RETHINKING ANOREXIA NERVOSA

A Feminist Phenomenological Approach

by

Eszter Zimányi

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Supervisor: Anna Loutfi

Second Reader: Allaine Cerwonka

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Abstract

This thesis argues for an approach to anorexia nervosa informed by feminist phenomenology, focusing on understanding this eating disorder in terms of bodily activity rather than seeing it as developing in reaction to media images. Furthermore, the thesis investigates the way anorexics experience their interpersonal relationships, as well as the ways in which therapy changes their intersubjective relations. This focus on the therapeutic process also signifies a shift from a lot of feminist scholarship by exploring what happens to anorexics once they have been diagnosed and their treatment has begun, rather than focusing exclusively on the investigation of the causes of the disorder. Furthermore, as intersubjectivity plays a prominent role in the present approach, this shift also means an engagement with what "the other side" thinks, that is, how the therapist lives through treatment and how s/he perceives the anorexic's experience.

The project involved conducting semi-structured interviews with six experts and two anorexics (one recovered, the other still under treatment). These oral accounts that serve as a basis for the analysis are not numerous, and cannot be taken as representative. Yet, the aim is to enquire into the lived experience of anorexics and their therapists, and not to draw any generalised conclusions. This, moreover, would work against the employed feminist phenomenological approach, which tries to understand the individual and the differences among people's experiences.

There seem to have been few attempts to investigate the possibilities of a feminist phenomenological approach to anorexia nervosa, and this project intends to initiate a dialogue between feminist phenomenology and the understanding of anorexic behaviour. Recognizing the potential of the suggested approach and conducting further research could contribute to the existing scholarship on the body in general, and on anorexia nervosa in particular.

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Introduction

> *(Reporter:) Can you explain that if you felt like you were going to die, that you had a fear of death, then why didn't you eat?*
> *(Anonym:) That's anorexia.* [1]

As this quote from a radio programme aptly demonstrates, the dynamics of anorexia nervosa, the eating disorder with the highest mortality rate, is not easy to grasp. As I will show in my thesis, feminist scholars have made numerous attempts to explain the causes of this disorder. While they point out important elements in the etiology of anorexia nervosa (especially in relation to media representations), they often appear to disregard some other factors (such as the workings of the family system). In order to fill in what I perceive as a gap – or difference of emphasis – in these studies, I propose a feminist phenomenological approach to anorexia nervosa, which, I argue, can open up new ways of thinking about its dynamics.

To set the ground for such an approach, I first look at the relation between feminism and phenomenology, and following Linda Fisher (2000a, b), I argue that the intersection of the two – often perceived as problematic – produces a fruitful approach, since phenomenological concepts (such as lived experience) are indeed useful for feminist research. Before turning to the specific issue of feminist phenomenology in the understanding of anorexia nervosa, I consider prevalent approaches to this disorder, so as to situate my argument in the larger context of existing (feminist) scholarship on this topic. I argue that a number of studies emphasise the socio-cultural roots of the development of anorexia (Bartky, Bordo 1989, Gremillion) and consequently the lived experience of the disorder is often

[1] From a radio programme on eating disorders in Hungary ("Mohó Sapiens"), broadcast on MR1 on 6th of April, 2009. The interview was conducted by Ágnes Veres with an anonym recovered anorexic.

pushed to the background, which, I argue, would be relevant for the understanding of the disorder.

As a next step, therefore, I move beyond the question of representation and the consequent body/mind split, which has been prominent and definitive of modes of thinking about anorexia, and I will demonstrate how a shift from a representationalist approach might open up ways of reconceptualising anorexic behaviour. According to Elspeth Probyn (1987), women are seen as pathologically susceptible to media images, which, argues Abigail Bray (1996), actually leads to the pathologization of women's reading practices. Thus, I follow Abigail Bray and Claire Colebrook's approach (1998), which aims to understand eating disorders in terms of bodily activity rather than in terms of a repressed or negated normal body, that is, they shift the emphasis to the lived body and lived experience of the anorexic. Furthermore, my interest lies in the investigation of the following questions: how do anorexics experience their interpersonal relationships and what effect does it have on them? In what ways does therapy change the intersubjective relations of the anorexic? If therapy can be seen as a shared project between the anorexic and the therapist, how does it affect the latter?

As an integral part of my project, I conducted interviews with experts and (recovered) anorexics. In "Feminist Phenomenology in Practice," I focus on the questions raised by the interviewing process, including the obstacles I encountered while trying to find informants and the ethical dilemmas I had to face.

In the subsequent chapters, I analyse and discuss the interviews in connection with the broader terms of isolation and therapy. The aim of these chapters is to show how feminist phenomenology can be applied to the understanding of anorexia nervosa. In "*It is just I and me*," following Maurice Merleau-Ponty's argument, that anorexia can be seen as a refusal of others (164), I show how anorexics become isolated from their family, from their peers and in the end, from their self. In the focus of the chapter entitled "*The Wavering, Interacting*

Togetherness of Bodies" is the way this isolation can be overcome with the help of a therapy that builds on connection, reciprocity and sharing. This requires the therapist to become deeply involved in the anorexic's disorder and recovery, and thus I put emphasis on investigating the therapist's experience and emotional response as well.

The assumption which initiated this project, namely that anorexia is more than a response to media images, was reinforced by the accounts of my interviewees (experts and patients), which revealed a variety of other driving-forces (most emphatically family issues) behind the development of this eating disorder. My informants' responses furthermore testified to the need for more research in this area. My study is far from filling this gap, yet I see it as initiating a potentially fruitful dialogue between feminist phenomenology and the experience of anorexics as well as their therapists, one that could open up new ways of understanding anorexia nervosa.

1. Towards a Feminist Phenomenological Approach to Anorexia Nervosa

In this part of my thesis, I discuss the way feminism and phenomenology interact, and I argue, following Linda Fisher (2000a, b) that it is viable to intersect the two in order to gain a different understanding of various phenomena that have played an important role both in phenomenology and in feminism – such as the notion of experience and the lived body. Pivotal to my discussion of anorexia nervosa is Dorothy Leland's (2000) feminist phenomenological view on psychotherapy as a process of narrativizing, that is, as "the joint composition by the therapist and client of a more coherent and clear-sighted story about the client's life" (241).

In order to provide the basis for a feminist phenomenological understanding of anorexia nervosa, the second part of this chapter considers prevailing approaches to this eating disorder. I show how most feminist thinkers concentrate on issues of control and docility in their analysis of the disorder (for example Susan Bordo and Sandra Lee Bartky). I propose, however, that this focus needs to be challenged in order to question the assumption that it is women's susceptibility to media images that play the primary role in producing anorexic behaviour. Instead, I offer a feminist phenomenological approach which will be explored in a more focused way in the next chapter, "Beyond the Problem of Representation."

1.1. Feminism and Phenomenology

In a qualitative study done about pregnant women's experience of medical care, Louise Levesque-Lopman argues that women were treated as "natural" objects rather than active subjects (109). As one of her interviewees pointed out, "the medical system that performed the surgery [Caesarean] on my body was *totally* unprepared to deal with my

feelings about the operation, my worries about my body or my worries about my baby. In fact, it pretended we didn't exist" (119). Levesque-Lopman therefore argues that "[t]he physician has been trained in scientific objectivity to perceive reality according to a specific set of medical theories," and thus women in labour have been denied subjective authority and a way to claim their experience as real (Levesque-Lopman 107, 108). Sandra P. Thomas – in her study on the lived experience of various conditions (including anorexia, cancer and addiction) – claims that "medicine's mechanistic lens" views patients' bodies merely "as malfunctioning machines" (Thomas 63, 64). Thomas and Levesque-Lopman thus seem to argue that the patients' feelings in general and their experience in particular, are neglected. While I do not agree with their usage of expressions like "the medical system" and "medicine's mechanistic lens," since these seem to presuppose a monolithic medical system that unquestionably objectifies (female) patients, their argument nevertheless points to the potential of a phenomenological approach in nursing and medicine.

Carol Bigwood, using her experience of pregnancy, highlights another aspect of neglecting the lived experience of the body. She claims that theorists like Judith Butler (her argument seems to be directed at post-structuralist and Foucauldian thinkers mostly) go too far in their denaturalization of the body, that is, they "attempt to avoid metaphysical foundationalism [which] leaves us with a disembodied body and a free-floating gender artifice in a sea of cultural meaning production" (Bigwood 59). Even though Butler for instance refrains from setting up nature and culture as opposites, nature in her account "has lost any independent, non-anthropocentric presence to become merely the product of human action" (59). As opposed to this, Bigwood aims to re-naturalize the body by "releasing it from a dichotomized nature and culture" with the help of a phenomenological approach (60).

Therefore it seems that the potential of a feminist phenomenology has not been fully recognized either in theory or in practice. In what follows, I argue for the validity of

intersecting phenomenology and feminism based on their common focus on concepts such as lived experience and the lived body.

The relationship between feminism and phenomenology has not always been seen as fruitful. Many feminists, argues Linda Fisher, view phenomenology and feminism as incompatible and as having radically different world-views (Fisher 2000a: 3). Numerous aspects of phenomenology seem to oppose feminist endeavours: phenomenology attempts to provide an account of essences or essential structures, tending toward a generic description, and a generic body; it does not constitute a politics; and does not acknowledge issues of gender or sexual difference (Fisher 2000a: 3, c.f. 2000b: 19). Phenomenology is thus seen by many feminists as both essentialist and masculinist. While Maurice Merleau-Ponty's work has been used by feminists – especially his ideas on embodiment, and lived experience (Fisher 2000a: 4) – a general scepticism towards phenomenology, and its benefits for feminists remained.[2]

However, Linda Fisher argues that it is viable to intersect phenomenology and feminism, and this interrelation can extend beyond a mere conjunction in order to consist in a more fundamental integration – in what might be called a phenomenological feminism or a feminist phenomenology (Fisher 2000a: 9). As Sondra Fraleigh points out, feminism and phenomenology have shared concerns, primarily the fact that they both challenge traditional Western philosophy (Fraleigh 11, c.f. 14). Furthermore, phenomenology – like feminism – emphasises the importance of individual consciousness, freedom and choice, and defies the Western body/mind dualism (Fraleigh 14).

As a more specific point of entry, Fisher demonstrates how such integration could start out from the focus on experiental accounts and analysis. As a philosophy of experience, taking as its main focus and goal the descriptive elaboration and thematizing of lived

[2] It needs to be added that phenomenology has also remained largely unaffected by feminism, or rather, that phenomenolog*ists* have overlooked feminism (Fisher 6).

experience and situation, phenomenology can provide particular insight into motifs and approaches for such accounts (Fisher 2000b: 33). Even though phenomenology seems to ignore questions of gender (a point criticized by feminists), it can accommodate a way of describing experience within a framework of sexual difference (35).

In line with Fisher's argument, Linda Martín Alcoff starts out from the examination of the role of experience in feminist theory in order to explore the points where phenomenology and post-structuralism differ and where they converge. Experience, argues Alcoff, was taken as the foundation for knowledge in feminist theory; however, it became challenged and rejected due to a move toward favouring a post-structuralist approach (Alcoff 44). She claims that it is necessary to recognize the cognitive importance of experience and rediscover the formative role experience plays in knowledge (39). In opposition to a post-structuralist emphasis on discursivity, Alcoff (similarly to Bigwood) maintains that "[e]xperience sometimes exceeds language; it is at times inarticulate" (47). Thus experience and discourse need to be understood as imperfectly aligned, having locations of disjuncture (Alcoff 47, 50). Furthermore, experience does not only refer to sensory perception: it includes cognitive and interpretive faculties as well (Alcoff 48). Alcoff points out that for phenomenology, knowledge is always unfinished, because of the open-ended nature of experience and of meaning, while for post-structuralism, the inevitability of incomplete understandings is based on the nature of language (48, 49). This expanded conception of reason and knowledge in phenomenology does not exclude the feminine, the concrete and the particular, and it attributes cognitive value to experience, acknowledging the way experience produces knowledge (and not just that knowledge is communicated through experience) (Alcoff 51). Subjectivity needs to be theorized from the perspective of its lived, embodied experience, where lived experience includes choices, intentions, and inarticulate affects that exceed discourse (Alcoff 50, 52). While Alcoff emphasises that phenomenology and post-

structuralism are not mutually exclusive or incompatible, her argument implies that experience is more graspable and describable with the help of a phenomenological than with the help of a post-structuralist approach.

Moreover, Maurice Merleau-Ponty's view on embodiment has been especially helpful for feminists. He sees the living body as a manner of relating to the world, an attitude toward the world. He does not first "describe the body as an object of natural sciences or life sciences but aims directly at cancelling all scientific preconceptions and discovering the body as it appears before it is posited as an object of any scientific study" (Heinämaa 37) – thus his goal is to see the body in perception (the pre-theoretical expressive body). The living body is, Merleau-Ponty argues, our entry to the world, our access to other things and to other bodies. It has limits, spatial and temporal, but without these limits we would not be freer in our dealings with things; instead, we would lose our grip on the world altogether (Heinämaa 44). Merleau-Ponty's emphasis on intersubjectivity in the construction of subjectivity is summarized by Sara Heinämaa as follows: "[i]t makes sense to compare the capacities of our own body to those of other bodies. But other bodies are given to us only through our own body, so the comparison is possible for us only because we have our own body" (44).

Phenomenology also gives central place to emotion in human existence, where the various forms of being emotional are viewed as diverse ways of being-in-the-world, and the phenomenologist is interested in the meanings of these (Thomas 65). Furthermore, phenomenology suggests giving a direct description (as opposed to a causal explanation) of emotions and the way they are experienced.

For this reason, a phenomenologist approach has been seen as generative in interview-based qualitative research that aims at uncovering women's experience of illnesses and of medical care. Louise Levesque-Lopman demonstrates how feminist phenomenology can be used as a tool for research that concerns itself with "starting from women's experiences"

(103). In this case, the interviewer has to learn to "listen in stereo", that is, to listen with restraint to the meanings of the experience of the respondents, paying attention not just to the experiences, but also to the way the narrative is framed and the discourses that might have shaped it (103). A feminist phenomenological approach advocates applying to the interview situation a feminist framework that builds connections and does not alienate the researcher from the participants (103). A crucial role is played by intersubjectivity (106) and the acknowledgment of the researcher's own lived experiences of everyday life – including experiences as researchers – all of which are considered a concomitant part of the research process (112).

In medical care, intersubjective relationships are most prominent in the interaction between caregiver and patient. In case of mental disorders, such as anorexia nervosa, the relation between the therapist and the patient will be definitive in this sense. Dorothy Leland discusses psychotherapy as a process of narrativizing, that is, as "the joint composition by the therapist and client of a more coherent and clear-sighted story about the client's life" (Leland 241), thus acknowledging the role of intersubjectivity in therapeutic practice. She argues that psychotherapy has been charged with obscuring larger social and political questions via individualizing practices (247). This meant that the root of a client's problem was identified as intra-psychic and therefore she was the one who had to adjust to the status quo. This view has been questioned by feminists, who aim to politicize psychotherapy, which is thus refigured as consciousness-raising, its goal being the creation of group identity and political solidarity (247). This led to seeing therapy as a way of re-narrativizing, where "women learn to generate alternative, feminist-inspired narratives for making sense of their experiences" (247). While retaining the focus on the individual, this approach allows recognition of the larger implications of disorders that are considered symbolic socio-culturally.[3]

[3] For instance obesity, anorexia nervosa and bulimia nervosa are among such disorders. In "Reading the Slender Body," Susan Bordo argues that the emphasis on consumption *and* on dieting, as well as on (weekday)

The shared emphasis on the exploration of lived experience, embodiment, emotions and intersubjectivity produces a dialogue between feminism and phenomenology, which provides the ground for intersecting the two. Before discussing how a feminist phenomenology can be utilized in the understanding of the experience of anorexia nervosa, I first look at the ways anorexia has been theorized by feminists and the meanings that have been attached to this disorder.

1.2. Prevalent Approaches to Anorexia Nervosa

In feminist theoretical approaches to anorexia nervosa, Michel Foucault's notions of docility, the gaze and disciplinary power (as outlined in *Discipline and Punish*) have been prominent (for example in the works of Sandra Lee Bartky, Susan Bordo, and Helen M. Malson). Anorexia has often been discussed in terms of empowerment versus disempowerment, raising questions of agency (for instance by Susan Bordo and Marlene Boskind-Lodahl). According to a number of scholars, anorexia is experienced as empowering in the sense that the refusal of food gives the feeling of control to women over one aspect of their existence, since they are otherwise subdued within their families and in their socio-cultural setting (Hilda Bruch in Boskind-Lodahl, Kyle D. Killian, Noelle Caskey, Susan Bordo). As Noelle Caskey points out, "[t]o refuse, literally, to 'take in' from the environment allows many anorexics the opportunity to take control over their own bodies for the first time" (265). Women are thus able, argues Courtney Martin, to focus on small and manageable areas (food, eating, and calories) instead of thinking about larger issues (work, love, and career),

performance *and* (weekend) letting-go produces bulimia as a characteristic modern personality construction (97). At the same time, "the coexistence of anorexia and obesity reveals the instability of the contemporary personality construction, the difficulty of finding homeostasis between the 'producer' and the 'consumer' aspects of the self" (*ibid*).

that is, in this way they attempt to hide inside and gain control over their bodies (59).[4] While this approach to anorexia highlights questions of control and power relations both within the family and within (a given) society at large, these scholars pay less attention to the bodily experience of anorexia than to the causes of the disorder.[5]

Apart from an emphasis on the lack or presence of empowerment, studies focus on the question of the socio-cultural construction of anorexia nervosa. In "Reading the Slender Body," Susan Bordo (explicitly referring to Bartky's Foucauldian approach) argues that "no body can escape either the imprint of culture or its gendered meanings" (109). Helen Gremillion's article (2002), "In Fitness and in Health: Crafting Bodies in the Treatment of Anorexia Nervosa," also examines what cultural discourses are at work in the treatment of anorexia, but goes one step further by questioning the givenness of categories like "health/healthy" and "fit/fitness."

Nevertheless, the emphasis on power relations, as well as on the cultural and social construction of the body seems to lead to a dismissal of its materiality. Helen M. Malson investigates how a discursive approach, informed by feminist poststructuralist and psychoanalytic theory, might also engage with the material physicality of the corporeal (anorexic) body. Therefore, Malson's study brings together the exploration of the discursive field with the physicality of the body, rather than separating the two, and this framework provides space for intersecting various approaches and theories. As it will be discussed later, psychoanalysis and phenomenology are related in their attempt to understand the corporeal

[4] Most of the theorists assume that eating disorders only affect white Western middle-class women, and in their discussion they take this group for granted (Szumska, Túry and Szabó 110). There have been few attempts at examining how other groups of people may experience eating disorders and what meanings the different contexts may have. An example is black women, among whom a less slim ideal is seen to exist (Levinson et. al. in fact argue that black adolescents see themselves as too thin [330]); therefore, they are claimed to be less at risk of developing eating disorders. While this approach points to the role of body ideals in the etiology of eating disorders, it seems to disregard other factors that might be influential (such as the availability of food, or family dynamics).

[5] At the same time their research is bound by their specific location, namely, the USA and the UK.

experience of various states.[6] However, studies of anorexics that employ a psychoanalytic analysis could be enriched by a phenomenologically informed approach (a point that will be elaborated in the next chapter).

Helen M. Malson and Victoria Ryan argue that quantitative psychological research testifies to the assumption that eating disorders are at least partly culture-bound (112). They claim that the cultural conditions producing eating disordered subjectivities are in fact reproduced in the treatment practices (113). Their focus in this study is the analysis of ways in which "the feminine" appears in nurses' accounts of treatment of eating disorders (113). Employing discourse analysis informed by post-structuralism, they show how a binary way of thinking is reproduced in medical discourse about women, eating disorder patients (they focus on anorexics) and nurses. They argue that a dichotomous way of thinking determines the discourse on women (as the other of men) and among women (along the binaries of good/bad, normal/pathological) (121). Their analysis partly relies on Jacques Lacan's argument that identity is constituted only through the relation to the other, and each side of the binary (for instance in the case of man versus woman) is defined in relation to the other (Malson and Ryan 115-6). This Lacanian model seems to be aligned with phenomenology in its emphasis on intersubjectivity as definitive in the construction of one's subjectivity; yet, prioritizing a binary way of thinking delimits the generative power of the suggested Lacanian approach.

Helen M. Malson et. al. argue that the alleged global "epidemic of obesity" has a counterproductive impact on the treatment of anorexics, since, in fact, "current normative health policy discourses of weight management have become anorexified" (417, 418). Therefore, deliberate weight-gain (a pivotal part of managing anorexia) has become culturally unimaginable (418). Furthermore, Malson et. al. point out that it is not just anorexia that can

[6] Elizabeth Grosz distinguishes two approaches to body theory in 20th century thought: she refers to one as "inscriptive," which she derives from Foucault, Deleuze, Nietzsche and Kafka; while she sees the other as derived from psychology, especially psychoanalysis and phenomenology, thus identifying a close connection between the two (Grosz 1993: 196). (She elaborates on the two positions in *Volatile Bodies – Toward a Corporeal Feminism*.)

be read in a Foucauldian way as an "individualized and hyper-disciplined micro-management of the body" (421), but the *treatment* of anorexics displays an identical attitude.[7] Their argument shows the flaws in the management of anorexic patients, yet I would suggest that this observation is culturally bound (US focused), and pushes into the background the various other components of therapy. It also ignores the fact that research has shown that without appropriate weight-gain, therapy cannot be effective (Wolfe 2004, Pászthy and Túry 2008).

As I have argued, a post-structuralist discourse analysis often seems to over-emphasise the socio-cultural roots of anorexic behaviour, which obscures the complex etiology of the disorder. While weight preoccupation and intense dieting seems to lead to anorexia easily, it is not necessarily the background of the disorder. At the same time, the study by Malson et. al. was based on interviews with anorexic patients, which foregrounds experiental accounts as a way of understanding the discourse surrounding eating disorders and body weight preoccupation.

Anorexia is often represented, both visually and in written format (in the results of statistics and studies), as a very dramatic and shocking way of existence. This, claims Jill Meredith Collins, is exactly why young girls develop anorexia: they crave drama in their lives, which romanticizes their existence (20). While it seems that anorexia has indeed become a "fashionable lifestyle" for some (especially in the USA), Collins' argument nevertheless obscures the complex roots of the disorder.[8] She argues that the ability to resist food and control calories empowers anorexics, yet she disregards the fact that the ensuing sensational approach and exhibition of the body achieves the opposite effect: it removes control from the one observed to the observer. Furthermore, anorexics often report the feeling

[7] Malson et. al. argue that in fact, this meticulous regulation of the body and the detailed scale of control is characteristic of the way in which power operates in modern societies in general (421).
[8] Similarly to Collins, Sandra Lee Bartky reproduces a sensationalising approach by recounting various shocking data about anorexia's effect on the female population (96).

of having lost control, as their assertion that they can start eating again whenever they want to, proves wrong.

The representation of anorexics as shocking skeletal bodies in need of medical help goes back to the nineteenth century.[9] In a historical account of the emergence and usage of medical photography, Erin O'Connor demonstrates how the portrayal of anorexic patients grew increasingly dramatic from the 1870s onwards. It was William Withey Gull who started to use "before and after" photographs of anorexic patients to prove the success of his treatment, and this way of documentation became a standard procedure in the 19th century to solidify the diagnostic profile of anorexia nervosa as "emaciation without an identifiable cause" (O'Connor 536).[10] While at the beginning, only the heads of the patients were represented, these were soon replaced by unclad torsos, and ultimately by wasted naked bodies (even dead ones) (540). These photographs provided a visual tool to identify the ones suffering from this illness, which entails a distancing, an identification of these bodies (as abnormal and different), and a reinforcement of the necessity of being cured.

Photography furthermore reinforced a connection between physical appearance and well-being, thereby obscuring the roots of the illness. The idea was that fattening up the patient is itself the cure (indicating a utilitarian approach to treatment), which showed the reliance on seeing and implied an ideal of female appearance that the therapy was aimed at (O'Connor 541, 542). Before and after portraits (a strange reversal of today's make-over

[9] Abstinence from eating was for a long time regarded as a sign of sainthood. In the seventeenth century, however, it began to be linked to organic causes and seen as an illness rather than a miracle. Joan Jacobs Brumberg traces the history of the evolution of the anorexic as patient in "From Sainthood to Patienthood" (in *Fasting Girls* [41-60]). She connects the development of this practice to the gradual pathologization of various states: "[the] evolution in the nature of who was expert in interpreting fasting cases marked the beginning of the long historic process of the medicalization of human behaviour" (Brumberg 49).

[10] It was also Gull who termed the disorder anorexia nervosa, preferring this terminology over anorexia hysterica, because "the disease occurs in males as well as females" (quoted in O'Connor 536). This implies the belief that only women can be hysterical, but it also points to a fact that is often obscured even in recent accounts of anorexia nervosa, which is that an increasing number of men become anorexic. Nevertheless, in Gull's time and even today, it is still seen as a gender-specific disease.

shows and slimming programmes) marked the success of the doctor in transforming the patients to fit the contemporary ideal (542).

In the 19th century, emphasis was laid on vision and a scientific gaze that was conceived as objective and unquestionably truthful, in which photography played a crucial role and was treated as the most reliable gaze.[11] Indeed, it was seen as providing "unmediated access to the mental patient's frame of mind" (O'Connor 547). Nevertheless, the photograph "worked to mystify the normative logic of medicine's interpretive paradigms," whilst it effectively "produced the very 'truth' it claimed the photograph revealed" (O'Connor 549). As Erin O'Connor argues, "[i]n anorexia nervosa doctors were able to stage the restoration of female health as the restoration of gender," and photography helped them establish a link between "aesthetic standards of femininity and the physical effects of re-feeding" (543). This furthermore stressed the role of appearance as an accurate measure of health (544).

Women's bodies were in fact seen as protopathological, "in need of constant surveillance and vigilant care" (551). Because menstruation has been seen as a "barometer by which doctors could read the internal health, mental as well as physical, of their patients" (Sally Shuttleworth in O'Connor 551), the cessation of menstruation in anorexic patients was cause for worry, along with the disappearance of the breast as a result of abstinence from food. With the emphasis on appearance, and the lack of visible signs of femininity, anorexia nervosa came to be figured more as a problem of sexuality than of neurology, where doctors were trying to remedy and fix the body's perceived unfemininity (O'Connor 553).

In fact, the restoration of femininity is still seen as a prominent objective: O'Conner points out that cure is seen as successful only after the menstrual cycle has become regular once again, and the body has resumed "normal" sexual functioning (560, footnote 57). In

[11] Rosemarie Garland-Thomson argues that disabled women have become not the object of the gaze (in the psychoanalytical sense, used as such by Laura Mulvey in feminist film theory), but the object of the stare (21). This concept emphasises the distancing and separation of looker and looked-at, and de-sexualizes the look. Insofar as (female) anorexics lose their femininity and sexual appeal as a result of starving, they also become the object of the stare, rather than of the gaze.

DSM-IV-TR (the Diagnostic and Statistical Manual for Mental Disorders currently in use) one of the criteria for anorexia nervosa is amenorrhea, that is, the absence of at least three consecutive menstrual cycles. The lack of a corresponding criterion for men that would reflect on the effect starving has on their reproductive capacities (if any) indicates the medical interest in the female gender as opposed to the male and the marked nature of anorexic women.[12] It encourages an approach that argues for curing anorexics so as to restore their reproductive capacities and documents the treatment as a success if long-term consequences are avoided.

The questions of control and empowerment as well as the emphasis laid on representations in the discussion of anorexia nervosa obscure various other factors that play eminent roles in the development and the experience of the disorder. While some studies do focus on the lived experience of anorexics, there seems to have been few attempts at understanding patients as they go through the various stages of both the disorder and the therapy. In order to examine these in more detail, I now turn to the discussion of a feminist phenomenological understanding of anorexia.

[12] However, ICD-10 (International Classification of Diseases) does specify the effect anorexia has on male reproductive capacities, and identifies loss of sexual interest and potency in anorexic men. Nevertheless, DSM-IV is more often referenced than ICD-10.
For a full list of diagnostic criteria of anorexia nervosa in DSM-IV and ICD-10, see Appendix 1.

2. Beyond the Problem of Representation

Anorexia can be seen as a response to certain familial conditions and structures, such as high parental expectations and enmeshment,[13] thus it can be understood as developing in intersubjectivity. An emphasis on representations as the cause for anorexic behaviour ignores this aspect of the disorder. In a phenomenological approach, however, embodiment and intersubjectivity become emphatically important. In this part of my thesis, relying on Abigail Bray and Clair Colebrook's (1998) critique of representationalism, I explore how a psychoanalysis-related phenomenological approach can be used to reread anorexia and its treatment.

Even though anorexia is becoming more and more widespread among men,[14] it is still seen as a gendered condition, affecting a significantly larger number of women than men. As I have argued, most thinkers approach anorexia nervosa from the question of (self)control and dis/empowerment, often viewing it as a form of protest against patriarchal ideals (motherhood, femininity). They emphasise the anorexic's alienation from her body, thus implying a split between mind and body, or rather, the approach to one's body as an image or representation. This is further reinforced by stressing the socio-cultural origin of anorexia, seeing it as an effect of media representations (the unattainable ideal body [image] generated by the media).

Seeing the (image-)reading practices of women as a primary cause of anorexia nervosa obscures various other factors – such as personal disposition and family dynamics – in the development of this disorder. In their study on blind people's experience with eating

[13] These concepts will be discussed in detail in the next chapter in connection with the anorexic's relation to the family.

[14] Szumska states that the difference in the occurrence of anorexia nervosa among men and women is diminishing, and boys are as dissatisfied with their bodies as girls (496-7). Túry et. al. furthermore point out that men are also under significant cultural pressure to conform to a certain ideal, which even results in the development of some specific forms of eating disorders that are more characteristic of men than of women (for instance muscle dysmorphia) (79).

disorders, Szilvia Dukay-Szabó and Ferenc Túry (2008) argue that the lack of sight does not prevent one from developing eating disorders, and they point out that the role of visual perception in anorexia has been overemphasised (287, 288). They conclude that while the ability to see can foster anorexic behaviour (via exposure to various media and the beauty industry), the development of anorexia in non-seers shows that other factors (personal disposition and familial structures) play an emphatic role (296).

In "The Haunted Flesh: Corporeal Feminism and the Politics of (Dis)Embodiment," Abigail Bray and Claire Colebrook (1998) emphasise that representations have been blamed for eating disorders, yet, the resolution of the problem is often seen to be located in changing these potentially harmful images, which, however, leaves the role of representation intact (35). I would add that for instance the ad campaign against extremely skinny models initiated by Oliviero Toscani (in Italy, in 2007) and the increasing opposition towards skeletal celebrities – while an important part of popular psycho-education – overemphasises the role of media representations in the development of anorexia nervosa.

In an attempt to shift the emphasis on visual perception and reconfigure behavioural patterns, Bray and Colebrook aim to understand eating disorders in terms of bodily activity rather than in terms of a repressed or negated normal body and they intend "to think the body beyond the problem of representation" (37, 38). In their view, the challenge feminists seem to encounter is the question of how to resolve the tension between wanting to see the body as material while avoiding biological determinism, and as representational effect while avoiding seeing the subject as an ideal projection or sign (42-43). They, however, point out that this strict division between representation and materiality seems to sustain a Cartesian dualism in feminist theory, and furthermore has brought debates over specific issues (as is the case with eating disorders) to a standstill (43). Representation, they maintain, is one factor among others in ethical problems of the body; it neither determines nor saturates the field (43). Even though

the body *is* a negotiation with images, yet it is also a negotiation with pleasures, pains, other bodies, space, visibility, as well as medical practice; and therefore "no single event in this field can act as a general ground for determining the status of the body" (43).

As mentioned before, the concept of intersubjectivity plays an important role in the phenomenologist understanding of subjectivity. In a phenomenology-based study done on anorexic daughters' relationship with their mothers, Maurice Apprey emphasises the role of intersubjectivity as formative (and in fact, decisive) in the development of the disorder. While his work is not manifestly feminist, both the topic and its approach align it with feminist interests and concerns.[15] Apprey demonstrates that in anorexia nervosa a plural intersubjectivity exists: "a mother and a daughter without precise boundaries between them and who are equally affected by an anterior mother in the person of a grandmother" (1068). The close relation between phenomenology and psychoanalysis surfaces in his account: using Merleau-Ponty's argument that anorexia nervosa is a refusal of others (Apprey 1058, Merleau-Ponty 164), Apprey refers to Julia Kristeva's theory of the abject[16] to argue that "some 'abject' mother, as it were, is a prime driving force behind the dysfunction of the anorexic" (Apprey 1059). Thus, he explains eating disorders in the context of the mother-daughter relationship, maintaining that anorexia "may be one way of shrinking or killing the mental representation of the (m)other," while bulimia aims to keep the (m)other but poison her, and food or weight phobia shows a yearning for the (m)other and/or rejection by the (m)other (1061). Apprey's psychoanalytical-phenomenological approach points to the importance of intersubjectivity in the constitution of anorexia nervosa, which is often pushed to the background when the emphasis falls on media representations as causes for the disorder. His discussion of the mother-daughter relationship points to the role of familial

[15] This again confirms that there are numerous points of convergence between feminism and phenomenology.
[16] The concept of the abject plays an important role in psychoanalysis. It refers to the inability to exclude, as Kristeva argues in *Powers of Horror* (56).

interaction, yet I argue that it is the family structure as a whole that needs to be examined and not just the effects of ("not good enough") maternal caretaking.[17]

With its emphasis on the indivisibility of the somatic and the psychic, psychoanalysis has been seen as potentially liberating in terms of a corporeal discourse, however, Bray and Colebrook point out that some of its aspects reinforce a representationalist approach, which seems to refute the endeavour to integrate body and mind (47). They refer to Jacques Lacan's theory of the three psychic orders: the Real, the Symbolic and the Imaginary; with a focus on the latter. As Tony Myers explains, the Imaginary "designat[es] the process by which the ego is conceived and born. This process is […] the mirror-stage [which] begins when human beings [are] about six months old" (Myers 21). To overcome their inability to co-ordinate their movements, infants identify with an image of themselves in a mirror, and "this image offers [them] a sober picture of [themselves] as a fully synchronized and united body […] affords [them] a pleasing sense of coherency, or, in other words, an ego" (21).[18] As Bray and Colebrook argue, Lacan's usage of the Imaginary posits the question of representation as fundamental to the production of the embodied subject by providing a notion of subjectivity that sees the self or ego as an introjection of the visualized or represented body (46, c.f. 53). Lacan's Imaginary is thus a psychic order of mirroring, reciprocities and identifications, where a representation of the self serves as a defining frame for the experience of an

[17] Arguably, mother-blaming seems to saturate psychoanalytical accounts in general, and anorexia scholarship in particular. For an exploration of how the "failures" of mothers have been perceived as primary (if not exclusive) causes for children's mental health problems, see Thomas and Marikay Vander Ven's study, "Exploring Patterns of Mother-Blaming in Anorexia Scholarship" (2003).

[18] While this is not my focus here, in order to clarify what can be perceived as the representationalist aspects of Lacan's theory, I would also like to introduce the concepts of the Symbolic and the Real briefly (and somewhat simplistically). Tony Myers argues that the "Order of the Real describes those areas of life which cannot be known," it is "the world before it is carved up by language" (25). The Real resists symbolization, it is meaningless and senseless (26). The Symbolic Order is that which "includes everything from language to the law" and which is bound together by the signifying chain, or the law of the signifier (Myers 22), that is, "the total network of available signifiers" (24). The subject as such is born through the entry into the Symbolic, which is also a subjection to the Symbolic, to language and law. However, the experience of the Imaginary, which precedes the Symbolic, persists in the subject, and, as Anika Lemaire points out, "[t]he truth about himself [*sic*], which language fails to provide him with, will be sought in the images of others with whom he will identify" (Lemaire 73).

incoherent self. Even though this approach emphasises intersubjectivity and reciprocity, it nevertheless entails the perception of the self as based on (and constituted via) representation.

Furthermore, Elizabeth Grosz claims that the anorexic practice of self-starvation is frequently diagnosed as a corporeal response to the incorporation of, and living out of, phallocentric representations – which, it is argued, contaminate women with potentially fatal body images (Bray & Colebrook 46). Corporeal feminists, like Grosz, aim "to refigure the body so that it moves from the periphery to the centre of analysis" (Grosz 1994: ix) and to foreground the body as "crucial to understanding woman's psychical and social existence" (Grosz 1994: 17); yet, they still seem to rely on the dualist way of thinking about embodiment and disembodiment, and they appear to see "a causal and unproblematic connection between cultural images and corporeality, representation and the body" (Bray and Colebrook 50). This entails, according to Elspeth Probyn (1987), that women are seen as pathologically susceptible to media images, which – argues Abigail Bray (1996) – actually leads to the pathologization of women's reading practices. The frequent use of the female anorexic as the paradigm case of representational consumption feminizes a reading/viewing practice figured as pathologically passive; furthermore, "the implicit denigration of this passive consumption sustains a Cartesian anxiety about the corruption of mind by an alien matter" (Bray and Colebrook 53). Thus a critical approach to ethical problems of the body questions the idea of the body as an effect of image consumption "by looking to the body's various effects and forces, rather than its capacities to be a sign, theatre or image" (52). Matter, or the body, would not be thought's "other" "if thinking were seen as a desiring production, comportment, an activity or an ethos," and the body were perceived as not essentially anterior or other (56).

Anorexia can be rethought by removing it from the sphere of representations, and by examining it from the perspective of lived experience and comportment, which becomes necessary if one considers the negative effect representations can have on the *understanding*

of anorexia. As Bray and Colebrook maintain, the body should be thought *as a body*, and not a body image or internal representation (57). This, I would argue, could be an entry point for discussing anorexia alongside other axes than power/control/representation, and would provide the possibility of a phenomenologist approach that would start out from the lived body and lived experience rather than from the effects of the socio-cultural production of body images.

Thus in the following chapters, I examine the lived experience and the intersubjective constitution of anorexia nervosa and its therapy. I argue that initiating a dialogue between the dynamics of this disorder and feminist phenomenology (for instance in relation to the concepts of autonomy and connectedness, experience and the lived body) allows a reconceptualization of the workings of anorexia nervosa which might provide us with an understanding of anorexics that differs from the more widespread views. The employment of a phenomenological approach – with its emphasis on intersubjectivity – also allows me to look at the therapist-patient relationship from the point of view of the therapist and examine what her/his experience of the process is, and how it speaks to the anorexics' experience.

3. Feminist Phenomenology in Practice

My research is centred on how anorexia is experienced by women as a way of existence that permeates and defines their everyday practices, and the way this disorder can be treated in intersubjectivity with an emphasis on reciprocity and sharing. In order to investigate this topic, I employed qualitative methods, more specifically, I have conducted two types of individual, face-to-face interviews: expert interviews with psychologists and psychiatrists specialized in the treatment of eating disorders and interviews with anorexics (one still under treatment, the other recovered).

In this part of my thesis, I explore the ways in which feminist phenomenology can be practiced and applied to interviewing situations. In order to do that, I first argue for the validity of experience by looking at how this concept can be understood in the theoretical framework of this research, following which I turn to the potential of using a feminist phenomenological approach to interviewing. The rest of this section is devoted to the description of the interviewing process, and my experience of data-collection, including ethical dilemmas as well as the difficulties I encountered while organizing the interviews, including lack of access to interviewees and time constraints.

3.1. The Validity of Experience

In my project, the question of experience occupies a prominent place, since I am primarily interested in the way anorexics live their bodies, their disorders and their treatment, as well as the way therapists relate to their patients and to the therapeutic process. Therefore, in my interviews, I give credit to the interviewees' experience, and even though I am aware of the criticism directed against accepting experience uncritically, without reflecting on the

forces that shape the interviewer's narratives (Scott, 1992; Lomsky-Feder, 2004),[19] my understanding of the validity of experience follows Alessandro Portelli's: "[o]ral sources are credible but with a *different* credibility. […] there are no 'false' oral sources […] the diversity of oral history consists in the fact that 'wrong' statements are still psychologically 'true' and that this truth may be equally as important as factually reliable accounts" (68, emphasis in the original). I am not suggesting that oral accounts are objective, on the contrary, oral sources are inherently non-objective, "artificial, variable, and partial" (Portelli 70), nevertheless they are not "false".

Relying on the concept of experience as "uncontestable evidence" risks naturalizing difference (Scott 24-5), even so, in my view, accepting experience as valid is a necessary step for *recognizing* difference (thus avoiding universality) and for crediting the personal, lived position. Diane Fuss repeatedly argues that the personal is not political (101, 117; c.f. Reinharz 426), insofar as "the relation between these two terms [can be seen] as a complex co-implication rather than a simple equation" (Fuss 102). I agree with Fuss's argument inasmuch as this co-implication means the acknowledgment of the personal position without the complete politicization of the individual. (By politicizing, I mean the treatment of her/his experience as evaluated only in terms of its political significance and without reference to her/his personal involvement in decision making.)

Nevertheless, it seems necessary to (re)define experience in order to situate my approach. Starting out from Teresa de Lauretis's understanding of experience, Louise Levesque-Lopman argues that experience is a process which effects subjectivity – which, in turn, is an unfixed, continuously constructed subjectivity, one that develops in interaction (104). Insofar as this interpretation acknowledges the interactive nature of subjectivity, I find it useful; yet, instead of emphasising construction, I would use the term negotiation and

[19] Not to mention that "[a] text and an author's authority can always be challenged" (Denzin 506).

reciprocity so as to further stress the importance of intersubjectivity as well as an engagement with one's surroundings in living one's experience.

Fuss argues that the conflation of ontology and epistemology are not fruitful inasmuch as it means that experience and truth as well as identity and knowledge collapse into one another (113). Yet, I would argue that the separation of epistemology from ontology is artificial, creating a boundary between the existing-self and the knowing-self, thus reproducing the Cartesian split between mind and body, and maintaining a way of thinking based on clearly separable binaries. In my project, I aimed at the conflation of the 'two selves' (the knowing and the existing, complemented with the experiencing and sentient self).

3.2. Feminist Phenomenological Interviewing

It is not only my theoretical framework that is grounded in phenomenology, but also my approach to the interviewing process.[20] My understanding of a feminist phenomenological perspective on interviewing follows Louise Levesque-Lopman's, who argues that applied to in-depth interviews, "feminist phenomenology as a tool for research that concerns itself with 'starting from women's experiences' […] means learning to 'listen in stereo' – to listen with restraint to the meanings of the experience of the respondents" as well as to "describe the 'reality' of these subjective experiences in terms of the perspective of the participants" (103, 124). Levesque-Lopman moreover contends that in such an interview situation, a feminist framework is applied, one that "builds connections and avoids alienation of the researcher from the participants" (103). She argues that an interview provides the possibility for the interviewees "to describe their experiences in their own way in terms that have often been

[20] While phenomenological interviewing has been broadly defined as "an interviewee-guided investigation of a lived experience that asks almost no prepared question" (Reinharz in Levesque-Lopman 111), my method is informed by phenomenology in a slightly different way and on other levels as well, which I discuss in the oncoming sections.

muted in their own personal discussions and conversations" and to uncover the meanings *they* attribute to these experiences (113).

Levesque-Lopman's approach is relevant for me on another level as well: her focus is women's experience with pregnancy and childbirth, which, she concludes, has been pushed to the background by a medical discourse that claims control over women's bodies and pathologises their pregnancy.[21] It is, however, not only doctors who generally speaking preserve a clear doctor/patient divide (Levesque-Lopman 107), but also nurses. Sandra P. Thomas in fact provides an example of the way phenomenology (especially Merleau-Ponty's ideas) can be applied in such a setting. In the centre of this approach is the question of sharing one's lived experience and "the particularistic and the universal dimensions of human lived experiences of health and illness" (74). Similarly to Levesque-Lopman, Thomas also emphasises intersubjectivity and building connections as part of a phenomenological approach in nursing, yet she goes further in exploring the various connotations phenomenological notions can have in the medical setting. By drawing on Merleau-Ponty's ideas, she claims that

> all nurses can practise [phenomenology] as a manner or style of thinking, learning to listen to patient concerns in a new way, alert to what is figural in the perceptions of their patients yet ever-mindful of their embeddedness in a particular sociocultural context. Being invited by a nurse to tell one's story surely benefits the patient [and h]earing the story enriches the nurse as well. (Thomas 74)

Both Thomas and Levesque-Lopman argue for a less rigid and more permeable boundary between medical staff and patients, and both recognise how this could enhance communication and create a more supportive environment. The potential of this can be shown via the relationship between therapist and patient in the treatment of anorexia, since mental

[21] As one of her interviewees said about her doctor's office: "[when I found out that I was pregnant] I wanted to cry but I felt like it wasn't okay, like it was a sterile environment. You couldn't show any emotion and, oh, it was just awful. […] It was so sterile. It was very routine" (117).
Another interviewee, who had a caesarean section, recalled her experience as follows: "But the medical system that performed the surgery on my body was *totally* unprepared to deal with my feelings about the operation, my worries about my body or my worries about my baby. In fact, it pretended we didn't exist" (119).

disorders seem to call for a more active engagement from the expert, and as I will argue in the subsequent chapters, the success of the therapy is also dependent on reciprocity and an intersubjective give and take between the two participants.

Nevertheless, the lived experience of anorexic patients (similarly to pregnant women) does not always seem to be taken into consideration: it happens that they are force-fed in hospitals, or if not force-fed, their therapy aims only at physical change, and does not pay attention to their psychological well-being.[22] I argue that a phenomenological approach (as described by Thomas and Levesque-Lopman) would ease the communication between anorexics, their nurses and their therapists.

3.3. Organizing the Interviews

Setting up the interviews was a long process, during which I encountered many obstacles. With the help of a fellow student of mine, I could get in contact with some psychologists and psychiatrists, who agreed to talk to me about their experience and help me get in touch with patients. However, the promises I received in March and April were not always kept, and so in the end I was not able to interview as many people as I originally intended to. Additionally, the difficulty in arranging meetings and discussions with those I could interview meant that I was running out of time and at one point I had to hasten the process and do six (out of my eight) interviews in one day.

Before each interview, I introduced my project and offered to answer any questions the interviewee might have in relation to it. I also assured them that they could skip any questions they did not want to respond to and I showed them the questionnaire before we started talking so that they knew approximately what to expect. I also asked permission to

[22] While I have no written sources to support this argument, I was told that this is the case by one of my interviewees and by a friend of mine who shared a room with an anorexic in a hospital some years ago.

record the interviews and to include their names (both of which were in some cases granted, in others rejected), while I asked the (recovered) anorexics to choose a name they want me to use when I refer to them in my thesis. Even though the experts were not made to sign any consent forms, I assured them that the interview recordings will be used only for my research purposes. I found it especially important to clarify these in the case of Flóra (an anorexic still under treatment, but no longer hospitalised), whom I asked to sign a consent form that contained all the above mentioned points.

The language of the interviews was Hungarian and thus the transcripts (where applicable) were also in Hungarian. I translated the excerpts that I include in the thesis.

The first interview I conducted was via the phone with Dr. Renáta Cserjési (a postdoctoral scholar at the University of Florence for Child Neurology, who did research on anorexia both in Hungary and Belgium), followed some days later by an interview with a recovered anorexic. I was allowed to record both interviews (they were forty minutes each), which I subsequently transcribed. Dr. Cserjési agreed that her real name be included in the thesis, and the recovered anorexic asked me to refer to her as Mariann.

After these were conducted, a significant time (two weeks) elapsed before I was able to do the rest of the interviews. This also meant, however, that on the basis of these two discussions and further research, I could rewrite and finalise my questionnaires.[23] The rest of the interviews were conducted in one day at the Children's Clinic of the Semmelweis University, with five experts (psychologists and psychiatrists involved in treating anorexics) and one anorexic. Some of the therapists asked me not to include their names, and to them I will refer to as psychologists/psychiatrists (depending on their title), or as therapists, while the anorexic chose to be referred to as Flóra. Out of the five experts, three did not feel comfortable with being recorded, but I was allowed to use a dictaphone in the rest of the

[23] In formulating the questions on which I ultimately based my interviews, I also received help and feedback both from my supervisor and my second reader as well as from Dr. Bea Pászthy, head physician at the Children's Clinic of the Semmelweis University. For a list of the questions, see Appendix 2.

discussions, including the interview with Flóra. Because of their busy schedule, two of the psychiatrists had only fifteen minutes to talk to me, while the rest of the interviews (including the one with Flóra) ranged from thirty minutes to one hour.

The interviews were semi-structured, and in many cases I relied on open-ended questions in order to leave space for non-planned discussions, which often shed light on aspects and issues that I had not thought of before. Apart from recording (where I was allowed to), I also took notes during the interviews for easier reference, except in the case of Flóra, where I felt we were both more at ease by approaching the interview as a conversation. Consequently, I did not stick to my questionnaire in this case, and I asked several follow-up questions and let her talk about topics that were not necessarily relevant to my focus. I also felt that this kind of attitude towards interviewing was more in line with my feminist phenomenological stance than a strict adherence to previously compiled questions that might or might not inspire the interviewee. As Thomas points out, "[a]ll knowledge takes place within the horizons opened up by perception, and all meaning occurs through perception" (Thomas 69). What stands out to the individual is dependent on various contextual factors, which includes the specific culture, one's body, time, and other people. Thus a phenomenological interview seeks to find out the specific ways people experience, which invites questions such as: "What aspects of the experience stand out to you?" (Thomas 69) These types of open-ended questions invite answers that reveal experiences the interviewee herself finds important.

This observation also prompted me to allow some time for each interviewee before every question, in case they wanted to add something, as well as asking at the end whether they wanted to discuss any issues that had not been touched upon before. This proved really fruitful as some of the interviewees shared their most exciting insights about their experience in response to this question. I also strove to modify and rearrange the questions as the

interview progressed so as to follow the interviewee's line of thought as opposed to mine. This endeavour is connected to Merleau-Ponty's usage of intentionality, which implies "relatedness to the world, the integral interconnectedness between humans and the lifeworld in which attention of humans is always directed toward specific events, objects and phenomena" (Thomas 70). What someone is aware of reveals what is meaningful to that person, and this can be revealed with the help of open-ended questions that encourage reliance on the interviewee's own thought process rather than the interviewer's.

The experts were helpful and expressed interest in the project, and I felt comfortable during the interviews. There was only one case, where I sensed some indifference or unwillingness to cooperate from the interviewee, and as her viewpoint appeared to be the furthest from my focus, her answers were often short or off the topic.[24]

The setting of the interviews can influence interaction and determine the outcome. The hospital setting meant that distractions and interruptions occurred (in one case we also had to change location during the interview), which disrupted the line of thought of the interviewee (Ritchie 37). With the experts, the location was their workplace, which meant that they knew the setting (and probably felt comfortable about it), but it might have also lead them to be more formal than necessary. Furthermore, this setting can prevent the interviewee (and the interviewer) from being at ease, which could be felt in the case of Flóra, with whom I met in the office of one of the psychiatrists. The issue of location, however, did not arise in the case of Mariann, with whom we could find a setting convenient for both of us.

[24] For instance she told me that she prefers cognitive methods as opposed to the psychodynamic approach to therapy and therefore she was not so much focused on the relations between therapist and patient. She also mentioned that in the past year, she has not really had any patients with eating disorders.

3.4. Ethical Dilemmas

My project raises various dilemmas and questions in connection with the interviewing process. In order to overcome these, I employed various strategies in both expert interviews and interviews with (recovered) anorexics. While in the case of the former, playing the student (Ritchie 76), and approaching the interview as part of an academic project seemed to resolve many issues (for instance, establishing trust, gaining sufficient information), interviewing women with eating disorders required more empathy, where I became emotionally more involved in the process.

I had to take into consideration the fact that psychologists and psychiatrists are bound by their obligation of confidentiality, which meant that they were reluctant to release information about their patients, and when they did, they never mentioned any specific data (for instance age or name) about them (which sometimes led to confusion during the interviews, since it was difficult to clarify who the interviewee was talking about if s/he had already referred to many cases previously).

Inasmuch as my project also concerned people who are (or were) physically and psychologically unstable, I had to take into consideration a number of other ethical issues as well. One of the dilemmas I had to face when interviewing (ex-)anorexics is the issue of giving back (K'Meyer 83). While I am far from implying a victimizing discourse by raising the issue of help, I believe that the question of reciprocity and empathy becomes important in interview situations in general, and with patients in particular. I thus strove for an "establishment of a human-to-human relation with the respondent and […] to *understand* rather than to *explain*" their position (Fontana and Frey 57, emphases in the original), for which it is important to establish rapport (60). In order to achieve this, I believe that I as an interviewer "can show [my] human side and answer questions and express feelings" in order

to gain greater insight and "to avoid the hierarchical pitfall" (65). Following from this, with Mariann and Flóra, I strove to "engage in a 'real' conversation with 'give and take' and emphatic understanding" (67).

3.5. Understanding Anorexics and their Therapists

As I have pointed out before, I aim not at explaining but at understanding anorexics as well as their therapists. Therefore, as a feminist phenomenological researcher, I avoided naming the interviewee's experience during the interview, and instead, "provide[d] the range for her to be self-reflexive and verbal about her experience" (Levesque-Lopman 122). In order to achieve this, I employed several open-ended questions, and started the interview with Flóra by asking her to tell me why she was going to the hospital, in order to let her choose how she refers to anorexia and therapy.[25] Moreover, I relied on Levesque-Lopman's suggestion to '*listen to and hear*' what is being said, thus be attentive to places where women spontaneously pause, reflect, and comment about something they have just said (122).

Even though I am aware that the process of interviewing and the subsequent inclusion of excerpts in my thesis entail the interpretation of what has been said, I would agree with Norman K. Denzin that "interpretation creates the conditions for authentic, or deep, emotional understanding. Authentic understanding is created when readers are able to live their way into an experience that has been described and interpreted" (Denzin 506). In this sense, interpretation (which is sometimes viewed as something negative, taking away "authenticity" from a given text, or the words that have actually been said) is a positive process (Denzin calls it an art [500]), which provides the possibility of enriching without falsifying. This ties back to my discussion on the validity of experience, while at this point, I would also argue for

[25] An important part of the therapeutic process involves making the patient recognise that s/he is sick and needs help (many anorexics, even when in danger of death, deny this). Not surprisingly, therefore, Flóra's answer was fairly straightforward: "I am here because I suffer from anorexia."

the validity of "experiencing the experience" (Clandinin and Connelly in Denzin 501) – as in the therapists' experience of anorexia – as well as of reporting (interpreting) that (experienced) experience – as in my account of those experiences. Louise Levesque-Lopman also contends that in a phenomenological approach, a crucial role is played by intersubjectivity (106) and the acknowledgment of "the researcher's own lived experiences of everyday life (including experiences as researchers) that are considered an integral part of the research process" (112). This argument seems to support the claim that the impossibility of objectivity can be viewed as a positive aspect of feminist phenomenological research.

It is important to note that anorexia is seen as a gendered illness that affects a specific age-group of girls. It affects a significantly larger number of women than men (Bordo 1986, Forgács), and among eating disorders, it is seen (together with bulimia) as the most gendered one(s) (Malson, Bordo 1986). Furthermore, anorexia is most prevalent among adolescents, and although there are quite a few exceptions, all the therapists I interviewed referred only to cases where adolescent girls were involved, and they all pointed out to me that they did not have the chance to work with male anorexics.

At the same time, I also experienced how the psychological terminology and categories differ from a feminist understanding of those. For instance, while feminists would question what can be regarded as healthy or normal, adequate or inadequate, psychologists and psychiatrists have a more clearly-defined idea of what those should refer to. In one case, I asked the interviewee whether the sex of the patient in her view could determine the experience of the disorder, to which she replied: "There was a boy, who wasn't a classical anorexic, I mean, it is very difficult to determine the criteria for boys, because they don't menstruate." This implies an adherence to the DSM-IV criteria[26] of the disorder, and even

[26] See Appendix 1.1

though ICD-10 does refer to a corresponding criterion in boys, since it is less definable ("loss of libido"), it was not seen as a point of reference in this case.

In the chapters that follow, I turn to the investigation of the anorexic's isolation and of the ways the therapist aims to connect with her and help her establish interpersonal relations. While I do not claim that the opinions of my interviewees are representative or a basis for generalization, I integrate and work with their views as informing and in some cases illustrating my points.

4. "It is just I and me"[27] – Anorexia as a Refusal of Others

Starting out from Merleau-Ponty's argument that anorexia does not merely represent a refusal of life, but it is "that refusal of others or refusal of the future, torn from the transitive nature of 'inner phenomena', generalized, consummated, transformed into *de facto* situations" (164), in this chapter I discuss the way anorexia can be seen as a result of a family system without boundaries, which actually triggers the anorexic's isolation from the family, from peers, and ultimately from (and within) the self. At the same time, I do not mean to imply a monolithic family structure applicable in every context, rather, on the basis of my research, I would say that the anorexic's family usually consists of the primary caregiver(s) (the parents), the children (the anorexic and her [or his] siblings), and possibly the grandparents; and it seems to be a relatively well-to-do family, where access to food is not an issue.

Anorexia nervosa can be read as a reaction to relations with others that are lived as dissatisfying: the family dynamics that is often claimed to produce anorexic behaviour in one of its members (usually a daughter[28]) is termed an enmeshed family (see for instance Killian 314).[29] Enmeshment refers to a familial system where there seem to be no borders among the members, everything has to be shared and nothing can be private (Csenki 2009: 41, Killian 314). As Jeremy Wolfe points out, a family is enmeshed if the members are "all over each other," for instance, they finish each other's sentences and they always "know better" what the other wants than the person herself/himself ("Successful Disasters: Eating Disorders"). This may also be the cause why anorexics are unable to recognize, separate and name various bodily sensations, or find inner points of reference, since they are always told by others how

[27] A quote from Mariann.

[28] While it is not exclusively adolescent girls who become anorexic, it seems that the refusal to eat as a response to enmeshment (and not just media representations) is still a gendered phenomenon.

[29] It is important to add, however, that an enmeshed family dynamics does not in itself produce anorexic behaviour, it is a contributing factor that does not necessarily predict the disorder. The co-existence of various factors (biological, psychological, and socio-cultural) is necessary to the development of an eating disorder.

they (should) feel (Lantos et. al. 305). The resulting absence of self-knowledge leads to a misrecognition of needs, which makes it difficult (if not impossible) for the person to feel comfortable, as her sense of comfort (in a given situation, in a given place, and within her own body) depends on others' projection of what she should feel. Lantos et. al. furthermore argue that the feeling of shame, inadequacy and ugliness can be rooted in infancy, as it can develop if there are no empathic responses to, or there is a misrecognition of, the infant's signs (305).[30]

The experience of isolation can be related to what Edmund Husserl terms the sphere of ownness (in *Cartesian Meditations* 92-99). Robert Sokolowski summarises the implications of this concept as the possibility of "'think[ing] away' the intersubjective dimension in principle, and to get down to a level in our own experience that precedes or underlies the intersubjective" (Sokolowski 154). In their refusal of others, anorexics seem to aim at "thinking away the intersubjective dimension" in practice, and thereby strive to exist exclusively in the sphere of ownness. Moreover, as they seem unable to live their emotions otherwise, they use the permanence of their body for self-expression.

While this chapter aims to investigate the experience of anorexics, I will not only rely on their accounts, but also on the therapists' perception of their situation. As I will argue in the next chapter, therapy is a shared project, based on the connectedness between therapist and patient. In this sense, self-knowledge and self-awareness are constituted in interaction and thus can be seen as the product of both the therapist and the patient, even if the emphasis is on getting to know the anorexic's self.

[30] While it is not possible to measure empathy and recognition, the implication here seems to be that there is no response to the infant's emotions and needs.

4.1. "'Thinking away' the intersubjective dimension"

The role of the mother in the development of anorexia has received significant attention (often with the implication that the blame is on her – see Vander Ven [2003]), yet many commentators argue that it is actually the family system as a whole that seems to contribute to the evolvement of this eating disorder. Susan Haworth-Hoeppner (2000) for instance identifies four conditions that underlie the production of anorexic behaviour: (1) a critical family environment characterised by excessive parental criticism; (2) coercive parental control; (3) unloving parent-child relationship; and (4) main discourse on weight. While investigating this specific family dynamics is necessary for the understanding of anorexia and for providing treatment that fits the individuals' needs, in the present subchapter I would like to concentrate on the first two conditions identified by Haworth-Hoeppner with a slightly modified focus. More precisely, my aim is to show how an enmeshed family system – characterised by parental criticism and control – contributes to the isolation of the anorexic and to her simultaneous refusal of food, which lead her to withdraw from family and from social life.

Enmeshment is characterised by over-controlling parental behaviour, when the parents themselves

> cannot cope with their insecurity, anxiety, and they cannot express their feelings and their desires. The ability to reflect – including self-reflection – is not adequate. Consequently, they overwhelm their child with their own inner worlds, who will not learn to differentiate between her and the others' feelings and desires; the reflective function will not develop in her either. (Csenki 2008: 254)

The resulting lack of boundaries seems to be suffocating for the child or adolescent. Mariann, a recovered anorexic, told me: "My mom is a total control freak. So she is not simply as controlling as a normal mother, but she really would like to control me to this very day." Isolation on the part of the anorexic can be seen as evolving from this overwhelming parental

(and more often, maternal) behaviour. Dr. Ildikó Ábrahám, a therapist, experienced similar attitudes in her patients' and their families:

> [Isolation is] the way they [the anorexics] can maintain some boundaries. So the lack of boundaries is really overwhelming for them. It evokes chaotic feelings in them, with which they don't know what to do, and [isolation] seems to them to be the only way to preserve boundaries within the family, with their surroundings.

Parental control appears to co-exist with emotional unavailability, and actual parental absence, to which arrangement the anorexic's response can be a withdrawal from situations where the family is physically together. Dr. Renáta Cserjési argued that

> [i]t is characteristic of the anorexic's family that everyone is always on the run, dad woks here, mum works there, and the discussion of problems somehow *always* happens at the table, it is somehow connected to eating. Interestingly, in a way symbolically, the anorexics reject this. They don't sit down with the family, they are not hungry.

Thus it seems that anorexics are eager to get out of this type of "knot of relations," of this boundary-less existence, and because they are unable to separate themselves from their parents otherwise, they choose to escape (Csenki 2009: 107). For Flóra, this escape did not only manifest itself in a withdrawal from family meals and other gatherings, but she actually left her parents and went to live with her brother:

> We fought a lot because of this [anorexia], in the past year I have spent a lot of time at my brother's, and that is also why I never was at home [she usually left around 7 am and arrived at 11 pm], I was always afraid to go home. And I didn't want to go home […] Sometimes I lived with my brother for two weeks, I took all my stuff to his place, I lived there.

Isolation does not only happen within the family: anorexics tend to withdraw from other relationships as well. The psychologists and psychiatrists I interviewed agreed that their patients' social networks become significantly limited as the disorder takes over their lives. Dr. Ábrahám said: "[D]uring their illness, their range of interests becomes very limited, they become isolated and their relations with others are reduced. […] When the disorder has been

going on for years the isolation has become so extensive that it is very difficult to get them out of it." Another therapist reported similar experience:

> They become isolated, they don't open up towards peers. They don't go out. They stay at home. Because of their problems with self-perception they find it difficult to socialise – because I am ugly, I am fat, nobody likes me, stuff like that. […] And it also depends on what stage of the illness they are in. During therapy we strive to make them connect with their peers, make them go out more. For instance to excursions with their class… I can think of four cases right now, where they did not even join these excursions, they didn't even go to their friends' places. Sometimes someone visited them. But mostly they went home and studied… That was all, that filled their days, that they shouldn't eat, how they shouldn't eat and how they should get rid of what they ate. But peer relations are minimal.

The experts, however, pointed to another trend among anorexics: at the same time as they delimit their relations with their families and peers, some of them seem to open towards other anorexics, with whom they feel they share similar experience and from whom they expect more understanding. One of the psychologists called this group-formation a "subculture," where "they keep in touch via blogs and chat programmes, they go to the gym together, they buy the same earrings, so on every level you can see how they imitate each other." Nevertheless all my interviewees (patients and therapists) agreed that the disorder significantly narrows down the interest in social life.

One of the reasons why the disorder reinforces negative feelings or misunderstandings in the family might be the way family members express their emotions: both Mariann and Flóra claimed that their families communicated their worries and their concern for their daughter via anger. Flóra said at the beginning of the interview that everyone in the family is worried and also angry, but she quickly added that their anger is the result of helplessness. This hasty correction implied to me that although she feels that her family is not taking her illness the way she would like them to, she is still trying to defend them, probably out of loyalty. As mentioned before, she also spends a lot of time at her brother's place, and she is

actually afraid of the arguments that her illness causes, which keeps her away from home for the bigger part of the day. Mariann had similar experience with her family's expression of concern:

> There were arguments, shouting, stuff like that, *but that was because they were worried*, as I see it now. Back then I didn't think about it that way, but now looking back, I see how scared they were. Especially when it was stated that it is indeed anorexia, and they read about it, and realised that this is something which kills every third patient, then they were really done for. And it happened that this anxiety turned into such tension that arguments at lunch ended with shouting, so I went into my room, bang bang, door slamming, it happened once or twice. [emphasis mine]

These instances can be seen as further examples of how the members of the family are unable to express their emotions (anxiety coming out as anger) or understand the emotions of the anorexic (shouting instead of trying to see what the actual reason behind the refusal of food is).[31]

At the same time, both Mariann and Flóra emphasised that they maintained good relations with their closest friends, with whom they could share their experience, and who served as support for them, or, for Flóra, even as her "refuge". Flóra actually talked a lot more about her friends during the interview than about her family. In fact, part of the reason why she prefers being with her friends could be that with them, she can share her feelings and talk about her disorder: "I like if my friends talk about it [anorexia] openly. I totally tell them everything. And yes, yes, they know about everything." She added that "it angers me if someone tries to disregard it [anorexia], act as if there was no problem at all, yet they know there is something wrong." To my next question, whether she discusses the disorder within the family, Flóra replied: "Within the family we don't actually talk about it… I don't know why, it just happened so. We don't really push it. Well, I only talk about it with my dad sometimes." By saying that talking about her problem and her emotions is important to her,

[31] As I mentioned earlier, the family of the anorexic often fails to express their emotions. It has not become clear, however, whether anger is a usual reaction that seems to replace other emotions as well, or it is in fact triggered by the anorexic's disorder.

yet her family fails to discuss these, she implied (although did not articulate) that their attitude bothers her. This silence in the family surrounding her illness is especially intriguing, since they attend family therapy as well, which means that they are forced to acknowledge that there is a problem, however, they still seem to be unable to address the issue at home. One could argue that one reason behind Flóra's disorder is this lack of sharing on a familial level, whereby she (her anorexia) signals the workings of the whole family.

Thus both in the case of Mariann and especially Flóra, the conflicts within the family seem to have been counterbalanced by the understanding behaviour of the closest friends. Yet both they and the experts pointed out that anorexia indeed results in a great degree of withdrawal from others. One of the aims of therapy is to break this isolation and help the anorexic connect with her family and with her peers, a topic I will discuss in the next chapter. Before that, however, I look at how the anorexic's isolation affects her sense of self and what effects social and familial withdrawal has on her self-perception.

4.2. "My body is from what I cannot escape"

The concept of embodiment emphasises the inevitable interrelatedness of body and mind, and is connected to the necessity of expressing emotions, which otherwise surface in bodily symptoms, a phenomenon known as somatisation. In fact, "[t]he body is the fundamental category of human existence: it exists before there is thought," and while it is the vantage point of perception, it "not only perceives but also gestures and speaks" (Thomas 71). Just like their family members, anorexics seem unable to express their feelings. Instead of verbalizing or otherwise communicating their emotions, anorexics – so to say – "write" their feelings on their body. Dr. Ildikó Ábrahám, a therapist, explained that "most anorexics suffer from alexithymia, they don't recognize their feelings […] It is difficult for them to verbalize

and to live their feelings". At the same time, they recognise that their bodies are always present to them, and they can withdraw from interpersonal relations but they cannot "escape" their body.

In *Phenomenology of Perception*, Merleau-Ponty differentiates between the qualities of an object and one's own body: "Its [the object's] presence is such that it entails a possible absence," whereas my body "is always presented to me from the same angle. Its permanence is not a permanence in the world, but a permanence on my part" (90). Going one step further, he points out that "[i]n so far as it sees or touches the world, my body can therefore be neither seen nor touched. What prevents its ever being an object, ever being completely constituted is that it is that by which there are objects. It is neither tangible nor visible in so far as it is that which sees and touches" (92). Anorexics seem to hold onto their bodies in the sense that its permanence allows them to use it for self-expression. Csenki, discussing the case of a patient she was treating, argues that an anorexic "lives her emotions and bodily sensations in a way that she does not understand them. The only well-known area is her body, thus she converts her mental workings to somatic symptoms" (Csenki 2009: 83). Even though they can withdraw from intersubjective relations, as one of my interviewees, Mariann pointed out, one's body is that which one cannot escape: "But really, even now [her stomach had just rumbled] it's like that. Even if you decide that now you are going to study from 1 to 9, I get hungry like five times in the meantime, and then you have to interrupt [studying], and that's what I mean, that it [the body] is good in many ways, and gives you a lot of pleasure, but it limits you in many ways."

Thus, an anorexic's negative self-perception is projected solely onto her body, and she associates her discomfort with it. When I asked her how she related to her body, Mariann said that "I didn't like what I saw, not at all, not even when I had lost weight." Another recovered anorexic (speaking anonymously on a radio programme) said that "I didn't like to look in the

mirror, I didn't see myself as beautiful at all, not before, nor during [anorexia], nor since, only occasionally." Furthermore, Flóra, who has been anorexic for six years, told me that "I never weigh myself. I hate to watch my weight. [Before I was hospitalized] I really only paid attention to how I felt, because if I felt bad, I felt fat." At the same time, these accounts imply that anorexic behaviour moves beyond the effort to attain an "ideal" and "beautiful" body, as these girls do not associate beauty with thinness.

As mentioned before, anorexics display a low level of social interaction, they withdraw from peers and other family members. One could argue that in a way they try to break away from any kind of intersubjective relation, and attempt to exist in what Husserl terms the "sphere of ownness." Dr. Ábrahám argues that "basically their only relation is the one with their body. […] Sometimes they live their bodies as it was an Other. […] And thus they deprive themselves of any objective feedback, any kind of objective mirror, of any type of sharing of emotions, of any kind of sharing, which would be the basis of relationships." While instead of the word "objective", I would use the term "intersubjective", I agree with her that anorexics seem to treat their and other people's bodies as objects as opposed to agents.[32]

In connection with the anorexics' relation to "other bodies," the interviewees were asked to reflect on the impact of media images upon the patients. Even though each of them acknowledged that to a certain extent media images play a role in the etiology of the disorder, they also emphasised that they do not see it as the sole reason. In fact, one of the therapists said that anorexics are much more influenced by the appearance of the other people around them than by the media. In line with this, Flóra said that she hardly ever watches TV, and she rarely browses the internet:

> (Flóra:) Actually, I have never really paid attention to advertisements, or stuff like that, but to the other girls, to the other people. So in my case, well, probably, there is

[32] This argument could be further investigated along the lines of the Husserlian differentiation between the naturalistic and the personalistic attitude towards living bodies (in *Ideas II*). In the case of the former, bodies are seen as effects of internal and external causes, while in the case of the latter, the emphasis is on responding to others' gestures and movements (c.f. Heinämaa 26-37).

> something in it, but it is not a hundred percent characteristic of me that I paid attention to posters or skinny to the bone models.[33]

The emphasis on observing others implies an attempt to distance themselves from a given situation and from others. Dr. Cserjési observed a trend among anorexics to behave in this way and she demonstrated it with an example:

> There is a kind of detachment in them. They observe everything from the outside. […] It must feel like – to bring an example – when you go to the disco, and instead of having a good time, and dancing, they are concerned with what others say about their clothes or about the way they dance. Those who are not anorexic think about it like this: I am here to dance, I have drunk a glass of something, I feel good and I am going to dance. They [anorexics] are the ones who stand at the bar and do nothing but continuously assessing what is happening. Meanwhile they do not feel good, because they are isolated, they are outside the group, they continuously survey and criticize whether they are better than the others or worse.[34]

The anorexics' perceived worries about how others see them might imply two things: on the one hand they are not able to completely disregard the intersubjective dimension and on the other hand they do not only strive to distance themselves from others, but by trying to adjust their behaviour to the standards they imagine others might have, they also attempt to create a distance from themselves.[35] Their self-perception thus seems to depend on others' views, and the ensuing lack of self-recognition together with the anorexic's isolation produce a 'refusal of others', which is among the main issues addressed during therapy.

[33] Yet, the appearance of other people and the anorexic's interpretation of it might be affected by media representations and thus an indirect link might exist between the patient's perception of others and media images.
[34] Once again I would like to emphasise that this attitude is not necessarily characteristic only of anorexics.
[35] It is argued that anorexics tend to be perfectionist, which again implies a will to meet other's expectations. Many of my interviewees (including the patients) supported this view.

5. "The Wavering, Interacting Togetherness of Bodies" – Therapy

"It's like the tale with the Snow Queen, when the queen puts splints of ice in the boy's eyes. The boy becomes totally emotionless and frozen. It is the same with anorexics. It takes a long time to melt this ice, until they become able to connect again. Until they become able to open up." (Dr. Ábrahám)

As I have argued in the previous chapter, the concept of intersubjectivity plays a significant role in the understanding of subjectivity in phenomenology. In this context, the claim that it is women's reading practices (their alleged susceptibility to media images) that produce anorexic behaviour, promotes a view of anorexia as a result of a one-way flow of information (from image to person). Yet anorexia nervosa is in many ways a reaction to relations with others that are perceived as dissatisfying, which ultimately results in "a refusal of others" – as Merleau-Ponty puts it (164). Starting out from this argument, in the present chapter I claim that psychotherapy (the therapist-anorexic relation) is based on sharing and therefore it provides the anorexic with the possibility of repairing her intersubjective relations and thus helps her to overcome her isolation. It also inevitably affects the therapist, which influences interaction between her/him and the anorexic, and so concentrating on the therapist's experience becomes necessary for understanding the anorexic.

First, I discuss the therapeutic approach that seems to be the most closely aligned with phenomenology, that is, psychodynamic therapy, in order to establish what the relation between anorexic and therapist is like and what level of reciprocity can be observed. Following Mary Jeanne Larrabee's discussion of connectedness and the person as multiple in unity (275, 277), I show the way therapeutic interaction fosters self-knowledge and changes self-perception, helping the anorexic to accept multiplicity in subjectivity and intersubjectivity. Furthermore, I consider what impact the patient's experience of connectedness (gained through the therapy) has on herself, her family, and the therapist in

order to show that on both sides (patient and therapist) there is give and take, which means that recovery (where the anorexic gives up her isolation) becomes a shared project.

5.1. The Psychodynamic Approach to Therapy

While there seems to be no articulation of a phenomenological approach in the therapeutic practice of eating disorders, many concepts central to phenomenology are in fact integrated into the process (including an emphasis on reciprocity and emotions). The approach that seems to be closest to the philosophical implications of phenomenology is the so-called psychodynamic approach[36] which has developed from psychoanalysis, object-relations theory and self-psychology (Ábrahám et. al. 197). As Katalin Lantos et. al. demonstrate, "psychodynamic therapy is based on the supposition that early relations play a significant role in the formation of the self, and within that, the development of a body image" (305). They argue that when the primary caregiver (usually the mother) mirrors the child's signs inadequately, imprecisely or inconsequently, a faulty body-self is created; and moreover, the feeling of shame, inadequacy and ugliness can develop if there are no empathic responses to the infant's signs (305).

The main goal of psychodynamic therapy is thus to teach patients how to recognize, separate and name various bodily sensations, as well as to search inner points of reference. The role of the therapist is not to interpret unconscious processes, but to help the patient in recognizing and verbalizing their affective sensations. Furthermore, it is important that the therapist should develop a connection that includes some of the peculiarities of the mother-child relations, such as credibility, empathy, reliability, focus on the patient and acceptance

[36] While the psychodynamic is just one approach among many others, in most cases it is part of the diagnosis and treatment of the patient, because – as the various authors repeatedly point out in *Eating Disorders and Body Image Disorders* (2008) – an integrated approach is the most likely to be effective, since biological, psychological and social factors all need to be considered in the etiology and treatment of anorexia (the bio-psycho-social model [Pászthy and Major 27]).

(Lantos et. al. 305). This connection is central to the success of the therapy, as it determines the attitude of the patient as well. One of my interviewees, Mariann (a recovered anorexic), spoke about her experience of the therapy in elated terms, repeatedly praising her therapist: finally conquering her reluctance to attend therapy, she realized "how good it was, the girl was really really really good, Kati [her therapist], it was terrific, working with her" and "it helped a lot that I got on really well with Kati, she really is a fantastic girl." Flóra (an anorexic still attending therapy) has similar experience:

> *(Me:) How do you experience therapy, what do you feel, what emotions do you have when you are going to a session with your therapist?*
>
> (Flóra:) I like it, actually. It all depends on what kind of therapist or psychologist one has. Luckily for me, both of my psychologists are really nice. And I really like going there, so whatever problem I have, I know that I can count on them, and I can come up here, and we can talk about it. Sometimes I leave the session deep in thought, sometimes totally energetic, filled with energy, that yes, I have to do this. It's always different.

5.2. Multiplicity in Subjectivity and Intersubjectivity

Mary Jeanne Larrabee argues for the understanding of the person as multiple in unity (277), and thus accords multiplicity a positive connotation. Referring to John Beahrs' interpretation, she concludes that "[the] existence [of multiplicity] is not the problem, rather what counts is the relation of the multiplicity to a person's ability to accept and integrate that multiplicity in some manner so that life can be lived" (Larrabee 283). In John Rowan's theory, the psychic organization is made up of subpersonalities (what he calls "the people inside us") (Larrabee 283). While splitting as an experiental dispersal of these parts is considered "normal," yet "[w]here splitting is a multiplying of subpersonalities that do not cooperate within the self for effective living, Rowan would move toward the labels of

abnormal psychology, such as multiple personality disorder or borderline personality disorder" (Larrabee 284).

Anorexics seem to struggle with finding borders between self and other, as well as with their dispersed "subpersonalities". As Sáfrán demonstrates, the therapeutic practice of psychodrama helps to achieve a separation between self and other (which is often blurred in the anorexic's relationship with her family in general and her mother in particular) and moves attention to the sentient body (453). At the same time, the so-called ego-state therapy strives to integrate disassociated self-states (Gáti and Árkovits 470), and so the various components of therapy serve to help anorexics – in Larrabee's terms – "to accept and integrate that multiplicity in some manner so that life can be lived" (Larrabee 283).

Furthermore, Larrabee discusses Kathy Ferguson's concept of mobile subjectivities, which includes openness to multiplicity in oneself, and especially in others (Larrabee 285), while she is keeping in focus the experience of *lived life* as opposed to "views of autonomy [that] are conceptually based and thus too removed from everyday lived life" (287).[37] This shows that multiplicity plays an integral role in subjectivity and intersubjectivity, and a co-operation among one's 'subpersonalities' seems necessary for developing self-knowledge and self-recognition.

The experience of the self's multiplicity seems to determine the lived experience of the body. As mentioned before, the phenomenological understanding of embodiment emphasises the interrelatedness of body and mind, and is connected to the necessity of expressing emotions, which are otherwise converted into bodily symptoms, a phenomenon known as somatisation (Thomas 71, Csenki 2009: 83). Merleau-Ponty argues that

[37] Here, the understanding of autonomy and an autonomous self is not so much connected to the question of free will or agency (as in the Enlightenment thinking), but rather it is related to the experience of connectedness. Larrabee suggests that "[i]t is in identity shared that people find a connectedness; it is in a recognition of differences that we can accept the autonomy of an other and perhaps the other's right to self-identity grounded in that autonomy, an autonomy that is often itself the goal of self-realisation through growing understanding" (282).

> the permanence of one's own body [leads] to the body no longer conceived as an object of the world, but as our means of communication with it, to the world no longer conceived as a collection of determinate objects, but as the horizon latent in all our experience and itself ever-present and anterior to every determining thought. (92)

Ábrahám also suggests that it is not possible in therapeutic practice to divide the somatic and the psychic, and thus an integrative approach is needed in order to achieve success (205).

For anorexics, however, the body (as opposed to the interrelation of body and mind) might occupy too prominent a place in providing a continuous sense of self. If the body receives a central role in the formation of self-representation, then bodily changes (especially in adolescence) will result in a higher degree of changes in identity; that is, if the body changes, it results in the change of one's whole identity (Túry et. al. 84). Dr. Renáta Cserjési, who worked with anorexics both in Belgium and in Hungary, emphasised that these patients seem to focus on small details as opposed to paying attention to the whole, they are somehow unable to concentrate on "the big picture." The preoccupation with the body can be seen as an example of this, and it is intensified by the anorexic's focus on specific body parts: Flóra told me that

> when I was in the first stage of anorexia, I paid a lot of attention to my body […] and I noticed every small change. So if I didn't go to the gym for two days, I felt that, I saw that my feet were growing, in a weird way, so that they are not muscular, but like floppy… And my hands were swollen, and… and my veins too. One notices these really small changes and is inclined to exaggerate them.

Mariann had similar experience:

> I had problems that I actually still have that I don't like the shape of my thighs. I know they aren't thick, I just don't like the way they look. And back then I lost so much weight that my thighs were so thin that they didn't have that shape I didn't like. And maybe I didn't like it that way either, because now it was like a stick, but I was glad that it was like that, and I knew that if I gained weight, I would gain it to that part, and that I really didn't want to happen. And maybe I didn't like how much weight I lost on the upper part of my body, but I thought it's great that my legs looked like that and I thought that I shouldn't gain weight.

The negation or the dismissal of the whole also leads to an incomplete self-awareness and self-knowledge, which makes someone more vulnerable to eating disorders and bodily dissatisfaction, as they become over-dependent on other's opinion of them (Lukács 2008a: 374). This results in a lack of consistent self-perception, as anorexics appear to see themselves the way various other people see them in a given moment, which prevents them from handling the multiplicity of their self adequately. Through therapy, the aim is to achieve a stable and safe self-perception (Sáfrán 460), and, as mentioned before, find inner points of reference for the patients in order to achieve co-operation among their subpersonalities and help them to cope with the multiplicity inherent in subjectivity and intersubjectivity. Furthermore, the aim of these sessions is to correct perceptive distortions, to foster reliance on sentience as well as body-awareness, and to thereby facilitate a reliable experience of self-perception (Sáfrán 460). In the case of Mariann, for instance, the therapy started a process which later culminated in her acceptance of herself: "I know that I am in harmony with myself since I started dancing. So it is now that I still know what I don't like about my body, but now I am able to say 'I don't care'."

5.3. Connectedness

To a great extent, the success of the therapeutic process – especially the psychodynamic component – relies on the connection between patient and therapist. As mentioned before, the quality of this bond determines the attitude of the patient, but its establishment is mostly the task of the therapist. In a sense, the therapist paves the way to recovery for the patient via introducing her to a different kind of connection than she has known. This also means that it is not just the patient but also the therapist who has to invest a

lot in the process. I argue that the development of this bonding can be best examined with the help of a phenomenological understanding of connectedness.

The notion of connectedness, as discussed by Daniel Stern (In: Larrabee), is understood as a variety of forms of "beings with". Stern's three forms of "beings with" are (1) a self-other complementarity; (2) the way the mother enables the infant to shift from one state to another (for instance from hunger to satiety); and (3) the "mental state sharing and tuning" (for instance the mother's cooing leads to the child's smiling) (Larrabee 275). While Stern's focus is the mother-child relationship, I would argue that this can be applied to the relationship between therapist and patient, as it is (psychoanalytically, as a transferential experience) often seen as a re-enactment of the connection between caregiver and child:

> *(Me:) In this system of relations what role do you as the therapist take?*
>
> (Psychologist:) In connection with individual therapy […] it is very interesting, I am a kind of identification surface, a kind of example to be followed. Looking at it from this angle, it is like a desired mother-daughter relationship, [I am the mother] to whom everything can be told, with whom everything can be discussed, with whom one can identify. For instance this patient of mine wants to be a psychologist. Wants to go to the same university I did.

These forms of being with are important parts of experiencing connectedness, and are enacted during the therapeutic process, in an attempt to revisit the caregiver-child relationship and help the patient understand the workings and the impact of these beings with. Therapy moreover fosters a negotiation between autonomy and connectedness as the patient recognises that achieving the former does not exclude the possibility of a satisfying experience of bonding. As Larrabee also argues, experiences should not be encapsulated in binary pairs, thus for instance autonomy should not be seen in absolute opposition to connection, instead, they should be seen as interacting with and evolving out of each other in complex ways (288). Therapy offers anorexics a way to negotiate control and instead of choosing complete isolation and escape, they become able to find a balance between autonomy and

connectedness. Mariann talked about how she lost and then regained a sense of control during therapy:

> Well, before I started [therapy], I felt absolutely in control, because I thought I could stop [refusing to eat] any time. And when I started therapy, I realized that it is not true. So it wasn't like, so I said to myself in vain that now I would like to eat, it didn't work, because I was afraid that if I eat just a little more, then I gain weight, and to places I didn't want to, that I will look horrible and I wouldn't be proportional, that sort of thing. And when I started going to therapy, I gradually begin to feel that it is under my control. At the beginning, at the beginning when I was going to therapy I felt that they tell me what to do and I am doing that, and then I gradually began to feel that I am also controlling things.

Importantly, she also recognised how her mother's over-controlling nature affected her, and by understanding the situation, she is now able to negotiate with her mother: "My mom is a total control freak. So she is not simply as controlling as a normal mother, but she really would like to control me to this very day. […] But now I try to pay attention to this and not let her bother me too much." Her case appears to fit the gender-roles often perceived in families with an anorexic, as there is an overbearing *mother* (rather than a father or both parents) exerting control over the *daughter*.

Larrabee's argument questions clear divisions between seemingly opposing terms (autonomy-connectedness) and emphasises the experience of intersubjectivity as an important aspect of subjective existence. Lukács points out that the psychopathological picture of anorexia nervosa is not adequately explained by negative and false thoughts of food and body image (2008b: 212). In fact, it is necessary to take into consideration other important elements, such as low self-esteem, mood imbalance, perfectionism, and interpersonal difficulties (214, c.f. Csenki 2008: 256). Thus both in the evolvement and in the treatment of anorexia, the question of autonomy, connectedness and intersubjectivity play a significant role.

However, the successful establishment of connectedness between the patient and the therapist can also posit various problems, as it could evolve into a difficulty of separation from the therapist(s) on the part of the anorexic. Dr. Renáta Cserjési conducted research in a Belgian clinic where they treated anorexics in isolation not just from their family, but also from other people, and she observed that the clinic was like a hotel and "one did not have a sense of it being a psychiatric clinic […] the atmosphere was really familiar, it didn't feel like a hospital. But the girls had problems with separation afterwards." As opposed to this, the Hungarian hospital where she worked, put all the patients with mental disorders in the same ward. Furthermore, "[i]n the hospital everyone is always in a hurry. You don't have time to deal with one person, or one type of problem," yet the fact that "they are not entirely isolated from the family has the advantage that they are developing together with the family, and it will be easier for them to go back."[38]

As I will discuss in the next subchapter, these problems can be resolved by the therapist's endeavour to first connect with the patient and then gradually let go of her, thereby providing her with a model of a satisfying relation.

5.4. Togetherness

Following Merleau-Ponty's argument, Sandra P. Thomas claims that the phenomenological concept of relatedness to the world gains importance not just in our relations with the world as such, but also with other people: life is spent in a "knot of relations," and connecting with other people provides "the potential for dialogue, through which persons receive recognition and affirmation" (Thomas 71). Thus the task of the therapist is to create the possibility of a reparative relationship that corrects early lacks (in the

[38] However, as many of the anorexics are treated as outpatients, the problem of returning into family life does not always arise in this form.

mother-daughter relationship) and thereby stimulates the formation of as yet undeveloped perceptual abilities (Ábrahám et. al. 203).

An important aspect of modern psychotherapy is that the relations between doctor and patient have changed, and the latter has become an active participant in his/her own treatment (Németh, Pászthy and Túry 477). As in Laura Csenki's case study of Dóra, the therapist in fact asks the patient what she needs help with in order to maximize the success of the relationship (Csenki 2009: 35, c.f. 96). This also entails that the therapist becomes (personally) more involved in the process of the patient's recovery: s/he actually lives through the patient's experience of loneliness and threat via the patient's projective identification with her/him (Ábrahám et. al. 205):

> A young anorexic girl's emotional and verbal unavailability became more and more frustrating for her therapist. The loneliness and helplessness experienced through counter-transference during the sessions only slowly allowed the therapist to perceive the "dialogue," "the wavering, interacting togetherness of bodies." The motionlessness of the girl made her more and more active. She experienced the girl's starving (her disappearing body, the defeated hunger) in her own body, and became hungrier and hungrier during the sessions. Because of the girl's firm insistence on control (her symptoms), and the expansion of her grandiose self, the therapist felt smaller and smaller, more and more insufficient. Through these counter-transferential experiences did the (non-verbal) presence of the Other become perceptible, as the girl was indeed talking, for which she "chose" a unique (body) language. (Ábrahám et. al. 203)

A special relation appears to exist between therapist and patient, a certain co-dependency on each other that is built on reciprocity and sharing: the anorexic seems to project her feelings to the therapist (transference), who projects those back but mixed with her own emotions and sensations (counter-transference). Most of my expert interviewees agreed that on the one hand this is a painful and strenuous experience, on the other hand, this is also the process that can initiate the anorexic's recovery by providing her with an experience of reciprocity and mirroring.

As I argued in the previous chapter, the anorexic's disorder produces (and is often produced by) a sense of isolation, and a high degree of detachment. She needs to overcome these by experiencing connectedness via her relationship with the therapist, which will be different from the overwhelming boundary-less family connections and which will enable her to form more satisfying intersubjective relationships, as well as to return to the family and social life. The (recovered) anorexics I interviewed experienced their relationship with their therapist as gratifying. During my interview with Mariann, I observed that therapy enabled her once more to relate to something, to connect to someone in a way that helped her in her dealings with food and ultimately with other people.

> *(Me:) And how did this experience [anorexia] change family life? How did family life change after you started therapy?*
>
> (Mariann:) It became much better, actually the therapy was weird, because I am, I always have been since I was a child, I am absolutely conscientious, and a perfectionist. So I am like if someone told me to do this, and I felt like like like I had to do that, then I did it perfectly, or as perfectly as I could. That was one of the problems in connection with anorexia, that if I could tell myself that I would not eat, then I did not eat. But it was also good for the therapy, if they said, Mariann, now you have to do this, like this, the way we write it down, then I did it. […] The first time I went to the therapy alone […] the psychiatrist was also there and he wrote the dietary for me, we wrote it down on a paper and then I went home and said that from then on, I am allowed to eat, because it is written on the paper, and everyone was staring at me […] why, Mariann, you were not *allowed* to eat so far? I remember how shocking that was for my parents. But but everyone was amazed that from then on I really ate those things […] they were wondering what they could tell me there [in the hospital] that made me eat, and I didn't really understand it either.

A recovered anonym anorexic (speaking in a radio programme) felt that treatment "gave back her life":

> *(Interviewer:) And you didn't protest? So did you want to go to the hospital at that point, or did you reject the whole situation?*

> (Anonym:) I had been going to bed for several weeks with a fear of death, wondering whether or not I would wake up the next day. I felt then that I was redeemed, that I got back my opportunity to live by getting into the hospital, that they could take me in.

She explained that the distance between her and the other members of the family (especially her teenage brother) diminished after her illness, and she was also able to relate to her family in a different way:

> (Anonym:) I have a brother who was in his teenage years then and his reaction to anything in the family was that he slammed the door and went cycling. It was only half a year or a year later when I was in hospital in a very bad condition that this bridge, this connection started to develop between us. He got scared then, I guess, he thought that he could lose me, and that's when we got really close.
> […]
> My relationship with my grandparents, my aunt, my mother, too, as well as with my little brother, became much much deeper…

Flóra has begun to have similar experience since the treatment started:

> When I was taken to the intensive care unit and even before that, they [the family] tried to help me, always. There is a danger that they might lose me, and nowadays the connection with them is getting deeper and we tell each other more and more.[39]

Establishing connection, however, is the task of the therapist, who has to invest a lot of emotions and energy in the process in order to make it work. Dr. Ábrahám's experiences imply that the fundamental integrity of the psychological and physical level entails that the therapist is affected somatically as well:

> What is striking in the therapeutic relationship, what makes this relationship very special is that anorexia is so much about the body as well, that it generates change in the therapist's body, too… And I noticed that until a verbal connection, a connection through words is achieved, I have these intense bodily experiences which I am sure are induced by the presence of my anorexic. […] And I hope that the way my bodily sensations become intense and change will sooner or later happen to her as well. And from then on, I feel there is a connection between us. And that the illness is so multi-levelled and so is the therapeutic connection.

[39] It is important to note, however, that Flóra had contradicting remarks about her family during the interview, on which I have already reflected in the previous chapter. She seems to be at a stage where she strives to accept herself as well as others, and attempts to (re-)integrate into the family.

Dr. Ábrahám also pointed out that the therapist's role is partly to reflect the feelings of the anorexic.

(Me:) How much do you get involved in the life of the anorexic?

(Dr. Ábrahám:) I hope a lot. I try to. One reason for that is that most anorexics suffer from alexithymia, they don't recognize their feelings […] It is difficult for them to verbalize and to live their feelings. In many ways, I need to become a model for her: she evokes feelings in me, and I recognise these feelings and reflect on them. At the same time, I have to help her recognise her own feelings.

(Me:) What impact does it have on you?

(Dr. Ábrahám:) It wears me out. It is not easy to work with anorexics because in the beginning, I have to feel *for* them. I have to mobilise a lot of emotions within me, a lot more than… than in the case of patients who live their emotions more easily.

For another psychologist, the experience is similar (she is talking about an anorexic she is treating at the moment):

> At the beginning I felt more like her, at the beginning I felt that in our relationship I functioned the way she did in her family, that she is the one, who can never do well enough, whatever she does. She cannot generate anything positive in the family climate, even though she is a good student, a good girl. That is how I also felt that whatever I do, I won't be good enough. Very often she hurt me, with which I didn't know what to do and she didn't know what to do with her own emotions either. So there was a little bit this transference in our relationship. But now we are at a phase, where one could say everything is perfect […] now I am the one to follow. These are extremes, and it is difficult for me to live these, that in one moment I am like this, in the other I am like that. But her life is lived in extremes. So I either eat or I don't eat. There is no in-between.[40]

The same psychologist told me that when she was treating this anorexic, the patient gave her the diary she kept. This seemed to imply that the anorexic actually wanted to share her experience with the therapist but was not able to verbalize her emotions face to face. Yet

[40] It is interesting to observe how she shifted to the first person singular even when talking about eating, which is more of an issue for the patient. This shift might imply her identification with the patient.

after a while, the therapist gave her back the diary, because she no longer felt she had to invest so much in the process:

> When I gave her back the diary, it was with the intention that it is no longer me who should work, but she should work. So if something comes up, she should bring it up, she should filter it, it shouldn't happen through me any more. It surely had a component… that I… I didn't want to be implicated so much. Yet this transition was good, in the sense that this separation was not so sudden, not so sharp, but it was a gradual transition […] It gained a different quality, from being very intense to gradually… so as we try to gradually let her go her own way.

Yet another therapist spoke about therapy in the following terms:

> I imagine it as a temporary, well, "crutch", the therapist serves as a temporary crutch for the patient, to help for instance her separation from the parents. And to help her take a step towards her peers.

Dr. Ábrahám said that anorexics need a very active therapeutic attitude, and the connection that is established with the therapist helps them with their connections with others,

> because they can use this experience as practice. When they feel comfortable in it, then they will bring in the problems that she struggles with day by day. And if we can reflect on those together, see why it is difficult for her to handle those situations, and what those evoke in her, and what it is that the other might experience, then she can benefit a lot from it. But it needs a safe relationship.

Similarly, although with a slightly different focus, another psychologist holds the view that the therapeutic interaction can be seen as a model for the anorexic of a relationship where it is not food and appearance that is discussed.

Therapy builds on reciprocity and interaction, developing in an interpersonal space. It becomes a shared project of the therapist and the patient, which affects both, although in different ways. The therapist helps the anorexic in recognising her feelings and leads her toward self-knowledge and self-awareness, assisting her on the road from isolation to connectedness. The shared nature of the process enables the anorexic to experience a meaningful connection with another person while not losing her autonomy, and she retains a

sense of self in interaction that helps her in recovering and provides her with a different attitude towards relationships (with others and with the self).

5.5. "Flower on the Volcano" – Towards Recovery

> *In art therapy, we also work with clay. For instance, the patients have to mould a form that represents their anger. Then they have to take that form and change it in a way that their anger is dissolved. There was this girl who first formed a volcano out of the clay and then, on the top of it, she put a flower.*[41]

It seems that recovery happens in intersubjectivity and has to be sustained via a balanced relationship to one's self and to others. In my interviews, I found that various strategies are used for facilitating recovery. For Mariann, dancing provided a way to manage her feelings and relationships: when she goes to dance practice, it allows her to concentrate on herself, but also be with others. To my question how individual or social an event her dance practice is, she replied:

> It's a really nice mixture of the two, because there are many people in the [classical ballet] class, about ten or twelve, and there are even more of us in modern [dance class]. But what you do, you do alone, there is the mirror, and you continuously look at what you are doing and how you are doing it. So in that sense it is just I and me, however, there are other people there, which is good, because in between movements, you can wink at the other, or smile, so it's got a social aspect.

Mariann's account points to a simultaneous experience of sharing and self-recognition, suggesting that the balance of the two facilitates recovery and prevents relapse. She also added that "I know that I am in a harmonious relationship with my body since I started dancing. So it is now that I am aware of what I don't like about my body, but now I can say 'I don't care'." Flóra, on the other hand, finds a way to self-expression via writing novels:

> (Flóra:) Writing allows me to get rid of the tension in me.

[41] Non-verbatim quote from Péter Csernyák, group therapist (he asked me not to record the interview, and so I reconstructed what he said from my notes).

(Me:) Do you write about things that you cannot discuss with others?

(Flóra:) No, no. Actually, I can discuss anything. I am an open person, so I can discuss everything with my friends. There are very few things, very few, and those are really personal, that I cannot share with others. And those I write down.

Flóra claims that she can discuss everything with her friends, so writing is not her way of coping with unexpressed feelings. Yet, at the end, she admits that the very personal side of her self can only be accessed and expressed via writing. I noticed another contradiction in her account: when I asked her whether she wrote for others or for herself, she said she is writing "just for herself." However, when I asked her whether she would not want her book published if she finished it, she replied: "I have actually written a book already. And someone read it through. But I was only 14 or 15 then." This again points to her need for sharing and a simultaneous refusal of it. Thus one can argue that writing can be one of the ways that might facilitate her recovery, in that it allows her to express what is really personal and share it with others.

One of the psychologists observed a similar trend among a number of anorexics: she said that writing (diaries and blogs) helps them to express what they feel, whereby they no longer communicate their emotions and experiences through bodily symptoms.

With the help of various therapeutic methods and practices (art therapy, group therapy, family therapy, individual therapy), anorexics are first made to connect with the therapist and then are gradually "let go", as one of the therapists put it. In a way, therapy aims to help the anorexic establish connection with the self, with the world and with others. Merleau-Ponty's words seem to capture the destination of this journey of the anorexic: "To be a consciousness or rather *to be an experience* is to hold inner communication with the world, the body and other people, to be with them instead of being beside them" (96, emphasis in the original). Thus, the anorexic needs to return to experience in order to be able to live her self in the intersubjective sphere of being.

Conclusions

In my thesis, I argued that the role of media images in the development of anorexia has been overemphasised, and therefore I suggested a shift towards the examination of the lived experience of anorexia and its therapy. I do not, however, argue for neglecting the impact of media representations. In fact, even if some of my interviewees claimed that media images do not affect the patients to a great extent, it still seems that bodily ideals are also communicated indirectly via the bodies of other people (which anorexics observe) and possibly via the family (in the form of parental criticism about appearance). Moreover, the anorexic seems to respond to these physically, which implies that s/he is not a passive recipient of various stimuli, but engages actively with those.

In that sense, the patient's recovery might not be the endpoint. Dorothy Leland's view of the processes and aims of psychotherapy has already been discussed: she shows that the politicization of psychotherapy by feminists has led to seeing therapy as a way of re-narrativizing the individual's experience in the larger (socio-cultural) context that affects the development and/or the experience of the disorder. Therapy – as discussed in this thesis – helps the anorexic in recovering, but it also returns to the question of larger implications: how is it possible to move beyond the question of the individual's recovery and address socio-cultural issues (within or without the framework of therapy), which would, in turn, foster recovery and prevent relapse?

On the basis of my communication with experts, it seems that psychologists and psychiatrists also perceive a lack of research in the question of the therapist's experience of the treatment of anorexia nervosa. Furthermore, while they pointed out in the interviews that the development of anorexia is only partly influenced by the media, they argued that popular psycho-education would be important in order to minimise the impact of media messages. At

the same time, one of the psychiatrists suggested (in response to one of my questions) that it would be important to research what the public opinion about anorexia nervosa is so as to find more effective ways of psycho-education and consciousness-raising in connection with eating disorders in general and anorexia in particular.

Thus, my research raises further questions and opens up further discussions that I had no chance to address within the limits of my thesis. These, however, could be investigated in order to gain new insights and a different understanding of anorexia nervosa.

Bringing together a feminist phenomenological approach with psychiatric practice, was one of the biggest challenges of the thesis, since there appears to be a substantial difference in the way the two operate. Yet, as I attempted to initiate a dialogue among various disciplines, this challenge can also be considered a strong point of the project. Moreover, my focus on the therapeutic process also signifies a shift from a lot of feminist scholarship by looking at what actually happens to the anorexics once they have been diagnosed and their treatment has begun, rather than focusing exclusively on the investigation of the causes. Furthermore, as intersubjectivity plays a prominent role in my approach, this shift also meant an engagement with what "the other side" thinks, that is, how the therapist lives through treatment and how s/he perceives the anorexic's experience.

The oral accounts that served as a basis for my analysis are not numerous, and cannot be taken as representative. Yet, as my goal was to enquire into the lived experience of the anorexic and the therapist, I do not aim at drawing any generalised conclusions or at making any general claims. These, moreover, would work against my feminist phenomenological approach, which tries to understand people's experiences.

There seem to have been few attempts to investigate the possibilities of a feminist phenomenological approach to anorexia nervosa, and I am far from claiming that my thesis has filled this gap. Rather, my research intended to introduce a possible way to explore the

philosophical implications of phenomenology in feminist research by initiating a dialogue between feminist phenomenology and the understanding of anorexic behaviour. I argue that recognizing the potential of the suggested approach and conducting further research would contribute to the existing scholarship on the body in general, and on anorexia nervosa in particular.

Appendices

1. Diagnostic Criteria for Anorexia Nervosa[42]

1.1. DSM-IV-TR

Adapted from ***DSM-IV-TR*** (a text-revision of the Diagnostic and Statistic Manual of Mental Disorders, published in 2000)

a) Body weight is less than is considered normal for height and age. Weight is consistently less than 85% of that expected, which can be due to either weight loss, or failure to gain weight during growth.

b) Despite being underweight, there is an intense fear of putting on weight and becoming fat.

c) Refusal to accept low body weight as a problem, excessive influence of body weight and shape on self-worth, or a distorted body image perception.

d) Amenorrhea (abnormal absence of a minimum of three successive menstrual cycles).

There are two identifiable types of anorexia nervosa:

Restricting Type: Throughout the present episode of anorexia nervosa, there has been no regular occurrence of binge eating or purging (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge Eating/Purging Type: Throughout the present episode of anorexia nervosa, there has been a regular occurrence of or purging.

[42] From: http://www.disordered-eating.co.uk/eating-disorders-diagnosis/anorexia-nervosa-diagnosis.html (last accessed: 4/30/2009).

1.2. ICD-10

Adapted from ***ICD-10*** (International Classification of Diseases, endorsed in 1990, in use since 1994)

a) Body weight is consistently 15% less (or lower) than that expected for height and age, or body mass index is 17.5 or less. This can be due to either weight loss, or failure to gain weight during growth.

b) Weight loss is caused by the avoidance of foods perceived to be fattening, along with one or more of the following behaviours: self-induced vomiting, purging, excessive exercise, use of appetite suppressants and/or diuretics.

c) Distorted body image perception driven by an intense, irrational fear of becoming fat, leads to the desire to remain at a low body weight.

d) Amenorrhea (abnormal absence of a minimum of three successive menstrual cycles) in women, and loss of libido in men. There may be changes in growth hormone, cortisol, thyroid hormone and insulin.

e) Puberty in girls and boys may be delayed if the onset of anorexia nervosa is pre-pubertal, but once recovery from the illness is made, it will often progress normally.

ICD-10 also includes 'atypical' anorexia nervosa, which refers to individuals who show some, but not all, of the characteristics of anorexia nervosa.

2. Interview Questions

2.1. Therapists

1. What approach do you use in the treatment of anorexia nervosa and why?

2. How much do you get involved in the patient's life during therapy? How do you experience this?

3. In your opinion what role does the therapist have in the patient's life?

4. What differences can you point out in this respect between inpatients and outpatients?

5. In your experience, how do anorexics handle their relations with others (family, friends, partner)?

6. What coping strategies do you offer to these patients if the management of these relationships posits a serious problem?

7. How do you see the everyday life of an anorexic? (before and during therapy)

8. What are the psychological difficulties that an anorexic has to face on a daily basis?

9. In your view, how do anorexics experience therapy?

10. In your opinion, does the experience of the disorder depend on the sex of the patient? If yes, how?

11. In your opinion what role does the media play in the development of anorexia?

12. How do you think anorexia is viewed by people in general? How much knowledge do people have about this disorder?

13. How can this knowledge or viewpoint influence the anorexic's (social) life?

14. Is there something you think is important and has not been discussed yet?

2.2. Anorexics

1. Could you tell me why you are here (at the hospital)?

2. Do you talk about these (the therapy and the disorder) with anyone? Why (not)? If yes, with whom?

3. What do you do on an average day? How do you organize your day?

4. How much time do you spend a day thinking about eating, calories, sports, weight, body?

5. Do you consider anorexia a disease?

6. How did the quality of your life change because of anorexia nervosa?

7. What and how has changed in your life since you have started therapy?

8. What do you expect from the therapy?

9. What does social life mean to you? What kind of relationships do you have with others?

10. What do you do in your free time? (with a focus on TV, media, internet, magazines, sports)

11. Are there any situations where you feel uncomfortable? How do you avoid these? Which are the situations in which you feel good?

12. How did you relate to your body before the therapy? How has it changed?

13. How did your family react to this situation? What has changed in the family since you started therapy?

14. How do you relate to therapy? What feelings do you have when you come to a session with your therapist?

15. In your opinion what role does the media play in the development of anorexia?

16. How do you think anorexia is viewed by people in general? How much knowledge do people have about this disorder?

17. How do you think this knowledge or viewpoint influences your (social) life?

18. What else is important for you? What aspects of the experience stand out to you that we have not yet talked about?

References

Ábrahám, Ildikó et. al. 2008. “Az evészavarok pszichodinamikus megközelítése és terápiája.” [The psychodynamic approach to and therapy of eating disorders.] In: Pászthy and Túry. 2008. 197-210.

Alcoff, Linda Martín. 2000. “Phenomenology, Post-structuralism, and Feminist Theory on the Concept of Experience.” In: Fisher and Embree. 2000. 39-56.

Apprey, Maurice. 1991. “The Intersubjective Constitution of Anorexia Nervosa.” *New Literary History*. Vol. 22. No. 4. (Autumn 1991). 1051-1069.

Bartky, Sandra Lee. 1988. “Foucault, Femininity, and the Modernization of Patriarchal Power.” In: Jana Sawicki**,** ed. *Disciplining Foucault: Feminism, Power, And The Body*. New York: Routledge, 1991. 93-109.

Bigwood, Carol. 1991. “Renaturalizing the Body (With the Help of Merleau-Ponty).” *Hypatia* Vol. 6, No. 3. Feminism and the Body (Autumn 1991). 54-73.

Bordo, Susan. 1986. “Anorexia Nervosa: Psychopathology as the Crystallization of Culture.” In: Helen Crowley and Susan Himmelweit, eds. *Knowing Women – Feminism and Knowledge*. Oxford: Open University Press, 1992. 90-109.

_____. 1989. “Reading the Slender Body.” In: *Body/Politics – Women and the Discourses of Science*. London: Routledge. 83-111.

Bray, Abigail. 1996. “The Anorexic Body: Reading Disorders.” *Cultural Studies*. Vol. 10. Issue 3. October, 1996. 413-429.

Bray, Abigail and Claire Colebrook. 1998. “The Haunted Flesh: Corporeal Feminism and the Politics of (Dis)Embodiment.” In: *Signs*, Vol. 24. No. 1. (Autumn, 1998). 35-67.

Brumberg, Joan Jacobs. 1988. *The Emergence of Anorexia Nervosa as a Modern Disease*. Cambridge & London: Harvard UP.

Caskey, Noelle. 1985. “Interpreting Anorexia Nervosa.” In: Susan Rubin Suleiman, ed. *The Female Body in Western Culture: Contemporary Perspectives*. Cambridge, MA: Harvard UP. 175-189.

Collins, Jill Meredith. 2004. “Nurturing Destruction: Eating Disorders Online.” *Off Our Backs*. November-December 2004. 20-22.

Csenki, Laura. 2008. “Érzelemszabályozás anorexia nervosában.” [Emotion management in anorexia nervosa.] In: Pászthy and Túry. 2008. 251-260.

_____. 2009. Thesis. (No title) University of Pécs. Institute of Psychology.

Denzin, Norman K. 1994. “The Art and Politics of Interpretation.” In: Norman K. Denzin and Yvonna S. Lincoln, eds. *Handbook of Qualitative Research*. London: Sage. 500-515.

Dukay-Szabó Szilvia and Túry Ferenc. 2008. “Az evészavarok, a testkép és a vakság kapcsolata.” [The connection of eating disorders, body image and blindness.] In: Pászthy and Túry. 2008. 287-297.

Fisher, Linda. 2000a. “Introduction: Feminist Phenomenology.” In: Fisher and Embree. 2000. 1-16.

_____. 2000b. “Phenomenology and Feminism: Perspectives on their Relation.” In: Fisher and Embree. 2000. 17-38.

Fisher, Linda and Lester Embree, eds. 2000. *Feminist Phenomenology*. Dordrecht, Boston, London: Kluwer Academic Publishers.

Fontana, Andrea, Frey, James, H. 2003. “Interviewing, The Art of Science” in Denzin, Norman K., Lincoln, Yvonna S. eds. *Collecting and interpreting qualitative materials*. London: Sage. 47-78.

Forgács Attila. 2008. “Médiaüzenetek – Evészavarok.” [Media messages – eating disorders] LAM 2008; 18(11): 822–824.

Foucault, Michel. 1975. “Docile Bodies.” In: *Discipline and Punish. The Birth of the Prison.* Alan Sheridan, trans. London: Penguin, 1991. 135-169.

Fraleigh, Sondra. 1991. “A Vulnerable Glance: Seeing Dance Through Phenomenology.” *Dance Research Journal*. Vol. 23. No. 1. (Spring 1991) 11-16.

Fuss, Diane. 1989. *Essentially Speaking: Feminism, Nature and Difference*. New York: Routledge.

Gáti, Ágnes and Amaryl Árkovits. 2008. “Az evésszavarok hipnoterápiája.” [The hypnotherapy of eating disorders]. In: Pászthy and Túry. 2008. 465-476.

Garland-Thomson, Rosemarie. 2002. “Integrating Disability, Transforming Feminist Theory.” *NWSA Journal* 14/3. Feminist Disability Studies (Autumn 2002). 1-32.

Gremillion, Helen. 2002. “In Fitness and in Health: Crafting Bodies in the Treatment of Anorexia Nervosa.” *Signs: Journal of Women in Culture and Society*. Vol. 27. No. 2. (Winter, 2002): 381-414.

Grosz, Elizabeth. 1993. “Bodies and Knowledges: Feminism and the Crisis of Reason.” In: Linda Alcoff and Elizabeth Potter, eds. *Feminist Epistemologies*. New York and London: Routledge. 187-215.

_____. 1994. *Volatile Bodies – Toward a Corporeal Feminism*. Bloomington and Indianapolis: Indiana UP.

Heinämaa, Sara. 2003. *Toward a Phenomenology of Sexual Difference*. New York, Oxford: Rowman & Littlefield.

Haworth-Hoeppner, Susan. 2000. “The Critical Shapes of Body Image: The Role of Culture and Family in the Production of Eating Disorders.” *Journal of Marriage and the Family*. Vol. 62. No. 1. (February, 2000): 212-227.

Husserl, Edmund. 1950. *Cartesian Meditations. An Introduction to Phenomenology*. Dorion Cairns, trans. Dordrecht, Boston, London: Kluwer Academic Publishers.

Killian, Kyle D. 1994. “Fearing Fat: A Literature Review of Family Systems Understandings and Treatments of Anorexia and Bulimia.” *Family Relations*. Vol. 43. No. 3. (July, 1994): 311-318.

K’Meyer, Tracy E. and Glenn A. Crothers. 2007. “‘If I See Some of This in Writing, I’m Going to Shoot You’: Reluctant Narrators, Taboo Topics and the Ethical Dilemmas of the Oral Historian.” In: Perks, R. and Thomson, A., eds. *The Oral History Reader*. London: Routledge. 71-93.

Kristeva, Julia. 1982. *Powers of Horror*. *An Essay on Abjection*. Leon S. Roudiez, trans. New York: Columbia University Press.

Lantos, Katalin et. al. 2008. “A testkép és mérése”. [Body image and its measuring.] In: Pászthy and Túry. 2008. 299-315.

Larrabee, Mary Jeanne. 2000. “Autonomy and Connectedness.” In: Fisher and Embree. 2000. 267-292.

Leland, Dorothy. 2000. “Authenticity, Feminism and Radical Psychotherapy.” In: Fisher and Embree. 2000. 237-248.

Lemaire, Anika. 1977. *Jacques Lacan*. Trans. David Macey. London: Routledge.

Levesque-Lopman, Louise. 2000. “Listen and You Will Hear: Reflections on Interviewing from a Feminist Phenomenological Perspective.” In: Fisher and Embree. 2000. 103-132.

Levinson, Richard, Brian Powell and Lala Carr Steelman. 1986. “Social Location, Significant Others and Body Image among Adolescents.” *Social Psychology Quarterly*. Vol. 49. No. 4. (Dec., 1986). 330-337.

Lukács, Liza. 2008a. “A nemi-szerep váltási krízisek és az evészavarok összefüggései.” [The connection between eating disorders and the crisis of changing gender-roles]. In: Pászthy and Túry. 2008. 367-376.

_____. 2008b. “A kognitív információfeldolgozás sajátosságainak újabb eredményei az evészavarok terén.” [New results in the peculiarities of cognitive information-processing in eating disorders]. In: Pászthy and Túry. 2008. 211-222.

Malson, Helen M. 1997. “Anorexic Bodies and the Discursive Production of Feminine Excess.” Jane Ussher, ed. *Body Talk – The Material and Discursive Regulation of Sexuality, Madness and Reproduction*. London: Routledge. 223-245.

Malson, Helen M. et. al. 2007. “‘I Don’t Think That’s Normal’: A Reflection on Accounts of Experiences of Treatment for Eating Disorders.” *Feminism and Psychology*. Vol. 17. No. 4. 417-424.

Malson, Helen M. and Victoria Ryan. 2008. “Tracing a Matrix of Gender: An Analysis of the Feminine in Hospital-Based Treatment for Eating Disorders.” *Feminism and Psychology*. Vol. 18. No. 1. 112-132.

Martin, Courtney. 2005. “The Famine Mystique.” *Off Our Backs*. May-June 2005. 59-62.

Merleau-Ponty, Maurice. 1945. *Phenomenology of Perception*. Trans. Colin Smith. London: Routledge, 1998.

"Mohó Sapiens – Étvágytalanság és falánkság." [Lack of appetite and voracity]. In: *Napközben*. [a radio programme]. Broadcast: MR1, April 6, 2009. Available from http://www.mr1-kossuth.hu/index.php?option=com_content&task=view&id=77793&dt=2009-04-06_10:21:59 (last accessed 5/5/2009)

Myers, Tony. 2003. *Routledge Critical Thinkers – Slavoj Žižek*. London: Routledge.

Németh, Laura, Bea Pászthy and Ferenc Túry. "A pszichoedukáció és az önsegítés helye az evészavarok kezelésében." [Psycho-education and self-help in the treatment of eating disorders"]. In: Pászthy and Túry. 2008. 477-484.

O'Connor, Erin. 1995. "Pictures of Health: Medical Photography and the Emergence of Anorexia Nervosa." *Journal of the History of Sexuality*. Vol. 5. No. 4. (Apr. 1995). 535-572.

Pászthy, Bea and Ferenc Túry, eds. 2008. *Evészavarok és testképzavarok.* [Eating disorders and body image disorders.] Budapest: Pro Die.

Pászthy, Bea and Melinda Major. 2008. "Gyermek- és serdülőkori evészavarok." [Eating disorders in children and adolescents]. In: Pászthy and Túry. 2008. 25-40.

Portelli, Alessandro. 1998. "What Makes Oral History Different." In: Perks, R. and Thomson, A., eds. *The Oral History Reader*. London: Routledge. 63-75.

Probyn, Elspeth. 1987. "The Anorexic Body." In: *Body Invaders: Panic Sex in America*. Arthur and Marilouise Kroker, eds. Montréal: New World Perspectives. 201-211.

Reinharz, Shulamit. 2002. "The Principle of Feminist Research, a Matter of Debate." In Messer-Davidow, Ellen. *Disciplining Feminism. From Social Activism to Academic Discourse*. Durham: Duke University Press. 423-437.

Ritchie, Donald A. 1995. *Doing Oral History: Practical Advice and Reasonable Explanation for Anyone*, New York: Twayne.

Sáfrán, Zsófia. 2008. "A pszichodráma alkalmazása az evészavarok kezelésében." [Psychodrama in the treatment of eating disorders]. In: Pászthy and Túry. 2008. 451-463.

Scott, Joan. 1992. "Experience." In: Judith Butler and Joan Scott, eds. *Feminists Theorize the Political*. New York and London: Routledge. 22-40.

Sokolowski, Robert. 2000. *Introduction to Phenomenology*. Cambridge: Cambridge University Press.

Szumska, Irena. "Az evészavarok prevenciójának kérdései." [Issues in eating disorder prevention]. In: Pászthy and Túry. 2008. 495-505.

Szumska, Irena, Ferenc Túry and Pál Szabó. "Az evészavarok epidemiológiájának újabb adatai." [The latest results of eating disorder epidemiology]. In: Pászthy and Túry. 2008. 109-120.

Thomas, Sandra P. 2005. "Through the Lens of Merleau-Ponty: Advancing the Phenomenological Approach to Nursing Research." *Nursing Philosophy*. Vol. 6/1. 63-76.

Túry, Ferenc. 2002. „Anorexia és bulimia – az evés zavarai a mindennapos gyakorlat szemszögéből." ["Eating disorders from the point of view of the general practitioner."] Hippocrates, March-April 2002. Vol. IV. No. 2. 110-115. [journal on-line]; available from http://www.medlist.com/HIPPOCRATES/IV/2/ 110.htm; accessed 1/27/2009.

Túry, Ferenc et. al. 2008. "Testépítés és testképzavarok." [Body-building and body image disorders]. In: Pászthy and Túry. 2008. 79-92.

Wolfe, Jeremy. 2004. "Successful Disasters: Eating Disorders." In *Introduction to Psychology* lecture series (Fall 2004): 12/7/2004. Massachusetts Institute of Technology. MIT Open Courseware. Available from http://ocw.mit.edu/OcwWeb/Brain-and-Cognitive-Sciences/9-00Fall-2004/LectureNotes/index.htm (last accessed 5/15/2009)