osgood has therapy appointments in an eating disorder clinic for a year, during which time she is regularly confronted with anorexics in the waiting room, where her sense of competitiveness is sparked: "I watched the bony, exhausted-looking girls exiting the office and felt almost doubled over with envy. *I'll get there. I'll show them*." (50; original emphasis). The italicised motivational mantras can be read as thoughts stimulated by the anorexic voice. Moreover, the envy she feels here seems to spur her on to 'become anorexic' too, even though, of course, she is at this point already diagnosed as such, which puts forward the question of what it means to have anorexia; is it the emaciation she so covets, the diagnosis, the voice, all of the above? Her case is thereby an interesting deviation from the 'normal' order of things, where diagnosis follows illness, although it can be argued that before she was diagnosed, she was already wannarexic and therefore, if not ill, then at least highly vulnerable to being so. She reflects on this herself in a discussion of one of the girls featuring in Greenfield's *Thin*, who was also a wannarexic, wondering: "So when is she actually anorexic? When she steps onto the grounds of the Renfrew Center? How many things on the list need to be checked off? When is there really a problem - when she decides that she wants to be anorexic or when she is formally diagnosed?" (129). Through these questions, Osgood points to the invisible divide between wannarexia, which is seemingly unproblematic, and anorexia, which is a diagnosable mental illness and medical problem, thereby highlighting the ambiguity of the notions of health and 'normal dieting'. In this way, she simultaneously invites the reader to situate her experience of anorexia in the general framework of illness and calls for caution in the labelling of people as either healthy or ill.

Osgood's focus in her scrutiny of the anorexics in the waiting room of the treatment centre is purely physical; she is interested solely in the emaciated body, which she "thought must be a transcendent state of being" (ibid). Her description of becoming anorexic is therefore ironically celebratory: “I watched with glee as my collarbone emerged from the flesh of my chest, and presto! I was anorexic” (ibid). This description both confirms how Osgood equated being anorexic with being emaciated and is reminiscent of her statement on the ease of becoming vulnerable to anorexia as: ‘Oh, but it was’, which creates the illusion that she was ill in the blink of an eye, even though she worked long and hard at losing weight. Despite her increasingly shrinking frame, however, she continues to “[consider] [herself] a completely ‘fake’ anorexic” (ibid) due to her awareness of having been a wannarexic, of having actively sought out anorexia. This feeling of fraudulence and ensuing competitiveness is strengthened during her treatment in hospital and to my mind characterises her illness experience of anorexia most clearly. Her primary representational strategy in illustrating her frustration is through comparison with other hospitalised anorexics, and she always draws the same conclusion: “*Thinner, thinner, thinner. Her knuckles could cut glass*. Most of them had been inpatient already and were still waifs, and they spoke nonchalantly of the other places they had been hospitalized [...] In the patient hierarchy, I may as well have been a kindergartener to their master’s degrees [...] I was not sick enough to be there” (57). Significantly, again, the italicised words of comparison seem to figure here as the anorexic voice, although they are first and foremost her own thoughts, too; in her narrative, as, presumably, in her mind, the anorexic voice and her own thoughts are thus impossible to distinguish.

Moreover, the idea of a hierarchy is reminiscent of Jacqueline Segal’s discussion of the competitiveness on EDU’s, and, as in Osgood’s narrative, this hierarchy is based not just on body weight and degree of emaciation but also on the number of hospitalisations and a history of being tube-fed, for example. Thus, Osgood begins to compare herself more broadly on the ‘anorexic spectrum’, shifting her focus from emaciation to more various anorexic achievements. At this point, then, the diagnosis of anorexia is no longer an “*accomplishment*” (84; original emphasis) in itself and neither is being thin; instead, it becomes fraught with expectations that she considers to be integral to a certain worthiness of having received the label, which she will never meet because her onset is ‘fake’. Significantly, after her anorexia has slumbered for two years, she relapses at university, when “[her] brain just clicked. A familiar companion, back again” (148). In her narrative then, the anorexic voice is the principal marker of illness; both in the midst of her illness experience and at the start of her relapse.

Woolf, too, experienced a psychological effect upon being diagnosed with anorexia. Although her illness was sparked by heartbreak, with very little focus on body shape, the diagnosis does add a certain kind of pressure. She explains: “On a personal level, let me tell you what the repeated use of that label does. It makes you sicker; it traps you in the condition. They have defined you as an anorexic, so you must be thin, right?” (17). Woolf, as mentioned before, became afraid of becoming fat. However, she did not, during her period of illness, consider herself *too* fat, as she was diagnosed (accurately, in her view) with “*atypical* anorexia because [she] [doesn’t] have the classic ‘distorted’ view” (74; original emphasis). Thus, the diagnosis of anorexia does not influence her body perception. Rather, it transforms eating into a fraudulent act because “[i]f you were a proper anorexic, you wouldn’t eat” (ibid). Interestingly, this idea of a ‘proper’ anorexic is reminiscent of Osgood’s conceptualisation of ‘fake’ and ‘real’ or ‘authentic’ anorexics and can also be found to some extent in Hornbacher’s evaluation of other, more emaciated anorexics. Hence, it seems to signify something not necessarily particular to Woolf’s mental state but to the illness experience of anorexia more generally, both inside and outside of treatment programmes. The extreme fear that Woolf develops for food and eating, however, is very much her own, and is unlike the food-fears found in the other two memoirs.

Woolf′s fear of food is closely related to her need for control. This need is so strong that when she is “being seriously threatened with hospitalisation” (92) she decides to gain some weight so as to maintain control of her life rather than become institutionalised. This is tied to her conception of hospitalisation as “the beginning of the end” (144). Hence, she pulls herself “out of the danger zone” (94). However, as she herself acknowledges when she is writing her memoir, “[she] never actually got better [....]” (15). At the time of writing, then, she still suffers from “‘functional anorexia’”, which entails that “you have a normal life, a career, a home; you maintain this alongside an eating disorder” (94). Her eating behaviour is thus still disordered and her anorexic mindset remains, as do her fears for eating and food. At the heart of this food-fear is the anxiety over eating and then “never being able to stop” (26), thus spinning out of control.

To my mind, her rules about and fear for food and eating characterise her illness experience most accurately, which she illustrates primarily through memories of troubled eating (or non-eating) experiences. These rules are based on “[her] orthorexic obsession with pure and unadulterated food” (158). Moreover, “[her] food has to be a certain way” (118) and so, she lists: “I can’t eat food which is too hot, but if it’s gone stone cold, forget it. Same with mouth-feel: too hard isn’t good (bread) and too soft is hopeless [...] The consistency of fruit is also crucial for me [...] When I look at food which is ‘wrong’ I just think, *Well, I won’t* *bother. Forget it.*" (117-8). Firstly, the italicised thoughts when food is off somehow could, as in Osgood's narrative, also be read as instances of the anorexic voice. Besides, this exhaustive rule-system means that, effectively, she can eat only very limited types of food. She reflects on this as follows:

> In essence, I can't eat normal food like a normal person: this is what anorexia means. To me, these rules make total sense [...] these are the rules which govern me. I wouldn't call it fussy eating: it goes way beyond that. Faced with unfamiliar food, which isn't the way I can eat it, I'm not being childish; I simply can't eat it. (118)

This inability to eat food that is incompatible with her system makes her feel "[impotent]" (ibid); she feels abnormal and is, it seems, afraid of being considered 'childish' or just a 'fussy eater.' In this way, I think she illustrates well the stigma on anorexia which she conceptualises as perceived as 'selfish female concerns' (see section 1). This example thus functions in her argument as a manifestation of an eating disorder, of a mental illness, which has left her incapable, disabled. In asserting her eating-disordered behaviour and thoughts, she creates a world of illness; the cited passages show the 'seeing as' of her anorexia, the way her mindset works and the ways in which she deals with this.

The most memorable eating-scene is undoubtedly her elaborate (more than 5 pages) description of a work lunch that Woolf was obliged to attend. Significantly, this scene is contextualised through illustrations of extreme anxiety before and after the lunch, too; these moments around eating are in Woolf's case just as compelling as the food consumption itself. She writes: "My anxiety had been building for weeks - the night before the lunch itself I didn't sleep at all." (96). The mental distress that she experiences just by thinking about this future event is telling, and corroborates well her assertion that her food-rules are a disabling symptom of a psychological disorder and not the behaviour of a fussy eater. Moving on to the eating-scene: "I recall the panic inside my head: it seemed insanely early to be sitting down to lunch, I was aghast at the thought of an entire meal. The anorexic voice seemed very loud in the hushed restaurant. Eating now - when you haven't even deserved it, surely it's only the morning? It was 1.30 p.m." (98). Her retrospective recalling of the time reveals that at the time of writing, she can see how the anorexic voice was unreasonable. However, during the lunch itself she was clearly feeling anxious precisely because this voice was convincing her that the idea of eating a full meal at lunchtime was wrong. The notion of volume in describing the anorexic voice is exemplary in this regard; it creates a sense of complete, almost physical and tangible overpowering. After the lunch, Woolf experiences the aftermath: “[...] for the rest of the afternoon, my body was silent. It was satiated - a feeling I’m really not accustomed to [...] the silence unsettled me; it was like there was a dimension missing [...] The spaghetti fears continued way into the night. Twelve hours later I was lying in bed, wide awake, staring into the dark” (100-1). Firstly, this passage exemplifies Woolf’s addiction to hunger, and her sense of confusion when this hunger, and its concomitant high, are suddenly absent. Secondly, the distress that follows eating this one meal lasts extremely long; it stretches almost an entire day. Taken together, then, this lunch caused anxiety not over the course of a few hours - the duration of the lunch - but over the course of several weeks, the fear of having to eat, eating and having eaten all exacerbating each other in the end. In her detailed description of this stress and the logic behind it, she contributes to her creation of a world of illness and a way of ‘seeing as’ a food-fearing anorexic.

A Brief Conclusion

The diagnosis of anorexia, be it a coveted label or not, wields substantial power over the life of the person who is diagnosed. Remarkably, all authors - even Woolf, who did not want to become anorexic and therefore did not ‘read up’ on the illness - have an almost immediate reaction to it. This reaction, in turn, is strongly emotional, and based on a medical interpretation of anorexia: there is a strong sense that upon diagnosis, things must change in order for this label to make sense; that eating behaviour and body shape must be formed accordingly. Thus, there is a certain perception that the medically listed symptoms must be fulfilled. Although their ways of representing their anorexia pre- and post-diagnosis vary, all three authors employ the anorexic voice as a primary representational strategy in illustrating their mental distress. Other symptoms that figure prominently are a preoccupation with the body, food rituals or -systems and the idea of a hierarchy that is created out of comparisons with other anorexics. In the cases of Hornbacher and Osgood, moreover, treatment had an overall detrimental effect on their illness, only aggravating their anorexia rather than reversing any symptoms due to the competitive atmosphere. The question of recovery, then, cannot be answered with treatment, or, as Woolf shows, with weight gain. This question, in these memoirs, remains.

Recovery: Is There Such a Thing, And What Does It Look Like on Paper?

Like the moment of diagnosis, recovery is difficult to separate from the period of illness in anorexia. As Catherine Garrett has argued, “the stories of ‘recovery’ and ‘anorexia’ are inseparable” (47) and in her argument they are therefore part of the same spiritual search, the anorexic period figuring as the negative rite, and the recovery period as the positive one in which the anorexic reconnects with the body and the world and eventually becomes stronger ‘through suffering.’ Pivotal in Garrett’s argument, as well as Merav Shohet’s, is that recovery is dependent upon the construction of a certain kind of autobiographical narrative; that the way in which the life story is told determines the way the narrator perceives her/himself and therefore whether recovery will be successful. This can be related to Sidonie Smith and Julia Watson’s argument that experience is discursive and that people understand themselves through language.

Apart from these more theoretical grounds for not separating illness and recovery in discussions of anorexia, there are more practical questions. For instance: when can we justifiably speak of recovery, and does that mean the end of the illness period? Or is illness part of the recovery period (or the other way around)? And if so, how would this illness/recovery period then fit in the overall illness/illness period? And when is recovery successful? In medical terms, recovery is achieved when the anorexic patient has reached a healthy weight. In psychological terms, recovery is achieved when the mental symptoms have ceased, or when new ways have been established with which to deal with these symptoms. This sounds quite easy: in the first case, you just have the eat, and in the second, you just have to talk (and listen).

In this chapter, I will look more closely at the ways in which Hornbacher, Osgood and Woolf conceptualise their recovery and the representational strategies they use to portray their experiences of this period. As recovery and autobiography are closely related, I will discuss these representations of recovery alongside larger narrative questions, such as narrative intent and reflections on the writing process.

Getting Better, Getting Worse, Etc, Etc: Marya Hornbacher on Recovery

When she was writing *Wasted*, Hornbacher was still in recovery from anorexia, and she reflects critically on this process in several separate parts which she has weaved through her illness narrative. One representational strategy she consistently uses in portraying her recovery is the questioning of the notion of health as indisputably healthy. She writes, for instance: “[t]he first months of ‘health’ are the most dangerous, the body reacting violently to the shock of being fed after years of starvation, the risk of heart attack high” (1). This description underlies the first scene of the memoir, in which she and another recovering anorexic, Jane, are having lunch, “playing normal” and “extolling the virtues of health and staying alive (ibid), when Jane suddenly has a heart attack and has to be rushed to the hospital. Through questioning the taken-for-granted implication of ‘normal’ health as healthy, she also invites the question of whether aiming for normalcy or health when recovering from anorexia is necessarily the most viable option: clearly, although considered ‘virtuous’, the form of health they have been instructed to follow is putting their bodies at risk. At later points in the memoir she also remarks on “[t]he maddening ambiguity of ‘progress,’ the intangible goal of ‘health’” (276) and expresses frustration at not being able to clearly delineate (for herself and for her readers) “little pie charts breaking health down into statistical slices” (284). During recovery, she is thus continually confronted with the ambiguity of ‘health’, trying to pinpoint what it is and how to achieve it. In this way, her ‘world of recovery’ (to slightly repurpose Radley’s concept) is partly characterised by the confusion of the ‘seeing as’. Through making explicit this uncertainty, Hornbacher asks her readers not so much to reposition themselves towards the concepts of health and illness in order to more fully engage with her argument, but rather to question their own understanding of these terms through sharing her confusion.

Drawing on the larger cultural argument she makes in her etiology hypothesis, Hornbacher also identifies her cultural environment as a complicating factor during her recovery. She writes that many women in her immediate surroundings are preoccupied with weight loss and controlling food intake, and that her decision to get better was therefore “a very lonely moment” (283), as the conversations about food and body-aversion are ways of bonding for women and therefore virtually non-stop. She concludes: “Wanting to be healthy is seen as really *weird*” (ibid; original emphasis). Hence, ‘letting go’ of eating-disordered behaviour is difficult for her; she cannot live by example, as healthy or normal behaviour seems to be uncommon, and so giving up this former obsession makes her odd rather than normal: she still does not fit in. Moreover, in this way her narrative can be categorised as an ecopathography, as she relates her recovery process to a larger societal context (as she does her illness period). In a similar vein, she invokes what Smith and Watson have termed the imaginary body, which “reflects social and familial beliefs about the body” (Smith and

Watson 50), thereby contributing to a multiply embodied autobiographical self. The inscription of such social beliefs on the body is highlighted in her introduction, too, when she states her case for recovery: “My terms amount to cultural heresy. I had to say: I will eat what I want and look as I please and laugh as loud as I like [...]” (5). Here, deviation from the imaginary body is portrayed as a rebellious act. I would argue that in this regard Hornbacher’s illness/recovery narrative has political value, in that it comments critically on the dogmas of dieting and having to be thin. The contrast she displays between her illness (when she was often stigmatised) and her recovery (when she realises she is still considered abnormal) in a way also underscores the poignancy of her questioning of normalcy and health as a principal representational strategy; the meaning of these concepts is clearly culturally established and impossible to ascertain.

Another approach Hornbacher uses to highlight her ongoing recovery process is through exemplification of the rupture between her personal and the medical understanding of her recovery. She describes, for instance: “My weight has ranged over the past thirteen years from 135 pounds to 52 [...] I have gotten ‘well,’ then ‘sick,’ then ‘well,’ then ‘sicker,’ and so on up to now; I am considered ‘moderately improved,’ ‘psychologically stabilized, behaviorally disordered,’ ‘prone to habitual relapse’” (2-3). The distant ‘I am considered’ and her use of apostrophes here designate, with a hint of irony, the dissimilarity between how she has been medically classified and how she perceives herself. Moreover, these ‘diagnoses’ stand in stark contrast to other medical interpretations of her health, made years earlier when she was still an inpatient; she describes reading her old medical records and finding “among other things, that [she] [is] ‘chronic,’ a ‘hopeless case.’” (3). In summing up these different diagnoses in quick succession, Hornbacher highlights, again ironically, the odd and arbitrary logic of this practice of labelling: how can she be chronic yet also improved? Through the use of the present tense, she creates a continuum between the past (in which she was ‘chronic’) and the present (in which she is ‘improved’). This rupture in interpretation is also underscored in her description of requesting and reading her medical records in the hospital as part of the research for her memoir (about two years before publishing). She sketches her appearance in the eyes of her old medical staff as follows: “I am Recovered [...] They are proud of me. It was a Long Haul, but I Made It” (143). She is thus conceived of, medically, as fully recovered. This is emphasised by the use of capital letters, which similarly seem to have been employed ironically.

In her private reflections on her medical charts, Hornbacher notes: “I am that girl, still. The ramifications occupy space in every cell of my body, every damaged organ and nerve, every memory tainted and skewed by the obsession that was and is my life” (ibid). Again, there is a sense of continuity that is underscored through the use of the present tense, and she thereby demonstrates the ongoing process that recovery is to her, both physically and psychologically; she is living daily with internal bodily and mental damage and so still lives with anorexia, albeit in a different way. This is similar to Garrett’s delineation of recovery, which is equally unending (which is not synonymous with unsuccessful). Her own conception of recovery, then, is characterised by the ongoing presence of her anorexia, which she alternatively describes as follows: “[i]t and I [the eating disorder] live in an uncomfortable state of mutual antagonism. That is, to me, a far cry better than once upon a time, when it and I shared a bed, a brain, a body” (4). Although she recognises the positive side to the changes she has undergone since her period of illness, she is open about the perpetual companionship of her eating disorder.

This presence of anorexia in recovery is most clearly illustrated through the anorexic voice. Hornbacher describes this in her original afterword, aptly titled “The Wreck: Now”, in colourful terms: “You eat your goddamn Cheerios and bicker with the bitch in your head who keeps telling you you’re fat and weak: Shut *up*, you say, I’m *busy*, leave me alone. When she leaves you alone, there’s a silence and a solitude that will take some getting used to. You will miss her sometimes” (286; original emphasis). In comparison to earlier instances of the anorexic voice, this is a huge turnaround; Hornbacher now ‘bickers’ with the voice rather than yields to it, thereby asserting her agency, and, perhaps most obviously, uses the word ‘bitch’ rather than the abstract ‘voice’ or the affectionate ‘lover’. Moreover, in this passage, the roles have reversed: the voice submits to Hornbacher’s demands, rather than the other way around. However, the positive side to the anorexic voice, which plays a role in the function of anorexia as a coping mechanism, is difficult to let go of for Hornbacher: she describes its slow disappearance as occasioning “an incredible loss” and “a profound grief” (ibid). Despite this being clearly a personal anecdote, it should be noted that in this passage, too, she does not use personal pronouns that directly reflect her; again, she uses ‘you’ and ‘your’. In this particular part of the narrative, I would argue that this ‘you’ addresses two readerships: her general one, and her recovering one. That is to say, her final pages seem to attempt to suggest, despite the generally negative content of the rest of the memoir, some form of hope for recovery. In this way, she is both asking her general readership to identify more closely with her plight and to create an exemplary scene that encourages other recovering anorexics to believe in the possibility of going against the anorexic voice.

Apart from the anorexic voice, Hornbacher describes her ongoing struggle with her anorexic identity. Having developed bulimia and anorexia at such a young age and in order to create a new identity, the identity construction she founded on these eating-disordered selves entailed, she realises in hindsight, that she had to get rid of "what self there was to be begin with" (90). Looking back, she writes: "I began to wonder [...] if total erasure had been my intent all along" (ibid). This complete removal of the remnants of her old self is most painfully experienced during the height of her illness period, when she faces a confrontational fact: "Now there was no self at all. I was a blank" (266). Consequently, during this time, she loses the ability to write, as she "lost the sense of first-person, the sense of being in the world that writing requires" (261). This complete reliance on her anorexic self, with no individual identity to fall back on, complicates her recovery process profoundly. She writes of her therapy sessions: "The experts say [...] What were you like before? And you simply stare at them because you can remember no before, and the word *you* means nothing at all. Are you referring to Marya, the constellation of suicidal symptoms? Marya, the invalid? Marya, the patient, the subject, the case study, the taker of pills, the nibbler of muffins [...]" (279; original emphasis). Firstly, the use of 'the experts' here seems to have been employed ironically, as this abstract entity is depicted as asking a question that, had they been truly expert, they would not have asked; clearly, Hornbacher is not in a position to answer. This again points to a rupture between a medical understanding of recovery and her own: whereas she experiences this as intensely personal, as a crisis of the self, the medical experts seem to be unaware of the highly individual dimension to this process. Moreover, this multiplicity of identities is medicalised, as all of these characterisations (such as 'the patient' or 'the nibbler of muffins') are based completely on symptoms she exhibited during her illness period.

At the time of writing, then, Hornbacher is not convinced that there is such a thing as a full recovery. This becomes clear in her discussion of terminology: "I am all right. We will not deal here with words such as *well*, or *recovered*, or *fine*. It took a long time to get all right [...]" (277; original emphasis). By distancing herself from these words, which imply a sense of health and normalcy, and instead opting for a more ambiguous alternative, Hornbacher indicates the need for terms that leave room for the inevitable ups and downs of recovery, which are not straight-forward and unpredictable as recovery is an incredibly individual and personal process that, in her case, centred on a crisis that encompassed literally everything. In her words: “I no longer had anything that I understood or could believe in” (279). Thus, designing recovery with a focus on weight gain falls grossly short of the needs of recovering anorexics such as her. This conception of recovery is revisited in her new afterword, called “The Letting Go”, which was added to the memoir in a reissued version in 2014. In this afterword, she describes an acceptance of and love for her body and a sense of complete embodiment: “This is it: this body is home. This is where I live and hang my hat [...] I like it here. It is my own” (291). For Hornbacher, recovery turned out to be an effort characterised by a kind of spiritual belief that healing was possible - in this way, she conforms to Garrett’s understanding of recovery (and anorexia) as a primarily spiritual search. This spirituality is, in turn, closely linked to a reconnection with the body, which requires respecting it for its knowledge and work and giving it time to heal from the damage done by anorexia. She also stresses how for her, the reconnection with her environment, especially her friends and family, was important in teaching her to live by example and to step out of her isolation. The psychological side to recovery involves “an active rewriting of [...] thoughts” (303) that dissociates pride or a sense of achievement from anorexia and illness and that instead applies this to strength and health (ibid). She stresses that different strategies work for different people, but is adamant about the fact that full healing is possible and that she came out of her recovery much stronger. However, as recovery is the progression of an embodied being to this state of healing, Hornbacher emphasises that the process itself is non-linear and that it cannot be neatly demarcated from the period of illness and the later period of health: “There is no instant at which we can say of recovery, Here, it begins. There is no day when we arrive, when we say, There, it’s done. We are not stories with narrative arcs [...] We are bodies. We are alive [...]” (306). Thus, like Garrett, she conceptualises recovery as very much a lived process, experienced through embodiment, which cannot be separated from anorexia or from later ‘health’.

As neither anorexia nor recovery can be easily made to fit a narrative frame, since both defy a linear structure and are inseparable, Hornbacher had difficulty writing her memoir. This is closely related to her trouble with remembering her experiences in a concrete and discursive way. She reflects on her writing process: “It is impossible to sufficiently articulate an inarticulate process, a very wordless time [...] This history is revisionist in that [...] way: I have added words, color and chronology to a time of my life that appears to me a pile of random frames scattered over the floor of my brain” (279). The reconfiguration of her anorexic past while still in recovery means, in Garrett’s understanding at least, that

Hornbacher is unable to construct a fully coherent narrative, and her expression of difficulty in finding the right words for an experience that she cannot recollect discursively seems to corroborate that. Moreover, she mentions a near complete loss of memory at varying points in her memoir (e.g. 164; 184; 207; 271). These remarks function to explain why some periods of her life are very scarcely narrativised; for the simple reason that she has no recollection of them. This memory loss seems tied to her emaciation at these varying stages of her illness. In leaving parts of her narrative out, albeit unintentionally done, her autobiographical narrator can be considered prone to conceptions of unreliability and is therefore vulnerable to whether her readers believe in the authenticity of her narrative. In order to strengthen her reader's trust in her, it seems, she does use verifying material. This material consists primarily of excerpts from medical records (e.g. 143; 195; 223) and conversations with family and friends (e.g. 256; 259). In addition, she cites and employs ideas from many theorists prominent in the field of eating disorders and related areas of study, whom she references through footnotes (these include, for example, Susan Bordo, Kim Chernin and Kathryn Zerbe). In this way, her narrative argument is given a broader foundation that enables her to rely on knowledge that is not solely autobiographical; she thereby strengthens her authority as narrator. Apart from a complicated memory recollection, Hornbacher can be said to be employing a complicated autobiographical subject. That is to say, she reflects on her attempts at identity construction in her early recovery period as follows: ”[...] I suppose it's not so strange to create a collage of memory - clippings that substitute for a linear, logical narrative. I did a very similar thing with myself' (ibid). Thus, her self is an invention based on a 'collage' of memories that she is still in the process of reinterpreting and reconfiguring. In this way, the autobiographical 'I' is not a very stable entity, which her descriptions of her ongoing recovery underscore.

As the medical understanding of her recovery already illustrates, Hornbacher has had her fair share of hospitalisations and diagnoses. She is thus intimately familiar with the processes of medicalisation that occur in medical settings, which turned her into "a patient, a case, a file full of forms" (145). Because of her extensive history of inpatient treatment, Hornbacher describes what appears to be her medical autobiography as follows: "The history of my life - one version of it, anyway - is contained in piles of paper and scrolls of microfiche scattered over this city in basement-level record rooms" (3). Interestingly, this medical history is described as just as 'scattered' as Hornbacher's own memory, which, albeit inadvertently, begs the question: are medical records really more reliable than people? Throughout her narrative, Hornbacher questions this through recounting various scenes in which medical knowledge is the ultimate authority and she, and her embodied autobiographical knowledge, its ultimate antithesis. When Jane is admitted to the hospital after her heart attack, for example, she describes asking the doctor to "give her an EKG, take her blood pressure sitting and standing, check her electrolytes" (2) because she recognises the symptoms (having experienced them herself). The doctor ignores her completely, on which Hornbacher later reflects: "I was floored. All I could see was Jane's heart monitor, ticking out her weak and erratic pulse, as this man stood here, peering down from on high, telling me that *he* was the doctor, that I, a mere young woman who had spent fourteen years in the hell of eating disorders, should keep quiet" (ibid; original emphasis). Her knowledge is thus completely silenced and its value discredited. Writing her narrative gives her back the agency that she was denied in this and other situations (e.g. 242-3; 270) and enables her to exemplify how the knowledge that she has gained through her anorexic and recovery period is in fact useful. She therefore says of her intention of writing her memoir: "I would do anything to keep people from where I went. Writing this book was the only thing I could think of [...] I wrote this because I object to the homogenizing, the inaccurate trend in the majority of eating disorders literature that tends to generalize from the part to the whole, from a person to a group. My only qualification [...] is this: I live it" (7-8). To my mind, Hornbacher thus attempts to overturn the medical master narrative through asserting her embodied memory as valuable knowledge. In this way, she simultaneously subverts the politics of memory, declaring that the 'seeing as' in her world of illness (and recovery) should be considered as a serious and genuine contribution to understandings of anorexia. This transforms her autobiographical narrative; it becomes more than a memoir in its insistence that autobiographical anorexia narratives be credited social and political significance.

How to Reappear Completely: Kelsey Osgood's View on Recovery

Osgood's thoughts on recovery in *How to Disappear Completely* are reflective of her conception of anorexia as contagious; for her, avoiding triggering material was the most important hazard to overcome. This began during her final hospitalisation, of which she writes: "[...] if girls began to talk about weight, I would hum low to myself so I couldn't decipher the specifics. Sometimes I was bold enough to ask them to change the topic, which was code for 'I'm out of the game'" (69). This game is, presumably, the perpetual competitiveness that reigned on the EDU and which was played through the sharing of anorexic specifics. At the time of writing, she is less vulnerable to such information, as she "finally developed a skin when it comes to the disease" (ibid). However, she does confess that she has deliberately not requested her old medical records while doing research for her memoir, afraid that "poring over the clinical reports and personal accounts will eventually, if not immediately, inspire me to stay up until all hours, contemplating, calculating: *If Anorexic A was this tall and weighed this much, she was definitely more underweight than I was, which means I wasn't a good anorexic*" (82; original emphasis). The italicised reasoning indicates the anorexic voice, which would entail that just by seeing and comparing old medical records, the voice will return. Hence, Osgood is not completely over the competitiveness and the preoccupation with comparing anorexic achievements; it is only through deliberate avoidance of triggers that she can live a life without the presence of the anorexic voice.

Her vulnerability to this voice, even in a limited way in recovery, can be related to her ongoing sense of fraudulence in thinking about her illness, which she repeatedly remembers as either non-existent or not severe. She reflects on this halfway through her narrative: "I realize now that the nonexistence of my eating disorder is sort of a hard shell. It looks pretty real on paper [...] Compile my anorexic résumé and no sane individual would give any merit to my claims of 'fake' or 'less than' anorexic status" (161). Through reading her writing, then, she is confronted with the fact that she is in a way dodging the acknowledgement of her anorexia. Yet, on the other hand, it does seem as though this insecurity with regard to her illness has prompted her, at least in part, to write her memoir. She argues, with incorporation of what appear to be the remnants of her anorexic voice: "*Maybe this is a good plan*. Maybe I should get all the information together, write a blow-by-blow narrative, make it something I can *touch* and therefore not *deny*, and finally lay it to rest" (162; original emphasis). Thus, through the construction of her illness narrative, Osgood seems to be looking for some sort of validation, which will then confirm that she was ill, and severely so, after which she can let it go. Simultaneously, however, Osgood does impart that her tendency to romanticise mental illness and anorexia slowly faded by her final hospital admission; that at that point, she "felt the allure of the insane asylum, the aura it emanated, lessen" (187). Yet this idealised picture has not, at the time of writing, completely disappeared (192). Hence, for Osgood recovery seems to be primarily a time of major contradictions, during which her desire to get better is larger than but still competing with her anorexic thoughts, especially in moments of doubt about the gravity of her illness period.

Osgood's primary representational strategy in portraying anorexia in its illness and recovery stages is an intentional avoidance of detail in terms of anorexic behaviours and achievements. Hence, she writes her memoir without detailing weight, caloric intake and behaviourisms. This is grounded in her conceptualisation of anorexia as contagious and spread through triggering material. In her view, this strategy is not only a responsible choice but also the most accurate and reflective of her illness experience. She writes: “After all, as an anorexic, I could never really possess my lowest weight. When I saw it on the scale, it was a lie [...]” (36). The same goes for her food intake, which she would calculate religiously but never consider reliable (ibid). Osgood thus argues: “if I were to lay it all out [...] I would be rendering an inaccurate portrait, making my disease seem tangible and solid when really the experience of it is deviously ephemeral” (ibid). This is reminiscent of Hornbacher’s characterisation of her illness and recovery periods as impossible to articulate, due to the fact that no words seem to accurately signify her experiences. Osgood’s subversion of the common practice of detailing anorexic behaviours and specifics in anorexia stories is, she argues, a conscious turn away from what she describes as the “misery memoir” (29), with its concomitant logic of “[t]he more horrifying one’s tale, the better the book sells” (ibid) (this is reminiscent of Garrett’s characterisation of popular anorexia narratives). In this way, Osgood similarly deviates from Couser’s conception of illness/disability narratives as nobody memoirs, as she does not aspire to write a different embodiment; rather, her memoir functions as a warning, a red flag, which does not necessarily celebrate or revisit difference. In her desire to communicate caution around triggering material, Osgood does politicise her narrative, making a case for a revision of cultural norms.

Her deviation from ‘traditional’ anorexia narratives through the avoidance of specificity is also exemplified in another element of her narrative intent, which is to “devalue [anorexia’s] currency” (37) through “[attempting] to show the bloody blue innards of the monster as opposed to its gleaming, sharp fangs or elegant black cloak” (ibid). In aiming to make anorexia unappealing to her readers, thereby minimising her wannarexic readership’s vulnerability, Osgood’s memoir can be characterised as a didactic pathography - in Hawkins’ understanding of this term - as she is primarily occupied with providing information and preventing romanticisation. Moreover, she diverges, to my mind, from the construction of Radley’s ‘world of illness.’ Although she does, to some degree, compose her story as a way of ‘seeing as’ rather than ‘a story about’, the reader is not drawn into the narrative through the centralisation of a different embodiment. Admittedly, this seems to be the point, as it enables her to voice criticism from more of a meta-level. Furthermore, it could be argued that, despite conforming for the most part to able-ist constructions of health and illness, she does demand of the reader a repositioning with regard to these terms; in her discussion of wannarexia, she does exemplify the ambiguity of the dividing line between illness, mental illness and vulnerability to illness. As wannarexia is examined not only within her own life but also within the larger scope of her cultural climate, Osgood's memoir can, as I argued before, also be categorised as Hawkin's 'ecopathography', for this contextualisation is central to her narrative.

Osgood argues that an important part of her recovery process was "sheer intellectual maturation" (227), as she slowly began to distance herself from her teenage identity construct - based on a romanticisation of mental illness and self-destructive behaviour - and to move more towards connecting with her family and friends (ibid). However, contrary to Hornbacher she does not perceive of recovery from anorexia as something that has made her stronger. She writes: "The normal processes of physical *and* emotional maturation were compromised. My bones and my brain and my heart [...] are weaker than they would have been had I never developed anorexia, and while I can help them to grow now, nurture what is left, they will never be as strong as they could have been" (244; original emphasis). This conception of anorexia is completely opposed to Garrett's argument, as it conceives of anorexia as an illness only, and not as also a spiritual search or a coping mechanism. In this way, she both does and does not cohere to Frank's quest narrative; on the one hand, she explicitly uses her own illness experience in the construction of a larger project, aimed at de-romanticising anorexia, but on the other hand this illness experience has not for herself been worthwhile: nothing has been gained, things have only been lost. It is only with regard to the former aspect, then, that her narrative can be placed within this category.

Unlike Hornbacher, Osgood does thus not perceive of recovery as a life-changing and extraordinary effort. In fact, she writes: "It is difficult to recover, but remarkable it is not. Approximately 90 percent of people who suffer do it" (246). This is tied to her argument against romanticised language in discussing anorexia, in which recovery is considered a remarkable feat that falls in the category "[s]truggle makes you stronger"" (ibid); the celebratory language used in discussions of recovery she sees as perpetuating the illness' mythical aura, as it inscribes the illness experience with a symbolic value it did not have before. Yet she does not minimise the challenging nature of recovery and admits, near the end of her memoir, that she has continued to be in the process of letting go while writing. To her, letting go ultimately means removing anorexia from her life completely, and she invites the reader to bear witness to this pivotal moment in her life and, by extension, her memoir: "I'm letting go. I’m actually doing it, right now, right this second. There is a pang of terror, still. Who will I be if I let go of my past [...] I write my future and there is no anorexia in it. I accept all the ramifications of my signature” (256). Osgood figures here as completely in control - both in the narrative and in her life - despite anxiety over what will remain of her identity without anorexia and over the unknown effects her memoir might have in the lives of other people. I would argue that at this point, near the end of her narrative, a shift occurs from Shohet’s SR (struggling to recover) to FR (full recovery) genre, as Osgood explicitly breaks away from any left-over remnants of her anorexia and clearly asserts her agency in designing her future. This not to say, however, that she posits the idea of a full recovery as possible. Moreover, she writes: “Is this the moment when everything makes sense, or did I miss it? [...] It must be in the near future, that elusive *soon* [...] This is the end of the story” (257-8; original emphasis). In posing this question, she shows an ongoing reinterpretation and reconfiguration of her past, present and future. Notably, although she boldly asserts her story’s ending here, the tentative phrasing of ‘that elusive soon’ invites a reading more closely aligned to Garrett’s and Shohet’s understanding of recovery as non-linear and uncertain; ambiguous and possibly unending.

In hinting at her ongoing re-interpretation of her illness experience, Osgood alludes to the complicated role of memory in her narrative, of which she writes: “even memories morph into something new as time passes” (254). Yet, although her illness narrative is based on personal memories, Osgood also uses other sources of knowledge; it seems as a means of verification. These sources are varied but include, for example, a study on pro-ana websites (92), the Minnesota Starvation Experiment (94-6), a *New York Times* article on the romanticisation of anorexia (96) and a *Newsweek* review of *Going Hungry* (243). In addition, Osgood deploys ‘biographic’ material, such as her friends’ descriptions of her when she was ill (143) or remembered comments from former hospital staff members (153). Hence, although her narrative is a memoir that is shaped around her life, it is also an essay on contemporary culture, and this variety of sources underscores the aim of Osgood’s larger project. In this way, the fluidity of identities that is characteristic of autobiographical writing is relatively limited in her memoir. This is due to the fact that she often takes up a meta-position, redirecting attention from her own story to larger cultural movements. Although she thereby contextualises her own experiences, this larger scope does not stand in service of her personal narrative; if anything, it is the other way around. Hence, she primarily employs figures of the body as ‘neurochemical system’ and ‘imaginary’ - in Smith and Watson’s terms, then, she does write from a “multiply embodied” (50) viewpoint, as her ill and recovering body and the imaginary body actively interact. Moreover, the cultural commentary she delivers is clearly from an ‘in hindsight’ perspective, and so there is no real conflation between her anorexic self and her recovering/recovered self; her illness narrative is clearly constructed out of insights gained in recovery. However, Osgood’s difficulty in accepting the validity and severity of her anorexia relativises that somewhat, as before the shift from the SR to the FR narrative there is a perpetual sense of lingering anorexic thoughts.

“Maybe, One Day, Cake Might Be A Pleasure”: Emma Woolf’s Recovery Memoir

Woolf’s *An Apple a Day*, subtitled *A Memoir of Love and Recovery from Anorexia*, is the only memoir that places recovery centre stage: her narrative is structured around recovery rather than illness. Her wish to have a baby is the main motivation for recovery, as she is at the time of writing still infertile due to being underweight. Significantly, Woolf explicitly ties recovery to a return to normalcy and health and relates this in turn to being grown-up and human: “I’m going to [...] start eating normal food, like a normal person, in a normal way [...] I’m not going to starve myself anymore; I’m going to be an adult and feed myself [...] I’m going to rejoin the human race; I’m going to take part” (14). This description both conceptualises anorexia as abnormal/disordered and recovery as a transformation from this deviant state to that of normalcy and health, which is a state that the rest of her world already occupies and which thus signifies humanity at large. The association with adulthood is emphasised by Woolf’s conception of anorexia as “a young person’s game” (21) and recovery as a turn away from that. She argues that “[p]art of this journey of recovery, and part of growing up, is that I have to accept I’m wrong” (54) and so she has to reconcile herself with societal conceptions of health and (normal) eating and devalue her own. Although she thus equates her illness with immaturity, this seems to be a purely personal metaphor as she is aware of the ageism that exacerbates the stigma experienced by anorexics of older ages. Notably, she uses here one of the metaphors that Hawkins has stipulated as characteristic of many illness narratives; that of a journey. As she mentions this journey and ‘growing up’ in the same breath, it may be assumed that recovery is to her what Osgood has called ‘sheer intellectual maturation’, which has connotations of ageing but which is not directly related to it.

Woolf is convinced that “[t]here is no magic bullet” and that “[t]o beat anorexia you have to eat” (14). As mentioned in the delineation of her illness trajectory, this is exactly what she finds the most difficult, as she relates eating to neediness and greed and therefore considers it incompatible with her need for control. Hence, she describes her primary concern in recovery as follows: “I worry that if I start, I’ll never be able to stop. And anyway, I don’t think I deserve to eat” (22). While convinced that for her, eating is the cure, as it will open the door to fertility and the possibility of starting a family, she is also aware of the fact that this will be the hardest part of her challenge. She explains this through her conceptualisation of anorexia as an addiction:

> Recovery from anorexia is hard, because it involves a whole new way of thinking [...] I gave up smoking [...] but *starting* to eat is a different challenge altogether. Getting through the withdrawal of nicotine was tough [...] but [...] there were immediate benefits to kicking the habit [...] With eating, for a recovering anorexic, there seem to be no rewards: all that will happen, for a certainty, is that you will gain weight. And that’s the thing you dread above all else. (22; original emphasis)

Firstly, this passage provides an example of a shift in personal pronoun, from ‘I’ to ‘you’, which can also be found in Hornbacher’s text, and which similarly seems to invite the reader to become more personally invested in her argument and situation. Secondly, it becomes clear here that the comparison with addiction is only accurate when it comes to describing anorexia as illness; not recovery from it, because this is based on an opposing set of behaviours. This is tied to the high from hunger that Woolf considers as primarily addictive. In order to ‘kick the habit’ of starvation, she will have to get used to the absence of this high, and the absence of an empty stomach. In the aftermath to the work lunch described in chapter 2, Woolf already confessed difficulty with feeling satiated, and while writing, during recovery, she is still struggling with such bodily sensations as fullness, as she feels this “throws everything off kilter” (101). Significantly, in her desire to remain in control during recovery, Woolf sets out “*red lines*” (ibid) at the beginning of her memoir, stating what she will and will not be eating, despite being aware that this is “part of the problem” (23). This way, she exhibits features of Shohet’s SR genre, in that in such moments she can be cast as ‘an experiencing patient’.

As Woolf made her recovery process public through her weekly *Times* column, there was a certain pressure to make progress, and to do so within a particular time frame. This makes her feel anxious at times because she feels burdened with providing an ending, and so she asks her reader rhetorically: “You know how it’s supposed to end, right?” (108), thereby explicating the general expectation, on her reader's part as well as her own (and her editor's) that she will be recovered - or as good as recovered - by the end of her narrative. This pressure comes with an accompanying sense of responsibility, and she candidly describes the moment when it dawned on her that through writing about her recovery from anorexia, she was responsible for that narrative and its consequences: "These were real people's lives: young men who'd never spoken about it, children whose parents were sick with worry [...] My intention had been to document my own experience and yet people seemed to relate to it" (29). Whereas Hornbacher and Osgood relate experiences of being influenced by various cultural representations of anorexia, Woolf *is* such a representation, and this role weighs heavily on her shoulders. Following that first realisation she therefore adapted her strategy somewhat: "That was a good lesson to me [...] in the power of the printed word: I've learned to be careful - still honest I hope, but careful - about what I write" (29). An example of this is her reluctance at documenting her weight gain in her column, as she is aware of the triggering nature this information can have for some of her readers (196). This reveals how her first incentive to write about her recovery from anorexia, namely to use publicity as a motivational factor, quickly shifted to a more general agenda, that was less focused on her own struggle and more connected to those of others.

Near the end of her memoir, looking back, Woolf writes of the publicity: "The exposure has been a mixed blessing: it has given me a purpose and a structure, a reason beyond myself for getting better [...] But it's also been difficult, at times, to keep writing about it." (230). The writing process was thus intricately related to her recovery process, as her readership came to play a large role in her motivation to get better. Although her wish for a baby was already a strong incentive, Woolf reminds her readers that "[a]t the heart of anorexia is a belief that you're not really worth a damn" (33) and that this depersonalisation, this larger scope, made it easier for her to continue eating; the responses to her column figured as a kind of affirmation, which is why throughout her memoir there are many excerpts from emails from readers with advice, words of encouragement and personal stories. These clearly play a vital role in her recovery, and so they do too in her narrative. Yet Woolf also acknowledges how challenging it has been to read the negative responses that inevitably started dropping in too, especially given her general dealings with rejection and failure. She writes: "When you're honest in the media people seem to think you're not vulnerable [...] Everyone has an opinion, especially when it comes to anorexia or other people's weight"

(230). Although this public recovery was, of course, her own decision, she does express feeling overwhelmed at the responses to her original article (29).

Significantly, Woolf also seems to incorporate her reader's responses to show the incredible variety of instructions she receives, thereby highlighting that normal or healthy eating is not a straightforward and uniform practice. Using the advice from both recovered and recovering anorexics, as well as that of her general lay readership, friends and family, she compiles all these different perspectives on eating and body care which the reader of her memoir can in turn read, too, as they are weaved through her own reflections on recovery. She writes, for example: "My mother says I need more cheese, healthy fats and oils in my diet [...] A woman from Paris emails that I should start eating meat and fish again, a professional cyclist from Scotland writes that 'seven pots of Quark per week' has been key to his physical rehabilitation" (127). Thus, whereas anorexia may appear in distinctive ways, so do general 'healthy' and 'normal' eating. The picture Woolf paints is therefore very diverse, and showcases her own confusion at all these different ways of eating and being healthy. In this way, she adopt a strategy similar to Hornbacher's, who also questions normalcy and health in her narrative argument.

The responses to her column also function as a means of verification and contextualisation. Woolf thus relies not only on personal memories, but also on those of others, thereby creating relations between her story and the stories of her readers. In this relationality, she is vulnerable as an autobiographical subject, as her agency in the memoir is relativised through this shared larger narrative. Yet, through this broadening of the autobiographical 'I', she simultaneously strengthens her overall argument, namely that anorexia is a serious and widespread problem which manifests itself in highly individual ways. In addition to these reader's responses, Woolf employs statistical data on anorexia (62), a study on abstinence in young girls in Ghana (141) and the findings of the Ravello Profile (235), among other things, to make a more solid case for her understanding of anorexia as an illness with neurochemical and cultural roots. She also relates conversations between her and her friends and family (e.g. 48), and between her and her psychiatrist (109), thus using biographical information. As her conceptualisation of anorexia is primarily that of a medical and cultural problem, the autobiographical 'I' is multiply embodied, as it is in Osgood's narrative, as functioning as 'neurochemical' and 'imaginary' body. In its laying bare of the reciprocity between subject, body and world, Woolf's memoir can similarly be categorised as an ecopathography and, in its aim to create awareness through spreading knowledge, as a didactic pathography.

The knowledge conveyed in the memoir is gained through first-hand experience with anorexia and through its concomitant different embodiment, both through recollecting memories of periods of illness and through reflecting on the period of recovery at the time of writing. Woolf is aware of the relatively ‘subversive’ nature of this source of knowledge. However, her correspondence with readers often entails her giving advice about recovery, either directly to recovering anorexics or indirectly to concerned parents of friends, and she writes about this: “[...] even though I have anorexia, I strangely *do* feel qualified to offer advice. In a funny way I’m more expert than any doctor or specialist, because I’ve been through recovery and I’m still going through it [...] I am intimately familiar with the dangers and triggers” (131; original emphasis). In this way, she values what Garrett has described as the “bodily, metaphorical, poetic ways of knowing” (Garrett 177) which are integral to overcoming the mind/body split characteristic of the illness experience of anorexia. Although Woolf is still struggling to come to terms with her body, a process that functions as a constant through the memoir, this acknowledgement of embodiment as knowledge is an important element to her recovery, and in concentrating her narrative on this constant repositioning towards her body, she creates a ‘world of recovery’. Not only does she construct a space for her readers in which they can understand recovery from anorexia as a way of ‘seeing as’, thereby requiring them to align themselves with her conceptualisation of the illness and of health, but she also occasions what Radley has termed ‘a lived ethics of bodies’ through centralising the slow progress her recovering body and mind are going through. In this way, she can similarly be said to fit in Couser’s idea of the nobody memoir, as her skepticism towards normalcy and her detailed elaboration of the physical and psychological developments in recovery create a deeper understanding of different embodiment which simultaneously questions hegemonic understandings of health and illness.

Woolf’s recovery encapsulates her entire memoir and, like Hornbacher in her original publication of *Wasted*, she does not believe in the possibility of a full recovery. She argues that “you never completely get over anorexia. It’s a deep scar, a mindset which stays with you for life, no matter how ‘normally’ you learn to eat, no matter how well you learn to live with it” (59). Firstly, the use of apostrophes in describing normal eating indicate Woolf’s scepticism when it comes to the existence of normalcy in eating and thus the dogma that requires her to return to that state. Moreover, she points here to the impossibility of removing the psychological dimension to anorexia, which seems tied in part to her idea of anorexia as primarily a neurological disturbance. Yet it also relates to her fear of giving up her anorexic identity, as she "[fears] that when the anorexia is gone, something huge will be missing" (148) in her identity construct, and she has no clear idea of how to replace that loss. Like Hornbacher, then, Woolf sees recovery as a crisis of the self, which makes it intensely personal. Because of this intimate dimension, however, recovery does come to figure as a journey akin to the positive rite of the spiritual search that Garrett describes. That is to say, Woolf believes that her anorexia and subsequent recovery have had a meaningful impact on her identity construction, despite the fact that she has lost much on the way. She writes: "I'm a different person from who I was, pre-anorexia [...] I'm quieter and more reflective [...] I have fewer but closer friends. The illness made me vulnerable but also more resilient" (237). The idea of resilience put forward here is comparable to what Garrett sees as a strengthening through suffering. Hence, Woolf concludes: "Nothing in life is wasted; everything is experience. Mental illness, too. In the oddest way, anorexia got be back in touch with myself. I can't pretend that I would have chosen to take the path I took, but I think I'm finally getting to where I need to be" (238). I would argue that in reflecting on her illness experience in this way, Woolf challenges the conception of disability or illness as completely unwelcome and devastating, because she underscores how, being experience, mental illness does not equal a regression in/of life.

Despite the hardships that her writing process came with, Woolf believes that sharing her story is important. She argues: "I want to challenge the stigma of mental illness and explore eating disorders from the inside. I'm writing this book because I genuinely think that it will help me (and others) beat anorexia" (167). In this way, she emphasises again how writing and recovering are closely related for her and, moreover, expresses a belief in the worth of her narrative for other recovering anorexics. This is an important realisation on her part, as it enables a way of conceiving of her memoir as more than an autobiographical or illness narrative, namely as also a cultural and political commentary with an activist aim at heart (hence the fitting categorisation as ecopathography). Moreover, through employing her own memories and experiences in order to convey a message, she goes against the politics of remembering, claiming a position from which to remember and recover, and remember and help others. This challenge, in combination with her desire to battle stigma, simultaneously underscores her aim to, like Hornbacher, reconfigure her marginalised position in such a way as to imbue it with autobiographical and larger societal value.

Concluding Remarks

Recalling the practical questions posed in the introduction to this chapter, a few things have become clearer in looking at the conceptualisations and representations of recovery as put forward by Hornbacher, Osgood and Woolf. Firstly, the beginning of recovery is not an identifiable moment in time, and neither are the end of illness and the beginning of health. Thus, it is impossible to construct a clear recovery period that is radically set apart from the illness period; rather, it seems to be more of a natural, non-linear flow. In this way, Garrett's idea of anorexia and recovery as part of the same period in life, be it a spiritual search or not, is very useful, as it allows for inevitable proneness to relapse. Moreover, the idea of success in recovery does not seem to be something that can be generally established; as with the period of illness, these authors illustrate the highly individual ways in which they have gone through or are going through recovery. To use language that indicates a generalisable and full recovery is thus unhelpful; as this and the previous chapter have hopefully shown, the ways in which anorexia and recovery are medically talked about are too black-and-white, too focused on binary structures such as health/illness and normal/abnormal to discern the lived experience situated in the middle.

Conclusion

In the introduction I raised the question of whether the documentary *Emma Wil Leven* would have benefited from a more autobiographical perspective, focussed primarily on Emma's own expression of her experience with anorexia, had she survived her recovery. I think that, after the elaborate discussion of three autobiographical illness narratives in the preceding two chapters, it is safe to say that such a shift in perspective could have had (at least) two different outcomes. On the one hand, more emphasis on her individual viewpoints and feelings would have made possible the creation of a world of illness and could thereby have enabled her to construct her way of 'seeing as' during her illness and recovery periods which, as my discussion of the memoirs has hopefully shown, is not a generalisable and quantifiable perspective; the 'seeing as' may change during the illness and recovery experiences and is very different for each (recovering) anorexic individually. Had Emma's narrative been autobiographical, then, her knowledge (gained through experience) would have been presented as valuable on its own terms. Consequently, the documentary would have required its viewers to reposition themselves with respect to their own understandings of anorexia and (mental) illness. On the other hand, as studies on stigma, mental illness and the illness narrative have shown, it would have been difficult for Emma to be considered a reliable narrator in the traditional sense of the word; although her narrative might have been considered authentic, her overall argument might have been questioned. Hence, although an autobiographical framework would certainly have contributed to a more experience-based understanding of anorexia, it is questionable whether Emma's position as narrator would have been characterised by viewers as something other than a manifestation of mental illness or psychological disturbance (much as it is now), and whether the impact it has had would have been equally extensive had her own testimony outweighed those of the people she loved. After all, as Couser has argued, authors of autobiographical illness narratives are generally as marginalised as their work, and so perhaps the emphasis on the biographical rather than autobiographical - a move away from (vulnerability to) marginalisation - is what sparked and enabled the widespread interest in viewers of *Emma Wil Leven* to think more deeply about anorexia.

My point in returning to Emma's story is not to explore alternate realities, but rather to give an indication of the difficulty in creating and interpreting cultural representations of anorexia, in which an autobiographical structure may both facilitate and complicate an understanding of the illness experience, depending on the framework within which the reader/viewer/listener is engaging with this representation. As the memoirs by Hornbacher, Osgood and Woolf all show, the autobiographical aspect to constructing an illness narrative is far from straightforward, especially when still in recovery, and this personal aspect was in all of their cases linked to a larger narrative argument that centred on the transformation of societal understandings of anorexia. In their incorporation of other material as sources of verification and contextualisation, they reveal their need to rely not just on self-representation but on representation through others as well. Although this trend may also be identifiable in other illness narratives or even memoirs generally, I do believe that with particular regard to the memoirs discussed in this thesis it indicates a need specific to the autobiographical narration of anorexia, in which ideas such as reliability and truth value seem to be quite contested and in which a certain degree of specificity can, if we follow Osgood's line of reasoning, be contagious and stimulate anorexic behaviours, yet a lack thereof be considered a symptom of a shaky memory, as in Hornbacher's text.

This conflicting set of factors is intimately linked to the question of readership and its concomitant framework for interpretation which, unfortunately, I could not address adequately in the limited scope of this thesis. However, as the three memoirs make clear in their individual ways, the readership of anorexia memoirs is generally a diverse one, a substantial part of whom is often personally invested in learning something from the narratives; be it anorexic eating behaviours, advice about recovery for a loved one or oneself, or general information to make anorexia more insightful, either on a personal or professional level (for example in medical settings). It does seem, then, that the reading experience of anorexia memoirs is characterised by more than an interest in someone's life or illness experience; they do appear to have a pedagogical function (for better or for worse). Hornbacher, Osgood and Woolf seem to be aware of the almost opposing ways in which their readers may approach their texts. That is to say, in their delineation of their narrative intent they reveal a desire both to produce a memoir that illustrates for a lay audience the ways in which anorexia manifested itself in their lives - thereby in a way 'educating' their readers through exemplification in an attempt to battle stigma - as well as a warning for wannarexic, anorexic and vulnerable potential anorexic readers as to the severe ramifications of anorexia and an expression of hopefulness and positivity with regard to recovery. Addressing these readerships at the same time, through the same narrative and in the same way disregards the very different ways in which readers may interpret their texts (Seaber 490). That is to say, what may be taken as a merely informative text for some - for example for medical professionals curious about the lived experience of anorexia - may be taken as highly triggering for others, for example for recovering anorexics or for readers who are especially vulnerable to develop the illness. In order to do justice to this dimension of the reading experience of anorexia memoirs, studies on reception would have to be incorporated, as well as, arguably, a wider selection of illness narratives.

As to the memoirs themselves, my main research question for this thesis has been how they illustrate the lived experience of anorexia nervosa and to what extent and in what ways they comply with or subvert the medicalised discourse on anorexia and disability. The discussions of the memoirs in the second and third chapter have hopefully made clear that the lived experience of anorexia nervosa is incredibly personal and therefore cannot and should not be homogenised. This is illustrated through the very different ways of ‘seeing as’ that Hornbacher, Osgood and Woolf construct in their worlds of illness: although they mention overarching symptoms (such as the anorexic voice), these are neither described or experienced in identical ways. This seems tied to the very individual ways in which they conceptualise their anorexia’s onset and the meanings they have ascribed to the development of their illness through their etiology theories. The process of ascribing meaning to the illness and recovery period is integral to the construction of an illness narrative and does, as Catherine Garrett and Merav Shohet have argued, seem to affect the ways in which the authors experience themselves and their (recovery from) anorexia. In this way, then, they also exemplify Sidonie Smith and Julia Watson’s argument on the discursivity of language; the highly individual ways in which Hornbacher, Osgood and Woolf write about their anorexia may well be an important factor in the ways in which they experience themselves and their recovery, too.

Despite the ‘seeing as’ being very personal, we can for the sake of argument revisit some of the primary strategies that the authors have used to illustrate their lived experience with anorexia and draw a preliminary conclusion about this experience. Firstly, the practice of diagnosis had an extensive influence on the illness experience of anorexia for all three authors; it seemed to spark a more speedy development of the illness and added a certain symbolic value - a value that was different for each of them but that in all of their cases transformed the label anorexia into (the beginnings of) an identity construct based on an anorexic ‘seeing/being as’. Moreover, the anorexic voice figures as an important feature of the illness experience; this voice appears at moments of doubt, during lows in the illness period and at the start of relapses, for example, and has the ability to wield complete power over the anorexic. This power is used, in turn, to spur the anorexic on to lose more weight, for example through the cutting of food intake or through the development of very complex food rituals that make eating an ever more anxiety-inducing practice (as can be seen in Woolf's recounting of her work lunch, for instance). The fear of or anxiety over food and eating is thus a related illustration of daily life with anorexia; in Hornbacher's and Woolf's texts, the reader is regularly confronted with long passages describing intense eating experiences that transform the practice of consuming food into a ritual of some sort, to use Garrett's terms, and that thereby highlight the completely different conceptualisations of the health/illness and normal/abnormal binaries during the anorexic period. Osgood's narrative, conforming to her desire to produce an 'unanorexic' text, is as good as devoid of such scenes. She primarily illustrates her life with/recovering from anorexia through the sense of competitiveness she has identified as characteristic of anorexics and anorexic communities and employs Jacqueline Segal's concept of a hierarchy repeatedly. The idea of competing against other anorexics is, remarkably, something that does not require other anorexics to be physically in the room with her; with the 'assistance' of the anorexic voice, Osgood can compare herself and the validity of her sense of being a 'fake' or 'fraud' with others through memory of anorexic achievements of fellow anorexics.

The difficult relationship the authors have with food and eating can be related to their similarly troubling connection to their body: as I argued in chapter 2, an important psychological symptom that drives much of their anorexic behaviour is a complete disconnection from the body or the wish to be without body at all. In this way, Hornbacher and Woolf very explicitly sketch their relationships to their bodies, their 'anorexic embodiment', and can be placed in Couser's category of the nobody memoir. However, neither they nor Osgood really celebrate this different embodiment; although they certainly require the reader to revisit the commonplace understanding of the health/illness and normal/abnormal binaries through centralising the progress of their anorexic/recovering bodies, they do conceptualise anorexia as a horrible illness. Then again, both Hornbacher and Woolf indicate near the end of their memoirs that the illness and recovery experiences shaped them into people they value being; more so than the people they were pre-anorexia. In this way, they express similar feelings as Garrett's participants and their illness and recovery experiences can therefore be classified as parts of the same rite of passage, especially since in both of their cases the process of constructing an autobiographical narrative played such an important role. The notion of celebrating different embodiment may thus be too strongly worded, but the idea of appreciating the outcome of the path taken is certainly applicable in their cases. Osgood stands in stark contrast to this type of appreciation; she laments having been wannarexic and anorexic as she considers the illness experience to have been an obstruction to her individual growth. Similarly, her narrative, although to a certain degree related to her recovery process, is less focused on her personal struggle to recover than it is on figuring as a warning for others.

To what extent and in what ways, then, do the authors comply with or subvert the medicalised discourse on anorexia and disability? First of all, they differ significantly in this regard. Hornbacher explicitly voices criticism towards medical practices, primarily through questioning the notion of health or normalcy as an aim in recovery, which, she makes clear, is not realistic or even ‘healthy’ for the recovering anorexic body. Moreover, she notes on several occasions how her embodied autobiographical knowledge was silenced in favour of medical knowledge, which endangered either her own or another anorexic’s body; in this way, she questions the validity of the hegemony of the field of medicine in producing understandings of and treatments for anorexia, as it does not take into account, even actively ignores, the lived experience of (recovering) anorexics themselves. This defiance towards the medical model corresponds to the social model of disability studies’ resistance towards the conception of disability as lack or deficiency; although Hornbacher concedes to having been physically and mentally impaired at varying stages during her illness, she opposes the idea that because of this disablement her voice is not worth hearing. Woolf makes a different case, as she conceives of her anorexia’s etiology as largely determined by neurological factors. In this way, she adheres to the biomedical explanatory model of anorexia. However, through the incorporation of responses from very diverse anorexic readers, and through her delineation of her own development of functional anorexia, Woolf does contest the importance of body weight, both for the practice of diagnosis and as the medical marker of success in recovery. She is adamant about anorexia being a *mental* illness and therefore places the root of the problem in psychological disturbance, which cannot be fixed through bodily restoration to health. Moreover, she questions the existence of the concept of a standardised and measurable health and/or normalcy, which can similarly be seen as a move away from medicalised discourse. Osgood, finally, is equally divided. On the one hand, she considers anorexia to be primarily a cultural phenomenon and therefore does not agree with the biomedical explanation of the illness’ etiology. However, she does believe in a more medicalised form of treatment that does not leave room for the construction of anorexic hierarchies and competitiveness. In terms of recovery, then, Osgood does vouch for a medical approach that treats anorexia as an illness that can be 'cured' (although she does not commit to the existence of a full recovery). Against medicalised interpretations, and in line with Garrett's argument, all three authors agree to some extent that anorexia and recovery cannot be separated, thereby blurring the common conceptions of anorexia as equated with illness and recovery as equated with health; by conceiving of these processes as intertwined, and by positing the impossibility of full recovery, their narratives thus subvert medical understandings of anorexia and disability.

Much more research can (and should) be conducted on the relationship between the construction of an autobiographical illness narrative and the recovery process from anorexia, as well as on the deeper connections, on a linguistic level, between the work produced in the fields of disability, mental illness and anorexia that further explores the ways in which anorexia memoirs explode, in more ways than one, the traditional binary constructions that determine our view of what it means to speak of a healthy or ill body and mind. Moreover, I have limited myself to a selection of three memoirs, but there are infinitely more, and others may well produce very different readings and alternative understandings of the lived experience of anorexia: *Solitaire* by Aimee Liu, the first anorexia memoir to be published in America (in 1979), may well portray anorexia very differently from my case studies, and within the French context, Isabelle Caro's *La Petite Fille Qui Ne Voulait Pas Grossir* sheds light on the contemporary modelling industry and its thinness regime. In terms of (eating-disordered) reader reviews, *Being Ana* by Shani Raviv has been highly praised, as well as *Diary of an Anorexic Girl* by Morgan Menzie. An interesting mix between medical insight and lived experience is portrayed in *Life Hurts: A Doctor's Personal Journey Through Anorexia*, written by Elizabeth McNaught, who was anorexic as a teenager and reflects on this experience when she is recovered and has become a doctor. The plentiful possibilities that autobiographical anorexia narratives offer for reform in practices of diagnoses, forms of treatment, and conceptualisations of anorexia as illness and recovery have also yet to be more fully explored; this, too, would benefit from a larger sample of narratives. Although, as I argued earlier, the individual ways in which anorexia is experienced cannot be made quantifiable or measurable, this does not entail that there is no use for these ways in current medical practice. Diagnostic practices, for example, could benefit from the insights provided by my three case studies; doctors would do well to take to heart the extensive influence of the *language* used in diagnosing anorexia upon the post-diagnosis illness experience, or they could relativise (in practice) the importance of the weight-criterium as it is currently stated in the DSM.

Apart from these autobiographies, there are also numerous anorexia biographies that are narrated by family members; popular in this subgenre are *Brave Girl Eating* by Harriet Brown (told by a mother), *Slim to None* (a girl's diary entries put together by her father), *This Mean Disease* (told by a son) and *Hope and Other Luxuries* by Clare B. Dunkle (told by a mother) - as in the case of *Emma Wil Leven*, these narratives cater not just to a general audience but also to one that is personally afflicted by the anorexia of a loved one. Moreover, there has recently been a steady growth of a hybrid form that combines these two styles of life writing: these new narratives often combine a parent's perspective with that of the (ex-)anorexic child. Popular examples are *Alice in the Looking Glass: A Mother and Daughter's Experience of Anorexia* by Jo and Alice Kingsley, *Hungry: A Mother and Daughter Fight Anorexia* by Sheila and Lisa Himmel and *The Anorexia Diaries: A Mother and Daughter's Triumph over Teenage Eating Disorders* by Linda and Tara Rio. These mixed narratives and the biographies I mentioned earlier show how the lived experience of anorexia is not limited to the anorexic him/herself - family, partners and friends may also be affected, and the narration of this 'indirect' emotional consequence offers an alternative way of approaching the illness. From a literary perspective, the mix between autobiography and biography is also intriguing on a conceptual level: in the case of anorexia narratives, it may for example be wondered whether the parental and the child's view are read differently, and whether the pact between reader and respective author varies, as well as the authority of the narrating voice.

In addition to these various forms of life writing there are also increasing numbers of fictional anorexia narratives, which offer another challenge altogether. As mentioned in the introduction, *Wintergirls* by Laurie Halse Anderson is very widely read, both by lay and eating-disordered audiences, but has been marked as triggering. The same applies to *Thinspo* by Amy Ellis, which tells the story of a pro-ana blogger. Other popular examples include *Life-Size* by Jenefer Shute and *Feeling for Bones* by Bethany Pierce. Both in fiction and autobiography, there are very few works that focus on male anorexics. A fictional exception to this rule, and relatively widely-read, is *A Trick of the Light* by Lois Metzger, although this novel is written by a female author. Especially interesting in these fictional anorexia narratives, I would argue, is the notion of authenticity in the relationship between the reception of such fictional accounts and the formation of understandings of anorexia - how can such works responsibly represent, to an often young readership, an illness as complex and individual as anorexia? And how does this notion of authenticity influence the conception of the pact between author and reader? Conversely, the realm of fiction arguably enables the reading of these texts as fictional, literary, and therefore with a focus on ‘entertainment’ or ‘leisure’; the awareness that such a story has not actually happened may function as a sort of disclaimer that this is not an accurate representation and therefore in a way protect the narrative from being read as a guidebook to anorexia. On the other hand, the author of a fictional narrative is not constrained by memory and actual events; the narrative is vulnerable to dramatisation and, in that way, to certain readers, romanticisation.

In conclusion, the three autobiographical illness narratives that I have discussed, although varying wildly in terms of form and content, all illustrate the lived experience of anorexia nervosa as highly individual, and as a serious illness that deserves to be recognised as such. Moreover, their authors all show, either explicitly or through implication, that their stories are worth hearing; that, in fact, they *need* hearing, as well as an acknowledgement that the current ways in which anorexia is understood and treated is strongly lacking because of its neglect of experience-based (autobiographical, embodied) knowledge. Applying this reasoning to a larger scope, I would argue that this also entails that the (medical) humanities are, and should be considered as, a vital component in the production of understandings of anorexia; working across disciplinary boundaries can be fruitful in bringing together the various levels at which anorexia exists - individual, medical, philosophical, societal, conceptual and so on. This thesis does not make anorexia fully understandable; that was, in fact, never the aim. Rather than answering questions, I have produced them, with only one certainty as an outcome: everyone involved with the production of understandings of and treatments for anorexia should read anorexia memoirs (and, preferably, learn from them).

Bibliography

Primary texts

Hornbacher, Marya. *Wasted: A Memoir of Anorexia and Bulimia*. Harper Perennial, 2014 (1st ed 1998). Print.

Osgood, Kelsey. *How to Disappear Completely: On Modern Anorexia*. Duckworth Overlook, 2014 (1st ed 2013). Print.

Woolf, Emma. *An Apple a Day: A Memoir of Love and Recovery From Anorexia*. Summersdale Publishers, 2012. Print.

Secondary texts

American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition. American Psychiatric Association, 2013. Web (UU online library).

Beresford, Peter. “Thinking about ‘Mental Health’: Towards a Social Model.” *Journal of Mental Health*, Vol. 11, No. 6, 2002, pp. 581-584. *Tandfonline*.

--- “What Have Madness and Psychiatric System Survivors Got to Do with Disability and Disability Studies?” *Disability & Society*, Vol. 15, No. 1, 2000, pp.167-172. *Tandfonline*.

Beresford, Peter, and Anne Wilson. “Genes Spell Danger: Mental Health Service Users/Survivors, Bioethics and Control.” *Disability & Society*, Vol. 17, No. 5, 2002, pp. 541-553. *Tandfonline*.

Berg, Kathleen Mary. “The Multidimensional Model of Eating Disorders.” *Eating Disorders: A Patient-Centered Approach*, edited by Moira Stewart, Judith Belle Brown and Thomas R. Freeman, Radcliffe Medical Press, 2002, pp. 29-47.

Björnsdotter, Malin, et al. “Grey Matter Correlates of Autistic Traits in Women with Anorexia Nervosa.” *Journal of Psychiatry & Neuroscience*, Vol. 43, No. 2, March 2018, pp. 79-96.

Bordo, Susan. *Unbearable Weight: Feminism, Western Culture, and the Body*. University of California Press, 1993.

Bray, Abigail. “The Anorexic Body: Reading Disorders.” *Cultural Studies*, Vol. 10, No. 3, 1996, pp. 413-429.

Bruch, H. *Eating Disorders: Obesity, Anorexia and the Person Within*. Basic Books, 1973.

Print.

Brumberg, Joan Jacobs. *Fasting Girls: A History of Anorexia Nervosa*. Random House USA, 2000 (1st ed 1988), 2nd revised edition. Print.

Coleman, Lerita M. “Stigma: An Enigma Demystified.” *The Disability Studies Reader,* edited by Lennard J. Davis, 2nd ed, Routledge, 2006, pp. 141-152.

Couser, G. Thomas. *Recovering Bodies: Illness, Disability, and Life Writing*. The University of Wisconsin Press, 1997.

--- *Signifying Bodies: Disability in Contemporary Life Writing*. The University of Michigan Press, 2012 (1st edition 2009).

Crisafulli, Michele A, et al. “Attitudes Towards Anorexia Nervosa: The Impact of Framing on Blame and Stigma.” *International Journal of Eating Disorders*, Vol. 41, No. 4, 2008, pp. 333-339.

Davis, Lennard J. “Introduction: Normality, Power, and Culture.” *The Disability Studies Reader*, edited by Lennard J. Davis, 4th ed, Routledge, 2013, pp. 1-14.

Dias, Karen. “The Ana Sanctuary: Women’s pro-Anorexia Narratives in Cyberspace.” *Journal of International Women’s Studies*, Vol. 4, No. 2, April 2003, pp. 31-45.

Easter, Michele M. “’Not All My Fault”: Genetics, Stigma, and Personal Responsibility for Women with Eating Disorders.” *Social Science & Medicine*, Vol. 75, 2012, pp. 1408-1416. *Elsevier*.

Finkelstein, Vic. “The Commonality of Disability.” *Disabling Barriers – Enabling Environments*, edited by John Swain et al., SAGE Publications, 1996, pp. 9-16.

Foucault, Michel. *Madness & Civilization: A History of Insanity in the Age of Reason*. Random House, 1965.

Fox, Nick, et al. “Pro-Anorexia, Weight-Loss Drugs and the Internet: an ‘Anti-Recovery’ Explanatory Model of Anorexia.” *Sociology of Health & Illness*, Vol. 27, No. 7, 28 November 2005, pp. 944-971. *Wiley Online Library*.

Frank, Arthur W. “Illness and Autobiographical Work: Dialogue as Narrative Destabilization.” *Qualitative Sociology*, Vol. 23, No. 1, 2000, pp. 135-156.

--- *The Wounded Storyteller: Body, Illness, and Ethics*. University of Chicago Press, 2013 (1st ed 1995).

Garland-Thomson, Rosemarie. “Feminist Disability Studies.” *Signs: Journal of Women in Culture and Society*, Vol. 30, No. 2, 2005, pp. 1557-1587.

Garrett, Catherine. *Beyond Anorexia: Narrative, Spirituality and Recovery*. Cambridge

University Press, 1998. Print.

Gedge, Elisabeth. ”Genetics, Disability and Symbolic Harm,” *Illness, Bodies and Contexts: Interdisciplinary Perspectives*, edited by Isabelle Lange and Zoe Norridge. Oxford, UK: Inter-Disciplinary Press, 2010, pp. 229-236.

Goffman, Erving. “Selections from *Stigma*.” *The Disability Studies Reader*, edited by Lennard J. Davis, 2nd ed, Routledge, 2006, pp. 131-140.

Gordon, R.A. “A Sociocultural Interpretation of the Current Epidemic of Eating Disorders.” *The Eating Disorders*, edited by B.J. Blinder, B.F. Chaiting and R. Goldstein, PMA Publishing Corporation, 1988, 151-163.

Gorwood, Philip, Amélie Kipman and Christine Foulon. “The Human Genetics of Anorexia Nervosa.” *The European Journal of Pharmacology*, Vol. 480, August 2003, pp. 163-170. *ELSEVIER*.

Greenblatt, James M. and Desiree D. Delane. “Zinc Supplementation in Anorexia Nervosa.” *Journal of Orthomolecular Medicine*, Vol. 33, No.1, February 2018, pp. 1-14.

Hunsaker Hawkins, Anne. “Pathography and Enabling Myths: the Process of Healing.” *Writing and Healing: toward an Informed Practice*, edited by Charles M. Anderson and Marian M. MacCurdy, National Council of Teachers of English, 2000, pp. 222-245.

--- “Pathography: Patient Narratives of Illness.” *Western Journal of Medicine*, Vol. 171, August 1999, pp. 127-129.

Hurley, Dermot J. “Family Therapy.” *Eating Disorders: A Patient-Centered Approach*, edited by Moira Stewart, Judith Belle Brown and Thomas R. Freeman, Radcliffe Medical Press, 2002, pp. 145-153.

Lejeune, Philippe. “The Autobiographical Pact” (1973). *On Autobiography*, edited by P.J. Eakin and translated by K. Leary. University of Minnesota Press, 1989. 3-30.

Malson, Helen. *The Thin Woman: Feminism, Post-Structuralism and the Social Psychology of Anorexia Nervosa*. Routledge, 1998.

McWade, Brigit, et al. “Mad Studies and Neurodiversity: A Dialogue.” *Disability & Society*, Vol. 30, No. 2, Feb. 2015, pp. 305-309. *Tandfonline*.

Morris, Jenny. *Pride Against Prejudice: Transforming Attitudes to Disability*. The Women’s Press, 1991.

O’Hara, Sarah K., and Katherine Clegg Smith. “Presentation of Eating Disorders in the News Media: What Are the Implications for Patient Diagnosis and Treatment?” *Patient*

Education and Counseling, Vol. 68, 2007, pp. 43-51.

Oosterom, Rianne. "Achttien en Uitbehandeld voor Anorexia, Kan Dat?" *Trouw*, 23 November 2016.

Orbach, Susie. *Hunger Strike*. Penguin Books, 1993 (1st ed. 1986). Print.

--- "Visibility/Invisibility: Social Considerations in Anorexia Nervosa – A Feminist Perspective." *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by Steven Wiley Emmett, Brunner/Maxel Publishers, 1985, pp. 127-138.

Pollack, Deborah. "Pro-Eating Disorder Websites: What Should Be the Feminist Response?" *Feminism & Psychology*, Vol. 13, No. 2, 2003, pp. 246-251. *SAGE.*

Pollock, Kristian. "Attitude of Mind as a Means of Resisting Illness." *Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease*, edited by Alan Radley, Routledge, 1993, pp. 48-70.

Power, Tamara, et al. "Autobiography as Genre for Qualitative Data: a Reservoir of Experience for Nursing Research." *Collegian*, Vol. 19, 2012, pp. 39-43. *Elsevier.*

Radley, Alan. "The Aesthetics of Illness: Narrative, Horror and the Sublime." *Sociology of Health & Illness*, Vol. 21, No. 6, 1999, pp. 778-796.

Reeve, Donna. "Psycho-Emotional Disablism in the Lives of People Experiencing Mental Distress." in *Distress or Disability? Proceedings from a Symposium Held at Lancaster University, 15-16 November 2011*. Centre for Disability Research Lancaster, edited by Jill Anderson et al. pp 24-29.

Ridgway, Priscilla. "Restorying Psychiatric Disability: Learning from First Person Recovery Narratives." *Psychiatric Rehabilitation Journal*, Vol. 24, No. 4, Spring 2001, pp. 335-43.

Russo, Jasna, and Peter Beresford. "Between Exclusion and Colonisation: Seeking a Place for Mad People's Knowledge in Academia." *Disability & Society*, Vol. 30, No. 1, 2015, pp. 153-7.

Schwartz, Donald M, et al. "Anorexia Nervosa and Bulimia: The Socio-Cultural Context." *International Journal of Eating Disorders*, Vol. 1, No. 3, Spring 1982.

Seaber, Emma. "Reading Disorders: Pro-Eating Disorder Rhetoric and Anorexia Life-Writing." *Literature and Medicine*, Vol. 34, No. 2, Fall 2016, pp. 484-508.

Segal, Jacqueline. "Listen to Our Stories: Young Women with Anorexia Nervosa Speak out about Hospital Experience." *BA Thesis University of New South Wales*, 2002, published online 5 June 2013 on www.narrativeapproaches.com

Shohet, Merav. "Narrating Anorexia: 'Full' and 'Struggling' Genres of Recovery." *Ethos*, Vol. 35, No. 3, September 2007, pp. 344-382. *JSTOR*.

Smith, Sidonie, and Julia Watson. *Reading Autobiography: A Guide for Interpreting Life Narratives*. University of Minnesota Press, 2001. Print.

Tierney, Stephanie. "Anorexia: Illuminating Impairment or Dishonourable Disability?" *Disability Studies Quarterly*, Vol. 22, No. 3, 2002, pp. 6-20.

--- "A Reluctance to Be Defined 'Disabled'. How Can the Social Model of Disability Enhance Understanding of Anorexia?" *Disability & Society*, Vol. 16, No. 5, 2001, pp. 749-764. *Tandfonline.*

--- "The Dangers and Draw of Online Communication: Pro-Anorexia Websites and Their Implications for Users, Practitioners, and Researchers." *Eating Disorders*, Vol. 14, No. 3, 2006, pp. 181-190. *Tandfonline*.

--- "The Individual Within a Condition: a Qualitative Study of Young People's Reflections on Being Treated for Anorexia Nervosa." *Journal of American Psychiatric Nurses Association*, Vol. 13, No. 6, 2008, pp. 368-375.

Tierney, Stephanie, and John R. E. Fox. "Living With the 'Anorexic Voice': A Thematic Analysis." *Psychology and Psychotherapy: Theory, Research and Practice*, Vol. 83, 2010, pp. 243-254.

Titchkosky, Tanya. "Coming Out Disabled: The Politics of Understanding." *Disability Studies Quarterly*, Vol. 21, No.4, 2001, pp. 131-139.

--- *Disability, Self, and Society*. University of Toronto Press, 2003. Print.

--- "Disability Studies: The Old and the New." *The Canadian Journal of Sociology*, Vol. 25, No. 2, 2000, pp. 197-224. JSTOR.

--- *Reading and Writing Disability Differently: The Textured Life of Embodiment*. University of Toronto Press, 2007. Print.

Titchkosky, Tanya and Rod Michalko. "The Body as the Problem of Individuality: A Phenomenological Disability Studies Approach." *Disability and Social Theory: New Developments and Directions*, edited by Dan Goodley et al., Palgrave Macmillan, 2012, pp. 127-142.

Warrier, Varun, et al. "Genome-Wide Analyses of Self-Reported Empathy: Correlations with Autism, Schizophrenia, and Anorexia Nervosa." *Translational Psychiatry*, Vol. 8, Article Nr 35, March 2018, pp. 1-10.

Williams, Sarah, and Marie Reed. "'It's Like There Are Two People in My Head': A Phenomenological Exploration of Anorexia Nervosa and Its Relationship to the Self." *Psychology and Health*, Vol. 27, No. 7, July 2012, pp. 798-815. *Tandfonline*.

Yager, Joel, et al. "Practice Guideline for the Treatment of Patients with Eating Disorders: Third Edition." American Psychiatric Association, June 2006. File found on www.psychiatry.org.