

'Pro-Ana' as Negotiating (Dis)order in Cyberspace: How Women Reproduce,
Restructure, and Challenge 'Psy' Discourse

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ABSTRACT

‘Pro-Ana’ as Negotiating (Dis)order in Cyberspace: How Women Reproduce, Restructure, and Challenge ‘Psy’ Discourse

Jodie Toni Allen

Current literature on the topic of anorexia is dominated by the disciplines of psy, which has meant that the practice of self-starvation is viewed as originating from the pathological nature of the *individual*; divorcing the experience of anorexia from the very social and cultural backdrop from within which it emerges. Contrastingly, socio-cultural approaches to anorexia have focused on the contextual features of the disorder that relate to the historical specificity of our contemporary condition. This has often meant that self-starving is conceptualized as the result of women either over-conforming to, or resisting, the cultural ideal of the slim body. The complexity of anorexic practice is neglected when it is discursively positioned in this way because there is a multiplicity of discourses which constitute the anorexic’s subjectivity. Due to the fact that psy discourse has particular influence on the anorexic experience this thesis employs a critical discourse analytic approach to explore how women, in the pro-anorexia internet community, negotiate their subjectivity through reproducing, restructuring, and challenging the discursive constructions of psy which are produced by the DSM-IV. The transgressive nature of the pro-ana community has meant that its members have been framed as either oppressed or liberated, as cultural dupes or as active agents; demonstrating a pattern which mirrors the same binary logic that has surrounded discussions of the ‘anorexic’ for decades. Through transcending these limitations, the findings of this study are used to articulate an alternative viewpoint of the community which challenges the dominant discourses which surround it at present.

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CHAPTER 1

1.1 Introduction

I don't know what I am! I mean I know what I am and maybe even who I am, but I just don't know what type of freaking ED I have [...] i'm not a good enough ana because im not underweight!.i think its stupid for a doctor to tell somone they arent really anorexic but, ednos just because they arent physically underweighti have to drop to 90 some-odd pounds before my doctor will admit there's a serious problem even if i have always had the same food obsessed thoughts and an obsession with losing weight.....i think its a bit obsurred ¹ (Michele, the Forum).

Michele is one of approximately 152,000 Canadian women suffering from an eating disorder, such as anorexia or bulimia nervosa (CMHA, 2001). In fact, this number is likely to be far higher considering that it does not include those who have not sought treatment for their illness. Anorexia (AN), characterized by dramatic weight-loss and an obsession with appearance and body weight, has one of the highest mortality rates among psychiatric disorders (Keel et al, 2003, p.179). Data from the Harvard Eating Disorder Research Centre shows that approximately 50% of women with anorexia or bulimia have full recovery, 30% have a partial recovery, and 20% show no substantial improvement in symptoms (Keel et al, 1999). In the last 20 years there has been a vast amount of research carried out on this topic, yet the prevalence rate continues to increase and anorexia is still renowned as one of the most difficult mental illnesses to treat. Although psychological and biomedical approaches to studying the disorder have contributed to our knowledge of anorexia, very few of these studies have investigated how individuals with anorexia negotiate with dominant discourses as they attempt to understand their experience. To

¹ Each narrative is included as it originally appeared in the Forum. Any spelling or grammatical errors are therefore a part of the original text.

this end, the general aim of this thesis is to explore, through a sociological approach, how individuals with anorexia articulate their experiences in their social context.

Both the concept of anorexia and the anorexic body itself are discursively constituted in a multiplicity of ways. It may be framed 'as an illness, as an extreme diet, as self-starvation, as a coping mechanism, as a means of achieving a positively construed identity or as a form of self punishment' (Malson, 1998, p.143). The discourses which produce each of these meanings influence (and are influenced by) the anorexic subject in many ways, and as the excerpt above illustrates, these meanings are often disputed by those they seek to describe. This ongoing struggle that exists between the anorexic individual and these hegemonic discourses makes for a complex relationship in which subjectivity is continuously being negotiated. It is this process of negotiation that is the focus of my investigation.

C. Wright Mills, nearly half a century ago, sought to theorize the connection between the 'personal troubles' of the individual and 'public issues' of society (Mills, 1959, p.8). Mills (1959) argued that the experience of the individual is always nested within a socio-cultural backdrop and he stated that, 'neither the life of the individual or the history of a society can be understood without understanding both' (p.3).

Psychological and bio-medical accounts of anorexia position it as a result of individual 'deficits and dysfunctions' (Malson & Swann, 1999, p. 397). The result of which has meant that the 'experiences' and 'practices' (Malson & Swann, p. 397) of the anorexic have been divorced from the very social and cultural backdrop from within which they emerge. This highlights a need for sociological investigation into anorexia because of its capacity to address the multiplicity of experiences and the role of various hegemonic

discourses, central to contemporary culture, which constitute the disorder and the experience of it. Many of the socio-cultural approaches to the study of anorexia have constructed the individual as a product of a culture obsessed with appearance and the thin body ideal. Although psychological and biomedical accounts of anorexia focus on the individual, and socio-cultural approaches centre on the contemporary context, frequently the negotiation between the two is largely left un-theorized with the exception of post-structural approaches to the ‘disorder’. From this theoretical standpoint, I am able to acknowledge and address this complex relationship which manifests itself through the individual’s practice of negotiation.

From a poststructuralist perspective, ‘discourse’ can be viewed as an entry point with which to analyze how society and the individual intersect. It enables us to transcend the boundaries of the individual’s narratives² and address the socio-cultural framework which constitutes these stories. For these reasons, I chose to perform a critical discourse analysis in order to analyze how individuals negotiate their subjectivity with psy³ discourse within the pro-anorexia community. As Hardin (2001) explains, working in this way, ‘it then becomes possible to decenter master discourses through individual accounts; yet concomitantly conceptualize those accounts through cultural and historical discourses’ (p.17). This multidimensional approach, I argue, is at the centre of the ‘sociological imagination’ which Mills described as ‘the capacity to shift from one perspective to another- from the political to the psychological’ (1959, p.7). In starting this project, the quest became to locate a master discourse which heavily influences the

² I use the terms ‘narrative,’ ‘discourse,’ and ‘account’ interchangeably when I refer to these as being a product of the individual.

³ The term ‘psy’ is borrowed from the book ‘Inventing Our Selves: Psychology, Power and Personhood’ by Nikolas Rose (1996).

construction of ‘anorexia’ while also gaining access to a collection of individual accounts which negotiate with this discourse. As the topic of anorexia has long been dominated by the disciplines of psy, which have designated it as falling under their domain, I was initially drawn to investigating how psychology constitutes the experience of anorexia. Due to the fact that anorexia, and eating disorders in general, are regarded as personal matters and are often the source of stigma in society, accessing a *group* of women struggling with disordered eating posed a challenge in and of itself. Aware of this challenge, and the fact that I sought to investigate how meaning was negotiated within and amongst the women themselves, rather than with myself as a researcher, I was drawn to the internet as a source of data. I found there to be a myriad of internet support groups which specifically targeted those in recovery from anorexia, and although they provided a wealth of individual narrative, much of the discussions pertained to the process of recovery rather than a dialogue about the concept of ‘anorexia’ itself. However, I discovered that the pro-anorexia community, often defined by its view of anorexia as a lifestyle to be pursued rather than an illness to recover from, was very much involved in reproducing, rearticulating, and disputing dominant discourses of anorexia. Furthermore, I quickly discovered that psy discourse appeared to be a focus of their dialogue with each other both explicitly and implicitly. These two characteristics of pro-anorexia led me to select one of the forums which make up this community as a site of study. Although the pro-anorexia community has only had an online presence since the late 90s, when it was started by only a few women who designed web sites in isolation, as a collective this group has received an enormous amount of interest from the press, and various clinical and academic professions since it emerged. By and large the majority of knowledge about

pro-anorexia produced by the media has positioned the community as a group of 'gruesome', 'pathetic,' and 'sinister' individuals who are out to recruit young women to engage in self-starving practices (Pollack, 2003, p.246 citing femail.com). Although an academic interest in the community surfaced simultaneously with the surge of media coverage, only a handful of studies have been published to date, leaving the topic of pro-anorexia largely under studied . It was these factors combined that sparked my sociological interest in this group of women. Through analyzing the literature on this transgressive community I found that, much like the topic of anorexia and the 'anorexic' herself, the pro-anorexia community and likewise the 'pro-anorexic' have been discursively constructed in a variety of ways. With this in mind, I approach this thesis with two main goals, both of which are interrelated. First, and foremost, I aim to explore how individuals in this community are negotiating their subjectivities through the hegemonic⁴ discourse of psy. Secondly, I wish to use the latter investigation as a means to articulate an alternative viewpoint of pro-anorexia which challenges the dominant discourses which surround it at present.

In approaching these two central objectives this thesis asks the following questions: What views do these women have on the DSM-IV and eating disorder classifications in general? How is 'anorexia' defined by those who participate in the community? In what way, if any, do these definitions reproduce, rearticulate, or challenge psy discourse's understanding of the disorder? How does the individual's understanding of their experience, or lack thereof, impact their emotional state and/or behavior? How do my findings as to the content and function of this community compare with the

⁴ I use the terms 'master discourse', 'dominant discourse' interchangeably with the term 'hegemonic discourse' to refer to psy discourse. The concept of hegemony is addressed specifically in Chapter 5.

discourses which have previously defined it? How do these alternative findings, if any, impact how this community should be studied? Finally, what can the pro-anorexia community offer to a researcher seeking to gain a greater understanding of anorexia and those who suffer from it? In order to approach these questions I have organized this thesis into a number of chapters which I will now summarize.

1.2 Chapter Outline

Beginning with Chapter 2, I first present how anorexia is officially classified by the DSM-IV. The criteria put forth by the latter is central to this investigation as within the realm of the eating disordered. I argue that no other publication, through its discursive constructions, embodies as much capacity to influence the anorexic individual's relation to herself, to others, and to the self she yearns to become. Following this I provide statistical evidence which illustrates the extent of anorexia as a social problem in contemporary Western society, while also providing a brief history which maps out how the 'disorder' was first discovered and defined by William Gull in 1888. Although the discourse surrounding anorexia saw its beginnings in the late 19th century, since this time, it has been discursively constituted in a multiplicity of ways. For this reason, I provide a summary and critique of the central components of biomedical, psychological, socio-cultural, and feminist discourses which have, and continue, to frame anorexia and the anorexic herself⁵ in various ways. Through critically assessing these discourses I am then able to introduce some of the conditions of possibility created by a poststructuralist approach which, as a perspective, is addressed in more detail in Chapter 4.

⁵ Although men do suffer from anorexia, 90% of all people with anorexia are women. In addition, this thesis is aimed at investigating the experience of women only and, therefore, I refer to the anorexic as being female throughout this study.

Similar to the topic of anorexia, the pro-anorexia community has also been conceptualized in a number of ways and Chapter 3 is focused on exploring the strengths and limitations of these various discourses which have produced certain ways of knowing 'pro-anorexia'. The central aim of this section is to critically assess previous research in order to articulate how I view pro-anorexia as a form of performed subjectivity, which enables these women to negotiate with the discourses that seek to describe them, and their experiences, in a supportive and safe environment.

This alternative way of knowing pro-anorexia is made possible as a result of my working from a poststructuralist standpoint and it is this same perspective which I use to explore how women with anorexia negotiate their subjectivity in relation to psy discourse. In order to frame how I approach my analysis, in Chapter 4, I summarize the fundamentals of poststructuralism, describe the modernist approach to anorexia characteristic of psychology and the DSM-IV, and reformulate the former as a unit which constitutes, rather than simply describes, the experiences and the individuals it claims to 'know'.

With the above foundation laid, in Chapter 5, I illustrate the methodological considerations that underlie my approach to investigating the role of 'psy' discourses in constituting anorexic subjectivity, and the ways in which these discourses are negotiated by the women in the community. In order to do so, I recapitulate the rationale for such a study by attending to the nature of anorexia as a social problem and summarize how my approach contributes to filling a lacunae in the existing literature on the pro-anorexia community. Following this, I present my justification for choosing to perform a critical discourse analysis while attending to both the general aim of such an approach and the

specific components of one such method under the CDA umbrella. Predictably, I also address the issues of validity and generalizability while also attending to the ethical considerations which are required by any program of research. In connection to such a method I then reflect upon the strengths and limitations of using the internet in CDA research which gives way to a concrete discussion which addresses how the data was located and collected.

Data collection was followed by a coding process which I considered to be the preliminary stage of analysis and Chapter 6 begins with describing how this was performed. The coding categories which were derived from the data were used broadly as a means to structure my analysis which first addresses how the women in the forum discussed the issue of classification on a fundamental level. Second, the analysis focuses on the specificity of two interrelated classifications, EDNOS (Eating Disorder Not Otherwise Specified) and Anorexia Nervosa in relation to how they are reproduced, rearticulated and challenged by the women on the Forum⁶. Although my analysis focuses on how these women negotiate their subjectivity through these categories, importantly, I also describe how these classifications, and their readings of them, impact their behavior on a concrete level and subsequently the nature and course of the illness itself. In order to frame the results of the study as a whole, and propose possible directions for future research, I conclude with a discussion of my findings in Chapter 7.

⁶ The 'Forum', when capitalized, refers to the pseudo name I gave the actual community forum which I chose as my site of data collection.

CHAPTER 2: ANOREXIA NERVOSA

2.1 A Picture of Disorder

Anorexia nervosa (AN) is considered to be a mental illness which manifests itself behaviorally. Individuals are described as being obsessed with losing or maintaining a low body weight through a combination of food restriction, exercise, self-induced vomiting, and laxative and diet pill abuse, among other means. Many of these women often report a fear of being seen as fat and are petrified by the prospect of gaining weight. Although anorexic behaviors revolve around food and weight, they are stated as being merely symptoms of underlying psychological and emotional problems. The disorder is currently defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as having the following diagnostic criteria:

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected) (*body weight 15% below that which is expected, my addition*).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration).

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) (APA, 1994).

Anorexia nervosa (AN) is a disorder with serious consequences, and is notoriously one of the most difficult mental illnesses to treat. As Katzman, Morris & Pinhas (2006) state, 'epidemiological studies suggest that the prevalence of anorexia nervosa (using DSM-IV criteria) in adolescents has been increasing over the last 50 years' (¶1). Although eating disorders usually appear in adolescence and young adulthood between the ages of 14-25, the disorder affects people across the lifespan. In fact, in recent years there has been an increasing number of children under the age of 10 being diagnosed (Cavanaugh & Lemberg, 1999). In Canada alone it is estimated that 25.7 per 100,000 girls and 3.7 per 100 000 boys between the ages of 10-14 years of age have anorexia (Katzman, Morris & Pinhas, 2006). These figures are even more important in light of research that has indicated that the annual death rate of those with anorexia is at least '12 times higher' than that of the 'annual death rate due to all other causes combined for females between 15 and 24 years old' (Cavanaugh & Lemberg, 1999). The most worrying fact is that an estimated 3% of the population of Canada is currently suffering from an eating disorder, which does not include those who do not meet full criteria for diagnosis, or those that have not yet chosen to seek treatment. Unfortunately, Data from the Harvard Eating Disorder Centre shows that approximately 50% of women with anorexia or bulimia have a full recovery, 30% have a partial recovery, and 20% have no substantial improvement (Keel et al. 1999). These data show that the disorder itself has

grave consequences, is difficult to treat, and is rapidly increasing. Although people do indeed recover from eating disorders, there remains no treatment to date that is proven to be completely effective in treating this population and the exact etiology of the disorder remains unknown.

2.2 'Once Upon A Time': A Brief History of AN

There is a common misconception that Anorexia Nervosa (AN) is a disorder which has only recently emerged when in fact researchers, such as Bell (1985), have located 'historical' documents which suggest that anorexia nervosa has been present for 'many centuries' (Crisp, 2006, p.147). It was in 1689 that Thomas Morton, 'a religious nonconformist and English physician', documented two individuals who presented with, what he referred to as, a " 'wasting' disease of nervous origins". It is this that we now consider as being the earliest account of the disorder (Gordon, 1990, p.12). After this, descriptions of anorexia nervosa virtually disappeared, with the exception of a few reports and not forgetting the well-documented pseudo-religious fasting girls found within Europe. The latter are described by Gordon (1990) as representing 'a kind of quasi-religious precursor of the condition' (p.13). This silence was not broken until William Gull, a 'British physician', and 'French neuropsychiatrist Ernest Charles Lasegue' simultaneously wrote of a number of self-starving individuals in their respective countries (Vandereycken, 1989, p.1). In fact it was Gull himself who coined the expression 'anorexia nervosa' to describe the severe food restriction behaviors of those he had encountered in his work. It is said to be these writings that instigated a surge of interest into the disease in the 20th Century (Gordon, p.13). Both practitioners believed

anorexia to be a 'nervous disease' (Gull, 1888; Lasegue, 1873/1964 in Striegel-Moore & Cachelin, 2001, p.635). Gull (1888/1964) centered his attention on the 'physiological correlates of the disorder' (Striegel-Moore & Cachelin, p.635) in accordance with his belief that the problem involved "simple starvation" (Gull, 1888 in Striegel-Moore & Cachelin, 2001, p.635), whereas Lasegue (1873/1964) described anorexia as a version of 'hysteria'. Although there appeared to be variations in their accounts, both concentrated on the 'nutritional' component of the disorder which as a result meant that anorexia was to be categorized as a physical problem (Striegel-Moore & Cachelin, p.635). The disorder was to remain framed by the dominant medical model until the publication of Hilde Bruch's (1978) book, entitled 'The Golden Cage: The Enigma of Anorexia Nervosa'. It was her 'biopsychosocial' approach which displaced the medical model as it argued that 'developmental factors and family dynamics' played more than a crucial role in the progression of the disorder. Although the ground was indeed broken by Bruch (1978), it would be up to feminist scholars (eg. Bordo, 1993; Chernin, 1985; Orbach, 1986) to undermine the efficacy of the medical model by positing the origins of the disorder as lying purely in the cultural realm. According to this group of feminists, patriarchy was the source of all ill when it came to anorexia (Striegel-Moore & Cachelin, p.635-36). The patriarchal society that women found themselves within was inextricably linked to what Bordo, (1993/2003) refers to as the 'empire of images' (xiii) which women were being constantly barraged with, and was viewed as the poison which fueled the cultural atomic bomb known as the slim body ideal. Today, bio-medical, psychological, and socio-cultural approaches to the study and treatment of anorexia compete for prime position. In addition, many expand this triad to incorporate feminist approaches, which have made

important contributions to how we understand the disorder today, although they are often subsumed under the heading of the socio-cultural paradigm. Although my investigation focuses on the psy discourses, I also consider the discourses of the competing approaches because as Hardin (2001) underscores, “discourses do not exist as secluded entities but survive within a matrix of multiple discourses, and analyzing any one discourse necessarily requires an analysis of those matrices” (p.12).

2.3 Biomedical Discourse

The organic origins of anorexia nervosa have been debated for centuries. In the past, AN has been posited as a result of,

primary hypothalamic dysfunction’ (Russell, 1977), of female reproductive endocrinal disturbances (see Halmi, 1987) and of abnormalities in growth hormone (GH) and GH-releasing hormone (de Marinis et al., 1991). And indeed, there is now considerable evidence of abnormalities in the hypothalamic-pituitary-adrenal axis of at least some women diagnosed as anorexic (Weiner and Katz, 1983) (Malson, 1999, p.78).

Current biomedical explanations of anorexia revolve around abnormalities in the brain’s serotonin function (5-hydroxytryptamine [5-HT]) (Steiger, 2004), the presence of a hormonal imbalance, while others argue that anorexia can be accounted for by a genetic predisposition within the individual. Although, numerous studies have presented evidence to *suggest* that anorexia nervosa should be considered a *disease* of natural origins, research to date has failed to provide any conclusive evidence to support its ‘organic aetiology’ (Malson, p.79). Although the ‘biological basis’ of AN remains unproven, the bio-medical community continue to assert that anorexia is indeed a ‘natural or quasi-natural disease category’ (Malson , p.79). As Malson (1999) argues, it would be

insufficient to deny the usefulness of the bio-medical approach because among other reasons, it would be impossible to erase the importance of the ‘physicality of the body’. Indeed, it would be a grave error to ignore the disastrous effects of self-starvation that rampage the body of the anorexic. However, constituting AN as a bio-medical problem, not only leads to the promotion of drug treatment as the primary means of treatment but also de-legitimizes potential research that approaches the disorder from other directions. As a result, limits are placed on the ‘kind of research questions and the forms of methodology’ that could be considered valuable additions in the quest to more fully understand the disorder, and consequently ‘psychological’ or socio-cultural’ explanations, until more recently, have often remain shelved on the sideline competing to be heard (Malson, p.79).

2.4 Psychological Discourse

The recent trajectory of theoretical work on the etiology of anorexia nervosa has demonstrated a shift in focus from “biological to psychological considerations” (Hoff, 1994, p.16). The consequence of this transition has meant that current research is guided by an ethos that, as Malson & Swann (1999) argue, situates the ‘origin’ of the disorder within the ‘individual’ ‘diagnosed as eating disordered’. More specifically, the individual’s ‘pathologized’ self-conduct is explained by way of reference to their “psychological deficits and dysfunctions” (Malson & Swann , p.397). Within the realm of psychology itself there are number of competing explanations. As Malson (1999) explains, these include, but are not limited to, ‘anorexia nervosa as cognitive dysfunction’ (p.81), and ‘anorexia as a familial pathology’ (p.86).

2.4.1 Cognitive Deficit Discourse

According to the claims of neuropsychologists, there are numerous cognitive deficits which are associated with the development and progression of eating disorders. According to Lena, Fiocco & Leyenaar (2004), the period of adolescence represents an ‘adaptive’ challenge to the individual as ‘physical and emotional changes occur’ and it is one that is especially taxing for those who exhibit ‘cognitive deficits’ (Lena, Fiocco & Leyenaar, p.108). The latter deficiency is said to damage the individual’s ‘ability to engage in realistic self-appraisal, to accurately assess stressful situations, and to formulate appropriate solutions to specific problems’. Thus, anorexia is viewed as a ‘maladaptive coping’ mechanism with which the individual restricts their food intake in an attempt to avoid the ‘physical changes of puberty’ (Lena, Fiocco & Leyenaar, p.109). It is also argued that ‘a deficit in interoceptive awareness’ is sometimes a precursor to the development of anorexia. This deficit impairs the individual’s ability to ‘identify’ their emotions, and those of others, which are crucial elements in developing and sustaining ‘healthy relationships’. Therefore, in the face of interpersonal difficulties, the individual turns to ‘maladaptive eating behaviors’ as a way to cope with the resulting tension they experience. For the individual with psychological deficits it is argued that a number of unpleasant experiences may follow as a result. These ‘unfavorable adolescent experiences’ are suggested to negatively impact the individual’s ‘self esteem’. It is this diminished ‘self-esteem’ which is argued to contribute to an individual turning to food restriction, exercising or ‘binging’ as a means to ‘combat feelings of worthlessness’ (Lena, Fiocco & Leyenaar, p.110). Despite advances in cognitive research on the eating disordered population, ‘research findings remain inconclusive and contradictory’

(Malson, 1999, p.82). Studies carried out by Strupp et al., (1986) and Kowalski (1986) indicate that individuals with anorexia ‘performed as well as, or better than, controls in some cognitive tasks’ (cited in Malson, p.82). In addition, as Myra & Cooper (2005) illustrate, ‘there is still no evidence that cognitive therapy, or indeed any psychological treatment, is effective in the treatment of AN’ (p.515). As Malson (1999) argues, it is this premise that the root of anorexia stems from within the individual that is problematic because it diverts our attention away from socio-cultural explanations. The experience of anorexia becomes divorced from the very socio-cultural context from within which it is ‘constituted’ (p.83).

2.4.2 ‘Family-oriented’ Discourse

In addition to cognitive deficit discourse which surrounds the topic of anorexia, the local milieu of the individual, i.e. their family, is frequently invoked by psychological literature as playing a central role in the individual’s development of the illness. The role of the familial environment in eating disorders is one that has long been debated. In fact, many current researchers refer back to Lasegue (1873) himself who underscored that it would be an error to study the individual with anorexia in isolation, inferring that the family played a crucial role (Schmidt, Humfress & Treasure, 1997).

As with the cognitive deficit discourse of anorexia, ‘family-orientated’ discourses represent AN as ‘psychologically meaningful’. A common denominator between the various familial theories is that they each view anorexia as a disorder that is produced and sustained by ‘the anorexic family’ itself (Malson, 1999, p.84). The ‘anorexic family’ is purported to have “high levels of unresolved conflict (Palazzoli, 1974); as tending to be

socially isolated (Humphrey, 1986) and as having overly close or ‘enmeshed’ intra-familial relationships (Minuchin et al, 1978)” (Malson, p.85). As a result of this turmoil, food restriction and other dieting behaviors are said to represent a quasi solution for the anorexic faced with the complex problem of the family dynamic (Bruch, 1982; Malson, 1999).

According to Humphrey (1989) anorexics are confused by their parents who, on the one hand provide the necessary nurturance required, but on the other hand ignore the ‘daughter’s’ need to express themselves’ (cited in Schmidt, Humfress & Treasure, 1997). One study discovered that deaths in the family of the anorexic were higher than in the families of the control population (Rastam and Gillberg, 1991). In addition, Walters and Kendler (1995) argue that ‘maternal over-protectiveness was significantly associated with anorexia nervosa (cited in Schmidt, Humfress & Treasure, 1997).

Over and above research which has focused on the abnormal mother-child dynamic, one heavily studied area of ‘familial dysfunction’ is that of ‘childhood sexual abuse (CSA)’ (De Groot et al, 1992 in Malson, 1999, p.84). However, to state that the literature on the relationship between CSA and eating disorders is inconsistent would be a gross understatement. Research completed by De Groot et al (1992) and Herzog et al (1993) resulted in a number of studies which suggested there to be ‘high rates of CSA amongst women diagnosed as eating disordered’. However, a large majority of those diagnosed with eating disorders do not communicate any instances of CSA in their history (Malson, p. 84; De Groot, et al, 1992). Furthermore, four out of ten studies fell short of proving that any difference existed between those with eating disorders and the normal population (Abramson and Lucido, 1991; Beckman and Burns, 1990; Rorty et al.,

1994; Stuart et al., 1990 in Schmidt, Humfress & Treasure, 1997). As Malson (1999) makes clear, 'to suggest a generalizable or causal relationship between eating disorders and CSA [...] seems unwise' (p.84).

Returning to a discussion of 'familial dysfunction' as a whole, in addition to the inconsistency between studies to support the existence of a relationship between ED's and family pathology, those studies which claim to provide empirical support for such have significant methodological shortcomings. For example, the majority of studies are conducted with eating disordered patients and only a small number have addressed 'non-clinical populations' with a mere three employing 'population-based samples' (see Rastam & Gillberg, 1991; Kendler et al, 1991; and Walters and Kendler, 1995 in Schmidt, Humfress, & Treasure, 1997, p.199). In addition, a large proportion of studies on the topic do not make a distinction between 'current family functioning, childhood family functioning and pre-morbid family functioning' (Schmidt, Humfress, & Treasure, p.199). The latter making it impossible to distinguish whether the family pathology preceded the eating disorder or occurred as a result of the strain placed on the family by the disorder itself.

Despite the plethora of studies on the family of the anorexic, the majority stop short of theorizing the 'relationship between such family pathologies and anorexia' and merely imply a 'causal relationship' (Malson, 1998, p.86). Although, as Malson (1999) points out, Minuchin et al's (1978) systemic theory does articulate how the malfunctioning family may be implicated in the family member's mental disorder. According to Minuchin et al (1978) the relationship between the anorexic and her family is one of battle in which her behaviors are seen to have a functional capacity as they

distract from the relationship problems that exist between the parents and thus provide a picture of 'family stability' (Malson, p.86). The family is described as 'enmeshed', with its members rarely seeking outside contact, which results in an over 'dependent' child who, while struggling to develop an autonomous self in the challenging years of adolescence, turns to anorexia as a 'pseudo-solution to these intra-and interpersonal difficulties' (Malson, p.86; see also Bruch, 1973, 1982).

It is crucial to consider the effects of discursively constituting the anorexic family as 'psychologically disturbed' because in constructing the experience of anorexia as solely an individual or family problem we are neglecting the role of the social (Sheppy et al, 1988 cited in Malson, 1999, p.85). For example, it is heavily documented that the family of the anorexic tends to be one that is diet and image obsessed. However, we must ask if these characteristics are unique to the so-called 'anorexic family' or whether these preoccupations are present to a greater or lesser extent in many families in 'contemporary Western society'? In which case, the "'anorexic family' may be better conceptualized as simply a 'bearer of our culturally sanctioned values'" (Rakoff, 1983 cited in Malson, p.85) rather than an anomaly in and of itself.

As Malson (1999) argues, although 'family-oriented' discourse offers a 'sympathetic and detailed' account of anorexia, its aim is to find a fixed etiology which can be employed to describe the situation of each and every eating disordered individual across the board (p.89). In other words, this "'homogenized picture of both the 'anorexic' and her family' (Malson, p.89) neglects the complexity of anorexic experience and existence of a variety of anorexic subjectivities. Importantly, it is worth considering the

very presumptions with which this type of research is conducted. As Malson (1999) contends,

These texts also often rely on a notion of 'the family', first as something that can be considered in isolation from its socio-cultural context, and second as a system of ostensibly equal relationships. These texts' silences about gender, power and politics serves to normalize the gender inequalities (in family and society) which much surely have some bearing on the distress that so many girls and women experience in relation to eating, embodiment and identity (p.89).

It has been the very task of socio-cultural theories, by mapping theoretically the contextual features of the disorder that relate to the historical specificity of our contemporary condition, to move beyond the realm of the individual in order to contribute to our understanding of the role of the social in anorexia. More specifically, in denying the fact that anorexia is solely a result of individual pathology, a space is created where we can consider the influence of the individual's external environment and the impact this has on the development of the illness.

2.5 Socio-Cultural Discourse

The body of literature that focuses on the socio-cultural components of anorexia is so large that it would be impossible to address it in its entirety without making flagrant generalizations; unless these texts alone formed the foci of this thesis. Therefore, in considering the scope of my research, I have chosen to select what I regard as the key discourses offered by the socio-cultural approach to anorexia. These refer to the cultural ideal of the thin body, the role of the mass media, and the stigma associated with 'fat' in contemporary society.

2.5.1 *Thin Discourse*

Given an understanding of contemporary western culture's obsession with the 'thin body', the notion of women's 'fat' as a 'silken layer' which 'celebrated their female sexuality' (Wolf, 1991 cited in Berg, 2002, p.30) makes the Victorian era seem more like a different planet rather than simply a recent period in history. It was during this time that, as Berg explains, 'an abundance of flesh was considered desirable and became associated with fertility and sensuality' (2002, p.30). The celebration of 'dimpled buttocks and thighs' and 'ample bellies' is long gone. Today, the cutesy dimple has become cellulite, shapely thighs are condemned to the Stairmaster and those with 'ample bellies' follow the Atkins diet. The beginnings of 'fat phobia' can be traced back to the 1920's when the short haired flapper⁷ appeared, and with her, the emergence of a new ideal; the slender body (Berg, 2002, p.30). However, the riotous flapper and high-spirited nature of the 1920s was soon after swallowed up by the depression of the 1930s. The curvaceous body did experience a short reprieve in 1940's and 50's alongside the 'domestic retrenchment and suburbanization' which characterized the Second World War period (Gordon, 1990, p.78). Some argue that the 'fuller body' was put on a pedestal during this time (Hurst, 2000 in Sisseem & Druann, 2003, ¶10) while others believe anxieties surrounding body weight were still present but appeared to be 'dampened' while people became focused on more 'pragmatic concerns' related to the war torn era they found themselves within (Gordon, p.78). The view of Marilyn Monroe as the feminine incarnate was finally buried in the 1960s by none other than Twiggy herself.

⁷ 'Flapper' was a term coined in the 1920s to describe a new type of woman who loudly proclaimed her rejection of 'respectable' behavior by drinking and smoking, cutting her hair short, listening to jazz music, and wearing clothes that made her look adolescent and boyish.

The androgynous beauty ideal of the 1960's is one that has remained up until this day and in the past few decades it has progressed to what can be referred to as the super-thin ideal, which many would characterize as underweight. In parallel to the female model's decreasing proportions, women in Western society are increasing in size most likely because of 'better healthcare and nutrition' (Berg, 2002, p.30). It is these two friction causing trends which, when viewed as two colliding tectonic plates, can be said to have caused the seismic phenomena of anorexia nervosa across contemporary society; its waves reaching an estimated 38,000 women in Canada alone (CMHA, 2001), and an even greater proportion of women in the U.S. However, anorexia is far from a natural phenomenon according to socio-cultural theorists and one popular assumption is that the mass media, synonymous with the development and rise of consumer society and advertising, is at the very heart of the dramatic increase in anorexia in the past few decades.

2.5.2 *'The Body is the Message': The Mass media*

In the past two decades, an enormous body of literature has addressed the influence of the mass media in relation to young women's body dissatisfaction, dieting, and disordered eating (e.g. Dittmar & Howard, 2004; Hargreaves & Tiggerman, 2003; Harrison, 2000a, b, 2001; Harrison & Hefner, 2006; Palladino-Green & Pritchard, 2003; Stice et al., 2001). Women are described as engaging in disordered eating as a result of their internalizing the 'thin body ideal' (Harrison & Hefner, p.153). This internalization process is commonly conceptualized as beginning when the individual adopts the socio-cultural body ideal as her own 'standard' which then propels her to meet this benchmark

through weight reducing behaviors (Thompson et al, 1999 cited in Harrison & Hefner, p.154). According to Harrison & Hefner (2006), this general theory is implied by a variety of approaches which are used to discern the effects of the media on ‘body image and eating disorders’, such as ‘social comparison theory (eg. Botta, 1999), and social learning theory (eg. Harrison & Cantor, 1997), and self-discrepancy theory (eg. Harrison, 2001)’ (p.154). Fashion magazines and advertising are saturated with pictures of the ultra-thin model who is normally around 5’10’ and 110 pounds. The average woman, on the other hand, is roughly ‘5’4’ and 140 pounds’ (Andrist, 2003, p. 120). Therefore, not only is there a large discrepancy between the two, the prepubescent body is largely unobtainable to the majority of the female population. Nonetheless, the drive to meet this ideal is so pervasive among women that it has been labeled ‘normative discontent’ (Rodin et al., 1985 cited in Dohnt & Tiggerman, 2006, p.141). So omnipresent is women’s dissatisfaction with their bodies it is quite understandable that the term ‘normative’ is invoked as a descriptor. However, I argue that using the expression ‘discontent’ suggests that a) women are just ‘put out’ by their negative body image and b) that eating disorders result from a woman being simply ‘unhappy’ about their physical shape. The \$300 billion cosmetic surgery industry (Twitchell, 1996) alone suggests that many women are not merely disgruntled and looking for options to improve their mental well-being, but rather, are so severely distressed and anxiety ridden that they are willing to go the extent of undergoing surgery in an attempt to lessen their suffering. However, as Berg (2002) argues, it is rather simplistic and insufficient to argue that the ‘presence of thin role models, weight-loss clinics and diet products alone’ are solely accountable for this degree of agony experienced by so many women (p.31). When a woman yearns to be

thin, it is not the body alone which she seeks to obtain but the “‘promises’ attached to [it]” (Berg, 2002, p.31). The thin body can be conceptualized as the first domino which automatically sets off a number of ‘rewards’ for the individual who maintains a low weight. The advertising industry ‘promises’ that a thin body equals popularity, sex appeal, and success in addition to symbolizing self-control through the mastering of the body’s natural urges, and candor of the mind and self. The social and personal power bestowed upon the thin body by the advertising industry appears to be too strong a temptation for many women to resist. Therefore, if the slender body is viewed as a sure path to the ‘happy’ life, it can be argued that for many with eating disorders the ultra-thin (read anorexic) body is seen as a definite way to secure an even *happier* existence. The latter argument is so often missed in socio-cultural explanations of anorexia, which designate the relationship between the mass media and eating disorders as their object of study, but it remains one that is embraced by poststructuralist theorists who study the disorder. Importantly, through attending to the multiplicity of discourses which frame anorexia, poststructuralist theorists warn against viewing self-starvation as simply a result of women ‘consuming too many ideologically unsound representations of women on television (Bray, 1996, p.420). As Probyn (1987) articulates through irony, all that ‘we can clearly hear from these descriptions is that women are pathologically susceptible to media images’ (p.203 cited in Bray, p.420).

In line with Probyn’s (1987) critique, I argue that positioning anorexia as a direct result of media exposure, or as solely an outcome of a culture which promotes a thin body ideal, neglects the ‘plural collectivity of embodied subjectivities, experiences, and body-management practices’ that are entrenched in, and constructed by current

discourses that are characteristic of “‘postmodern’ culture” (Malson & Swann, 1999: 137-138). One of these discourses, which features prominently within the contemporary context, relates to how individuals are positioned to avoid becoming ‘fat’ and driven to exert much of their energy into fighting the ‘battle of the bulge’.

2.5.3 *Fat discourse*

Contemporary Western culture has long declared a war on fat and many women are heavily invested in the ‘battle of the bulge’. This fear of fat can be split into two different but connected categories; physical and moral. Given the knowledge that we are experiencing an ‘obesity epidemic, [one that] puts millions at risk from related diseases’ (WHO, 1997) I argue that a woman’s energy may appear to be most efficiently invested in avoiding obesity, because by *choosing* to prevent weight gain the individual is indirectly granted probably immunity from a whole host of illnesses that ‘characterize’ ‘modern culture’ (Peterson, 1997, p.200). These include, but are not limited to, heart disease, diabetes, high blood pressure and cholesterol, some types of cancer, and psychological problems such as depression. In preventing weight gain, the individual is also able to avoid the social ostracizing that occurs in a culture that questions the moral dignity of overweight individuals. As Berg (2002) explains, ‘excess female flesh, once a symbol of fertility and abundance, is now associated with being out of control, laziness, lack of willpower, incompetence and unattractiveness’ (p.32). The terror induced by ‘fat’ is not limited to the physical body it relates to but rather the symbolic meaning it holds.

The symbolic power of ‘fat’ is one with a long history. There are periods in the past when being ‘fat’ was associated with affluence, as Luciano (2000) explains,

During America's Gilded Age⁸, fat men enjoyed a flurry of popularity: plump bodies were equated with plump wallets, while thinness, in this age of excess, was associated with poverty. Millionaires were depicted with bulging waistcoats, gold watch chains stretched across their ample midriffs, their size reflecting their power. There was even a Fat Man's Club founded in 1866 (p.20).

In the case of women, one can refer back to Renoir's 1887 painting, 'The Bathers' which reflected the norm of his era where the voluptuous female was the essence of beauty and attractiveness. However, 'fat' has long been connected with a hefty measure of moral indignation. In Proverbs 23:20-1 excess of flesh is seen as an individual flaw, 'Be not among winebibbers; among riotous eaters of the flesh; For the drunkard and the glutton shall come to poverty: and drowsiness shall clothe a man with rags' (cited in Gilman, 2004, p.50). The view of the body as that which contaminates the soul is the very foundation of Cartesian dualism. As Malson (1999) explains, 'in this discourse human existence is constructed so that the spiritual or mental is seen as entirely separate from the physical realm' (p.233; Bordo, 1990). Not merely separate, the mind/self is vulnerable to the acts of the body in a context where the latter is viewed as 'Other' and 'potentially dangerous and excessive' (Malson, p.233; Bordo, 1990, 1992). Therefore, in order to protect the integrity of the self the individual must exercise self-control over the body. Although anorexia can indeed be viewed as an act of excess, it may also be understood as a stalwart attempt to preserve integrity of character in a cultural context where overweight individuals face harsh discrimination. First, I explain more specifically how anorexia can be interpreted as a way to display a purity of character, and second, I

⁸ The 'Gilded Age' is a term which is used to refer to the post-Civil War era in America which is said to have existed between 1865 and 1901. This 'reconstruction' era was marked by vast economic and industrial development and a sharp increase in immigration (Cashman, 1984).

explore how being overweight can lead to the individual being on the receiving end of certain prejudices in their everyday lives.

For some, anorexia is conceptualized as the ultimate body narrative that exudes self-mastery as it can be viewed as demonstrating exceptional capacity of the mind to conquer the natural body. As Malson & Ussher (1996) argue, the 'anorexic body' 'signifies self-control and therefore the integrity of the mind/self' (p.274). They explain how 'self-starvation' is often interpreted by those with anorexia as a means of 'self-production', contrary to the common view that it represents a means of 'self-destruction' (p.276). One woman explains, 'I thought the more weight I lost the more evil I could get rid of so the better person I'd be' (p.274). This statement reveals that not only is the anorexic body an effort to obtain the 'promises' put forward by contemporary culture and its mass advertising regime but simultaneously a way to avoid the 'promises' which are attached to the overweight body.

Jokes made at the expense of overweight individuals are an everyday occurrence in the media. These negative stereotypes not only affect the self-esteem and emotional well-being of those whom they target but also mean that overweight people are concretely affected in their everyday lives. Prejudice against overweight individuals is rampant in contemporary Western society and spans across all life domains. These include, but are not limited to, employment, medical and educational settings, and the problems posed by the insurance industry. (Puhl & Brownell, 2001). Rothblum, Miller & Garbutt (1988) reported that study participants, asked to review 'job applications for sales and business positions' by viewing 'written descriptions of target applicants', made

‘significantly more negative judgments for obese women than for non-obese women’ (Puhl & Brownell, 2001).

Medical and health settings also represent sites where discrimination against overweight individuals occurs. As Puhl & Brownell (2001) point out, this is particularly important given the understanding that prejudice among clinicians and other health care workers may discourage overweight people from seeking medical attention. At the very least this bias has the potential to affect important ‘clinical judgments’ regarding this population (p.792). Research conducted on physicians attitudes (n= 400) through the administering of an anonymous survey showed that this group viewed obesity as a condition which ‘aroused feelings of discomfort, reluctance, or dislike’. It is important to note that obesity as a category only came after ‘drug addiction, alcoholism, and mental illness’ ‘among dozens of other categories’ (Klein, Najman & Monroe, 1982 in Puhl & Brownell, p.792).

Although popular misconceptions regarding obesity can be explained by way of ignorance, both the medical profession and academic setting indicate that education, whether of a general nature or specifically clinical, does not reduce the likelihood of obese people facing discrimination. The areas of medicine, education and employment are only some of the realms in which overweight individuals face discrimination. Dining out or traveling on public transportation, also pose a host of problems for the overweight due to ‘inadequate seat size’ and general access limitations. Although research is limited in regards to housing, jury selection and adoption, preliminary findings suggest that obese individuals face prejudice in these areas also (Pohl & Brownell, p.797). Bearing in mind the evidence presented to suggest that overweight individuals have a significantly

lowered quality of life as a result of stigmatization and discrimination, it comes as no surprise that there exists a moral panic around 'fat', so much so in fact that it would be more than acceptable to label contemporary Western society as 'fat-phobic'. From a socio-cultural perspective one may view fat discourse as the 'push' factor and the thin body ideal as the 'pull' factor implying that in modern society the individual must avoid becoming fat and pursue a thin body to escape being ostracized. Although the DSM-IV criteria lists 'fear of fat' as a sign of *individual* pathology (anorexia), this fear exists in various strengths among the 'normal' population and is simply exaggerated in the case of eating disorders. I argue that, in the case of anorexia, there exists an irrational degree of fear but one that is based on a particular cultural logic. Furthermore, contrary to psychological theories, anorexia appears to be a problem which also has its roots in the social and cultural framework of society rather than just in the individual herself. With 90% of eating disorders occurring in women and only 10% in men, the socio-cultural factors which contribute to the development of anorexia are hardly gender neutral. It is the gender specificity of eating disorders that has led feminist theorists to investigate the gendered component of the disorder.

2.6 Feminist Discourse

Since the mid 1970's, feminist theorists have debated the causes and origins of anorexia nervosa. The contrasting feminist perspectives, which at times overlap, are multiple and for this reason it remains impossible to identify a theoretical approach common to each of them. I do not claim to cover all feminist theories which have designated anorexia as their topic of inquiry, rather what I do aim to present are some of

the main arguments which provide a picture of how anorexia is constituted as a gendered issue.

To start with, a definitive binary logic permeates feminist discourses which articulate anorexia and the 'anorexic'. Is the 'anorexic' a female oppressed or liberated, a cultural dupe or an active agent? Does she represent feminine incarnate, hyper-masculinity or androgyny?

According to Bruch (1978) the typical anorexic is distinguished by "cleanliness, no rough play, or destructive behavior and no disobedience or talking back"; a woman that was incessantly occupied by her "not being good enough, not living to 'expectations'" (p.43 cited in Saukko, 1999, p.31). As Saukko (1999) argues, Bruch's version of the 'anorexic' as a passive girl from a wealthy background who has succumbed to the pressure of 'media' ideals and 'peer pressure' echoed the 'postwar anxieties about suburban conformity degenerating the American character, the deleterious effects of unprecedented wealth, and mass propaganda' (p.40). However, what makes Bruch relevant to a specifically feminist discussion is her repugnance for 'female dependency and domesticity' (Saukko, p.49). Bruch described the mothers of anorexics as 'women of superior intelligence and education' who had chosen to sacrifice potentially successful careers in order to raise a family. (Bruch, 28-31 cited in Saukko, p.42). The fallout from such a decision, according to Bruch, left these women obsessed with their children who they would push to acquire the 'dreams' they had long left behind. The result of which left a young women who dreaded the limitations which represented her mother's existence but also, due to her being raised to be 'dependent and obedient' (Saukko, p.42) saw the autonomy required by a successful career more than a

daunting prospect. As Saukko (1999) clearly points out, it is this interpretation of Bruch's which constitutes the 'anorexic as a critical symbol of the tragic nature of suffocating traditional femininity of the fifties' (p.42). For Bruch (1978) the docile 'anorexic' is at least rendered such as a result of her being caught in a contradictory bind. Whereas, according to Boskind-Lodahl (1976), anorexics find themselves at no such T-junction but rather on a direct mission to embody the very notion of femininity. As she explains,

far from rejecting the stereotype of femininity - that of the accommodating, passive, dependent woman - these young women have never questioned their assumptions that wifedom, motherhood, and intimacy with men are the fundamental components of femininity (p.346).

Both Bruch and Boskind-Lodahl's version of anorexia follows a pattern in feminist discourse whereby eating disorders are frequently the flag to be hoisted when patriarchy's oppression of women needs to be communicated. Although Bordo's (1993) work, some three decades later, clearly has its root in earlier feminist constructions of the 'docile' anorexic, she also attempts to synthesize this conception with the notion of the anorexic as a woman who is rebelling against patriarchal dictates.

Bordo (1993) argues that anorexia can be viewed as a 'protest against the limitations of the ideal of female domesticity'. The rejection of the fleshy body of the maternal figure in favor of the streamlined masculine body symbolizes women's acquisition of 'power' (p.209). They become both liberated from 'a reproductive destiny and a construction of femininity seen as constraining and suffocating' while simultaneously acquiring the attributes associated with the male body; 'detachment, self-containment, self-mastery, control- that are highly valued in our culture' (p.209). Bordo

(1993) suggests that the highly documented aversion to ‘hips, stomach, and breasts [...] and relief at amenorrhea’, typical of those with anorexia, is concrete evidence to support an interpretation of self-starving as expressing ‘rebellion against maternal, domestic femininity’ (p.207). Nonetheless, although anorexia *can* be viewed as a protest against oppressive patriarchal ideals, Bordo (1993) appears more at home articulating the anorexic’s fervent pursuit of thinness as ‘hopelessly counterproductive’ (p.160). Bundling up anorexia with agoraphobia and hysteria, Bordo describes these as ‘pathologies of female protest’ which legitimizes the very oppressive structure which produced them (p.159). More concretely, anorexia *is* for Bordo a quasi-rebellion where the protest is fruitlessly etched on the body rather than being ‘embraced as a conscious politics’ (p. 159). According to Bordo, the anorexic woman is devoid of ‘any social or political understanding at all,’ and moreover, unlikely to develop such a capacity for critical thinking as a result of her being completely overpowered by her obsession with her body which ‘render[s] any other ideas or life-projects meaningless’ (p.159). Not only is the anorexic engaged in a futile protest according to this perspective, but she is also completely unaware of engaging in it in the first place. There is no doubt that anorexia is caught up in the sociopolitical context of contemporary society but by constructing these women as cultural dupes incapable of critical thought, we are delegitimizing their accounts of *their* experiences. In other words, the multiplicity of experience is silenced because the speaker is rendered incapable of seeing what her anorexia *really* is, and constructed as lacking an understanding of the larger social and political issues which are characteristic of the society in which she lives.

Similarly to Bordo (1993), Orbach (1986) articulates the anorexic as a docile being whose practice represents an ‘unconscious protest against patriarchal oppression’ (97-118 cited in Bray 1996). Weight-loss is perceived to be an area where women can exercise control in a context where their lives are governed by others (Bruch, 1978; Franks, 1986; Szekely, 1989 in Gilbert & Thompson, 1996). However, in the quest to gain control and exert their power, these women, according to Orbach (1978), are succumbing to ‘society’s pressures to focus on their weight and appearance rather than on issues of real importance in their lives’ (Gilbert & Thompson, 1996, p.188). These societal pressures which remain hard to dissolve in the abstract are made edible for female consumption by none other than the mass media. According to Orbach, once digested by women the weight of these pressures is what fuels the anorexic protest. As Bray (1996) rightly argues, Orbach’s depiction of anorexia as that which results from ‘an interpellation of media representations, suggests that women only come to know themselves through the media’ (p.419). This ‘image of a docile childlike female viewer’ (Bray, p.419) portrays women as catching anorexia off of the television screen or magazine page, suggesting ‘that anorexia is the disease of the McLuhan age, disseminated by telecommunications’ (Ellmann, 1993, p.24 cited in Bray, p.419). Perhaps this could be extended to a discussion of pro-anorexia which then might explain why these women are described as being toxic for young internet surfers, because now women are catching it off of their computer screens as well! From this perspective, I argue, the female viewer resembles a cultist who has fallen victim to an inescapable but ‘systematic program of psychological manipulation that exploits, rather than fulfills, needs’ (Langone, 2005). Therefore, if the media is perceived as having a cult-like strength and

the female viewer is by her very nature without the tools to resist, the question becomes why is it that not all women who are exposed to the media ‘catch’ anorexia? Polivy & Herman (2002) answer this question by arguing that the media cannot be held accountable for causing eating disorders because ‘exposure to the media is so widespread that if such exposure were the cause of EDs, then it would be difficult to explain why anyone would not be eating-disordered (cited in Shade, 2003, p.2). This question is left unanswered by ‘modern’⁹ feminists who espouse oppressive patriarchal ideals of femininity as the sole cause of eating disorders. However, it is a challenge that poststructuralist and postmodern feminists (eg. Malson, 1999; Saukko, 2000, 1999; Burns, 2004; Probyn, 1987) have risen to, both implicitly and explicitly, through their acknowledgment and mapping of ‘numerous other discursive contexts within which ‘anorexia’ can also be located (Malson, p.139). As Malson (1999) argues,

as a complex, heterogeneous and shifting collectivity, ‘anorexia’ is, as argued elsewhere (Malson and Ussher, 1996, Malson, 1998), expressive of a multiplicity of societal concerns and dilemmas that are particular to the socio-economic, cultural and political dynamics of contemporary Western culture (p.139).

In addition, ‘modern’ feminists contributed to bringing qualitative methods into the research arena in order to rectify the ‘biases of traditional quantitative methods’ and to allow behavior to be contemplated as part of a context rather than as a separate entity. A parallel goal is to utilize this method to facilitate the researcher in their quest ‘to obtain an assessment of subject’s views of events rather than relying on the experimenter’s own

⁹ I use the term ‘modern’ feminist to describe feminist theorists which differ from those working from a poststructuralist perspective, for example, Bruch (1978); Orbach (1986) & Boskind-Lodahl (1976). Although Susan Bordo (1992, 1993) is often described as being a poststructuralist feminist, I do not include her in the group of the latter due to fact that, in the case of her work on anorexia, she does not acknowledge the multiplicity of discourses which constitute anorexia as do Malson (1998, 1999), Bray (1996), Saukko (1999, 2000) & Probyn (1987). It is this latter group of theorists, which I argue, take a clear feminist poststructuralist stance to the study of anorexia.

definition' (Gilbert & Thompson, 1996, p.185). However, I argue, this goal is incompatible with the perspectives of Bordo (1993); Bruch (1978) and Boskind Lodahl (1976), because by viewing anorexics as a homogeneous, static 'collectivity' (Malson, 1999), who lack the capacity for critical reflection, they are denying the 'subject's view of events' a place in research (Gilbert & Thompson, p.185). It is poststructuralist feminists' rejection of an essential anorexic subject, their appreciation that there exists a "plural collectivity of embodied subjectivities, experiences, and body-management practices" (Malson & Swann, 1999, p.137-138) when it comes to anorexia, and their recognition of the constructive capacities of language and discourses, which ultimately sets the stage for the subject's voice to be heard. Furthermore, as a result of the poststructural approach the researcher is relieved of the futile task of searching for what anorexia *truly is*, and able to investigate *how* anorexia is experienced by those that engage in it as a practice and therefore how anorexia is perceived and reconstructed.

The goal of this chapter was to introduce some of the central feminist discourses of anorexia so that I could explore both the conditions of possibilities which they have created, and the limitations they have imposed, in relation to the study of anorexia. I have described what I deem to be the 'modernist' approach to anorexia which is characteristic of Bruch (1978), Bordo (1993), and the others, in order to emphasize how viewing the anorexic as a woman either over-conforming or resisting patriarchal ideals neglects the complexity of the anorexic experience. In addition, I have argued that the intricacies of anorexic practice, and the meaning the *individual* attaches to their illness, become overlooked as result of positioning her as a woman who lacks the capacity for critical thought. Positioning the individual as largely oblivious to the cultural context within

which she lives, the meaning the individual herself attaches to her anorexia is excluded from the program of research. This is problematic, I argue, because the multiplicity contained in individual narratives is abandoned in favor of the researcher's view of events (Gilbert & Thompson, 1996, p.185). However, as I have argued, it is a poststructuralist feminist approach which provides access to this diversity of meaning, because they grant importance to the individual's own view of their experience and perceive the individual as one who has the capacity to reflect on their experience critically. In presupposing that there exists a plurality of anorexic subjectivities, dominant discourses are not viewed as predetermining individual experience, but rather, constructing a framework from within which these women negotiate the meaning of their practice. Acknowledging this is of crucial importance because the very objective of this thesis is to explore the complexities of this negotiation process. The complexity of, and contradictions within, the narratives of individuals are created in the act of discussion with others who share a common ground (anorexia). It is this type of dialogue which is facilitated by, and forms the very basis of, the pro-anorexia community which as a result of it existing online is also accessible to researchers.

CHAPTER 3: PRO-ANOREXIA IN CYBERSPACE

In this Chapter I provide a description of the context which has given rise to the pro-anorexia community online. More specifically, this is achieved by delineating how a combination of factors such as the extent of young people's internet use, the sensitive nature of certain health issues, and the unique aspects of communicating online, have interacted to create and reinforce the pro-anorexia community. However, because these same factors have also produced the online pro-recovery community, I describe how, when viewed in detail, the latter is seen as failing to fulfill the same needs as the pro-anorexia community which has resulted in it becoming the less 'popular' alternative. Due to the transgressive nature of pro-anorexia groups, they have been at the receiving end of a barrage of criticism from the media, while also provoking academic interest in their practice. In light of this, I explore the various discourses which surround pro-anorexia in order to begin articulating an alternative viewpoint of the community which I continue to illustrate and support within my analysis.

3.1 The Internet as a Source of Health Information

The internet has grown increasingly popular in the last decade and along with it the popularity of computer mediated communication (CMC). The internet is now a given in any discussion of adolescent culture, with teenagers regarding it as 'an information resource, an entertainment utility, and a tool for social connection' (Pew Internet and American Life Project, 2001 cited in Shade, 2003, p.1). This demographic group is spending more and more time online and are engaging in a wider range of activities, such

as shopping, chatting, downloading music, and designing their own web pages.

Increasingly, young adults are turning to the internet for health related information and the reason for this can be divided into three sections. Firstly, the internet is easily accessible for many young adults; a fact supported by NPR's 1999 survey which found that 75% of adolescents were able to access the web from their homes and nearly all were able to do so from school (Kids & Technology Survey, 2000). Secondly, the web holds a wealth of health information which adolescents may find otherwise difficult to access or in the case of 'sensitive' issues be frightened to ask. Lastly, using the internet enables adolescents to tailor the information they receive to fit their specific needs. Borzekowski & Rickert's 2001 study, which surveyed a large sample of 10th grade students, found that 'half (49%) had tried to get some type of health information from the internet' (p.816).

When the group was asked, out of a possible 11 different health issues, which were the most important to be accessible via the internet 'girls gave significantly higher scores for having available internet information on birth control, diet and nutrition, exercise, physical abuse, sexual abuse and dating violence' (p.816). In looking at these preferences it appears that young women feel safer exploring sensitive and personal issues or experiences on the internet. The internet is utilized for this purpose because of its provision of anonymity which makes it a safe environment for such exploration.

Anorexia, and eating disorders in general, are also a sensitive issue for many, in part because of the stigma associated with mental illness. Aware of this potential stigma in face-to-face situations, women may chose to turn to the internet as a safe alternative.

I argue, therefore, that the internet is perfectly suited to young women with anorexia who seek to connect and explore their experience in a safe environment. In fact, this chapter is

based on this very argument. This supports a web based research terrain as a means to study how women experience anorexia and negotiate with dominant discourses. It is also important to recognize the ability of the internet to transcend geographical boundaries. Because physical location is not a factor online, individuals with common concerns are able to connect with one another when they most likely would never have had the opportunity to meet otherwise. This is perhaps why support groups are a flourishing phenomena online.

3.2 Online Support Groups

There is an abundance of health information on the internet and online support groups represent an integral part of this resource. These groups offer individuals, with common health problems or concerns, the opportunity to communicate with one another through a variety of avenues which include chat rooms, forums, bulletin boards, listservs and one to one email interaction (Rapaport, 1991). There are a variety of benefits that have been reported for those who utilize support groups. However, the majority of research has studied the dynamics of face-to-face support groups, of which one of the most popular is Alcoholics Anonymous (AA). Although I acknowledge that there are differences between the 'real' and the 'virtual' support group, I do argue that many of the same benefits which are extended to members meeting face-to-face are also available for those who interact online. In fact, there appears to be added benefits to seeking support online, such as those which pertain to the issues of anonymity and accessibility.

It has been acknowledged that people suffering from an illness often become isolated from those in their immediate circle because it is rare that others in their family or peer group will have the same illness and be able to entirely understand the experience they themselves are faced with (Cline, 1999; Freund & McGuire, 1995 in Wright & Bell, 2003). It is this void which can be filled by participating in online support groups. As McGinnis (2001) argues, 'support from another person who shares a similar experience helps patients recognize that they are not alone'. Having broken the shroud of isolation individuals find a space where they can discuss their illness experience and learn from others who face a similar situation. Although, those with anorexia do not face the same degree of stigmatization as those with other mental illnesses, such as schizophrenia or physical illnesses such as AIDS, it is a widely known fact that individuals with eating disorders are extremely secretive about their behavior and their experience in general. Often, this is due to the fear that family or peers will intervene and force them to gain weight. In addition, although there has been a surge of interest in the popular media with eating disorders, anorexia is still largely misunderstood by the general public. It is the anonymity provided by online support groups which means that those with anorexia are able to talk about a large part of their lives which they have most likely kept hidden. A study conducted by Wright (2000) on internet support groups for people suffering from physical and mental illnesses (including 'eating disorders') reported that the 'the most frequently mentioned advantage of these groups was the perception that there was less stigma attached to one's illness/condition by other online support group members due to the anonymity of the medium than in the face-to-face world' (Wright & Bell, 2003). An important part of this, according to Wright (2000), was that participants felt more at ease

talking about their illness experience because their physical appearance was not revealed in an online context. This advantage, I argue, is particularly relevant to those with anorexia because the disorder is tied up with issues of body size, weight and shape. This fact is echoed by Wood & Smith (2001) who found that ‘participants in online exchanges have been found to disclose more about their conditions, probably because they do not sense being as readily judged [...]. given the lack of nonverbal cues to indicate disapproval or disappointment’ (p.102 in Wright & Bell, 2003, p.43). It is also the ubiquitous nature of the internet which makes it very appealing; as a result this kind of support, and its benefits, are constantly available.

In addition to the research that has focused on the social benefits of participating in online support groups there is also a large volume of literature which has solely investigated the ‘relationship between social support and health outcomes’ (Wright & Bell, 2003, p. 40). Two main models exist to explain the positive impact of social support on stress levels,

(a) the buffering model suggests that social support shields individuals from the negative effects of stress, such as weakened immunity and depression, over time (Dean & Lin, 1977; LaRocca, House & French, 1980); and (b) the main effects model asserts that there is a direct, rather than buffering relationship between social support and physical and psychological outcomes (Aneshensel & Stone, 1982; Thoits, 1982) (Wright & Bell, 2003, p.40).

Due to research indicating that adolescents are a) heavy internet users, b) increasingly turning to the internet as their primary health information source and, c) that girls significantly value specific types of health topics to be available online, such as diet, nutrition and exercise, it comes as no surprise that anorexia has a big presence online, and particularly so in the form of pro-anorexia internet sites.

3.3 A Thin Divide?: Pro-Anorexia Vs. Pro-Recovery

3.3.1 *The Pro-Anorexia Community*

This is a pro-ana website. That means this is a place where anorexia is regarded as a lifestyle and a choice, not an illness or disorder. **There are no victims here** (Ana's Underground Grotto, 2004, emphasis in original).

The telling statement above is located on one of the most long-standing pro-anorexia sites on the internet. The webmaster of this site clearly articulates that anorexia is viewed as 'a lifestyle and a choice, not an illness or disorder'. One may view it as the mission statement of the pro-anorexia community as it is to be found in variations on the majority of like-minded sites. 'Pro-ana', as defined by one site owner, stands for 'proactive, volitional anorexia' (Ana's Underground Grotto, 2004). Although variations in style and content exist among the sites in the community, the large majority include pages which cover five main themes: tips and tricks, tools, 'thinspiration' and celebrity weight statistics, links, writing and poetry, and information on the site's owner (Starving for Perfection, 2002). In addition, anorexia is referred to as 'Ana', and bulimia as 'Mia', which both signify the community's act of reifying the disorder. What 'Ana' represents may vary from site to site or between individuals; 'she' is described as a 'friend', 'enemy', 'savior', or 'goddess' to name but a few of her descriptors. One web site owner speaks to the multiple identities of 'Ana',

Ana can be a demoness that haunts and possesses you, or Ana can be a Saviour that enlightens and shows you the way ... or Ana can be both at the same time. Ana can be your secret lover, your secret critic, your secret best friend (Ana's Underground Grotto, 2004)

‘Tips’ and ‘tricks’, as they are referred to in the pro-anorexia community, normally consist of ways to deceive family and treatment professionals about food avoidance and weight loss, while also providing pointers on the practice of weight loss itself. The pro-ana website ‘Cerulean Butterfly’ explains how ‘taking antacids will help reduce hunger pains’ and advises readers to ‘pack a bag lunch to bring to school, and make sure people see you make it. Then, when you get to school, throw it out or give it to someone else’ (Cerulean Butterfly, 2006, text in original form). While the author of the Blue Dragonfly pro-anorexia website suggests buying ‘thin clothes’ as they act as an incentive for continued weight loss when hung next to regular clothes, as the former ‘torture[s]’ you as ‘you can’t get into them’ (Blue Dragonfly, 2006).

Although the exercise expenditure charts, lists of food’s calorie content, BMI¹⁰ calculators, and popular mainstream diet information found on these pages are labeled as pro-anorexia ‘tools’, they could equally be argued to represent the ‘tricks’ of ‘normal’ dieting. Within these categories individuals appear to be using ‘accepted’ medical calculators of health and nutrition for the destructive end of furthering their anorexia. On the guest books, which many of these sites have, participants sign their name (or pseudonym) along with their weight ‘statistics’. This information normally includes the following: HW (highest weight), LW (lowest weight), CW (current weight), GW (goal weight), UGW (ultimate goal weight) and often their BMI. This kind of statistical

¹⁰ ‘Body mass index (BMI) is a measure of body fat based on height and weight that applies to both adult men and women’ (National Heart, Lung, and Blood Institute, 2006). Underweight = <18.5; Normal weight = 18.5-24.9; Overweight = 25-29.9; Obesity = BMI of 30 or greater. An anorexic BMI is usually assumed to be anything that falls below 17.5. (Cerulean Butterfly, 2006)

information is often displayed for celebrities in the 'thinspiration' sections of these websites.

'Thinspiration' refers to pictures of very thin and often emaciated models and celebrities which are used for their ability to inspire their viewers to engage in or continue with their weight-loss endeavors. Towards the same end, pictures of extremely obese individuals are also posted to 'deter' the reader from eating. The latter are referred to as 'reverse triggers' (Ana's Underground Grotto, 2004). The community itself appears to be aware of the potential strength of these images in encouraging disordered eating behaviors, and as a result there is often a 'disclaimer' message which precedes the images warning the reader that what they are about to view could be of a 'disturbing' nature. However, these kinds of messages are normally prefaced with 'if you do not have an eating disorder'.

The links sections of web sites in the pro-anorexia community provide lists of other pro-anorexia websites, forums, chat rooms, bulletin boards, and online journals alongside their URL's. Although the sheer length of these lists enables us to realize the strong presence of pro-anorexia on the internet, many of these links are broken because the sites have been shut down and have been forced to move elsewhere. As Shade (2003) explains, 'many of the pro-ana sites are leading a peripatetic existence, migrating from one free homepage service to another' (p.1). The nomad like character of the sites is in part due to the media controversy which ensued around the pro-anorexia community beginning in 2001. As a result, many of the popular internet servers, such as Yahoo! and smaller companies banned sites which contained 'pro-anorexia content' (Shade, 2003, p.1). Nonetheless, since this date the pro-anorexia community has continued to flourish

with site owners using numerous ways to prevent their ‘creations’ from being closed down. For example, some provide an opening page which describes the site as being ‘pro-recovery’, or anti ‘pro-anorexia’ after which the remainder of the site is clearly pro-anorexic in content.

Personal writing in the form of essays and poetry are normally a staple of the pro-anorexia web site. Much alike others in the community the Cerulean Butterfly site presents a ‘letter to ana’ and a ‘letter from ana’,

My dearest Ana,
Thank you for all you have made me. Thank you for taking that fat, bloated, disgusting creature I was and putting her on the road to perfection. I'm almost there. I can feel my bones grinding against the bedsprings when I sleep at night and I know I'm almost there, I'm almost perfect, I'm almost all that you can make me. There are days when I hate you, when I feel so dizzy I cannot stand and I wish to God that I had never let you into my life. I wish that whatever switch was flipped in me that made me anorexic could be turned back off. I weep for the sad freedom that my fat body granted me, for the joy I had then. It is in these moments that you come to me and show me how much better I am now. I look in the mirror and I think, "My God, where would I be without her?" I put on my size 0 pants and feel an overwhelming joy - I was a size 14 until you came along. I know that I'm not perfect, and I'm grateful to you for sticking by me though I sometimes try to push you away. Our love is a battle, but one I know you will always win. (Cerulean Butterfly, 2006)

The majority of writing on pro-anorexia sites is used by the community’s participants to express their thoughts and feelings on a variety of topics which pertain to anorexia itself and the pro-anorexia ‘movement’. The owner of Ana’s Underground Grotto explains her ‘essay’ section as a place where people can ‘come together to share vision, experience, ideas, expressions’ (2004). Poetry, popular song lyrics¹¹, and journal/diaries of the owner and various participants are also among that which you may find in these areas of the sites. Frequently, the web site owner

¹¹ The popular song lyrics, which are sometimes listed on pro-anorexia sites, include the following artists and titles: Saves The Day - Cars and Calories; Pulp - Anorexic Beauty; Silverchair - Ana's Song; Superchick – Courage.

includes a 'bio' section describing their 'story' detailing the reasons they attribute to their developing anorexia, the pattern their eating disorder has taken since it began, and a variety of other personal information which pertains to their life history in general (Blue Dragonfly, 2006). However, just as with any other part of these web sites in the pro-ana community, this area varies in the content it offers. Since the emergence of the pro-ana 'movement' a number of sites have begun advocating and even selling the notorious 'red bracelet'. Not to be confused with the Kabala version of the same, the 'red bracelet' worn by those with anorexia is done so to communicate 'solidarity' with fellow individuals and to symbolize anorexia itself. One of the largest 'manufacturers' of these bracelets, the Blue Dragonfly site owner, explains the 'red bracelet' as 'a way for you to wear something and feel connected to the 'ED' community' (Blue Dragonfly, 2006). These bracelets have become so popular and their use so widespread throughout the community, that a current Stanford School of Medicine survey, investigating the characteristics of people who participate in the pro-anorexia community, includes a question which asks respondents whether they own one or not. Predictably, the Stanford survey addresses both pro-anorexia involvement while also enquiring into individuals' use of 'pro-recovery' sites, which are discussed as being polar opposites of each other. In May 2005, Stanford's medical school published their findings from a previous study which found that 40% of respondents had visited pro-anorexia web sites, however, close the same amount (34%) had visited pro-recovery sites, with the remainder (25%) having experienced neither (Shaw, n.d).

3.3.2 The Pro-Recovery Community

The anti-thesis of the so-called destructive pro-anorexia community is the amply named pro-'recovery' community, which can also be found online. One of the most

comprehensive sites in this particular online community is the Something Fishy Web Site on Eating Disorders (SFWED). Since opening its doors in 1995, Amy, a recovered anorexic and her husband Tony, have expanded the site to offer a multitude of resources to support those suffering from eating disorders, their families, and their friends. 'Something Fishy' presents information on all aspects of eating disorders from symptom identification to treatment possibilities. A large section of the site is reserved for bulletin boards, chat rooms, and the like, where those affected by eating disorders can connect and support each other. It provides recovery 'tools', such as self-help exercises, interactive gaming opportunities aimed at helping individuals learn more about themselves and their problems, a recommended reading list, and this is to name but a few. It is interesting to note that this site is also translated in Spanish and French, which has increased its accessibility and subsequently its following. 'Pale Reflections', one of the other 'big' names in the recovery community, launched its site in 1998. Although nearly, but not quite as comprehensive as the 'Something Fishy' site, the 'Pale Reflections' web site predictably offers a variety of resources for the recovering individual and interested others. Although both these sites are relatively long-standing and encyclopedic in their provision of resources there are a great number of smaller sites which aim to serve the same population with assistance in the recovery process. However, using the 'Something Fishy' site as an example, the majority if not all of these sites make it clear to the visitor that the owners have gone to all ends to ensure that their site is a 'safe and as non-triggering an environment as possible'. Concretely, this means that certain rules and regulations have been set which govern the visitor's participation in the site. It is clearly outlined that the discussion of 'weights', 'calorie amounts', 'body mass', 'numbers and

tips' is forbidden in all areas. However, it appears to be slightly more complicated than that. The SFWED's¹² 'Remember It Hurts' community is one of the most longstanding parts of the 'Something Fishy' website. Resembling a bulletin board, where people can post messages asking questions and write replies to a variety of eating disorder recovery topics, this interactive area is strictly monitored by the web site's owners and other moderators. Messages that talk about eating disorder behaviors are 'not permitted' and participants are reminded that,

This is an ED site, so we realize there will be *some* behaviors discussed. Details are not necessary. I assure you, your behaviors are no different than anyone else here [...] we want you to dig into the issues underneath all that. What were you feeling this morning, this afternoon, this evening? [...] What problems are you facing and having a hard time coping with? How is your therapist challenging you and how do you feel about that? [...] I know it's difficult to break the habit of being so absorbed in ED thinking that you don't want to talk about anything else—but this is one of the essential parts of breaking the self-destructive cycle of an ED. **You all have to challenge each other, and you must also challenge yourself** [...] **If posts are filled with excessive talk of behaviors and details they will be edited or closed. We don't do this to make you feel bad—we do it because we CARE** (SFWED, 2006, all text in its original form).

Although this bulletin board is described as being a place where those with eating disorders can *freely* discuss their experience, relay their fears, ask questions, and gain support from others in a similar situation, there appears to be a significant amount of limitations to this freedom. In fact, one may go as far as suggesting that this bulletin board bears a striking resemblance to 'treatment' itself; behaviors are prohibited, thoughts are 'edited', and the support must be sought within the parameters of authority. This environment may appear unattractive to those individuals with anorexia who have logged onto the internet for its promises to accommodate spontaneity of thought and

¹² SFWED is the abbreviation for 'Something Fishy Website on Eating Disorders'

uncensored venting of feelings. Additionally, anorexia manifests itself through symptoms (behaviors) which are often inextricably linked to the everyday experience of the individual. The self-editing that posting on SFWED's bulletin board requires may be a difficult task for the individual caught in the midst of an eating disorder, which by its very nature presupposes the individual to be obsessed with the behaviors they find themselves engaging in. For some, this will not pose a difficulty but more of a demand they feel unwilling to meet. It is widely known that the symptomatic behaviors of anorexia are maintained by the individual in order to distract themselves from the 'issues underneath' (Something Fishy, 2006, spelling corrected). The question remains then, where do those individuals suffering from anorexia go to find support when they are not ready to enter into the advanced stages of recovery which require 'dig[ging] into the issues underneath'? (SFWED, 2006).

Often described as a defense mechanism among professionals who treat eating disorders, anorexia represents a way of coping for individuals. The DSM-IV states a 'refusal to maintain body weight' as its first criteria for diagnosis which demonstrates that the disorder itself is not defined by a willingness to recover, but to the contrary, by an exceptional determination to further engage in disordered behaviors in an effort to continue to lose weight. With this information in mind, one can conclude that the pro-recovery community remains off limits for many with *anorexia*. For those fully immersed in the pattern of starvation their online support options as a result become rather limited. However, the pro-anorexia community where individuals can communicate freely, spontaneously, and in an uncensored environment is all too available. I do not argue that participation in the pro-anorexia community is a 'healthy' substitute for the pro-recovery

community but the lack of alternatives makes pro-anorexia the *only* alternative¹³ for those who feel they are not yet able to recover.

It might be useful to draw a parallel between anorexia and cancer sufferers. I doubt that participants in an online cancer support group, who express their decision to let the disease run its course instead of accepting the grueling realities of chemotherapy, would have their messages 'edited' or 'erased' because they did not meet the requirements of a recovery orientated discourse. One may argue that the physical origins of some cancers mean that the disease is out of the individual's control, whereas a mental illness such as anorexia is within the control of the individual and is treatable. This leads to the argument that the two should be conceptualized as being completely different. However, in addition to studies which suggest that 25% of those with anorexia have an 'incurable chronic condition' and as many as 20% of all cases end in mortality within 17 years of onset (Piccini, 2000; Garner & Garfinkel, 1997), the physical changes that occur in the body as a result of starvation suggest that recovery from anorexia relies less on the will of the individual and more on the uncontrollable physical ramifications as is the case with cancer¹⁴. More concretely, the neuropsychological changes that impair brain functioning are said to prevent the individual from recovering, or from having the motivation to recover, until weight is restored to a healthy level. Based on this argument, I contend that with the pro-recovery community's support conceptualized as an out-of-

¹³ Perhaps more women would participate in the pro-recovery community if there were less restrictions placed on the individual and they were able to speak more freely. For example, instead of banning talk which refers to 'anorexic' behaviors, women could be allowed to discuss such things and other women in the forum which have begun the healing process could be encouraged to respond to them offering support on how to adopt more healthy behaviors. This could also be a job for the site moderators, although not usually professionals, they are often people who have experienced an eating disorder their self and could offer information and supportive tips targeted towards recovery.

¹⁴ See the infamous study of Keys et al (1950) for a full description of the physical and psychological effects of starvation.

reach resource, the pro-anorexia community, although possibly ‘triggering’¹⁵ to many with anorexia, represents the sole alternative for those seeking support. With this understood, I argue that an investigation into the pro-anorexia community is required; one that is not focused on proving the destructive potential of these sites, but rather, one that recognizes they are a reality that needs to be more fully understood.

3.4 Pro-Anorexia Research: Constructing The Good, The Bad, & The Ugly

Although supposedly flourishing since the late 1990s, the pro-anorexia community did not attract academic interest until 2003. In fact, popular forms of media, such as newspapers, women’s magazines, and television (news and talk shows), were the only source of information for anyone wishing to learn about pro-anorexia until this date. Just as anorexia as a subject is constituted by a variety of discourses, as described earlier, pro-anorexia as an object of inquiry is equally constructed in multiple ways. This section aims to present and critique a range of ways in which pro-anorexia has been conceptualized to date.

3.4.1 Pro-Anorexia as Quantifiable Destruction

Rising to the challenge of this new phenomenon, Chelsey et al (2003) completed a quantitative content analysis of pro-anorexia web sites in an effort to provide a schematic of the community. Although the themes they identified remain accurate today, if only due

¹⁵ ‘Triggering’ is often used to refer to the impact of pro-anorexia sites which encourage ‘anorexic’ behaviors and thought patterns. This term relies on group-dynamic theories (group polarization) which argue that ‘interacting with a small subset of like-minded others our framework for social comparison could become rather warped. We could quickly acquire an exaggerated perception of the rightness of our views because we found others who not only agree with us but who are even further out on the attitudinal limb’ (Wallace, 1999, p.79).

to their generality, they offer little else in regards to how the space is used, the functions it might have, or the meanings articulated within it. However, their findings which indicate that ‘pro-anorexia sites are better organized, comprehensive, and more numerous than sites based on recovery or professional services’ (p.124) make it startlingly clear that the former have a ‘competitive advantage’ over pro-recovery and professional sites and that this in itself demands investigation. At the very least, this quantitative study has made it evident that for any researcher seeking to learn more about anorexia in an online context, the pro-anorexia community is the one that holds the greatest wealth of information. This online community, an unbounded opportunity to some researchers, spells disaster for Chelsey et al (2003) and many of their fellow medical professionals who clearly articulate it as one that inflicts harm on each young woman that encounters it. As Chelsey et al (2003) explain, the popularity of pro-anorexia sites over and above those ‘based on recovery or professional services’ is important ‘because of the *tremendous* potential of pro-ana sites to *harm* and pro-recovery sites to *help*’ (p.124, my emphasis). I do not wish to completely refute the possibility that these sites may have harmful effects on those that visit them, and it is important to note that this is a whole discussion in and of itself. Rather, I argue that conceptualizing these sites as ‘harmful’ is a problem when it precludes any investigation into the community as a meaningful space. Often, the articulation of the pro-anorexia community as toxic is immediately followed by the quest to censor the sites within it, or to close them down completely. These actions fail to contribute to our understanding, of the community, and the function it serves for those individuals who participate within it. The latter is in fact my primary objective, as I seek

to explore how this community of women negotiate their subjectivities and come to understand their experiences through negotiating with psy discourse.

3.4.2 *Pro-Anorexia as Toxic*

The pro-anorexia community has been at the receiving end of a barrage of negative criticism, both from the medical profession, and the popular media alike. Frequently referred to as ‘gruesome,’ ‘pathetic,’ and ‘sinister’ (Pollack, 2003, p.246 citing femail.com) by the media, they have also been described as ‘support[ing] the devil’!! (Graham, 2001 in Chicago Tribune in Pollack, p.247)) as one ‘director of an eating disorders clinic’ religiously exclaimed. One journalist labelled the content of these sites as conveying the “noisy preaching of the gospel of ‘empowerment’ joke,” stating, ‘we are not scared that their eating habits will expose the ‘pathetic little naked-emperor reign’ of non-obsession eating for ‘what it *really* is’ (Taylor 2002, p.3-5). This austere reception is a product of an underlying conception that this community is toxic and those that participate in it are inevitably poisoned by its content. This construction is not far from the ‘image of a docile childlike female viewer’ (Bray, 1996, p.419) which is characteristic of Bordo’s (1993) perspective of the anorexic. Bray (1996) challenges this standard feminist articulation that ‘poisoned text’ creates ‘toxic bodies’ (p.422) and states, ‘the female subject’s purported close identification with the text is read as undermining impartial judgement and the capacity for objective and rational reading’ (p.422 cited in Pollack, 2003, p.248). Not only does this infantilize those that participate in the pro-anorexia community it enfeebles their practice. As Probyn (1987) clearly articulates, ‘to consider [the anorectic’s] fast solely as a causal reaction to the

interpellations of discourses is to impoverish her act' (p.205 in Pollack, p.248). Nonetheless, regardless of the cultural ramifications of positioning the pro-ana community as toxicity embodied, the concrete results of this discourse led to many of these web sites being erased from cyberspace. As Dias (2003) explains, 'in July 2001, an American eating disorder advocacy group, ANAD (Anorexia and Nervosa and Associated Disorders), made pleas to servers like Yahoo to take down these sites, with 115 sites shut down four days later' (Reaves, 2001 in Dias, p.36). Although this attempt at censoring proved unsuccessful, because for each site that was removed another or more sprang up in its place, it has nonetheless sparked an important debate which surrounds the notion of the internet as a neutral and democratic public space.

3.43 Pro-Anorexia as Ethical Dilemma

The Centre for Democracy and Technology (CDT) in the United States commissioned a paper in June 2006 entitled 'Preserving the Essential Internet' as a part of their larger campaign to maintain the 'robust openness and unfettered freedom' of the internet (CDT, p.1). One of their central concerns is that broadband operators are now seeking to 'obtain payment from services (*e.g.*, Yahoo!) used by their subscribers, or to enter into special arrangements with certain Web sites or content providers' (p.6). This introduction of 'gatekeepers or centralized control' threatens the internet as 'an open platform for speech' (p.1) and the CDT argue that the Internet's neutrality is central to its 'unique ability to foster free, democratic participation, economic activity and innovation' (p.2). Although the CDT and other like minded free speech activist organizations have not spoke out about the censoring and erasure of pro-anorexia websites (Shade, 2003,

p.6) that began in 2001, they remain as one example of how private interests are undermining the democratic nature of the internet. If sites escape being eradicated entirely, they face being included in the lists of popular 'protective' software programs, such as 'CyberPatrol' which is often purchased by parents in their efforts to protect their children from the 'dangerous' ideas found on the internet . As Vandergrift (2006) notes,

Ironically, some of the most powerful and positive learning sites (according to my value system, of course) are filtered out using such software. For example, *CyberPatrol* blocks access to the Ontario Religious Tolerance Site because it includes Wicca among its 62 religious and ethical systems. This site also includes information on abortion, cults, the death penalty, and Satanism (§6-7, emphasis in original).

Often described as a cult, it is no surprise that a large amount of pro-anorexia web sites have been removed from the internet given that they too have been described as 'support[ing] the devil' (Graham, 2001-Chicago Tribune in Pollack, 2003, p.247) and promoting their own 'death penalty' (Vandergrift, ¶7). The latter based on the assumption of Hoff, 'Director of Programs at the U.S. National Eating Disorders Association,' (Shade, p.4) who stated that pro-ana sites represent the equivalent of 'placing a loaded gun in the hands of someone who is suicidal' (Shade, p.4 citing Hoff). The creator of the Cerulean Butterfly Pro-ana site referred to the media as a 'pitchfork-and-torch-bearing-mob' and the imagery this conjures up requires no explanation (2006). However, as Vandergrift (2006) argues, this misguided belief held by many parents and professionals that young adults will never be 'exposed' to 'these dangerous ideas' has very real consequences. She explains,

such ostrich-like behavior focuses our attention on banning things, diverting our energies from the real educational process of helping

students sort out, select, and look critically at the information and the individuals they encounter in the virtual world (¶8).

This avoidance style approach to transgressive content on the internet itself makes young adults vulnerable to the ‘controversial’ ideas they are bound to stumble upon because they have been stripped of the chance to develop the skills necessary to critically assess that which they encounter. Aside from the ethical debate that surrounds censorship, if we assume that young adults will inevitably be privy to a variety of ideas that transgress mainstream boundaries, and that we cannot ‘protect’ them completely from the internet or other media, then censorship becomes a weapon rather than a protective shield. The pro-anorexia community’s successful resistance to censorship is just one example that illustrates the futile nature of such attempts and furthermore, how censorship can have the reverse effect of fueling the proliferation of the communities it wishes to silence.

Following the high profile media coverage of the pro-anorexia community, many of these sites reported on their homepages that they had received an overwhelming number of hits (visitors) immediately after having been mentioned in the media. The creator of the Cerulean Butterfly pro-anorexia site describes on her site how, [her] “site has gotten a lot of exposure because of the TIME magazine article that came out this week. She also explains how ‘KTVU, KCRA, New York Times, Time magazine, and WebMD have all run or are going to run stories featuring this site’ (Cerulean Butterfly, 2006). Also referring to the same article, ‘Anorexia Goes High Tech’ (Reaves, June 31st 2001), one anti-pro anorexia visitor, on the same site, stated, ‘I can’t believe that the TIME magazine has actually indirectly become the source of promoting this website by writing about it.’ This is clear evidence to suggest that not only has censorship been ineffective in eradicating these sites, but that it has also produced the opposite effect of

drawing more attention to such communities. This ironic effect of censorship which makes controversial groups even more visible, rather than silencing them, was described back in 1972 by Cohen,

A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion...the moral barricades are manned...socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more *visible* (p.9 cited in Treseder, 2003, p.4, my emphasis).

Fortunately the result of this particular ‘war on terror,’ that targeted the pro-anorexia community as a ‘weapon of mass destruction,’ has meant that academics interested in anorexia are forced to move beyond condemning this transgressive community because it will not simply disappear. In fact, it becomes vividly clear that we stand to learn much more about anorexia by attempting to understand what these young women are communicating in this discursive online space. Condemning their practice and trying to silence them precludes any meaningful investigation

3.4.4 Pro-Anorexia as Rebellion

The notion of pro-anorexia as a resistant collectivity challenging hegemonic discourses is part of one of the most prevalent debates in the academic literature on the subject to date (see Pollack, 2003; Cherry & Snyder, 2005; Fox, Ward & O’Rourke, 2005; Day & Keys, 2005; Hepworth & Mulveen, 2006). A key theme which emerges from this debate is the exploration of the tension which arises from conceptualizing the pro-anorexic as an ‘active agent’ when her agency is based on (over)-conforming to the very dominant discourses which it aims to subvert. This contradiction may be seen as a

remnant of feminist arguments such as Bordo (1993), who frame anorexia as discursively positioned within a framework, buttressed solely by narratives of resistance and over conformity that focuses on the cultural ideal of the slim body. However, researchers such as Cherry & Snyder (2005) provide a new twist which confuses the boundary of these polar opposites. Their discussions are not limited to the thin ideal, but also include pro-anorexia as entering into a discursive struggle with bio-medical discourses.

Cherry & Snyder (2005) embrace the area between the two polar opposites so often invoked in any socio-cultural discussion of anorexia. They reject the assumption that those with anorexia represent a group with a 'false sense of agency' and similarly reject that their active agency is not without its limitations. As Cherry & Snyder (2005) explain, 'attempting to bridge a gap between the two views, we wish to consider the creators of the pro-ana websites as active agents who innovate upon yet simultaneously are constrained by social and cultural structures'(p.4). For them, pro-anorexics rearticulate 'the cultural ideal of beauty into an ideal of thinness' and in their quest for the emaciated body, rather than simply a slender body, they transcend the thinness norm and present a body which is at best regarded as unattractive by society and at worst, one which invokes repugnance and sheer horror. This assumption challenges the commonly held belief that the anorexic's pursuit of thinness is a result of her over-adherence to the beauty ideal because the latter includes other concerns such as 'facial structure, hair color and texture, being well groomed and make-up, and grace in movement' (p.14-15) which become irrelevant if the body is thin. Their argument also challenges the notion of the anorexic as one who is simply obsessed with embodying the thin ideal because the emaciated body is conceptualized as a resistant body rather than one which embodies an

ideal. This appears to be the innovative aspect of pro-anorexics, according to Cherry & Snyder (2005), which leaves us to consider the other part of the equation they present; the constraints imposed on the group by the very discourses which they have used as their source of inspiration. Although pro-anorexics have rearticulated the cultural ‘ideal of beauty’, their choice of the body as the site of their protest indicates that they have not questioned the ‘idea of the body as a continuing project [...] or the prevailing assumption of appearance as a sign of self-worth and evidence of self-control’. Nonetheless, the fact that these women have used the familiar canvas of the body to communicate their resistance does not undermine their agency as ‘determined, knowledgeable actors in social reconstruction of their (our?) world’ (Cherry & Snyder, 2005, p.18). Fox, Ward & O’Rourke (2005) support this conception and propose that pro-anorexia represents an alternative explanatory model¹⁶ of anorexia which subverts the “medical, social and feminist models that regard anorexia as a condition to be ‘cured’” (p.945).

Fox, Ward, & O’ Rourke (2005) perceive the pro-anorexia community as one that has developed its own explanatory model (anti-recovery) which is constituted through its rejection of the medical EM. Thus, the focus of this alternate EM lays in the ‘safe management’ of anorexia rather than treatment as an option (p.959). Fox, Ward & O’ Rourke (2005) suggest that the ‘tips and tricks’ sections of pro-anorexia web sites, which discuss everything from how to avoid behaviors being detected to what vitamins are essential to a malnourished body, are indicative of the community’s ‘commitment to

¹⁶ Kleinman (1980, 1988) coined the term ‘explanatory model’ to refer to the ways in which people interpret illness. Applicable to both the professional and the ‘patient’, Kleinman (1980) viewed lay explanatory models as ‘idiosyncratic, changeable, and heavily influenced by cultural and personal factors’ (Hodgson, 2000). Whereas Helman (1994) explains clinical EM’s as that which are ‘based on single, causal chains of scientific logic’ (p.111) which include a definition of the problem, ‘causation, timing and distribution, prognosis and management’ (Fox, Ward, & O’Rourke, 2005, p.946, see also Goodman 2001, p. 175; Hedgecoe 2001; Patel, 2005).

survival and living with anorexia' (p.960). They argue that some of the advice found on these sites suggests this 'safe management' approach (p.959) which aims to 'sustain health while living with a debilitating condition'. Ferreday (2003) in her research on the pro-anorexia community also found that much of the information on these sites was structured around 'how to survive and how to avoid becoming seriously ill' (p.284). This perspective, I argue, by constructing the pro-anorexic as one who is not only resisting the medical model but also one who is active in limiting the damage to her health through 'safe management' (p.959), challenges the notion of the community as that which is involved solely in promoting illness. I also found evidence to suggest that rather than trying to recruit young women to self-starve, owners of pro-anorexia web sites often post warnings which are aimed at dissuading individuals from participating in the community if they were 'looking to learn' about how to 'become' anorexic (Cerulean Butterfly, 2006). Not only do they try to deter, what they refer to as 'wannabees', but they also clearly describe the pain and dangerous nature of their practice as making for a miserable existence. For example the following can be found on the Cerulean Butterfly site discussed previously,

Do you want to stand in front of a mirror, vainly trying to see what other people see, and not see it, and cry, because you don't know what's happened to you anymore?

Do you want to throw up blood, stare at it, and keep throwing up, even though blood is a bad sign, because you simply don't care anymore?

Do you want to sit, crying, in the hallway of your home, because you know you didn't get everything up, even though all you've tasted for the past half-hour is stomach bile? (2006)

Unfortunately, rather than being discussed as a group of women who are aware of the danger of the practices that they engage in and who are helping each other in limiting the damage to their bodies caused by the illness, too often the sheer fact that pro-anorexics have chosen their body rather than their voices to communicate is read as evidence to suggest that they still deserve the label of cultural dupe which was pinned to anorexics in general over a decade ago.

As stated previously in Chapter 2, the notion of the anorexic as one who lacks the capacity to critically engage with the discourses that constitute her experience is still ever-present in literature which surrounds the topic. This pattern has also been replicated in some of the literature which surrounds the pro-anorexia community, therefore, in the section that follows, I will address this as it pertains specifically to the pro-anorexic.

Researchers such as Day & Keys (2005) present the idea that pro-anorexics can be viewed as agentic but only to undermine this very argument by concluding with the characteristic feminist response that describes this as merely false-consciousness. The authors argue that 'Ana', the name given to anorexia by many in the pro-anorexia community, is 'constructed as [a] dominant, consuming and dictating force[]' and rather than being a personification of anorexia itself it represents "the 'feminine ideal' portrayed in the media and the strive towards this' (p.10). The importance of this, according to Day & Keys (2005), is that although pro-anorexics may view their practice as one taken up by choice, what their act really represents is a submission to the patriarchal ideal of femininity. They invoke Foucault (1977) in order to present pro-anorexics as an example of how the 'power of institutions' is particularly effective when 'people are unaware of this [power], or when they believe that they are acting out of choice' (p.10). I wish to

avoid making generalizations about the community as a whole because just as any other collective, it is founded in ambiguity and contradiction. I argue that some of the women may seek to fulfill the 'feminine ideal', and view the anorexic body as being indicative of it, while others may be driven by other cultural ideals, express other motivations, and interpret the anorexic body quite differently.

The feminine ideal presented in the media is a thin, often very thin woman, with perfectly coiffured hair, who has perfectly applied make-up to cover all 'scars, blemishes, or even pores' (Cortese, 1999, p.54) and who is the epitome of 'sexual seductiveness' (Baudrillard, 1974/1988 in Cortese, p.54). The latter of which relies on her being dressed in tight fitting, and often, revealing clothing which accentuates her breasts and buttocks. She is also commonly displayed in advertising as sensitive, caring and as fulfilling the needs of others, whether it is as nurturer to her children or pandering to the needs of a man. The anorexic body, far from the 'ideal', often has thinning hair or even bald patches on the head, with lanugo¹⁷ hair on the body and face. The anorexic woman is characteristically described as wearing baggy clothing in order to hide her weight loss, which has resulted in atrophied breasts and dry yellow skin. As a result of starvation she becomes obsessed with her regime, withdraws from those close to her, becomes irritable and experiences a severely reduced libido. Hardly the 'perfect provocateur' (Cortese, p.54), the anorexic woman's body frequently induces shock and disgust not dissimilar to that experienced when viewing images of concentration camp victims in WWII.

Returning to the argument of Day & Keys (2005), I argue that the image of the ideal woman and the anorexic, when drawn in parallel, contradicts their view that pro-

¹⁷ Lanugo hair is a fine hair which develops on the body of severely malnourished individuals as the body's attempt to keep itself warm.

anorexics are striving for the “‘feminine ideal’ portrayed in the media’. Some may argue that the anorexic begins by striving for the ‘feminine ideal’ only to get completely consumed by the illness which itself generates the emaciated body. However, many, if not all, of the ‘thinspiration’ sections on pro-anorexic websites include not only the ultra-thin model but also display pictures of severely anorexic women, as a source of inspiration, which suggests that the emaciated body is a goal from the beginning and certainly not one that deters the individual. Furthermore, Day & Keys’ (2005) and others, present the media backlash as one that is aimed at the community’s discourse, which positions anorexia as a positive and rewarding experience. In other words, it is not the anorexic body but rather the community’s transgressive discourse around the illness which censorship aims to target. However, in a well articulated alternate reading, Ferreday (2003) argues that it is not the pro-anorexia community which is the sole target under attack; it is also the anorexic body.

3.4.5 Pro-Anorexia Sites as Embodied Dystopia

Much of the debate which surrounds cyber communities is concerned with the fact that communication online is disembodied. For some, such as Locke (1998), the disembodied nature of the online community is a negative attribute because it is based on what he refers to as ‘de-voicing’. This elimination of facial and bodily gestures reduces the online person to a “‘person-typist’ whose mood and personality can never really be known’ (Ferreday, 2003, p.278). This is troubling for Locke (1998) because it removes the ability of the receiver to gage when he or she is being fed misinformation. For others, such as Pascoe (2000) the disembodied nature of the internet community is its finest

attribute because it provides an opportunity for 'everyone [to be] equal,' 'neutral and unmarked' (Ferreday, p.279-81). In other words, the idyllic potential of the online community is buttressed by it offering a disembodied communication experience where individuals can interact 'unmarked by gender, race, class, national and sexual identity' (p.281). Thus, according to Ferreday (2003),

The individual netizen is perpetually burdened with the work of erasure; with one finger always on the delete key, he or she must remove all reference to those identity positions that may be seen as disruptive in order for the utopian virtual community to come into being. By analyzing the ways in which this process of deletion comes to be seen as beneficial (and the form it takes), it is possible to see how individuals and communities who flout this ideal of unmarked citizenship may become targets for censorship (p.282).

It is the pro-anorexia community's refusal to perform acts of erasure, its embodied character, and its creation of *marked* identities which has invited hostility. More concretely, this online collectivity refuses to consider the notion of community as a place where the body is excluded, and to the contrary, the body and community are viewed as an essential pair. As Ferreday argues, 'the pro-ana community comes into being through the bringing together of like bodies' (p.287). Furthermore, it is the controversial 'sick' anorexic body which they are revealing in a community where, in addition, they are also creating a space where 'its [] possible to speak out about one's experience of embodiment and of encountering abuse and prejudice as a result of being positioned as other' (p.287). With 'anorexic embodiment' as *the* core foundational element of the pro-anorexia community, suggesting that for them anorexia is an 'identity position rather than [] a debilitating illness,' it becomes fair to argue that medical discourse's focus on treatment is being challenged. In other terms, medicine's agenda of providing a 'cure' is itself

viewed by the community as an act of ‘erasure’ (p.287). Ferreday (2003) indicates that this fact provides evidence to suggest that the ‘ideal society’ is one where the anorexic body does not exist; ‘one from which all undesirable bodies have been purged’ (p.287).

Ferreday (2003) presents a refreshing twist to the discussion of pro-anorexia as a form of resistance. She transcends the predictable route evident in much of the literature on the subject which discusses pro-anorexia as resisting or over-adhering to the cultural ideal of the slim body. However, although original, her argument that pro-anorexia challenges the medical model because it is a community which refuses to submit to medicine’s effort to *eradicate* the anorexic body, neglects to acknowledge that it is the importance placed on the clinical sign by medicine itself which has in fact encouraged the *embodied* aspect of the pro-anorexia community.

The notion of the ‘clinical sign’ is a product of medicine. According to Austin (1999), it is a ‘construct that presupposes that any underlying pathology can be linked to a physical sign, an indicator that can be observed and measured’ (p.247). As Foucault (1977) explains,

The [medical] examination transformed the economy of visibility into the exercise of power. Traditionally, power was what was seen, what was shown and what was manifested Disciplinary power, on the other hand, is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. *Their visibility assures the hold of the power that is exercised over them. It is the fact of being constantly seen, of being able to always be seen, that maintains the disciplined individual in his subjection* (p.187 in Austin, 1999, p.247, my emphasis).

Pro-anorexia’s outright refusal to be a disembodied community is an example of a group of subjects who are fulfilling their ‘compulsory’ task to make themselves visible. By making ‘anorexic embodiment the very basis of community’ (Ferreday, p.287), pro-

anorexics could be viewed as submitting to the dictates of the medical model rather than resisting it, contrary to the argument put forward by Ferreday (2003). In fact the very power of medicine relies on the fact that ‘pathology or deviance can be *seen*’ (Austin, p.247). Contrary to the traditional notion of the anorexic, and now pro-anorexic, as cultural dupe, if we assume that these individuals represent a collectivity who are ... knowledgeable and have a critical awareness of their surrounding context, then we must ask, why would they persist in making their bodies visible online, as opposed to simply their voices, if it meant making themselves vulnerable to scrutiny by the medical profession? If we consider Foucault’s discussion of Bentham’s Panopticon as a structure organized around a central tower where subjects were persistently visible, we can conceptualize the pro-anorexics as inmates whose voices alone would keep them invisible but the presence of their bodies online renders them detectable by medical professionals and the media. The crucial difference being that their detection in cyberspace does not ‘assure[] the hold of the power[] is exercised over them’ due to the very fact that the internet provides a protective buffer between the subject and those that attempt to govern them, rendering the latter’s efforts futile. This is perhaps evident in the fact that consistent attempts at censoring pro-ana sites has proven to be a fruitless endeavor. Thus, the concept of pro-anorexia as resistant remains, because the community is pictured as utilizing the clinical sign of medicine as a tool to strip the former of its authority. This is achieved by the community demonstrating how that which is constantly visible is not in this case able to be controlled. In other words, the embodied nature of the community means that the sick body is made visible but at the same time it remains inaccessible to those who wish to govern, correct, or cure it. This, I argue, is a

contributing factor to the medical profession's hostility towards the pro-anorexia community. However, I consider the media and public outcry against pro-anorexia to have its roots in something different altogether. As Ferreday argues, Time magazine's reference to the "'ick factor' (Reaves, 2001) of seeing anorexic bodies', indicates that 'it is not only the 'thought' of pro-ana that provokes disgust, but 'there is also often a slippage between disgust at the content of the sites and disgust at the anorexic body'. (2003, p.288). Although extreme thinness may bring about feelings of pity, 'the image of excessive hairiness', according to Ferreday, exhibits 'bestiality and masculinity which threaten the traditional object status of feminine'. This claim supports my earlier argument that pro-anorexics may not always be seeking to embody the 'feminine ideal,' nor are their anorexic bodies always interpreted as being indicative of any such archetype. In addition, Ferreday develops this argument as she explains how the feelings of disgust incited by the anorexic body are so uncomfortable an experience that it eventually transforms into a 'desire to remove its cause' (2003, p.289). Thus, the conceptualization of the pro-anorexic as victim is quashed and replaced by the pro-anorexic as dangerous, so that drive to remove the body of disgust can be rearticulated as a protective measure to ensure the safety of 'vulnerable others, such as teenage girls'. As one article on a BBC news site perfectly illustrates,

[these sites] [...] are run by people with serious agendas, including those who are anti therapists... [who] promote false and dangerous practices on how to lose weight.... I would quite like to see an individual being sued for the advice they're giving (Jade, 2004 in Jackson & Elliott, BBC, 2004).

Interestingly, the disgust that the anorexic body invokes means that it is also one that is stigmatized. According to Hepworth & Mulveen (2006), it is this "stigma associated with

eating disorders in ‘real life’” which makes the pro-ana sites, in their provision of a safe and nonjudgmental environment, so appealing to those looking for support. This is the very foundation of the notion of pro-anorexia as ‘sanctuary’, which, I argue, is the most useful of explanatory frameworks if only because it transcends investigations which seek to explain what the community as a *whole* symbolizes and rather, aims to address the *multiplicity*¹⁸ of functions the community holds for what is viewed as a ‘*plural* collectivity of subjectivities’ (Malson, 1999, p.137-138).

3.4.6 Pro-Anorexia as ‘Sanctuary’

The term sanctuary is commonly used to describe a protective environment where those who exist within its borders can experience safety. Since ancient times people exercising their religious or political ‘right of asylum’” have sought sanctuary in the Church or a ‘foreign country’. Animal sanctuaries are defined by their assumption that ‘all animals in the sanctuary, human or nonhuman, are of equal importance’ and each is ‘given the opportunity to behave naturally in a protecti[ve] environment’ (Wikipedia, 2006, ¶1). I find this description of the ethos of an animal sanctuary particularly useful in regards to the pro-anorexia community because this online space gives its members the ‘the opportunity to behave naturally in a protecti[ve] environment’ where they are safe from judgment and criticism. In her article, ‘The Ana Sanctuary: Women’s Pro-Anorexia Narratives in Cyberspace,’ Dias (2003) explains how she conceptualizes this internet community as a space ‘in which women who are struggling from anorexia can potentially find sanctuary from the surveillance and regulatory mechanisms of control in the public

¹⁸ The community has been described by the participants as providing a safe place where they can, talk openly about their experience in a non-judgmental environment, receive support from other women in similar circumstances, and reduce feelings of isolation caused by their eating disorder which has meant that they have withdrawn from their family and friends.

sphere' (p.31). Although the internet is a public domain, Dias argues that the internet provides a safe haven for this group in contrast to 'traditional public spaces and places in the built environment' (p.31). Closely linked to the notion of sanctuary is that of support and as Hepworth & Mulveen (2006) argue, support comes in two forms on pro-anorexia websites. The first type is where individuals give and receive 'support for their eating disordered weight loss' and the second form of support is where women encourage 'healthy eating/recovery from [their] eating disorder' (p.291). The latter kind of support is rarely documented in academic literature, seldom mentioned by the medical profession, and completely absent from popular media discourse on pro-anorexia. Whereas the supportive exchange that occurs regarding 'eating disordered weight loss' (p.291) is their very focus.

A clear example of this is the argument of George (2002) who claims that the pro-anorexia community's use of 'support' is deceiving because they encourage anorexia rather than provide 'referrals to doctor's care or tips for recovery' (cited in Ferreday, 2003, p.290). What this ignores is the fact that pro-anorexia sites do offer some recovery orientated support as Hepworth & Mulveen (2006) have argued. More importantly, George (2002), and many others, claim that the term 'support' can only be used to describe that which promotes acceptable practice (healthy behavior) and any exchange which endorses alternative behavior is not 'support' at all.

While I strongly disagree with the argument that 'support' must come with a host of conditions, what George's (2002) comments emphasize is that too often the medical professional, media, and academic milieu are interpreting the pro-anorexia community through their own terms. The result of this, as Dias (2003) argues, is that the 'alternative

definitions and understandings that [these women] may have of their own mental states' (Dias, p.32), and about their own community, are dismissed and remain unexplored. I argue that these alternative meanings need to be addressed as they divulge a wealth of information about how anorexia is experienced which is predominantly unavailable elsewhere. The fact that these women consider their exchange to be of a supportive nature is what is of importance. By acknowledging the community's definition of 'support' the researcher is more open to understanding the varied functions these sites hold for those who participate within them. Furthermore, the way in which meaning is constantly shifting, as a result of these women's re-articulations, reveals the very foundations of the community itself. In support of this crucial point Dias (2003) argues, 'what women struggling with anorexia may not be able (or ready) to say to family, friends, or professionals, they may be able to say in a safer and less confronting space of cyberspace' (p.32). The notion of pro-anorexia community as 'sanctuary' implies that, for those who approach it in this way, these women's alternative narratives are equally if not more important than the 'traditional' discourses which are imposed on them from the outside.

Dias (2003) found that a certain number of themes were reoccurring within and among the pro-anorexia web sites where she conducted her research. These included:

Not feeling understood by those around them; feeling out of control; feeling isolated and in pain; using the eating disorder as a form of coping and a security blanket; recognizing that they still needed that security blanket even though they are aware of the potential dangers of anorexia; needing support and connection; feeling ambivalent towards both ana and recovery; and, resisting dominant interpretations of their experiences of disordered eating (p.38).

Contrary to the notion of pro-anorexia representing a collectivity of misinformed devil worshippers who are out to recruit and corrupt young minds into self-starvation, these narrative themes suggest quite the opposite. Dias (2003) found that the pro-anorexia community, for the individuals she encountered, represented a unique space where they can express their feelings and experiences openly without fear of recrimination while also reducing feelings of isolation by connecting with others in a similar situation. Also, far from the assumption that these women are locked in a state of denial, she explains them as ‘actually quite articulate and seemingly aware of their circumstances’ (p.28).

Ironically, I argue, this notion of the pro-anorexic as a conscious individual with an ability to communicate her experience clearly, may fuel the ‘hostile critiques of these websites’, which as Dias explains, are based on the idea that “young women’s ‘deviant behavior is going on because they are not under the supervision of ‘legitimate’ authorities” (p.39). Therefore, not only is this so-called ‘deviant’ community running rampant in cyberspace but it is being carried by articulate individuals, which may mean they are perceived as posing an even greater threat to social order. If we consider two of these ‘legitimate authorities’, in the case of pro-anorexia, as being professionals who are qualified to treat anorexia and supervised pro-recovery sites on the internet we can then ask why a transgressive community has evolved given the so-called utility of these legitimate sources of ‘support’? Dias (2003) begins to answer this question, first, by identifying a paradox inherent in the professional treatment of eating disorders. An irony revolves around the fact that, in a context where research has shown treatment to be most effective when it is begun during the earlier phases of the disorder, women are often unable to receive treatment until they reach the final stages of the illness. Secondly,

through invoking the Stages of Change Model (SCM) developed by Prochaska & DiClemente (1982) and the practice of narrative therapy, she explores the dynamics of support found within the community in order to illustrate how these women are in fact helping each other in ‘conventional’ ways similar to those used by professionals. This is interesting because it challenges the notion of pro-anorexia as a community which rarely offers ‘traditional’ forms of ‘support’. Furthermore, through acknowledging that there exists various forms of support Dias (2003) illustrates the heterogeneity of the community which is often generalized as a whole. I will use these two angles as a point of departure but will endeavor, in the section that follows, to provide a more detailed description while making what I consider to be important additions.

First, I asked why these women are using the pro-anorexia community to gain support for their illness, instead of turning to professional treatment, the so-called ‘legitimate’ form of support? The politics of diagnosis and the cost of professional services are central factors in answering this question.

As Dias (2003) argues, ‘in order to access treatment, women have to be clinically diagnosed by a physician and often have to meet rigid criteria for diagnosis and admittance [...]if their health is not seriously compromised and their weight is not low enough, they do not qualify for treatment (p.39). Dias further explains that a large number of individuals that she treated were acutely aware of this fact and often ‘avoided seeking treatment for fear of rejection’ (p.39). The ‘rigid criteria’ includes ‘weight loss leading to maintenance of body weight less than 85% of that expected’ (15% loss) and ‘amenorrhea, i.e., the absence of at least three consecutive menstrual cycles’ (APA, 1994). The latter criterion has been disputed by research studies which indicate that

menstruation persists in individuals even at critically low weights. However, for an official diagnosis of anorexia to be made it must be present in addition to a weight-loss that is equal to, or exceeds, 15% of total body weight. What this means is that individuals who are often very sick but not 'sick enough' to receive an official diagnosis are refused treatment. Ironically, it is commonly known that once weight-loss exceeds 15% the individual is completely consumed by the disorder and much less likely to seek treatment and if they do they are much less likely to be successful in their recovery efforts. As Dias (2003) illustrates,

‘the success rate of treatment programs for anorexia is very low- not solely the result of the failure of specific treatment techniques, but largely because once anorexia reaches a critical and chronic stage it is much harder to recover (p.39).

Even for those who meet full criteria for diagnosis, the vast majority of outpatient treatment and residential programs¹⁹ remain inaccessible because they are rarely offered by the public health care system, and private insurance companies in North America seldom reimburse these services. Where services are offered in the public realm they are often so limited that waiting lists are excessive in length. Therefore, treatment in the private sector remains the only alternative for many of these women which in reality is rarely a viable option because of the cost. This amounts to \$30,000 USD per month²⁰, for a residential program, in the United States (Martin, 2006, ¶10) and this figure is only slightly less in Canada. In this context, where professional treatment is largely inaccessible to even those who are seriously ill, it is understandable why these women

¹⁹In Canada the public health care system does pay for those who require acute hospitalization. Outpatient treatment and residential programs are sometimes offered, but usually they are reserved for acute cases and have extensive waiting lists which sometimes can exceed 18 months.

²⁰ The recommended length of stay required for the treatment of anorexia is two to three months.

begin to seek out other forms of support such as that which is available on the internet.

In a context where women are ‘avoiding seeking treatment for fear of rejection’ (Dias, 2003, p.39) and where, even those who fulfill the strict criteria for a diagnosis have very limited treatment options, it becomes understandable why the pro-anorexia community has become extremely popular. This online group provides support which is open to all, is accessible 24/7 and most important, often unavailable elsewhere. There are also a large number of women who are not yet ready to seek treatment for their problem which is in fact characteristic of those in the initial phases of anorexia. These can be referred to as the precontemplation and contemplation stages of change according to the SCM²¹ model.

As Dias (2003) explains, ‘in the early stages of anorexia, before a person is ready to accept help, treatment is usually not very successful. Although not explicit Dias (2003) could be seen as referring to the precontemplation and contemplation stages of the SCM. The former is distinguished by denial of the seriousness of the problem, if it is accepted that there is a problem at all, disinterest in recovery, or simply unwillingness to begin the

²¹ The stages of change model (SCM) is widely considered to be an indispensable tool among those who treat behavioral problems and disorders (Zimmerman, Olsen & Bosworth, 2000, ¶5). Not surprisingly, this approach is frequently employed in the treatment of anorexia. There are considered to be 5 stages of change each of which require ‘specific action’ on the part of the physician if they are to ‘enhance’ the process for the individual (Zimmerman, Olsen & Bosworth, ¶4). The ‘precontemplation stage’ is characterized by the ‘patient’ being ‘uninterested, unaware or unwilling to make a change’; often the person is in denial of their anorexia at this time. The ‘contemplation stage’ is when the individual is ambiguous towards the prospect of changing their behavior. At this time the ‘patient’ is weighing up the pros and the cons of changing and often communicates their fear of losing the benefits the behavior has provided them with. The ‘preparation stage’ is predictably the stage where the individual is ‘preparing to make a specific change’, but also a time when they may engage in ‘small changes’ as an ‘experiment’. The ‘action stage’ is where concrete changes in behavior are made. It is assumed that individuals who make abrupt changes, such as a ‘New Years Resolution’, often fail in these attempts because the previous stages have been skipped over. This shows that ‘action’ alone is insufficient to make ‘lifestyle changes’ and the thought processes which distinguish the previous stages are necessary foundations for long term change. The ‘maintenance and relapse prevention stage’ is where the ‘patient’ has to overcome the ‘discouragement’ caused by “occasional ‘slips’” and maintain their behavior in spite of these. It is acknowledged that ‘patients’ more often than not ‘recycl[e] through the stages of change before the change becomes truly established’ (Zimmerman, Olsen & Bosworth, ¶5-10).

process. Contemplation is riddled with ambiguity while the individual grapples with the benefits of entering recovery and the disadvantages, or fear, of recovery. As Dias (2003) argues, the pro-anorexia community provides the individual with support when they are not yet ready to seek 'face-to-face support' (p.39). I also found this to be the case in my research that many in the community are indeed in the initial two stages. One woman explains the role of the community as she comments, it is for '[those] who are stuck in the eating disorder mentality and aren't sure if they should quit or continue with the obsession' (Thin Files, 2006) Not only does pro-anorexia provide support that is unavailable elsewhere for those in the early stages of change but the dialogue they engage in on these sites, for example weighing the benefits and drawbacks of living with their anorexia, is that which is required to enable them to move onto the next stage. Dias (2003) provides an excellent example of this when she refers to the 'letters to ana' and the 'letters from ana' which are mainstays on these web sites (see the example I provided on p.45). These 'letters' are examples of pro-anorexics weighing the pros and cons of their behavior through writing to their anorexia (or ana) and describing what 'she' offers them but also what she takes away. Dias (2003) provides another example of one such letter she found in the course of her research,

Dear Ana, I feel trapped by you.... Where is the love you promised?... Why is it the more I control what I eat and weight, the more out of control I feel?... You are my only friend, my biggest enemy. I worship you, and you destroy me... (S.C.a.R.E.D. Forum User, 2001-2002, emphasis in original, in Dias, p.40).

Clearly, the ambiguity about her anorexia, which this woman conveys in her description of 'ana' as her 'only friend' but also her 'biggest enemy', is that which needs to be expressed and worked through if the individual is going to surpass the contemplation

stage and move forward into the action stage. As Dias (2003) notes, this exact letter writing exercise is one frequently used in ‘Narrative Therapy’ as a method to encourage the “externalization of the ‘eating disorder voice’” (Epston et al in Dias, p.39) which enables them to ‘gain some psychological distance and recognize that the eating disorder does not define them (Dias, p.39). In clinical terms this is referred to as reducing the ego-syntonic nature of the problem, which means the behavior is acceptable and consistent with the self and its goals of weight loss, and increasing the ego-dystonic perceptions which would see the eating disorder as an alien and unwelcome problem which is separate to the self. What the presence of these letter writing exercises, and others, on pro-anorexia sites suggest is that the community’s provision of a safe and nonjudgmental environment which facilitates open expression and encourages dialogue about the problem, is one that assists the individual in their process of change and possibly recovery. Identifying the community as one which encourages these women to reflect on their experience in ways which are commonly used in therapy as a means to promote recovery, challenges the notion of pro-anorexia as that which provides ‘improper’ forms of support or encourages young women to worsen their health. Pro-anorexia, therefore, appears to meet the support needs of a large number of women who are either unable to access professional treatment or not yet ready to take such a step. However, this assumption does require that we ask, why are these women not using the pro-recovery community? The latter of which has been suggested to also offer a supportive environment for those who are unable or unwilling to seek the services of a professional.

The original objective of this section was to answer the question: why is pro-anorexia a popular alternative to professional forms of support *and* to the pro-recovery

community? Having attempted to answer the first part of this question, the pro-recovery community still remains to be considered. In an effort not to be repetitive, I refer to the discussion of pro-recovery sites on p.50 where the restriction placed on the freedom of expression and the amount of rules and regulations regarding 'acceptable' narrative were discussed. Now, I want to fuel this discussion by providing evidence explaining how the restrictive nature of pro-recovery sites, such as the Something Fishy web site, render them useless as forms of support for many with anorexia, which in turn makes pro-anorexia the only suitable alternative.

One visitor to a pro-ana site explains her choice to leave the pro-recovery community and seek a pro-anorexia alternative,

I must refer to 2 bulletin boards. Something Fishy and House of Sins. Being a member of the Fishy Board didn't help me recover from my eating disorder, I couldn't express myself freely, I was always afraid my post would be closed...[...] it doesn't help those who are stuck in the eating disorder mentality and aren't sure if they should quit or continue with the obsession. If you would ever say you wanted to continue with your eating disorder, you were ignored, had a closed post, or received a million responses of people that were "shocked" about your decision. If you aren't in recovery you don't belong here. [...]..I think The Fishy Board helps those who have already made the decision to get better and never look back. For those people... the board is helpful. I started to look for a Board where I could express myself without being afraid of what I said [...] [It] [...] is a place where we can talk freely, all of us (at least a huge percentage) want to get better, do not want to have an ed, are sick of this way of living, but don't see therapy, recovery sites, etc as a helpful place." (Thin Files, 2006).

This woman clearly articulates that, much like the option to begin treatment, the pro-recovery community represents a 'support' option which is out of reach for many with anorexia. It appears that not being sick enough to warrant treatment, and not being well enough for the pro-recovery community leaves these individuals with one alternative for

support; the pro-anorexia sites where they do not fear rejection and can express themselves openly. Interestingly, this individual also illustrates how for those in the pre-contemplation and contemplation stages, pro-recovery was not a good 'fit' for their present readiness to change, a 'fit' which is heralded as a crucial factor by physicians who emphasize that the professional must meet the 'patient' where they are at if any progress is to be made.

Thus, rather than being a form of demon-worship, a dangerous cult, or even representing a lifestyle choice, the pro-anorexia community is actually a place of sanctuary for many of those with anorexia. It is a safe-haven which offers support to the individual who finds themselves in a variety of situations, such as, not being ready to recover (a DSM-IV symptom of anorexia itself), being refused professional treatment, or finding they are unable to access such services.

This extended discussion of pro-anorexia as 'sanctuary' (Dias, p.31) was provided for two reasons. First, Dias's (2003) conception of pro-anorexia as 'sanctuary' (p.31) and Hepworth & Mulveen's (2006) appreciation that pro-anorexia has a strong social support theme highlights the conditions of possibility for the researcher who approaches the community from a non-judgmental standpoint. By transcending the arguments which position the community as a dangerous and censorship worthy entity, they illustrate how it is possible to learn a great deal about the meaning and the function that this community holds for the pro-anorexic herself. This perspective also acts to challenge previous notions of pro-anorexia which position the community as that which is solely engaged in promoting illness, because it shows how it is also encourages recovery and provides support. Furthermore, I argue that these contradictions in meaning

become accessible to the researcher due to the online nature of the pro-anorexia community which provides an opportunity to meet ‘subjects where they are in a dialogic process of inquiry’ (Acker et al.,1991 in Pollack, 2003, p.249 referring to Probyn, 1987). Secondly, Dias (2003) draws attention to the role of psy discourse, of which the DSM-IV plays a central role, in constituting the experience of anorexia. I used the latter as a point of departure in this thesis, which aims to investigate more fully the ongoing struggle that exists between the anorexic individual and the hegemonic discourse of psy, This process of negotiation is conceptualized as forming a complex relationship in which subjectivity is continuously shifting, and one which also provokes a need for alternative forms of support which are often unavailable elsewhere.

3.4.7 The Pro-Anorexia Community: A Complicated Picture

The notion of pro-anorexia as toxic, as an ethical dilemma, as rebellion, and as embodiment, all have one crucial assumption in common; they each attempt to remedy the tension that surfaces from conceptualizing the pro-anorexic as exercising agency/resistance when her act is simultaneously viewed as (over)-conforming to dominant discourses. This friction is dissipated by constructing her as either an active agent resisting normative ideals or as a victim of social determinism by way of her conforming to cultural prescriptions of beauty and thinness.

I argue that there are two interrelated theoretical limitations to working within such a dualist framework. Firstly, as a result of my working from a poststructuralist perspective, I argue that efforts invested in trying to position the pro-anorexic as either conforming or resisting presupposes that subjectivity is always one-dimensional and

stable. In a postmodern context where identities are created in ‘ambiguity and incoherencies,’ the pro-anorexic identity cannot not be truly understood if it is ‘suppressed and redescribed’ (Cover, 2004, ¶28) as either rooted in acts of conformity or resistance. Especially within the context of an internet discussion forum, the pro-anorexic ‘identity’ is constantly being constructed, deconstructed, and reconstituted. What it means to be ‘pro-anorexic’ is constantly shifting as a result of processes of negotiation which occur through online interaction. It is this process and resulting dialogue which offers a wealth of information for the researcher looking to more fully understand this community and the women who participate within it.

Second, approaches which attempt to suppress this inconsistency, through positioning the pro-anorexic as either a woman who is conforming *or* resisting, in doing so remain focused on how pro-anorexia *should* be interpreted rather than how the pro-anorexic herself conceptualizes her practice. In other words, interpretations are made based on society’s norms (or the researchers frame of reference) of what constitutes unhealthy/healthy behavior, or what behaviors should be defined as acts of conformity or resistance. This thesis attempts to meet the subjects where they are in dialogue in order to learn how *they* define pro-anorexia and perceive *their* own behavior. It is the multiplicity of sometimes conflicting subjectivities, which arise through these women negotiating with dominant discourses that offer the richest information.

CHAPTER 4: A POSTSTRUCTURALIST APPROACH TO A MODERNIST PSYCHOLOGY

The assumption that the pro-anorexia community is actively engaged in negotiating with hegemonic discourses and in effect is producing alternative accounts of their experience is one that presupposes a certain approach to research; that put forward by poststructuralist theory. In the section that follows, first I describe the modernist underpinnings of psychology, and the DSM-IV, which have created tensions that a poststructural approach seeks to remedy. Second, I explain how poststructuralist theory achieves this by challenging scientific discourse's claim to 'objectively describe and explain [the] reality' (Malson, 1999, p.38) of mental illness. Finally, I delineate my conception of the DSM-IV which relies heavily on Foucault's (1977; 1983) notion of power and Rose's (1996) critique of the psy disciplines.

4.1 The Modern Handbook: DSM-IV

The current media, academic and popular preoccupation with anorexia, which shows no signs of losing momentum, has been coupled with an increase in popular knowledge of the DSM-IV. This is the Diagnostic and Statistical Manual that contains, among other information, the criteria that must be met in order for an official diagnosis of mental illness, including anorexia, to be made. As Strong (1995) argues, 'from a modernist perspective, in which empirical science is capable of providing objective truths, the DSM approach to understanding and treating the emotional and mental difficulties of human beings makes compelling sense' (p. 2, c.f. Schwartz & Wiggins, 1986). This rationale is understandable given the accomplishments of medicine in

discovering cures for many diseases and altogether eliminating others, such as smallpox for example. It may be fair to argue that a cure for cancer or AIDS, if discovered, will be the outcome of a modernist approach to disease. As Strong (1995) explains, due to the fact that the first studies of mental illness gained their authority as derivatives of 'medicine', it became reasonable to accept that this "science of medicine" would extend to the treatment of 'mental disorders' also (p.2). As a result of this conclusion, the DSM was cultivated in much the same way as 'other biological classification systems' (p.2). However, as Strong (1995) points out, 'biomedical classifications of pathology' are buttressed by etiological certainty whereas,

Psychiatric explanations of the etiologies of 'mental disorders' have been a source of conflict since the earliest days of psychiatry (Grob, 1985; Klerman, Vaillant, Spitzer & Michels, 1984) and the American Psychiatric Association (1987) has adopted a descriptive and apparently non-etiological based approach to the classification of 'mental disorders' in the DSM-IV (American Psychiatric Association, 1994). (p.2-3).

This is indeed evident in the DSM-IV where the majority of mental disorders are marked as being of 'unknown aetiology' (Crowe, 2000, p.72). However, although the DSM-IV declares that 'No laboratory findings have been identified that are diagnostic of Schizophrenia's' or 'a Major Depressive Episode', to name but a few, (1994, p.280 & 323 in Crowe, p.72) its structure as a manual is premised on the belief that mental illness is of biological origin and that these etiological pathways 'will eventually be scientifically discovered' (Strong, 1995, p.3). This postulate views mental illness as that which manifests from within the individual as a result of some faulty internal dynamic (Crowe, 2000, p.71). This view of the individual as 'dysfunctional' holds considerable weight because psychology is assumed to hold the same degree of legitimacy as that of

its empirical brother, medicine. Because this network of assumptions-infiltrate the 'professional culture' (Crowe, p.72), and as a result also the general public, both psy and its individualizing approach, are bestowed with an unprecedented power of influence in both the discursive and the concrete realm. Psy's influence is buttressed by the belief that it offers us absolute truths about human existence and the *nature* of 'mental illness'. However, this very assumption is undermined by a post-structural approach which, among other things, argues that there exists no ultimate truth to be uncovered, and rather, a multiplicity of co-existing realities which are each discursively constructed.

4.2 A Brief Overview of the Poststructural Approach

Poststructuralist theory is characterized by its complete rejection of essentialist concepts that view language as a transparent lens which reflects reality. Instead, 'it is [seen as] constructive of reality' (Parker, 1990 in Malson, 1999, p.38). Furthermore, it refutes foundationalist claims that assume the existence of basic truths while rejecting the notion that there is an underlying reality to be discovered. While its origins lie in structural linguistics, poststructural theory is less concerned with language as a unit itself and more interested in discourses which are context specific and 'regarded as patterns of ways of representing [...] phenomena in language' (Crowe, 2000, p.70 referring to Lupton, 1998, p.4). Predictably, poststructuralist theory problematizes scientific discourse's claim to 'objectively describe and explain a reality existing anterior to and independently of discourse' (Malson, 1999, p.38) and rather, rearticulates the objective fact as an illusion. This is because 'facts' (Lawson, 1985 in Malson, p.38) are seen as being context dependent and multiple and it is assumed that there exists no prediscursive reality to be

uncovered. As Bhaskar (1978) points out, this is not to claim that objects do not exist and act independently of our descriptions, but [rather that] we can only know them under particular descriptions' (p.250 in Malson, p.38). Through dismissing the presence of ultimate *Truth*, poststructuralism creates a space for a multiplicity of *truths* to be recognized. As a result of this presupposition, it becomes possible to comprehend the pro-anorexic as offering an alternate truth of anorexia and their experience in general, rather than a false notion of anorexia due to the fact that it may contradict dominant psycho-medical ways of knowing the 'disorder'. However, the process of negotiation that the pro-anorexic must go through in order to realize this alternative truth is one which is 'contingent on the availability of circulated discourses' (Hardin, 2001, p.13). In the case of anorexia and pro-anorexia the 'pool' of available discourses predominantly emanate from the disciplines of psy. As Hardin (2001) explains, "from a poststructuralist orientation, a discourse is always spoken about in relation to a discursive object, such as 'mental health' or 'anorexia nervosa'", for example (p.12). Therefore, I argue, the reason why psy knowledge has infiltrated so many discourses of anorexia, is because it has successfully claimed this object as falling under its own field of expertise.

4.3 Reconfiguring the DSM-IV

In line with a poststructuralist approach to psy discourse, I argue that the DSM-IV, contrary to the presupposition that it represents an impartial device of clinical utility that exists in a professional vacuum, is an amalgam of 'normalizing truths' (Hardin, 2001, p.17) which affect how individuals interact with one another and understand themselves. Within the realm of the eating disordered, I argue that no other official discourse,

through its discursive constructions, embodies as much capacity to influence the anorexic individual's relation to herself, and to others. In support of this claim, Rose (1996) argues "the vocabularies, explanations, techniques of psy" warrant concern due to the degree they produce "a certain way of understanding and relating to ourselves and others" (p.2). More poignantly, he argues that 'psychology' "has played a rather fundamental part in 'making up' the kinds of persons that we take ourselves to be" as a result of its professionals having successfully 'implant[ed] their professional knowledge' 'within [their] clients' (Rose, 1996, p.33). By viewing the DSM-IV as an amalgam of "knowledge and power" I suggest that it closely resembles a "disciplinary technology" (Foucault, 1977, p.197). Through understanding that women are extremely 'familiar with the clinical knowledge about AN' (Surgenor, Plumridge & Horn 2002, p.29) it becomes fair to argue that their 'interiorization' of, and subsequent acting on this 'knowledge' elucidates, what Foucault argued as being the 'specificity of power relations' (1983, p.220). This is because there exists no explicit 'coercion' but rather a discourse that shapes the 'conduct' of women who suffer from eating disorders (p.220). This is not to argue for a social or linguistic determinism, but rather to suggest that the DSM-IV frames the conditions of possibility in which these women articulate their experience. In conceptualizing discourse as a framework, I acknowledge that there is the potential for these women to discursively move within it. A presupposition which is connected to Foucault's (1983) articulation of the relationship between power and freedom.

For Foucault (1983), power and freedom are neither exclusive entities nor contradictory forces, but rather they are inextricably linked because 'freedom must exist for power to be exerted'(p.221). As Foucault explains, 'it would not be possible for

power relations to exist without points of insubordination which, by definition, are means of escape'. It is this 'strategy of struggle' (p. 225) that provides a space for dominant discourses to be reproduced, restructured, or challenged (Fairclough 1992, p.95). It is this room for negotiation, '*in potentia*', which Foucault realizes that enables us to perceive the individual as capable of 'travers[ing] the field in new and creative ways (Hartman, 2003, p.10). It is this assumption which connects Foucault with Fairclough's (1995) position which views 'discourse [as] socially constitutive as well as socially shaped' (Fairclough & Wodak, 1997, p. 258). The productive nature of the hegemonic discourse of psy is viewed as itself provoking the participants, in the (pro)-anorexia community, to engage in a debate with it while also producing their own alternative discourses. As Foucault argued, "discourse can be both an instrument and an effect of power, but also [...] point of resistance and a *starting point for an opposing strategy*" (Foucault, cited in Bristow, 1997, p. 178, my emphasis).

Moreover, it is the post-structural conception of 'discourse' which itself grants the researcher with access to such a debate. As Hardin (2001) argues,

[it] provides the flexibility to move beyond the individual level of analysis of accounts and instead, focus on cultural, social, historical and political practices that make those accounts possible. It then becomes possible to decenter master discourses through the accounts of individuals; yet concomitantly conceptualize those accounts through cultural and historical discourses (p.17).

In this way, I am armed with the dexterity to investigate the master discourse, the individual's narrative, and the ways in which these constitute each other. More specifically, I am able to explore how the discipline of psy 'produces people in particular ways' (Hardin, p.17) while simultaneously carving an analytical space

in which I can grant importance to the individual's own understanding of their experience and explore how they in turn rearticulate and create new discourses.

CHAPTER 5: METHODOLOGY

In this Chapter I describe the methodological considerations which form the basis of my approach. To this end, I explain my method of investigating how women with anorexia negotiate with psychological discourse in order understand their experience of their 'illness' while also reproducing, rearticulating, and challenging this discourse as they produce their own accounts of their experience. For this purpose, I begin with a brief summary of previous literature on the community in order to explain how my approach departs from it in a way which adds to the current knowledge of pro-anorexia.

5.1 Rationale for the Study

5.1.1 *The Pro-Anorexia Internet Community: A Brief Recapitulation*

The pro-anorexia internet community is one of the only 'public places' where, I argue, a transgressive discourse around the disorder is being constructed. Although, women with eating disorders come to together in other public places, as a result of therapy groups for example, these are normally 'facilitated' by a therapist and this professional presence limits alternative viewpoints which are considered to detract from the goal of recovery. Therefore, these sites are key to a critical understanding of anorexia because they provide a free and democratic space where individuals can participate in debates, discuss the disease and the hegemonic discourses which constitute it. The nature of this transgressive discourse is produced by the individuals on these sites who are redefining anorexia, not as an illness to be cured, but mainly as a lifestyle to be pursued. In line with this conception of the illness, participants on these forums, message boards, and websites have constructed their own terminology. Anorexia is referred to as 'Ana',

and bulimia as 'Mia', which both signify the community's act of reifying the disorder. Pro-anorexia sites provide information on how to lose weight rapidly, how to deceive treatment professionals, and provide motivation in the form of 'thinspiration' (pictures of glamorized models). They also frequently provide an anorexic set of commandments, such as, 'thou shall not eat without punishing oneself afterwards' (Starving for Perfection, 2002). On the other hand, pro-recovery sites solely provide information and support for those who are in recovery from anorexia. They emphasize the dangers of engaging in self-destructive behaviors, offer tools on how to reduce problematic behaviors related to food and exercise, and generally offer support for those struggling with the problem itself or with the difficult task of relinquishing their behavior as a way of coping in everyday life.

As mention earlier, the media has demonized pro-anorexia sites describing them as 'gruesome', 'pathetic' and 'sinister' (Pollack, 2003, p.249) while also describing them as the "antithesis" of self-help websites for recovering anorexics" (Taylor, 2002, p.1). The academic community has only recently started to research the pro-anorexia 'movement' and there exists only a handful of studies currently available. Chesney et al (2003) completed a quantitative study of pro-ana websites which offered statistics on the content of a large number of sites. Treseder (2003), in her work on the pro-anorexia community, argues that 'pro-anorexics' fit into one of a variety of sub-types. These include: 'defenders' (p.13); 'victims' (p.14); 'lifestyle advocates' (p.15); 'sufferers' (p.17); "recent converts" (p.19); "Wannabees" (p.20); "Cheerleaders" (p.21). Both of these studies, I argue, neglect the complexity of anorexic practice as they make an effort to compartmentalize the group, and their community, into a number of 'digestible'

categories with which to make generalizations. In addition, Chesney et al (2003) and Treseder (2003) have divorced the experiences of the anorexic from the very social and cultural backdrop from within which they manifest.

However, other studies debate the contextual features of the disorder that relate to the historical specificity of our contemporary condition. Ferreday (2003), argues that the members of the pro-anorexia community, in an effort to enable ‘communication between people with eating disorders’, inadvertently attempt to counter the ‘medical model of anorexia, whose emphasis on recovery tends to isolate individual sufferers’ (p.284). Pollack argues that these sites can be viewed as an “explicit rejection of the psychiatric institution’s medicalization of the disorder” and suggests that the movement can be theorized as a political backlash (p.249), or as an act of over conformity to media ideals of thinness (Bordo, 1993 in Pollack, p.248). I argue that the complexity of anorexic practice is also neglected when it is discursively positioned within a framework, buttressed solely by narratives of resistance and over conformity, that focuses on the cultural ideal of the slim body. I do not wish to deny the contribution of such an approach but rather argue that, reducing the disorder to a “grisly metaphor” of the postmodern era (Probyn, 1987, p. 211) is theoretically insufficient in its failure to acknowledge the multiplicity of discourses that constitute the anorexic’s subjectivity.

From quantitative studies, that provide percentage breakdowns on what to find on pro-anorexia sites, to qualitative research that debates the pro-anorexia community as comprising of individuals who are either resisting or over-conforming to dominant discourses, no study to date has addressed the myriad of ways in which this group is *negotiating* master discourses. It became clear early on in my research that the epicenter

of this hegemonic struggle was situated around the topic of diagnosis. More specifically, it is often related to the criteria for eating disorders outlined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) either explicitly or implicitly. It is important to note that no research to date has been conducted on the role of the hegemonic discourse of the 'psy' disciplines in relation to either pro-anorexic or pro-recovery internet communities. My research aims to contribute to filling this gap in the literature by addressing the role of this hegemonic discourse in the multiplicity of experiences that exist within a pro-anorexia community.

2. Purpose of this study

The objective of this study is to explore the ways in which individuals with anorexia negotiate with this hegemonic discourse of psy in order to understand their experience of their 'illness'. More concretely, using a critical discourse analytic approach to understand narratives of participants on a (pro)-anorexia forum, the aim of this project is to examine how psy discourse is called upon by individuals to constitute anorexia as a discrete subject position (problems of definition) and how they negotiate their position in relation to it (problems of positioning). Furthermore, in response to previous literature on the community itself, I wish to use these findings to challenge current discourses on pro-anorexia and articulate what I perceive to be its defining characteristics.

I approach this analysis with three broad theoretical assumptions, documented in detail in Chapter 4, which relate to my working from a poststructuralist approach. Each of these assumptions have been developed in detail in the theory component of my thesis. These presuppositions are as follows: first, that participant's narratives are not

independent, but rather, are informed by the social and cultural context from within which they emerge. Second, institutional discourses are not merely reflective of reality but constitute one version of 'reality' in a context where meanings are never fixed but are rather, constantly shifting. Lastly, that the individual is 'both shaped by discourse and at the same time constitutes discourse' (Titscher, 2000, p.146). In other words, the individual works within a framework of existing discourses but is also able to create their own constructions of their experience which as a result may influence dominant explanations. Critical discourse analysis uses texts as a resource with which to examine how individuals are "influenced by (and equally influence) the social, cultural, historical and political discourses that created such texts, and not as reflections that mirror a 'lived experience' or reality" (Hardin, 2003, p. 537). It is CDA's congruence with poststructuralism which initially led me to consider this as perspective from which to work from.

5.3 What is Critical Discourse Analysis?

As Van Dijk (2001) argues, CDA 'is not a method, nor a theory' that can simply be plugged into a social problem. It is a "critical perspective on doing scholarship: it is, so to speak discourse analysis 'with an attitude'" (p.96). CDA understands language use 'as a form of social practice' (Fairclough & Wodak, 1997, p. 55). More specifically, it concerns itself with the function of discourse in producing and re-producing 'power-relations' in society (Wodak, 1996, 17-20). What distinguishes CDA is its political investment and emancipatory agenda. In other words, its goal is to have an effect on the 'social practice and social relationships' which it studies. (Titscher, 2001, p.147). Almost

always, it does this with the welfare of ‘dominated groups’ as its motive and seeks to work in a way that is ‘consistent with their best interests’ (Van Dijk, 2001, p.96). This would suggest that CDA is particularly biased research and indeed it is. Moreover, CDA does not discard this claim but rather embraces it. As Van Dijk states, ‘CDA is biased – and proud of it’ (p.96). In a research community still largely dominated by positivist philosophy that seeks to remain objective to the end, CDA might appear to be ‘less than’ research. Van Dijk (2001) confirms this very point as he explains that ‘no scholarship is attached as ferociously because of its alleged lacking or deficient methodology as critical scholarship’ (p.96). These ‘accusations’ can be recognized in part as a result of ‘complex mechanisms of domination’ that aim to ‘marginalize and problematize dissent’ (p.96). However, even though this may go far in explaining the reasons why critical research is often negated and pushed aside, it also provides CDA researchers with a very specific goal; ‘critical research must not only be good, but better scholarship in order to be accepted’ (Van Dijk, 2001, p.96).

Understanding CDA as a perspective rather than an explicit method or theory does not mean that it does not offer various practical guidelines, principles and analytical procedures which when employed must be made explicit and followed systematically. However, what it does mean is that the researcher is encouraged to employ the facets of an approach, or various approaches within CDA, which facilitate the research process. This has enabled me to attend to the specificities of my research problem and avoid comprising its complexity. Concretely, this has allowed me to employ certain steps of the many suggested by one scholar of CDA, Norman Fairclough, while not being forced to incorporate others he provides which do not fit with my research aims. In order to be

rigorous in my approach, what will follow is an illustration of Fairclough's approach in general, coupled with an explanation of the aspects which I employ in this particular study.

5.3.1 Fairclough's approach to CDA

In broad terms, the 'theoretical framework' of CDA is based upon 'Althusser's theory of ideology, Mikhail Bakhtin's genre theory, and the philosophical traditions of Antonio Gramsci and the Frankfurt School'. This is not to forget, Michel Foucault, who has also inspired much of Fairclough's approach to CDA (Titscher et al, 2000, p.144). Fairclough's method represents one of two main approaches to CDA. Wodak (1990) and Van Dijk (1984) are heavily 'influenced by cognitive models of text planning', whereas Fairclough borrows from Halliday's (1978) 'systemic functional linguistics' (Titscher et al, 2000, p.144).

Fairclough's method of critical discourse analysis, which is largely derived from his 'social theory of discourse,' relies extensively on the ideas of Michel Foucault (1972, 1979, 1981) (Murray, 1995, ¶18). Fairclough argues that CDA is 'concerned with the investigation of the tension between the two assumptions about language use: that language is both socially constitutive and socially determined' (Titscher et al, 2000, p.148). This conceptual relationship is deeply embedded in the theoretical foundations of Halliday's (1978, 1985) functional-systemic linguistics. Halliday's theory assumes that all texts have three functions:

every text has an 'ideational' function through its representation of experience and representation of the world. In addition texts produce social interactions between participants in discourse and therefore also display an 'interpersonal' function. Finally, texts also have a textual

function in so far as they unite separate components into a whole and combine this with situation contexts (Titscher et al, 2000, p.148).

As Titscher et al (2000) illustrates, 'Fairclough operationalizes [Halliday's] theoretical assumption that texts and discourses are socially constitutive' (p.149) by stating that discourse 'is always simultaneously constitutive of (i) social identities, (ii) social relations and (iii) systems of knowledge and beliefs' (Fairclough 1993:134, cited in Titscher et al, 2000, p.149). The ideational capacity is what constructs systems of knowledge and the interpersonal component is what produces relationships of interaction between 'social subjects' (Fairclough, 1995). In concrete terms of the pro-anorexia community, I perceive the hegemonic discourse, of which the DSM-IV plays a huge role, as having an 'ideational function' through its representation of *the* anorexic experience. It constructs the category of anorexia as it is known today²², although it actually constitutes *just* one way of knowing anorexia, albeit the dominant one. This 'ideational function' becomes evident in the narrative of anorexics when they refer to this diagnostic criteria to negotiate with 'anorexia' as a discrete subject position. In turn, the (re)articulated discourses of these individuals also have an ideational function through the many ways in which they (re)constitute what it is to have 'anorexia'. At the same time, the disciplines of psy have an interpersonal function as they determine the ways in which these individuals interact and relate to each other. However, the discourses of the individuals themselves also follow the same pattern, because in the process of their (re)articulating dominant discourses they not only (re)conceptualize what it *is* to have 'anorexia' but as a

²² The *DSM-IV* diagnostic criteria for anorexia nervosa are: 1) a refusal to maintain normal body weight (at least 85% of expected), 2) an intense fear of gaining weight or becoming fat, 3) a disturbed perception of one's body weight or shape, and 4) in postmenarchal women, amenorrhea for at least three consecutive cycles (APA, 1994).

result, their relation to each other and how they interact. This illustrates how dominant hegemonic discourses and the discourses of individuals are entangled in a complex manner, while also remaining inextricably linked. This problematizes the notion that there exists a simple causal relationship between the two, and suggests instead a constant dialectical process which results from processes of negotiation inherent in such a hegemonic struggle. It is this relationship between dominant discourses and individual narratives which Fairclough's step based model aims to investigate. His method can be broadly separated into three steps: Discourse Practice, Text, and Social Practice. He is careful to point out that these are not meant to be mutually exclusive.

5.3.2 Discourse Practice, Text, and Social Practice

Discourse Practice: In examining the 'discourse practice', Fairclough (1992) lists a number of elements that may be focused upon. These include: 'interdiscursivity', 'intertextual chains', 'coherence', 'the conditions of discourse practice' and 'manifest intertextuality' (p. 232- 238). 'Interdiscursivity' considers 'what discourse types are drawn upon in the discourse sample under analysis'. A 'discourse type' could be psychological discourse or 'scientific medical discourse' (p.124, p. 232). 'Intertextual chains' refer to regularly and systematically linked sequences of discursive practices, for example: 'the chain which links medical consultations with medical records' (p. 130). 'Coherence' asks how the texts are actually interpreted. For example, looking at what 'establishes the coherent link between the two sentences' (84): She is severely underweight. She is anorexic is the assumption that women with anorexia must be severely underweight. As Fairclough points out, this is where the "ideological 'work'" of

discourses is apparent. Finally, ‘the conditions of discourse practice require that we address how the text is produced, distributed and consumed, while ‘manifest intertextuality’ refers to identifying ‘what other texts are drawn upon in the constitution of the text being analyzed (p.233).

Text: The second stage involves a closer investigation of the text at hand which Fairclough (1992) refers to as falling under the category of ‘interactional control features’. These include a host of issues which the researcher can focus upon, such as: the use of metaphor, ‘topic control’ (p. 154), ‘modality’(p. 158), and ‘politeness strategies’(p. 235), among others. More specifically, rather than being matters of style, metaphors provide a window into how an individual perceives their reality at the same time illustrating what master discourses they are drawing upon to articulate their experience. Attending to how the topic is controlled within a conversation, or in this case a message thread, enables the researcher to learn a significant amount about what the general concerns of the group are through viewing how they ‘chain topics together’ (p. 155). Whereas, the analysis of ‘modality’ within a sample enables the researcher to ascertain what Hodge & Kress (1998,123) refer to as the individual’s “‘degree of ‘affinity’ with the proposition” (Fairclough, p.158). For example, the statements ‘I sort of have an eating disorder’ and ‘I definitely have an eating disorder’ demonstrate two different measures of affinity. The first, in opposition to the second statement that shows the individual as having a ‘high degree of affinity with the[ir] proposition, indicates that the individual has a low ‘degree of affinity’ with their claim. The latter may be viewed as expressing her lack of power in making such a decision in a culture of expertise where the doctor holds

such authority. On a broader level it could indicate the scientific discourse that privileges objectivity (doctor) over subjectivity (individual in question) as the independent observer is given precedence over the individual's own account of their experience. Lastly, the 'politeness strategies' employed by individuals in a group can illustrate points at which, in Goffmanian terms, people are trying to save 'face' or avoid losing it. These tactics can reveal a great deal in terms of social relations between members in a group, and how these social relations alter topically according to the type of debate.

Social Practice: The goal of this stage of analysis is to identify 'the nature of the social practice of which the discourse practice is a part.' The aim is to specify 'why the discourse practice is as it is' (p.237). In this vein, Fairclough denotes great importance to considering 'whether the discourse supports or challenges social practices' (Murray, 1995, Ch6, ¶57).

As Murray (1995) explains, Fairclough refers to Gramsci's concept of hegemony and Althusser's discussion of ideology as he tackles the third dimension of 'social practice'. Murray (1995) highlights that Fairclough's reliance on ideology may be viewed as incongruent with his overall approach, which is heavily influenced by Foucault. This assumption is based on Foucault's rejection of the concept of ideology. I argue that by looking closely at one of the three reasons why Foucault took this position, combined with the goals of Fairclough's approach to social practice, the two theorists appear to complement rather than contradict each other. Foucault found the concept of ideology problematic because, in denoting something which is false, it infers that it is connected to something which is true. The idea that a discourse can be either true or false was rejected

by Foucault who rather, was focused on how truth was *constructed* in discourse and the purposes which these constructions served (Foucault, 1991). Similarly, Fairclough also rejects the idea that any one truth exists and the goal of his approach to social practice is to illuminate the function of discursive practices which are ‘reproducing, restructuring or challenging existing orders of discourse’ (Fairclough (1992, p.95). On this level, I believe Fairclough’s approach to be congruent with that of Foucault. I also argue that Foucault’s notion of power as productive is key to Fairclough’s notion of social practice and particularly so in my own research. As Foucault argues, ‘power subjects bodies not to render them passive, but to render them active’ (Sheridan, 1980, p.217). I view the power of the psy discipline itself as rendering the participants in the pro-anorexia community active; it incites their efforts to negotiate with it and produce their own discourse on ‘anorexia’. However, as I use the Gramscian concept of hegemony at times I acknowledge the unequal power relations at play in a context where psy discourse is hegemonic and the discourses of individuals, such as those on the pro-anorexia sites, although less powerful, are involved in contesting the former’s claim to legitimacy.

5.3.3 Application to the (Pro)-Anorexia Community

It would be impossible to incorporate each and every aspect of Fairclough’s method. In fact, it would prove fruitless unless the aim of the research was to address the applicability of his method itself rather than using it to address a concrete social issue. For these reasons, I have selected various elements of each of Fairclough’s three stages that I believe are relevant given the nature of a) the pro-anorexia community itself and b)

my specific line of investigation (the relationship between psy discourses and anorexic subjectivity).

Firstly, in exploring the discourse practice on the (pro)-anorexia forum I will attend to the discourse types (interdiscursivity), instances of manifest intertextuality, while also examining coherence within the narratives. In line with the second element (text), which moves away from *what* is being said and addresses *how* it is being said, I will focus on politeness strategies as they emerge at ‘moments of crises’ (p.230). The latter are moments where disagreement, misunderstanding and conflict arise between participants in the forum. The purpose of this is to gain insight into the ‘social relations’ between individuals on the forum and moreover, to identify moments where dominant discourses are being debated either implicitly or explicitly. The issue of ‘modality’ (158) will be examined to measure an individual’s level of ‘affinity’ with particular statements, and to determine their positioning in relation to the comments of others, or master discourses (e.g. preferred, negotiated, or oppositional positions (Hall, 1993). Lastly, social practice will be examined by looking at power relations. More specifically, I will explore how the individual’s processes of negotiation (identified as problems of definition and problems of positioning) support, challenge, or restructure dominant discourses in either ‘conventional’ or ‘creative’ ways (p.237).

5.4 Sampling & Sample Size

Discourse analysis demands a great attention to detail and it is very time-consuming. For this reason, a sample size that is too large would most definitely make analysis ‘unmanageable rather than adding to analytic outcomes’ (Bondarouk & Ruël,

2004, p.8). Some qualitative researchers use the notion of ‘saturation’ as it is employed in grounded theory. This works on the logic that the researcher analyzes ‘additional protocols until [they] obtain no new categories, properties or relationships among them which often happens after the analysis of 5 to 10 protocols’ (Wood & Kroger, 2000, p.80). However, in discourse-analytic work, the researcher is concerned ‘not so much with exhausting categories as with identifying some of the ways that people use language and working through these in detail’ (Wood & Kroger, 2000, p.81). I do not claim that my findings are generalizable to the entire pro-anorexia community as that is not the aim of this study. This research is concerned with investigating the multiplicity of discourses that exist in one (pro)-anorexia discussion forum within the community. However, I will attempt to describe the process by which I collected my data in as transparent a manner as possible. As Potter & Weatherall (1994) have argued, the work of the discourse analyst cannot be summarized in a ‘set of manual-like rules or statistical procedures’ (cited in Lamerichs, 2003, p.47). Although this reflects the type of work discourse-analytic researchers do, I have made every attempt to be as systematic and methodical as possible in the process, which has demanded that I provide concrete justifications for the decisions I have made in this and other areas of the project.

5.5 Validity & Generalizability: A New Take on Old Terms

As Merriam (1993) argues, ‘Notions of validity and reliability must be addressed from the perspective of the paradigm out of which the study has been conducted’ (cited in Murray, 1995). Many positivist researchers take issue with qualitative research because they assess the latter using their own criteria (Denzin & Lincoln, 1994; Merriam 1993 in

Murray, 1995). As Janesick (1994) argues, imposing quantitative concepts onto qualitative research is ‘theoretically and methodologically flawed’ (Murray, 1995). From a poststructuralist perspective that rejects the possibility of “any single, ‘correct’ interpretation”, the concept of validity cannot hold the same meaning within qualitative work as it does with quantitative research (Murray, 1995, Ch5, ¶25). On this basis, the perspective with which this study is approached is that which is recommended by Janesick (1994), Mason (1996), and Miriam (1993), who collectively argue that the concept of validity in qualitative research is related to deciding if the research provides ‘a recognizable description or credible explanation of the phenomena’ (Murray, 1995, Ch5, ¶26). As Murray (1995) illustrates, it is the ‘reader of the work [who] must then assess the transferability of the findings’ (Ch5, ¶26). With regard to generalizability, again this is a concept that cannot be transposed onto qualitative research directly from its quantitative counterpart. The reason behind this being that a poststructuralist approach to research that seeks to attend to the multiplicity of experiences, views and subjectivities that exist, makes ‘reliability in the traditional sense of replicability pointless’ (Janesick, 1994, p.217 cited in Murray, Ch5, ¶26). As Murray (1995) contends, in reference to Creswell (1994), if the researcher lays out clearly their ‘assumptions, biases, and values’ and provides the necessary details on what data was used in the analysis and how it was collected, then the ‘possibilities for replication in similar contexts are enhanced’ (Ch5, ¶26). I have presented my program of research in rigorous detail for this very purpose.

5.6 Ethical Considerations

The internet, in its provision of discussion forums, web sites, newsgroups and chat rooms, offers the qualitative researcher virtually limitless possibilities to collect rich data. However, using the internet to conduct research also raises some critical ethical questions which relate to 'privacy,' 'confidentiality' and 'informed consent' (Eysenbach & Till, 2001, p.1103). The consideration of these issues is largely determined by whether the research site is regarded as a public or private space. The American Sociological Association's code of ethics states that distinguishing between the two is of the utmost importance due to the fact that informed consent must be sought 'when behavior of research participants occurs in a private context where an individual can reasonably expect that no observation or reporting is taking place' (cited in Eysenbach & Till, 2001, p.1104). To the contrary, the ASA states that researchers 'may conduct research in public places or use publicly available information about individuals (such as naturalistic observations in public places and analysis of public records or archival) without obtaining consent' (cited in Eysenbach & Till, 2000, p.1104). The Forum is understood to be a public space because the information found within it is available to anyone in the public that may wish to access it and therefore the messages contained within it are viewed as public archives. In addition, according to Eysenbach & Till (2000), "the number of users of a community determines how 'public' the space is perceived to be: a posting to a mailing list with 10 subscribers is different from a posting to a mailing list with 100 or 1000 subscribers" (p.1104). In the case of the Forum there are over 1103 members and this number speaks to the public nature of the information found within it. I assume the same position as Rafaeli (1995) who states,

We view public discourse on CMC [computer mediated communication] as just that: public. Analysis of such content, where individuals', institutions' and lists' identities are shielded, is not subject to 'Human Subject' restraints. Such study is more akin to the study of tombstone epitaphs, graffiti, or letters to the editor. Personal? - yes. Private? – no (cited in Paccagnella, 1997).

Although informed consent can be waived when the information is regarded as being public, it is still necessary to respect confidentiality as the researcher would with any other archive, such as medical records. For this purpose, the actual name of the forum being studied has been changed and it is referred to as the *Forum*. The majority of individuals within this forum already use pseudo-names. Nonetheless, they have been replaced with secondary or additional pseudo-names to protect the individual's anonymity on the internet. Because the text of the message archives is the focus of discourse-analytic research, rather than the participants themselves, I was able to passively observe the information and did not at any time interact with any member of the Forum either directly or via the internet. This also erases the possibility of damaging the community which can be a direct result of a researcher announcing their presence.

5.7 Strengths & Limitations of this Study: Using the Internet for CDA.

Chouliaraki and Fairclough (1999) state that 'CDA begins from some perception of a discourse-related problem in some part of social life' (p.60). Considering the centrality of the internet in contemporary social life it would be difficult to argue against the fact that every kind of social problem is bound to be present, in some form or another, in cyberspace (Mautner, 2005). The internet is not only an information resource to many, but is also a medium with which to communicate with others. The internet transcends

geographical boundaries and enables people to interact that would be unable to do so through traditional means. Because of this the internet has resulted in a multiplicity of voices currently located in cyberspace. It is this diversity that initially led me to consider internet discussion forums as a site of research to investigate anorexic subjectivity. The structure of the internet discussion forum is designed for the purpose of debate and it is this process of deliberation in naturally occurring and authentic talk that makes these online forums such a rich source of data for qualitative researchers. In addition, both the ubiquitous nature of the internet and its constant around the clock availability, provide a context where individuals can spontaneously communicate. This opportunity for spontaneity is the backbone that supports the authentic character of the data available on the internet. The reflexive nature of communication can often be compromised in face-to-face interaction, especially where sensitive, personal or taboo topics are being discussed. It is the anonymity which the internet provides that makes it a safe place for individuals to follow their natural inclination or impulse without having to edit their comments or questions through fear of being judged. As Mautner (2005) argues, what the internet discussion forum offers to the researcher is a 'highly dynamic, interactive space for debate' (p.813). However, it is this anonymity which the internet provides that has also been at the centre of the debate around the reliability of the data that it offers.

There is no doubt that due to the anonymity of the internet it is virtually impossible to verify someone's 'true' identity. In the modernist sense this is problematic because the researcher is prevented from accessing, or at least verifying, if they are in fact privy to viewing an individual's 'true' self. However, the very notion of the fixed, stable and unitary self is problematic to those working from a poststructuralist

perspective, which views the individual as having multiple selves that are constantly shifting and often context dependent. In this light, the need to verify whether someone is presenting their 'true' self actually becomes moot. However, not all challenges that the internet provides can be overcome through theoretical positioning.

The size of the internet is both a 'blessing and a curse' (Mautner, 2000, p.815). The researcher will not struggle to acquire data, however, the sheer amount of data available offers its own drawbacks methodologically. More specifically, this means that the researcher is required to be especially rigid in the application of criteria for selecting data which equates with identifying: 'authorship (e.g. institutional versus individual, gender, expert or lay status), time of publication, as well as geographic, cultural and national origin)' of the data being analyzed. This is a task that the internet itself makes difficult to accomplish (Mautner, p.816). In my search for an adequate discussion forum to mine for data, I became acutely aware that various forums provided none of the above information whatsoever which made applying selection criteria to them virtually impossible. However, I realized that the more developed forums, which not surprisingly had had a longer presence on the web, were more likely to provide information such as the gender of the members, time and date stamps and extensive 'mission statements' that made it possible to judge whether the forums were individual creations or the product of institutions. These were decisive factors that led me to select a specific forum for study due to its detailed provision of this type of information. There were also issues that influenced my decision to use the 'X forums' domain as a starting point because, in their providing a space for the individual to create forums rather than the organization, I was assured that the forums I would search within would indeed be individually 'owned'

rather than extensions of various institutions. A forum of the latter form, which more often than not comes with extensive rules and regulations on what *can* and *cannot* be said, would have severely compromised the authenticity and spontaneity of the individual voices I seek to explore. However, authenticity comes at a price as the researcher is faced with the problems characteristic of ‘web content [that] is not subject to the ordering and standardizing influence of institutions’ but rather, is ‘unstructured, and quintessentially anarchic’ in form (Mautner, p.817). Thankfully, this fluidity is one of the most attractive offerings of internet data because it provides the researcher access to such a diversity of voices.

5.8 Locating the Forum & Collecting the Data

Within the pro-anorexia community there are websites, personal homepages, and discussion forums. I decided to use the latter in my research for two reasons. Firstly, because the amount of data (instances of narrative) is far greater on discussion forums than on either websites or personal homepages. Secondly, personal homepages and websites tend to have narrative flowing in one direction only; from the author to the reader. The reader very rarely has a chance to respond to what they have read unless there exists an option to write a comment in reply. In contrast, the very structure of the discussion forum permits debate to occur, and allows interaction to be a reflexive process. Messages are posted and replies given in a continual process which constitutes what is commonly referred to as a message thread.

First, various search engines such as Google, Yahoo, and Mamma were used to find pro-anorexia discussion forums on the internet. The majority of forums within this

community, as with many others online, are hosted as sub domains by parent websites. The latter offers ‘free remotely hosted message boards’ to anyone wishing to start an internet forum. After signing up, they can design and customize according to the type of web community they wish to start. The popular ‘X-Forums’²³ was selected as the remote host and after the initial pro-anorexia forum was identified I was then able to navigate through many similar forums under the same domain. This navigation is made possible because of the Web Ring design. A Web Ring is a “group of websites with a common theme, configured in a loop, allowing the surfer easy access to subsequent sites in the ring by clicking on links” (Scotmist web site). The forums surveyed had anywhere between 2 and 5000 members, with the majority harboring between 500 and 1000. Although discourse analysis is concerned with the ‘parts of text rather than participants’ the number of participants (members) that belong to a particular forum directly affects the number of messages that can be found (Wood & Kroger, 2000, p.78). The forum²⁴ I selected was by far the most popular pro-anorexia forum hosted by the ‘X-Forums’ company. At the time of data collection, this forum had 1113 members with a total of 134,623 that had been posted and archived. The comprehensiveness of this forum is due to the fact that it has been consistently revised to include an increasing amount of features for its members. Beginning as version 1 in 2004 the creator then developed a version 2 and later a version 3. The figures for these three versions are as follows:

²³ I have changed the name of this company to ‘X-Forums’ in order to protect the anonymity of the forum and its participants.

²⁴ The name of the forum has not been included to protect the anonymity of the members who participate within it. For this reason, it will be referred to as simply the ‘Forum’.

Forum Version	Original Version 1	Version 2	Version 3
Members	5118	1113	1844
Total Messages	42,870	134,623	49,389

Many of the message archives on Version 1 had been erased during web maintenance procedures and Version 3 appeared to still be in its infancy with regard to the amount of messages posted. For these reasons, I chose to perform my data collection on Version 2 of the 'Forum'.

This particular forum has an elaborate design and houses 11 subsections (sub-forums). These sub-forums are labeled under headings such as, 'Information Station', 'General', 'Ana/Mia and other ED's Discussion', 'Viva Entertainment' etc. Each of these are further sub-divided into anywhere between 3 to 13 discussion themes. Once you click to enter one of these themes you are presented with a list of topics (the titles members have given their message thread). One message thread can exceed 40 messages as a result of members posting replies to the initial topic. However, most message threads contain between 0 and 15 message replies.

The sheer number of messages available on this forum meant that it would have been impossible for me to include all of them in my analysis. Therefore, based on my topic of inquiry, to investigate how psy discourses constitute anorexic subjectivity, I selected the sub-forum 'Ana/Mia and other ED's Discussion'. This sub-forum is divided into 13 discussion themes, such as 'Ana Discussion', 'Mia Discussion', ED-NOS Discussion, COE Discussion, etc. I selected the 'Ana Discussion' and 'ED-NOS Discussion'. The latter was included because after reading all the messages within this discussion I found many, if not all, surrounded the topic of anorexia. At the time of data

collection there were 1764 topic headings which together held 21432 message posts within the 'Ana Discussion'. The 'ED-NOS Discussion' was comprised of 37 topics which accounted for 578 message posts. I looked at all 1764 topics on the 'Ana Discussion' and also read all of the 37 topics on the 'ED-NOS Discussion' in search of topic headings that indicated members were either posing questions, or making statements, about psychological discourse either explicitly or implicitly. This process left me with 31 topics (message threads) in the 'Ana Discussion' and 10 topics (message threads) in the 'ED-NOS Discussion' of which I selected 9 in the 'Ana Discussion' and the first 3 in the 'ED-NOS Discussion'. These 12 threads were chosen out of the possible 41 on the basis that they contained the most explicit references to psychological discourse and the DSM-IV.

5.9 Coding as Preliminary Analysis

In the very initial stages of analysis, the 12 message threads were read and re-read and issues and topics within them were noted. This led me to devise 10 coding categories which then enabled me to methodically code each message. The message was designated as the unit of analysis. Once each message was coded it became clear that the 10 categories were far from mutually exclusive and that each message could be broadly categorized under 3 discussion categories: i) classification as a concept, ii) EDNOS as problematic diagnosis, and iii) anorexia as a shifting category. The first theme refers to instances where women are found to be in a debate about the utility of eating disorder classifications in general. The second refers to how the diagnosis of Eating disorder not otherwise specified (EDNOS) is viewed as problematic within the Forum. Finally, the

third section encompasses how anorexia is reconstituted by these women and subsequently articulated as a shifting category. Working with these re-coded texts (messages) I then began to perform a more detailed analysis that addressed the specificities of each member's discourse according to Fairclough's three steps: Discourse Practice, Text, and Social Practice. This meant looking at issues of intertextuality and politeness strategies, and how these were articulated in face of dominant psychological discourse, respectively.

CHAPTER 6: ANALYSIS

6.1 (Un)popular discourse: The Fundamental Struggle with Classification

I begin my analysis by exploring how women on the Forum discuss the issue of psychological classification. Through a careful reading of the data, I found that individuals viewed classification from one of three places on a continuum. Some fully accepted the idea as a tool to describe their experience, others completely rejected the concept, while another group of individuals found that although some aspects of having a 'label' were beneficial to them, they also found it to be problematic at the same time. The structure of their responses led me to using Stuart Hall's concept of viewing positions²⁵ to organize this section of the analysis. Considering the diagnostic classification of anorexia as that which is produced by the DSM-IV, these women are understood to be operating from a 'dominant', 'negotiated' or 'oppositional' code (Hall, 1993, p. 515-16).

6.1.1 Dominant (Reproduced)

Jane: I feel like too much a poser to actually have a label. I am just sort of in the gray area of ana and mia (The Forum).

Sarah: yeah, a lot of times I feel like I'm undeserving of a label, as dumb as that may be. But I try not to put myself in one little box, because it's too hard to fit, and there's not much point in trying (The Forum).

²⁵ Hall (1993) produced his encoding/decoding model to be applied to media texts in general, and not specifically to Internet text. However, I have used it to structure the first part of my analysis because it is a seminal model which was among the first works which considered media text reception as heterogeneous, contextual and potentially subversive, the latter of which forms the very basis of my view of these women's narratives in the pro-anorexia community. It is also important to note that Hall's appreciation that there exists various ways of positioning oneself in relation to a text (or discourse) is viewed as compatible with a Foucauldian approach to dominant discourse, which assumes the latter, although exerting power on the individual, provides a space for 'points of insubordination' (1983, p.225) or room for alternative readings and new articulations.

Marie: Actually, I do care.... Not because I want a label, but because if I know exactly what it is maybe I can fix it (The Forum).

In these excerpts these individuals are discussing their opinions in regards to using labels to describe their experience of anorexia. These labels are a product of the DSM-IV, and are an integral part of their classificatory system or in Foucauldian terms, their 'system of differentiations' (1983, p. 225). This dominant classificatory system produced by psy discourse is upheld by these particular individuals. Jane explains that she feels 'like to too much a poser to actually have a label' and this is a recurrent theme amongst individuals on this forum. In using the term 'poser' she is expressing her feeling that her eating disorder experience is less than authentic because she does not meet the full criteria of either anorexia or bulimia, but rather she falls 'in the gray area' between the two. It is her adoption of this dominant psy discourse that leads her to not only believe that her experience is inauthentic, because she does not 'fit' into a category, but also that she herself is fake. The result of this is that she sees her experience of 'anorexia' as not being 'real'. In concrete terms, this could lead to her, and the others who have adopted this dominant discourse, to avoid seeking treatment for their eating disorder because of its inability to fit within institutional criteria.

Sarah's response to Jane's post emphasizes that she too feels 'undeserving of a label' but she has given up 'trying' to 'fit' because it is simply too 'hard'. The latter comment indicates that this is something she aspires to be. As Vaz & Bruno explain, with reference to Hacking (1990), 'if a norm of behavior comes to exist in reality, it is reinforced by the fact that no one desires to be outside of it' (2003, p.278). If the DSM-IV's criteria for anorexia is viewed as the 'norm' that individuals aspire to meet in order

to authenticate their experience, then this may go far in explaining why so many individuals on this forum, much like Jane, express their desire to further their illness in order to achieve this. In Foucauldian terms, these criteria may be viewed as the minimum 'external frontier' of anorexic perfection (1977, p.183). The main component of the DSM-IV criteria regards weight loss as central to diagnosis. More specifically, it demands that an individual must have lost 15% of their normal body weight in order to warrant a diagnosis of anorexia. I argue that the weight criteria may be internalized by the undiagnosed individual as an indicator of authentic anorexia, which then inspires them to meet the classification in order to validate their experience of anorexia. This exposes how the 'micro-penalties' of normalization practices are not directed at 'what one does, but at who one is' (Foucault, 1979, p.178 in Vaz & Bruno, 2003, p.277). It appears that it is insufficient to merely practice anorexic behaviors, one must be anorexic; the authority of which lies within the DSM-IV in its ability to define who *is* an anorectic. In everyday terms, this could mean that young women are seeking to lose more weight in their eating disorder as a result of psy discourse rather than the disease itself.

Marie exclaims that she *needs* the label rather than wants it because without such a descriptor she does not know how to proceed with the process of getting better. This illustrates the paradox of living within a culture of expertise, and a society where, as Nettleton confirms, 'health is something which lies within the control of the individual' (1997, p.208). The repercussion of neo-liberal ideology constructing health in this way means that Marie is responsible for fixing herself, but at the same time is unable to describe her experience 'reliably' because that lies in the doctor's or psychologist's

domain of authority. However, there are individuals who reject adopting this view *completely* and who enter into a negotiation that challenges this authority.

6.1.2. Negotiated (Restructured)

As Hall (1993) argued, the negotiated position is made up of a combination of dominant and oppositional components. The way in which these excerpts are formulated in contradiction illustrates how individuals can adopt parts of a hegemonic discourse while rejecting others, as they negotiate with it to form their own discursive accounts.

Emily: It seems like so much of our identity is tied up into the names and labels we fall under. To go nameless is to go lost. So, yeah, I guess it does bother me a little. But at the same time- if you know what you are yourself, the only time names are relevant is when you're trying to explain yourself to others. And I avoid that anyway. *Pas de grandes choses* (The Forum).

Emily recognizes that much of her identity is dependent on the categories that precede her as an individual, and she communicates that she understands the severity of this reality as she states, 'To go nameless is to go *lost*'. However, attending to the issue of modality, Emily's comment, 'I guess it does bother me a little' indicates that this is not a great worry to her. This is made clear by the 'subjective modality marker' ('I guess') and her use of 'hedging' ('a little') (Fairclough, 1992, 159). On the one hand the severity of not having a label is expressed because one becomes 'lost' but simultaneously she negates the severity of being 'label-less' as she explains it as more of a nuisance ('bother'), and a 'little' one at that, rather than a central difficulty. This contradictory pattern continues and cements her negotiated position as she states that her subjective knowledge of herself is paramount *but* only until she enters into an interaction with

another person. At this point she finds it easier to use the DSM-IV definitions to describe her experience, rather than relying on her own subjective description. In order for her to avoid her own knowledge of herself being marginalized she avoids interaction with others. What becomes apparent here is the seductive nature of power; Emily is free to resist the discursive power of psy, which displaces her subjective knowledge with its objective terms, but at the cost of her interaction with others. The latter is impossible if she is to function within society. In other words, she is free to comply. As Foucault (1983) described, ‘the exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome’ (p. 221). This capacity of the DSM-IV to constitute an individual’s relation to their self and others is not obvious. Unlike Emily’s negotiating process, that revealed initially that she grasped the constructive capacity of labels in relation to identity, not all individuals are aware of how their subjectivity is influenced by the DSM-IV and remain convinced that they are challenging its definitions. Although they appear to be committed to opposing the idea of classification, such as Louise’s excerpt below, their responses are riddled with ambiguity. As Hall (1993) argues, ‘the negotiated version of the dominant ideology is thus shot through with contradictions, though these are only on certain occasions brought to *full visibility*’ (p. 516, my emphasis).

Louise: nah, I don’t care about labels out of the ed world, so I don’t care about them inside” [...].my eating disorder is pretty much a daily buffet of anorexia, bulimia, COE, and everything else in this goddamn eating disorder list. Theres no way I can possibly just choose one that totally describes my problem. Except EDnos (The Forum).

Louise states clearly, and with conviction, that she has no concern for labels. She asserts her individuality and the uniqueness of her disordered eating behavior, ‘There’s no way I

can possibly just choose one that totally describes my problem'. However, in order to explain the particularity of her experience she paradoxically uses the dominant DSM-IV definitions. She has had to use the very frame of reference she wishes to negate in order to show her resistance to it. Louise emphasizes how creative negotiation with dominant discourses is an event which must still work within the available discourses and cannot occur completely outside of these frameworks. More specifically, by employing a metaphor of the 'buffet', she presents her unique subjectivity as parts of 'anorexia, bulimia, COE²⁶, and everything else in this goddamn eating disorder list'. Much like when a person visits a buffet they have the freedom to select from a host of different food items, arrange them on their plate differently to the next person, and leave what they do not desire to eat. Nevertheless, the choice extends only to what is presented by the restaurant in question and not beyond what is actually available. This metaphor shows why Foucault refers to the term 'conduct' to explain the 'specificity of power relations' because it is used to describe the act of leading people and also refers to 'way[s] of behaving within a more or less open field of possibilities' (1983, p.220). Louise illustrates that, although she understands her behavior to be particular to her, she must use common definitions which are set by the 'more or less open field of possibilities' (1983, p.220) set by psy discourse, to claim the uniqueness of her experience. My argument does not aim to deny the particularity of Louise's subjectivity, in fact it is the inability of the classificatory system of psy to account for such multiplicity that I critique. I seek to emphasize that individuals are wrongly limited to a predefined set of tools to explain their experience. The result of this is that the complexity of their practice as individuals is not only neglected, but they also remain unable to communicate it. This is not to say that the

²⁶ C.O.E. is the abbreviation for compulsive overeating.

limitations placed on individuals by systems of knowledge are completely impermeable.

After all, Foucault has clearly made the point that "there are no relations of power without resistance" (1980, p.142) and this resistance is the very goal of those who operate from an oppositional code.

6.1.3. *Oppositional (Challenged)*

According to Hall (1993) the oppositional position consists of decoding the message of the dominant discourse in a 'globally contrary way'. The individual deconstructs the preferred meaning and challenges it completely through using an 'alternate frame of reference'. Hall (1993) provides the example of the person who listens to a political debate on the 'need to limit wages but 'reads' every mention of the 'national interest' as 'class interest' (p.517). The excerpts below are used to illustrate how individuals are operating with an 'oppositional code' (p.517) in their deconstruction of the hegemonic discourse of psychology. Through discussing the same topic of labeling/classification they communicate their total rejection of such a system while challenging its utility as a means to understand their own experience.

Karen: I mean, does anyone here really not care what they are- *anorexic, bulimic, ed-nos, compulsive over exerciser, anorexic with purging tendencies, purple and plaid kangaroo* who hoards food in her pouch? I mean, isn't it a little silly? We've all got a problem. Its just labels (The Forum, my emphasis).

The discursive use of humor often highlights moments of contradiction and opposition. In this case, Karen has to refer to the hegemonic discourse in order to negate it. She invokes the DSM-IV's classifications, 'anorexic, bulimic, ed-nos, compulsive over exerciser, anorexic with purging tendencies' so that she can add her own 'category'. She

creates this 'category', the 'purple and plaid kangaroo who hoards food in her pouch' to illustrate, what she views as, the absurdity of the previous 'official' classifications. In other words, through this ironic addition she is inferring that receiving the label of anorexic or bulimic is just as useful to the individual as being labeled as a 'purple and plaid kangaroo' because just as the latter, the former also does not come close to describing the specificity of individual experience. The excerpt below shows another young woman who, in commenting on Karen's post, also adopts this oppositional code.

Catherine: I agree. Most of the time, when I mention it, I refer to it just as my ED, but from now on I'm the purple and plaid kangaroo (The Forum)

As Catherine embraces Karen's concept of the 'purple and plaid kangaroo' she is also expressing that it might be just as useful (or useless more to the point) to frame her experience with the label of 'kangaroo' as it would be to refer to it as an 'ED'²⁷.

Identifying the absence of an action is just as important to any interpretation of discourse as recognizing what is present. Notice that Karen does not simply use the term 'kangaroo' but embellishes it by including the descriptors 'purple and plaid'. The addition of these specifics conjures up the image of a specific 'type' of kangaroo which enhances the humorous impact of using the 'Kangaroo'. However, there is also a serious point behind her choosing to exaggerate the image in this way. She includes the sub-type categories of the DSM-IV, 'anorexic with purging tendencies', 'bulimic purging or non-purging', and anorexic²⁸ rather than simply, anorexic and bulimic. The function of this is

²⁷ ED is the commonly used abbreviation for Eating Disorder invoked by professionals and lay persons alike.

²⁸ The use of the term 'anorexia' in isolation, without additional descriptors, is commonly employed to describe the typical restricting anorexia rather than the purging sub-type. Purging refers to the act of ridding one's body of calories by vomiting, misusing laxatives, or diuretics.

to illustrate how *even* the DSM-IV's use of specific categories (sub-types) that attempt to account for variations in eating disorder experience fail to account for the multiplicity of practices within the 'population'. The insufficiency of the previous is only cemented by her combining the DSM-IV sub-types with the irrelevant and trivial specifics that the kangaroo is actually 'purple and plaid'.

An alternate but similar route to the same interpretation, which also leads to reading her comment as an example of an oppositional code, would be that she uses the kangaroo reference to express that individuals with disordered eating are classified in the same way as animals in the zoo. Thus, articulating that the DSM-IV is primitive and an over-simplified approach (fit for animals) that cannot account for the complexity of the individual's eating disordered subjectivity.

Rather than highlighting the insufficient complexity of the categories laid out by the DSM-IV, as Karen did in the above excerpt, Laura adopts an oppositional code by rejecting not the way they are structured, but the entire concept of 'category' itself.

Laura: I don't care which 'category' of ED's I fall into. It doesn't make a difference to me, or to my eating habits. There's not much point to me pinpointing myself as something because my eating habits change daily anyway (The Forum).

Laura places the term category in quotation marks to undermine the concept itself and to communicate her belief that they are useless constructions, rather than useful classifications, for describing the actualities of lived experience. In the same fashion, Joanne acknowledges that classifications are just an attempt to package experience, and the complexity it implies, into discrete categories so that they appear manageable for the

professionals who are imbued with the task of describing them; this implies that the categories do not assist those who experience a problem to understand it.

Joanne: It's a label and only a label. It's just a nice way to have everything all classified and put away in nice little boxes. A problem is a problem doesn't really matter what it is (The Forum).

Laura expresses that she understands classification as a way of 'pinpointing' or rationalizing an experience into a logical and fixed form, when really her lived experience escapes the confines of such a description as it is constantly shifting. Thus, for her constantly changing practices, which she explains as 'habits [that] change anyway', the DSM-IV's categories are deficient because of their inability to accommodate her reality. A conclusion that ultimately leads her to disregard them as a way to describe her experience and adopt what Hall (1993) refers to as an 'alternate framework of reference'; although her message post stops short of telling us what the specificities of this alternate frame actually are. Nevertheless, Laura's choice to use the narrative form of the first person, 'There's not much point to *me* pinpointing *myself*' (my emphasis), rather than the third person 'There's not much point to *them* pinpointing me' is particularly significant as she acknowledges the fact that contemporary health discourse situates 'health [as] something which lies within the control of the individual' (Nettledon, 1997, p.208). Laura understands that if there is any 'pinpointing' to do then she will be the one to do it. But, importantly, she then conveys her choice to refuse this role and in effect is rejecting to conform to the rational, *self*-controlled, and *self*-responsible behavior demanded by the new public health agenda in its efforts to limit the burden of the individual on the state. Yet, this is simply one interpretation of many that could be made. Perhaps, the best example of a direct oppositional code would be that provided by one individual on the

forum whose simple but equally powerful statement, 'Fuck Labels' (Karen, The Forum), quite nicely sums up her position.

The sheer strength of this type of oppositional code may be refreshing in a context where many fall prey to accepting dominant discourses as the only route to understanding their experience. However, before reveling in the glory of the oppositional code it is wise to recount Foucault's (1983) assertion that resistance is the very fuel of power because without it there is no need for power. Therefore, the question remains, is the tenacity of the oppositional code itself that which rejuvenates the dominant discourse giving it its power? This does not imply that in order to conquer its power we must submit to its cause and assume the dominant meaning, but rather that we must be aware that resistance to power is a product of power itself. Thus, it is this symbiotic relationship which means that although resistance may fuel power, it also has the domino effect of creating further possible sites of resistance because resistance is produced by power. This connection is also referred to by Fairclough (1992) in his acknowledgement that dominant discourses simultaneously influence, and are influenced by, the individual in a multiplicity of ways.

The act of making interpretations of narrative has an abstract function of constructing one possible meaning of an utterance. This process is only useful, especially from a CDA perspective which aims to assist those within the dominated groups which it studies, in so much as it generates a suggestion for concrete action. In abiding by this presupposition, I explained above that it is indeed possible that those individuals who adopt the dominant meaning outright may in fact be encouraged to lose further weight in order to achieve a 'label' so that they can authenticate their experience. I gave reasons as

to why I also thought that those individuals who assume a negotiated position may be left without the tools to communicate their suffering because of the limiting nature of psychological discourse which neglects the complexity of experience. There is also the possibility that the individual who takes up an oppositional standpoint will be affected by their choice of positioning. More specifically, those who completely reject the efficacy of the DSM-IV and its classifications are in danger of not accepting professional help due to their connecting the 'inferior' classification system with those that utilize it. Having reached the conclusion that any expert help they receive will be sure to be inadequate, they avoid seeking treatment. All three of these potential outcomes emphasize that regardless of positioning, whether it be preferred, negotiated or even oppositional, the fact remains that the relationship between dominant discourses and the individual is not only complex but also has concrete ramifications for the individual in question.

6.2 Specifying the 'Unspecifiable': EDNOS

In the section above the members of the pro-anorexia community were shown to be negotiating their subjectivity through discussing the 'utility', or lack thereof, of the DSM-IV's classifications/labels on a fundamental level. While the individuals show varying degrees in their level of acceptance or refusal of the DSM-IV's classifications as a mode to describe their subjectivity, each of their views demonstrate a common theme. This commonality is structured around the fact that each of them voice their frustration with being unable to 'fit' into a category of anorexia or bulimia etc. This lack of 'fit' between their experience and the categories in the DSM-IV meant that, for those who adopted a dominant position, they viewed their 'anorexia' as inauthentic. The individuals

who assumed a oppositional code attribute the 'lack' of fit as hinging on the fault of the DSM-IV itself which fails to account for their variability. Thus, to recapitulate, regardless of whether the error was viewed as laying within the individual herself or the classificatory system, their inability to 'fit' into the categories available proved to be a point of contention for them. This tension posed by individuals whose experiences do not fall within the parameters set out by the DSM-IV criteria is one that was also felt by the professional community, albeit for different reasons, which led to the development of the 'catch all' category EDNOS²⁹ (Eating Disorder not otherwise specified). EDNOS is viewed by many to be 'a convenient, generic place to stow away a variety of eating disordered behavior that does not conform to the diagnostic criteria for Anorexia and Bulimia Nervosa' (Somerset & Wessex Eating Disorders Association, 2004). The frustration caused by the restrictive and exclusive nature of the categories of anorexia and bulimia should suggest that the general diagnosis of EDNOS, in its ability to be more inclusive and less 'discriminating', would be welcomed by those individuals on the Forum. However, unlike the previous discussion on the general issue of classification where individuals were found to operate from preferred, negotiated and oppositional codes, the debate around the specific topic of EDNOS was severely skewed. Every individual rejected the efficacy of EDNOS as a diagnostic category. Nonetheless, the reasons for this rejection were varied and differed between individuals, and for this

²⁹ Criteria for EDNOS: 1. All of the criteria for Anorexia Nervosa are met except the individual has regular menses. 2. All of the criteria for Anorexia Nervosa are met except that, despite substantial weight loss, the individual's current weight is in the normal range. 3. All of the criteria for Bulimia Nervosa are met except binges occur at a frequency of less than twice a week or for a duration of less than 3 months. 4. An individual of normal body weight who regularly engages in inappropriate compensatory behavior after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies). 5. An individual who repeatedly chews and spits out, but does not swallow, large amounts of food. 6. Binge eating disorder; recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa (APA, 1994)

purpose, the proceeding section will be organized around these different ‘oppositional’ themes.

6.2.1 EDNOS as Failed Anorexia: The New Abject

As Squire points out, ‘the dearth of material examining bulimia exists in sharp contrast to the wealth of material on anorexia’ (2003, p.18). Many argue that this preoccupation, both academically and in the lay population, is expressive of the cultural values of Western society, such as those which emphasize control, self-discipline, and will-power. Each of the latter attributes are often assigned to the anorexic due to her apparent capacity to transcend the dictates of the natural body³⁰. On the other hand, bulimia symbolizes impulsivity, complete lack of control, absence of ‘discipline’, and a disorder of the untamed appetite. As Burns (2004) explains, ‘[bulimia] is shameful in its indulgent excesses, revolting in its final scenario (the vomit spattered toilet, the streaming eyes, the stench). This stimulates guilt and self disgust (McCarthy and Thompson, 1996: 10.)’ (p.269). Bulimia is frequently referred to as anorexia’s ugly stepsister, a label that illustrates its marginalized status in the eating disordered world. Two bulimic women illustrate this, ‘I almost feel that anorexics are the successes’, ‘you could consider a bulimic as a failed anorexic’ (‘Fran’ and ‘Jill’ in Burns, 2004: 276-277). Chernin (1983) also emphasizes the point that anorexia is representative of a degree of willpower that women seek to accomplish, in her description of a conversation she overheard between two women in a sauna at a health club,

³⁰ It is equally possible to view anorexia as a fervent lack of control due to the individual being governed by her obsessions. In this case anorexia is a perfect picture of excess. However, this interpretation of anorexia is far less frequent in literature on the subject and the association of anorexia with self-mastery is a dominant theme.

‘I’ve heard about this illness, anorexia nervosa,’ the plump one is saying, ‘and I keep looking around for someone who has it. I want to go and sit next to her. I think to myself, maybe I’ll catch it....’

‘Well,’ the other woman says to her, ‘I’ve felt the same way myself. One of my cousins used to throw her food under the table when no one was looking. Finally, she got so thin they had to take her to the hospital...I always admired her’ (p.22).

Both of these women display a strong sense of admiration for women with ‘anorexia’. The first woman wanted to ‘catch’ the disorder and have the ‘ability’ to refuse food with the aim of eventually obtaining the ‘slender body’. The second woman ‘admired’ her cousin’s ability to restrict her food intake even though this was what led her to starving herself to the point where she needed to be admitted to *hospital*. It would be rare indeed to find such a conversation between two women where they were explaining their desire to become bulimic. The disgust, shame and guilt that is associated with bulimic bingeing and purging, in all its messiness, is not something women seek to achieve. In addition, individuals with bulimia are frequently of normal weight or slightly overweight and rarely ‘slim’ or underweight which is large part of anorexia’s so-called appeal. This is one of the factors which have led many theorists to conceptualize bulimia as anorexia’s abject sister. A predictable conclusion considering that, as Derrida (1974) noted, we live in a society where language is structured around binary opposites: good/bad, masculine/feminine, mind/body etc. Far from being arbitrary assignments, as Burns (2004) explains, ‘the dualistic conceptual categorizations that characterize western epistemology are far from neutral and involve the assignment of moral meanings’ (p. 270 referring to Gergen, 1995; Shildrick, 1996). Thus, we understand meaning not from a term used in isolation but from the relationship the word has with its opposite. Bulimia is what anorexia is not, it is (un)-pure, (un)-controlled, and demonstrates an absence of will.

EDNOS is viewed in a similar way, as that which is not anorexia. This view is illustrated by Heather's question,

Heather: Just wondering which criteria we all *fail* to meet in ana/mia/coe etc. to *make us 'NOS'*. I am *not* quite as underweight as would make me ana yet [...] so how about you all?" (The Forum, my emphasis).

Heather indicates that individuals are *made* EDNOS as a result of their *failure* to meet 'ana/mia/coe' criteria. She is EDNOS as a consequence of *not* being anorexic because she is *not* underweight. This pattern is replicated in the messages which respond to Heather's initial post, 'I'm not quite ana because I'm not underweight *enough*' (Tania, The Forum, my emphasis). The negative attribution style these women use to explain their situation, which consists of explaining what they are not, rather than what they are, is in fact exactly how the DSM-IV delineates the category of EDNOS (see footnote 5 above). This pattern of replication is perhaps clearer in the more detailed description provided by Natalie below, which also emphasizes the degree to which the DSM-IV has implanted itself in the individual (Rose, 1992 in Rose, 1996, p.34).

Natalie: Humm...well. I'm ED-NOS because first, i'm not underweight and i never have been. I've already had a BMI of 19 but it's the lowest I've been. Then, I have my periods, which is obvious. Humm... I have binge periods and restricting ones. I've used laxies sometimes, i'm not exercising a lot and I fast sometimes. I'm never vomitting. All together, it makes that I'm mainly maintaining my weight and even if I can lose 15 pounds in a short time, I'll gain them and more in an even more shorter time. My binges aren't big ones...always about 1000-1500 cal. Most of the time, I don't purge in any way. So I'm not bulimic and i'm not anorexic....maybe coe? I don think! [sad emoticon face] (The Forum).

Clearly, Natalie views her being EDNOS because of what she is not. Not only does she refer to her not being 'underweight' (required for AN) but she also explains that even at her lowest she had a 'BMI of 19'. This BMI result is significant because it indicates that

she is conveying that she has a body mass index higher than that required for a diagnosis of anorexia (BMI= 17.5 or under). She states that she is still menstruating and therefore is telling the group that she does not have amenorrhea which is required for a diagnosis of AN. She includes in her description that she also has 'binge periods' and 'sometimes' uses 'laxies' (laxatives) which are two behaviors which are associated with bulimia, however, she then excludes the possibility of her being bulimic because she states that she 'never' vomits and that her binges 'aren't big ones...always about 1000-1500 cal's'. Vomiting is nearly always the second part of the binge-purge cycle of the bulimic, although purging can also include exercising in an attempt to rid the body of the calories consumed. Natalie also includes a calorie amount far lower than that which is associated with a bulimic binge; this is 'often 3,400 calories in about an hour' (Cannon, 1998, ¶3). Binging which is not followed by any form of purging normally denotes the existence of COE (Compulsive Overeating), although this is characterized by a BMI in the 30s. Natalie brings up the possibility of COE only to reject her association with it by saying 'I don't think!' and including a sad emoticon face. This communicates not only her rejection of COE as a viable diagnosis but also her feeling of horror at the possibility of such a label. This is not uncommon among those with eating disorders, and this is perhaps because not only does COE represent chronic obesity but more importantly it also symbolizes the furthest point away from anorexia.

Thus, for these individuals EDNOS represents their failure to be anorexic. The former becomes a derogatory label due to it indicating that the individual is (dis)qualified from the category of anorexia and the so-called prestige which is attached to it. The notion of EDNOS as fake or failed anorexia 'has the effect of reinforcing the

psychological discourse performed and preserved by health professionals' (Harding, 2003). This is because, if individuals are seeking to escape the confines of an EDNOS diagnosis in order to assume an 'authentic' anorexic position, they do so under the guidance of the DSM-IV criteria which explicitly provides a list of requirements which need to be met. The implicit and explicit intertextuality in the excerpts above indicate that this professional discursive construction, the DSM-IV, is exactly what is being used for this endeavor. It becomes a measuring tool or yard-stick with which to measure their progress, or lack thereof, in obtaining an 'authentic' diagnosis. The DSM-IV, in this case, is viewed as a device of 'meaning production' which is producing the anorexic, for without the criteria (especially the weight cut-off point) these individuals seeking to disassociate their self from the EDNOS label would be without a standard to meet. As Rose (1996) explains, 'devices of 'meaning production' – grids of visualization, vocabularies, norms, and systems of judgment- *produce* experience; they are not themselves *produced* by experience' (cf. Joyce, 1994 in Rose, p.25). Furthermore, psy not only plays a "rather fundamental role in 'making up' the kinds of persons we take ourselves to be", as Rose has argued, but also plays an integral part in "'making up' the type of persons' we wish to become (1996, p.10). If bulimia is positioned as the opposite of anorexia and EDNOS as an anorexic that lacks, it becomes clear why those with eating disorders yearn to assume the subject position of anorexia over any other. Moreover, this highlights how, as Rose argues, within 'regimes of subjectification' 'there is a temptation to stress the elements of self-mastery and restrictions over one's desires and instincts – [an] injunction to control or civilize an inner nature that is excessive' (1996, p.32).

6.2.2 EDNOS as Diet: An Eating Disorder Non-Identity

EDNOS is viewed above as an inferior ‘identity’ because of what it is (not).

However, for some individuals on the Forum EDNOS represents a non-identity and this is the source of their frustration. In other terms, EDNOS is understood by some individuals on the Forum as not being a ‘true’ eating disorder at all.

Marie: I heard ednos was Chronic Dieting...where you keep going on and off diets even though your weight is healthy-ish. Here...
<http://www.findingbalance.com/default.asp> (The Forum).

An eating disorder is commonly portrayed as a ‘diet that went wrong’ in the popular media, but it is often viewed by these women as an attempt to trivialize the severity of their experiences with food and their bodies. EDNOS, conceptualized as ‘Chronic Dieting’, suggests that it is simply an extension of normal dieting practices. The Stedman’s medical dictionary defines the term ‘diet’ as a ‘prescribed course of eating and drinking in which the amount and kind of food, as well as the times at which it is to be taken, are regulated for therapeutic purposes’. Firstly, self-starving and purging behaviors, the consumption of dangerous amounts of laxatives which wreak havoc with the body’s electrolytes, and other common eating disorder behaviors are far from being ‘regulated [acts] for therapeutic purposes’. In fact, rather than healing the body they result in its destruction. Secondly, the view of EDNOS as ‘yo-yo dieting’, which is often used interchangeable with ‘chronic dieting’, suggests that it is really a term which describes much of the female population whose weight fluctuates as a result of dieting. Therefore, I argue that EDNOS is rejected by those who find themselves within its boundaries because it is understood as having too general a meaning, which either

neglects the specificity or severity of their experience. As Carol explains, referring to EDNOS as a category,

Carol: that term is so fcking vague. It's like saying all pencils, pens, crayons, and markers are 'writing utensils', and nothing more (The Forum).

Carol's aversion to the classification of EDNOS appears to be connected to the fact that the term is too broad in nature. The inadequacy of the term lays in the fact that it attempts to generalize that which is specific. Perhaps, to extend her metaphor, we might interpret her use of 'pencils' and 'markers' as conveying much more. 'Pencils' are used to lightly illustrate an object and the result is easily erased, whereas a 'marker[]' is a permanent instrument used to underline or emphasize an object so that it will not be misunderstood. It is possible that Carol views dieting as a pencil and an eating disorder as a marker, the latter being something that is hard to erase, and felt by its permanent, rather than fleeting presence. The seriousness of her predicament is not conveyed by the catch all category of EDNOS. Rose explains that,

[psy] objectif[ies] their subjects individualizing them, denoting their specificity through acts of diagnosis or of measurement. These sciences render individuals knowable through establishing relations of similarity and difference amongst them and ascertaining what each shares, or does not share, with others (p.115).

If we assume that Carol is aware on some level, as many contemporary subjects are, that psy strive for a 'brevity of criteria sets'; because that which can be defined exactly can be diagnosed and treated appropriately, the fact that her experience falls under a category which is ambiguous and loosely defined may indicate that it is less worthy of attention

than the other eating disorders such as anorexia and bulimia. Rebecca communicates her feelings about the ambiguity of the EDNOS classification,

Rebecca: [...] So that's EDNOS i guess. Hell i hate this stuff. I'm more than specified, stop insulting my with 'not specified'!! (The Forum).

Rebecca demonstrates that some individuals have internalized psy's assumption that that which is important is sure to be specified. Although EDNOS is a precise category, in effect it specifies the individual's problem as 'unspecifiable'. As Rebecca states, "stop insulting [me] with 'not specified'". In other words, the frustration provoked by this category stems from the fact that it suggests that the person's experience is identifiable solely as a result of it being unidentifiable (within the boundaries of anorexia and bulimia). Monica speaks of her feelings about being diagnosed as EDNOS,

Monica: Yeah, its weird not to have an 'identity.'..I wish I knew what the hell I am (The Forum).

The dis-ease that surrounds not being 'identifiable' is linked, I argue, to the knowledge that we live within a culture of 'expertise'.

Whether it be physical or psychological health, the discourse that surrounds these topics exposes a transition from conceptualizing the 'subject' as a 'passive recipient of advice and health care to one who possesses the capacity for self-control, responsibility, rationality and enterprise' (Nettleton, 1997, p.213-214). The subject as a 'client', rather than a 'patient', infers a choosing consumer subject who, through exercising their capacity to 'purchase (or accept) the range of expertise and tools now available' (Peterson, 1997, p.199 my insertion) can instigate their own healing process. Here lays the paradox; an autonomous, self-responsible subject who exercises their responsibility

and autonomy *through* consuming the advice of an 'other' (expert). The subject is the central player in designing their lifestyle but their moves are choreographed or orchestrated by someone from behind the scene. As Rose (1996) argues,

although our subjectivity might appear our most intimate sphere of experience, its contemporary intensification as a political and ethical value is intrinsically correlated with the growth of expert languages, which enable us to render our relations with our selves and others into words and into thought, and with expert techniques, which promise to allow us to transform our selves in the direction of happiness and fulfillment (p.157).

If individuals today have become accustomed to relying on the ability of so-called 'engineers of the human soul' (Rose, 1996, p.157) to 'guide' them on their route to wellness, it becomes clear why being designated as unidentifiable by these very same experts could pose a source of discomfort. For if the 'expert' cannot specify your problem into a precise diagnosis they cannot 'suggest' a route to fixing the problem, thus the individual is left with an unsolvable problem in their eyes, because that which cannot be defined cannot be repaired. Rose (1991) articulates this reliance on experts that we have developed in contemporary Western society,

we cannot "know ourselves" without some other instance providing the means to that knowledge, we cannot "free ourselves" without the tools provided to us by expertise. Over fifty years ago Robert Musil remarked upon a peculiarity of modern times: one can no longer have any experience without so many experts butting in who know so much more about it than oneself. Today, if the experts do not insist on rights of entry, we offer them invitations, call them on a telephone help-line, or seek them out in their lairs, for we seem to have become unable to understand ourselves without them (Rose, 1991, ¶49).

As Kim states, as she refers to her doctor,

Kim: I was kinda hoping she could say 'you have [this] and we treat it like [this]' (The Forum).

This is the fear that forms the basis of Monica's despair which is evident in her statement, 'Yeah, its weird not to have an 'identity.'..I wish I knew what the hell I am' (The Forum). In other words, you must be able to label your painful experience if you wish to be privy to the course of action you must take to free yourself of it. Perhaps this is clearer in the following statement, one that frequently appears in various ways on the Forum, 'if I know exactly what it is maybe I can fix it (Marie, The Forum). The possibility of hope that is inscribed on a definitive diagnosis, as opposed to EDNOS, may be that which pushes individuals in the Forum to yearn to be considered as anorexic. A yearning described by two individuals below,

Victoria: something just crossed my mind....arent some of us pushing a lil harder to considered ana, not to be discovered or anything, but just so we have an identity, does this make any sense [...] not that I ever wanted to get an ed, but since ive already always had one, i wanted one that would give me the recognition ive always wanted. does this make sense? Sorry if i offend anyone with this (The Forum).

Sadie: Distraught ~ Yeah, that makes perfect sense. Striving for something just to fit in. Feeling left out is such an awful awful feeling (The Forum).

However, this discomfort with being classified as EDNOS may be understood in an alternate way. Victoria associates being considered anorexic, rather than being described as EDNOS or bulimic, with 'recognition'. It may be that she views the label of anorexic as one that does justice to the amount of effort she has invested, or the pain she has endured, in trying to achieve the 'perfect' body. She can be viewed as yearning for the label of anorexic because it denotes willpower, self-control, and determination- at least in her view and that of many others in the forum. However, 'recognition' also means acknowledgement in other ways and the ability to be recognized is crucial for the

individual with an eating disorder who is, or seeks to, obtain professional help for their problem. In a context where ‘pride of place’ is given to those ‘everyday practices where conduct has become problematic to others or oneself’ and concern surrounds that which is ‘troublesome or dangerous’ (Rose, 1996, p.26), EDNOS, as a category which houses those individuals who lie on the boundaries of normal and abnormal, is displaced by anorexia which is definitively abnormal. As Kim explains,

Kim: I’m too skinny to be ‘normal’ or to get my period but too fat to be anorexic. My doctor says my body’s in ‘semistarvation mode’ as opposed to ‘starved’. Which is worrying. but just not worrying enough (The Forum).

This is very much the case when it comes to treatment accessibility and funding prerequisites in the cases of those with eating disorders. As Dias (2003) argues, ‘in order to access treatment, women have to be clinically diagnosed by a physician and often have to meet rigid criteria for diagnosis and admittance [..]if their health is not seriously compromised and their weight is not low enough, they do not qualify for treatment’ (p.39). Dias further explains that a large number of individuals that she has treated were acutely aware of this fact and often ‘avoided seeking treatment for fear of rejection’. I also found evidence to support this on the Forum,

Louise: You know that my doctor doesn’t believe im anorexic or bulimic?! He hays im to much at a “healthy” weight to have an eating disorder...it makes me feel so lost. I have an Ed, i have a problem, i know it (The Forum).

Agatha: Ok. So there is this Anorexia Clinic near my neighborhood that I wanna seek help from. (I actually called them 2 months ago.) But it says on the ‘rules’ that “if you are an anorexic patient you are underweight and have lost your period”. Ok, so...Im underweight but I still havent lost my period, does that mean if I seek their help I wont be accepted? It pretty much sucks that I don’t even wanna find out because Im afraid they will turn me down because according to the fucking medical thingys you have

to HAVE or DO NOT HAVE what says on their damn 'rules' (The Forum).

According to DSM-IV criteria, or as Agatha calls it, 'the fucking medical thingys', both these individuals are EDNOS. Louise is classified as such as a result of her still maintaining a 'healthy' weight and Agatha because she still menstruates. Louise tells the Forum how her doctor described her as not having an eating disorder at all because she was "too much at a 'healthy' weight". What this communicates is that the behavior and physical manifestations these two individuals demonstrate, although not normal, are not sufficiently abnormal to warrant acknowledgement. The inability of Agatha and Louise to be 'recognized' by the professional community, due to their falling under the category of EDNOS, may explain why Victoria yearned to be labeled as an anorexic in order to receive recognition. It is this recognition which provides access to treatment. It is common knowledge that insurance companies rarely pay for residential treatment of eating disorders, except hospitalization required for physical complications, and when they do reimburse for these services they most often require that the individual has an official diagnosis of anorexia or bulimia. Some policies explicitly state that EDNOS is a category which is not covered³¹. In Foucauldian terms, the efficient nature of psy's productive power becomes acutely visible here. The discipline itself can be implicated in producing the anorexic both explicitly and by default. The individual with EDNOS may, as Victoria does, yearn to be classified as anorexic which could in turn motivate her to worsen her condition, such as losing more weight, in order to meet this objective. Imagine that these individuals must make their selves more sick in order to receive

³¹ It is important to acknowledge that the increasing specificity of the DSM-IV categories are in part a result of insurance companies' requirements.

treatment to get well. It is also more than likely that the person who is refused treatment for EDNOS will go on to develop a 'full-blown' eating disorder, such as anorexia or bulimia, because of the progressive nature of disordered eating. This is particularly important because study after study has shown that once an individual's weight has dropped significantly, or their purging has become out of control, they are much less likely to be treated successfully. The majority of treatment plans clearly state that the individual must be of a certain (healthy) weight before psychological treatment can begin, simply because anything prior to this is futile given the degree of impairment that results from starvation. Rather than the DSM-IV being a text which is concerned with 'constructing normality', as Crowe (1999) argues, I conceive it as constructing abnormality in light of these findings in the Forum. The individuals above, whose narratives I have included, remain acutely aware that their exclusion from the category of anorexia (or bulimia) has serious repercussions in terms of treatment accessibility, nonetheless they do retain the conviction that they have eating disorders. As Louise stated firmly, 'I have an Ed, i have a problem, i know it' (The Forum). However, for others on the Forum, their not meeting the DSM-IV criteria for anorexia or bulimia made them question whether they really have a problem at all.

6.2.3 EDNOS as 'Poser' Identity

Some individuals on the Forum expressed that with the label of EDNOS, it was difficult to ascertain whether they were actually sick.

Alex: It's stupid, really. "I'm not anorexic. Okay. I'm not bulimic. Okay. I don't have COE anymore. Am I sick at all? Pff. *The most irritating thing about ednos is that you're not sure whether you're sick or not.* If you are,

not good. *If you aren't you're a poser*, not good. So having ednos is...Not good? YEP (The Forum, my emphasis).

The above excerpt illustrates how anorexia and bulimia are perceived as legitimate eating disorders in that receiving a diagnosis of either indicates clearly that you are sick. The category of EDNOS, on the other hand, although also in the DSM-IV, is seen as invalidating the legitimacy of the individual's eating disorder which forces them to question whether they are 'sick at all'. Again, we see EDNOS being compared to 'anorexia' and 'bulimia', although in this case someone with EDNOS has not failed at being anorexic per se but rather is posing as an anorexic. A poser is defined as 'a person who habitually pretends to be something he is not' (WordNet ® 2.0, © 2003 Princeton University), or in less formal terms, it refers to a 'wannabee' who 'talk[s] the talk but do[esn't] walk the walk' (Jargon File, 2000). These women above assume that because they refer to their experience as anorexia, while they are 'officially' EDNOS because they do not meet the full criteria for AN, they are simply pretending to be anorexic. Because psy is viewed as having 'authority grounded in [their] claim to truthful knowledge and efficacious technique' (Rose, 1996, p.99) these individuals are 'tied [...] to the knowledges that experts profess' (p.77). In constructing an essential anorexic subject position, through the DSM-IV, psy has eliminated the possibility of thinking that other forms of anorexia may exist. The women in this pro-anorexia forum are working to suggest some of these alternative forms of anorexia that for now exist on the margins of the hegemonic definition. This essential anorexic subject position, as a classified category produced by psy, may also be conceptualized as what Hacking (1999) calls an

‘interactive kind’. Before this is more fully explored, a short detour is required to sketch out exactly what Hacking means when he speaks of an ‘interactive kind’ (p.102)

Hacking (1999) uses the term ‘kind’ to highlight the ‘principle of classification, the kind itself, which interacts with those classified’ (p.104). He differentiates between ‘indifferent kinds’ and ‘interactive kinds’ through the concept of awareness. The former refers to a kind of object which is unaware of how it is classified and as a result is not affected by how it is described. Hacking uses the example of a Quark, ‘Quarks are not aware. A few of them may be affected by what people do to them in accelerators. Our knowledge about Quarks affects Quarks, but not because they become aware of what we know, and act accordingly’ (p.105). An ‘interactive kind’, on the other hand, is aware and as a result can change as a consequence of how it is classified. Hacking (1999) gives the example of the ‘child viewer’,

Once we have the phrase, the label, we get the notion that there is a definite kind of person, the child viewer, a species. This *kind* of person becomes reified. Some parents start to think of their children as child viewers, a special type of child (not just their kid who watches television). They start to interact, on occasion, with their children regarded not as their children but as child viewers. Since children are self-aware creatures, they may become not only children who watch television, but, in their own self-consciousness, child viewers. They are well aware of theories about the child viewer and adapt to, react against, or reject them (p.27).

I quote Hacking at length here in order to secure a template with which to fuse his concept of the ‘interactive kind’ with a discussion of EDNOS as a ‘poser’ identity. I argue that psy’s DSM-IV classification of anorexia has constructed a definite kind of person, *the* [anorexic], a species’ (p.27). As Hacking makes it clear, we must not view the anorexic herself as socially constructed, but rather the *idea* of the anorexic. This idea of the anorexic, the construct, which has been ‘reified’ as a ‘species of person’ (p.26-7) is

what the individuals on the Forum, quoted below, are aware of and interacting with³².

Each of them are comparing their 'statistics' with the construct of anorexia provided by the DSM-IV.

Rebecca: *raises hands* what makes me feel like a poser is i got a BMI of 18. not even 17.5, ana bmi and i am going on recovery. i don't deserve recovery i'm too fat (The Forum).

Cindy: heh...at 112 i felt like a poser...now i KNOW i am!! i'm 121 now! that's an extra 9 f**kin lbs in just 3 weeks! How the f**k did i let myself gain that much? How can i even think i'm ana now? (The Forum).

Beatrice: oh man im so glad im not the only one who feels that way! Im constantly telling myself im just a poser and im not a good enough ana <sad confused emoticon> (The Forum).

Rebecca is not of the anorexic kind because she has a BMI of 18 as opposed to the 17.5 which is a number that clearly demarcates the anorexic as a 'species of person' (p.26).

Cindy uses her weight in pounds to arrive at the same conclusion through comparison.

But this does not explain why these individuals choose to refer to themselves as 'posing' or 'wannabee' anorexics rather than individuals with EDNOS. The answer for this, I argue, is found in the comparison of how these two 'kinds', 'anorexic' and 'EDNOS', are constructed, or rather, how the 'eating disordered kind' as a meta-kind is constituted.

From talk shows, such as Dr. Phil or Oprah, to medical documentaries or docudramas, one commonality exists when it comes to eating disorder representation; the anorexic body occupies prime position. Often, it is an anorexic who is on the extreme end

³² Whether the 'official' construct of anorexia carries over into clinical practice is less obvious. Some women in the Forum explained how they were refused treatment because they did not meet the full criteria for AN. Other women described how professionals, used the DSM-IV definition as an 'ideal type' or blueprint, accepted that symptoms vary from person to person, and offered them the same treatment as would be given to someone who met full criteria.

of the self-starving continuum. This indicates that there is a strong interaction between expert culture (the DSM-IV) and the representations in popular culture.

For example, in November 2003, Entertainment Tonight (ET) aired an emotionally charged clinical intervention which aimed to *save* '56 pound' anorexic, 'De Hart', whose extreme state of emaciation clearly indicated that she was on the verge of death. Perhaps, rather than having the goal of raising an important social issue, this representation capitalizes on the knowledge that spectacle sells, and that the 'shock factor' is proportionate to audience ratings. Regardless, the overrepresentation of anorexia means that bulimia and EDNOS (which are often incorrectly viewed as being less dangerous than AN because they are less shocking visually) are not represented. The message conveyed is that the anorexic body is a 'body that matters' (Butler, 1993) while bulimic and EDNOS bodies are 'those that do not' (Ferris, 2003: 259). Thus, what results is that the eating disordered individual, as a species of person, is constructed as being an anorexic. As a result, Rebecca, Cindy and Beatrice, in order to view themselves as 'truly' eating disordered, believe they must be of the 'anorexic kind'.

If these three individuals eventually become 'officially' 'anorexic', according to DSM-IV criteria, as a result of their yearning to be of the 'anorexic kind', they are challenging the notion that anorexia merely 'surface[s] as the result of psychological and emotional problems' inherent in the individual (Hardin, 2003, p.213) They undermine psychological discourse which asserts that anorexia develops and is maintained as a result of the individual's deficit and dysfunctions, because they explain how they are, in part, engaging in self-starving practices in order to meet the DSM-IV classification of anorexia. If individuals engage in 'anorexic' behaviors as a result of their yearning to

obtain the ‘anorexic’ identity, as Hardin (2003) suggests, the very idea of the ‘anorexic’ as a kind of person will change. This is what Hacking (1999) refers to as the ‘looping effect of human kinds’ (1995a in 1999, p.34). Hacking (1999) explains this ‘phenomenon’,

[people] can make tacit or even explicit choices, adapt or adopt ways of living so as to fit or get away from the very classification that may be applied to them. These very choices, adaptations have consequences for the very group, for the kind of people that is invoked. [...] What was known about people of a kind may become false because people of that kind have changed in virtue of what they believe about themselves (p.34).

As Hacking (1999) states, individuals can both ‘adapt’ in order to ‘fit’ or ‘get away from the classification’³³ (p.34). The individuals above have adapted in order to ‘fit’. However, because ‘anorexic’ practice is described above as something one chooses to engage in, in a context where psychological discourse views it as being a result of unconscious processes, these women may eventually alter the dominant meaning of ‘anorexia’ itself. The women discussed in the next section have adopted alternate ways of conceptualizing anorexia in order to ‘get away from the classification’ set by the DSM-IV. These individuals may also be considered to be a part of a ‘looping effect of [anorexic] kinds’ (p.34) as they rearticulate the very meaning of anorexia. In the section that follows I explore how the concept of anorexia is restructured and some of the possible impacts that these women’s reformulations may have on the category of anorexia itself (p.34).

³³ Because mental illness is a source of stigma in society many individuals describe having such a ‘label’ as a negative experience because of the prejudice that exists towards those with mental health problems. However, the label of ‘anorexia’ appears to be viewed differently by women with eating disorders. It is often not seen as a stigmatized identity but rather something they wish to be described as having. Perhaps, ‘anorexia’ is different in this respect, in part due to the popular media glamorization of anorexia and their portrayal of it as a ‘disease’ of the wealthy and successful actor/celebrity.

6.3 Reconstructing Anorexia

Cindy: we're the ones who've got the whole concept of ana susses out, cuz it's NOT about some magic number (The Forum).

Cindy's statement illustrates one side of a debate found on many pro-anorexia web sites, including the Forum, which I chose as a site of research. This debate surrounds the question of how 'anorexia' should be conceptualized. In the Forum, participants defined 'anorexia' in one of three ways, each of which related to either the individuals body weight, behaviors, or thoughts and feelings, although these categories were not always mutually exclusive.

6.3.1 Anorexia as 'Weight'

The previous section illustrated how anorexia is construed as a positive identity to many of the Forum's participants. Anorexia was viewed as 'superior' in comparison to EDNOS and, as other studies have indicated, this conclusion is also drawn by many sufferers when it is contrasted with bulimia. Numerous studies have considered why it is that anorexia is viewed by women as the 'superior' eating disorder. Literature on the topic calls attention to the symbolic properties of the thin body in contemporary Western culture and its being attributed to a host of internal qualities such as self-control, success, and willpower. Much less attention has been paid to how this 'superior' category is guarded by those with eating disorders. For those who consider their selves to be 'anorexic', and who wish to protect the exclusivity of 'their' category, body weight is invoked as a signifier upon which the 'anorexic' boundary is set. The following comment, posted by Jenny is illustrative of this,

Jenny: um well you know what? you aren't anorexic if you are overweight. Sorry (The Forum)

Hannah, quoted below, started a thread asking the question, does size matter? Penny clearly articulates in her reply that Hannah cannot be 'anorexic' according to 'medical' standards, and as a result of this assumption she argues that her experience represents simply a desire 'to be skinny'. By positioning Hannah as someone who is simply yearning after the slim body, Penny categorizes her as being 'just' another woman who is preoccupied with dieting. This emphasizes the commonality of her experience and simultaneously protects the exclusivity of the 'anorexic' category.

Hannah: im big lass and am anorexic so is it true that size doesnt matter or bmi (The Forum).

Penny: OKAY. Here is the medical definition of anorexia
-weight loss of 15% or greater below the expected weight for height
-self-imposed food intake restrictions, often hidden
-absence of menstruation
-intense fear of weight gain
so no, you are not anorexic, you just want to be skinny, and probably dont do it healthily. if people are telling you you're anorexic, they're lying, or they believe that if you continue your current behavior, you will become anorexic (The Forum).

Hannah's question is one that is often posed in the Forum, in various ways, and it is frequently used as a subject with which to initiate a discussion thread. Individuals ask if they can be considered anorexic if they are normal weight, overweight, or even underweight but simply not underweight enough to meet DSM-IV criteria. Penny's response also illustrates how the DSM-IV, especially the 15% criteria, is brought into the discussion in order to mark the boundaries of the anorexic subject position. In the case of 'anorexia' the 15% criteria is what Foucault referred to as the 'external frontier of the

abnormal' as it 'traces the limit that will define difference in relation to all other differences' (Foucault, 1977, p.183). These requests for inclusion, as they may be called, are what I describe as 'direct' requests. Another style that was more commonly found on the Forum was that illustrated by Rhona below,

Rhona: [...]how can I say I have ED issues when I'm so f*ing fat
<question mark emoticon face> Pardon my implied French...touchy
subject for me (The Forum).

Rhona can be seen to be using an indirect request for inclusion in the category of anorexia. By using this type of approach, stating that she cannot possibly have a problem at all because of her size, sympathetic responses are often elicited from those who reply. Such responses often include statements which downplay the importance of weight as a criteria and which act to transfer the focus to the painful experience of the individual, highlighting her thoughts, feelings or behaviors. This shift in focus is made explicit by the responder as they list certain thoughts or behaviors which they describe as the 'true' indicators of 'anorexia'. Other women indirectly draw attention to a discussion of thoughts, feelings, and behaviors, through rejecting weight as a signifier. Sam illustrates the latter of these two responses, "Fuck weight. Since when were eating disorders 'all about weight'" (The Forum).

However, while some individuals granted another person's request for inclusion, they did not appear to act in the same way when it came to offering their selves the same 'leniency'. This conflict is evident in Sam's later message, on the same thread, which shows a complete reversal in position from her statement above.

Sam: JUST FUCKING BAN ME FROM THIS GOD DAMN PLACE.
SIZE DOES FUCKING MATTER AND I AM A GOD DAMN COW.
ALL OF YOU ARE ALL FUCKING SKINNY AND I AM JUST ONE

FUCKING HUGE DISGUSTING TUB OF LARD. YOU ALL HATE ME, I FUCKING KNOW IT. I DON'T DESERVE THIS PLACE. FUCKING GET RID OF ME (The Forum, emphasis in original).

This illustrates how women on the Forum were eager to discount weight as an indicator for others, but when it came to discussing their own situation the overwhelming importance of weight became extremely clear. This discursive pattern indicates two important themes, one of which relates to medical discourse and the other which conveys an important aspect of the pro-anorexia community, both of which are inextricably linked.

I would like to refer back to medicine's reliance on the 'clinical sign' (Austin, 1999, p.247). The accounts above both support and contest the centrality of 'weight' in the classification of 'anorexia'. As opposed to cognitive or affective processes, body weight is a 'physical sign' that is both visible and calculable. The acceptance of a concrete physical indicator, a cut-off weight in the case of anorexia, reinforces the 'authority' of medical professionals who are said to hold the 'power' to 'define what constitutes a clinical sign and establish its linkage with health or pathology' (p.247). In other words, the individuals who are accepting that 'anorexia' is defined by weight are acting in collusion with medicine and its discourse. Their accounts also strengthen the power of the 'normalizing gaze' which, similar to the 'clinical gaze' according to Austin (1999), 'requires the acceptance that there is something of significance to be gazed on, that pathology and deviance can be *seen* (p.247, emphasis in original). Furthermore, through emphasizing the fundamental role of weight in 'anorexia', these individuals are cementing the idea of 'embodied deviance' which is,

the historically and culturally specific belief that deviant social behavior (however that is defined) manifests in the materiality of the body, as a cause or an effect, or perhaps as merely a suggestive trace. In short, embodied deviance is the term we give to the scientific and popular postulate that the bodies of subjects classified as deviant are essentially marked in some recognizable fashion. Palpable and visible, the body's contours, anatomical features, processes, movements, and expressions are taken to be straightforward, accurate indications of an individual's essence and character (Terry & Urla, 1995, p.2,6, in Austin, 1999, p.247).

The notion of the 'clinical sign' and the term 'embodied deviance' (p.247) presuppose a type of exclusivity within the categories laid out by the medical profession. Sam for example, in her account above, being aware of this makes a concerted effort to pull down the exclusive boundary of weight in an attempt to make the category of 'anorexia' open to others. However, when she refers to her own experience, she does not extend this offer of 'inclusivity' to herself, which indicates that although she wishes for a non-weight determined anorexic category as an ideal, she realizes that her experience must be constituted in reference to a weight factor. Sam's conflict highlights how the pro-anorexia community may be seen by its participants as a popular alternative to professional care, as a result of its atmosphere of 'inclusivity', which provides a more accepting environment when compared to a professional's office. Dias (2003) supports this assumption and further points out that too often individuals with anorexia, who fail to meet the full criteria, avoid seeking professional treatment through fear that they will be rejected or their experience negated. This pro-anorexia community aims to remove that fear which prevents individuals speaking about their experience. However, other sites in the community appear to uphold these exclusive barriers similar to that of medicine. As one individual describes,

Lara: Yeah, I don't really like the other forums...I've explained why in several threads lol People here are all supportive and there's none of those self-important snots who expect to be put on a pedestal because they have a low weight, or put anyone down because they have a higher weight (The Forum).

The difference between the Forum and other pro-anorexia sites, which is noted by Lara, illustrates the error which is made by assuming that the pro-ana community is one homogenous entity about which generalized theories can be made. Many second-wave feminist theorists, such as Bordo (1992), have sought to position 'anorexia' as either over-adherence to, or rebellion against, cultural dictates. Similarly, literature on pro-anorexia – although not without exceptions - has tended to position pro-anorexia as either over-conformity to, or rejection of, medical and psy discourses. The accounts of individuals on the Forum, such as Sam's, who exists within her own contradictions, highlights how subjectivity is constantly being negotiated, rather than occupying a fixed space, and how a multiplicity of discourses exist not only within the community but within the individual herself. It is this basic assumption that subjectivity is fluid, which has allowed me to thoroughly consider these women's alternate notions of 'anorexia', such as that which is defined by one's 'behavior' or 'thoughts and feelings'. Otherwise, as a researcher viewing 'anorexia' as a fixed subject position, these women's conceptions may have been dismissed as illegitimate and possibly overlooked. Gergen (1991) highlights the error of working from such a perspective in the contemporary context as he explains,

Under postmodern conditions, persons exist in a state of continuous construction and reconstruction; it is a world where anything goes that can be negotiated. Each reality of self gives way to a reflexive questioning of irony, and ultimately the playful probing of yet another reality. The center fails to hold (in Strong, 1995, p.53).

The view of anorexia as defined by body weight is one ‘reality’ of the women on the Forum. Yet, it is one ‘truth’ which itself yields to the other ways in which ‘anorexia’ is constituted, and it is these which will form the basis of the remaining two sections.

6.3.2 Anorexia as ‘Behavior’

The accounts below were taken from a message thread in which women in the Forum were discussing their views on what constitutes a ‘hardcore’ anorexic. Although the term ‘hardcore’ can be used to describe someone who is dedicated, devoted or even addicted to a course of action, it appeared to relate, in the case of this message thread, to the notion of authenticity. More specifically, an ‘anorexic’ authenticity which is confirmed by the persistent presence of certain food and exercise related behaviors.

Karen illustrates this in her account,

Karen: [..] The difference between a dabbler in crash dieting and a “hardcore” anorexic is like the difference between someone who has discovered he/she likes pot, and someone who’s a tweaker or a cokehead (The Forum).

According to Karen, an amateur dieter resembles someone who simply has developed a fondness for pot whereas a “hardcore’ anorexic” is more fittingly compared to a ‘tweaker’. This imagery emphasizes the strong behavioral component of anorexia. Marijuana is a more commonly used and less addictive substance in comparison to cocaine, which is one of the most highly addictive drugs available today. In addition, a ‘tweaker’ is a slang term used to describe a crack cocaine addict who ‘look[s] for rocks on the floor after a police raid’ (IPRC, 2004). Crack, a more potent and damaging form of

cocaine, is characterized by chronic uninterrupted use, severe impairment in functioning, and desperation during withdrawal. The latter of these symptoms is described accurately by the term ‘tweaker’. The crack addict’s daily behaviors are structured around their addiction and this I believe is the reason why Karen chose to use this type of addiction to describe the ‘reality’ of a “‘hardcore’ anorexic’. Her account illustrates how she views the ‘anorexic’ as someone whose behavior is constantly structured around weight-loss behaviors. Rather than being described as someone of a certain weight, the ‘anorexic’ is depicted as someone relentlessly pursuing certain behaviors. As Sam describes,

Sam: [...] I don’t think it’s how you look though. Because the skinniest girl can have bones sticking out of her body left and right but you can’t call her a hardcore anorexic. What if she eats A TON of food. I don’t know <confused emoticon> (The Forum).

For Sam, it is impossible to assume that an individual who appears to be at an ‘anorexic’ weight is actually ‘anorexic’ because without the knowledge of her behavior (amount of food she consumes) this fact cannot be confirmed. If the individual is known to ‘eat[] A TON of food’ this undermines the label of ‘anorexia’ because it is contrary to the behaviors normally associated with this ‘disorder’. Emma describes these types of behaviors, such as calorie counting, ‘restriction’, and purging, which are characteristic of anorexic practice.

Emma: i guess i am a bit different. i think most people with eds are hardcore. If you purposely decide to not eat something healthy because of the calories or make yourself puke to stop calorie absorption, i would call that hardcore. i mean 500 calories may seem like a lot to us but when you of human needs, restriction you body to 500 calories for a long period of time is hardcore (The Forum).

Many women on the Forum, after admitting they have ‘failed’ to meet the anorexic weight criteria, provide detailed descriptions of the food and exercise related behaviors they engage in as alternate evidence to prove their status as an ‘anorexic’. This, I argue, may be a reason why many pro-anorexia web sites in the community describe anorexia as a lifestyle rather an illness. The former, defined as ‘a way of life or style of living that reflects the attitudes and values of a person or group’ (Stedman’s Medical Dictionary, 2002) refers to a way of behaving in everyday life. This concept of ‘anorexia’ as behavior is a more inclusive definition because it downplay the rigid weight cut off point as the defining feature of ‘anorexia’. As a result, the notion of ‘anorexia’ as a lifestyle, or a way of behaving, creates a community which is open to a larger number of individuals who wish to be included but fail to meet the strict criteria set by the DSM-IV. Although the act of minimizing the importance of weight may be understood as challenging the DSM-IV, as also demonstrated by Dana below, classifying anorexia as made up of a set of associated behaviors frequently leads individuals to invoke the term ‘functioning’, which as a concept forms the very foundation of the DSM-IV. At the very least the use of this term indicates that while individuals may construct an alternative framework within which to describe their experience, they are ‘always dependent upon available and circulated social and historical discourses’ (Hardin, 2001, p.16) and the ‘key’ words which these discourses produce. This is evident in Dana’s use of the word functioning,

Dana: [...] it’s not necessarily the weight as much as the behavior and how it affects your *functioning* (The Forum, my emphasis).

A large number of ‘mental disorders’ are described in the DSM-IV as being such because, in addition to other factors, they also cause an ‘impairment in social,

occupational, or other important areas of *functioning*' (APA, 1994, my emphasis). This phrase can often be found in the form of criterion E or F attached to various 'disorders' in the manual, and where it is not stated explicitly it is always implied. According to Crowe (2000) the presence of such criteria demonstrates how the 'DSM-IV (APA 1994) reinforces a normative expectation that individuals function productively in society' (2000, p.73). Crowe (2000) describes the basis behind this expectation,

The predominant neo liberal and rational economic ethos, which permeates most contemporary western cultures, requires individuals who can contribute to the economic wealth of that society. When the success of societies is evaluated on purely economic criteria it becomes crucial that individuals can participate in enterprises of production and reproduction. [...] As a behavioral attribute productivity could be defined as the use of time and space in culturally sanctioned ways in order to meet culturally determined goals (p.73)

From this perspective, the 'anorexic' is viewed as having a 'mental disorder' because her behavior prevents her from being a productive member of society who efficiently contributes to the economy. I argue that the notion of productivity, which is defined as "practical efficiency in the 'attainment of goals generally accepted as reasonable'" (Sass, 1992, p.2, cited in Crowe, 2000, p.73), explains in part why many in the pro-anorexia community choose to describe 'anorexia' as a lifestyle rather than a 'mental disorder'. This is because the term lifestyle illustrates how some women in the community consider 'anorexia' to be a 'style of living' (Stedman Medical Dictionary, 2002) which is consistent with *their* goals as individuals. In the reverse, 'anorexia' is not understood as a 'mental disorder,' by these individuals, simply because it is inconsistent with the 'goals generally accepted as reasonable' by society. If these women in the community referred to 'anorexia' as a mental disorder they would be demonstrating how they held the same goals for themselves as that which society designates they should.

However, the pro-anorexic's use of the term 'lifestyle' is frequently invoked by 'outsiders' to demonstrate how this community is promoting destructive behavior as safe conduct.

Thus, the community's view that 'anorexia' represents a 'lifestyle' is considered by many academics, medical professionals and media personnel, as being indicative of how these women represent a group of misinformed, naïve or unaware individuals. Two dichotomous positions are erected, the 'pro-anorexic' is either ignorant of the dangerous aspects of her behavior if she construes her 'disorder' as a lifestyle, or she is described as being aware of such implications if she refers to it as a mental 'disorder' or 'illness'. This demonstrates that, as Cover underscores through Butler (1990), even though identities are founded in 'ambiguity and incoherencies', these very elements are 'suppressed and redescribed' to serve the cultural need for consistent and cohesive subjectivities that 'social participation and belonging' are contingent upon (2004, ¶28).

Through acknowledging this need for 'consistent and cohesive subjectivities' (¶28) it becomes possible to recognize the extent to which ambiguity exists within the pro-anorexia community. Although 'anorexia' is viewed by some women as a lifestyle which is consistent with their individual goals, it is not considered to be without its problems or damaging consequences. For many, engaging in 'anorexic' behavior is consistent with their goal to survive, to gain temporary relief from emotional problems, or to develop a sense of self-worth. As Cindy explains, '[..]My ED is my crutch if you like- it helps me stand and walk' (The Forum). The fact that these results are often temporary or even pseudo-achievements in some cases is irrelevant, they become real benefits for those that yearn after them. However, they are not without the awareness that

using anorexic behavior to achieve these goals means that their health is seriously compromised, and this contradiction forms the very basis of their ‘anorexic’ subjectivity.

Many on the Forum expressed how they were riddled with this ambiguity,

Tracey: [...] i know it’s a horrible way to live, because in some respects I exist inside my head, and i know there’s no way out. no matter how hard you try, you’re trapped by the fact that you know it helps you keep a handle on life...i know without doubt i have food issues...and i use them to control my emotional space as much as my body.. more so in fact (The Forum).

Tracey views her ‘anorexia’ as a way to ‘keep a handle on life’. In psychological terms Tracey would be described as using anorexic behaviors as a coping mechanism³⁴. This view of ‘anorexia’ as that which helps the individual regulate ‘emotional space,’ by remaining in the cognitive realm ‘inside [the] head,’ represents a third way of knowing ‘anorexia’. This conception of ‘anorexia’ is put forward by some women in the Forum who believe the disorder should be defined by the individual’s mindset rather than body weight or behaviors.

6.3.3 Anorexia as ‘Mindset’

Lara: how much you weight doesn’t determine your mental state- which is what anorexia really is (hense the name, anorexia nervosa). There isn’t a magical weight that will clearly make you anorexic, though for a medical diagnosis, there is. Which is fucken stupid. You sound anorexic to me. Remember, it’s all about what’s going on in your head, not on the scale (The Forum).

Karen: [...] Being “ana” as such is not dependent on weight. It’s a mindset. The DSM-IV is very silly...and not just on the diagnostic criteria for EDs. It’s hard to meet all the diagnostic criterium for anorexia nervosa, and you might die before you even get there. Sad but true. The medical system is

³⁴ The term ‘defense mechanism’ would be used in the case where a thought process or behavior is employed by the individual on an *unconscious* level. A ‘coping mechanism’ is a thought process or behavior which is *consciously* used by an individual to help them deal with a situation or life event.

only read to help people when they are so far gone its unlikely they'll survive long... (The Forum).

In the Forum, the most popular way of describing 'anorexia' was in relation to the individual's thoughts and feelings. With the common knowledge that 'anorexia' is discursively claimed by psy as a 'mental disorder', Karen's assertion that 'anorexia' is a 'mindset' may be understood as positioning her to be in collusion with psy discourses.

The same conclusion could also be made about Beth based on her account,

Beth: I know there's text book junk. But it IS IN THE MIND. It's not a physical disease it's psychological (The Forum).

In her research on internet boards discussing anorexia, Hardin (2003) found that women were also discussing anorexia as a 'mindset'. The accounts she came across stated that regardless of 'weight' an individual could be anorexic if "they have 'anorexic' thinking" (p.214). Hardin (2003) argues that as a result of conceptualizing anorexia in this way, women assert that they have the "required 'anorexic' thinking" and 'articulate the obligatory psychological and emotional pain associated with the desire to lose weight, regardless of how much they weighed' (p.214). As Sascha below illustrates, I found this to be evident in my own research,

Sascha: [...] Just because you can't see my ribs, doesn't mean that I don't have a problem. Ana is more intense that others realize. It is a lifelong suffering disorder. I swear from the moment I wake up until I go to sleep, food and my weight are what I think about the most (The Forum).

According to Hardin (2003), discursively positioning anorexia in this manner reproduces 'psychoanalytic literature' which claims that anorexia is a result of individual deficit and family dysfunction (p.214). I agree that this is one possible result of their constructing

anorexia in this manner. In fact, I referred to this in Chapter 2 where I stated that the psy disciplines position anorexia as being a result of the individual's cognitive deficits' (Lena, Fiocco & Leyenaar, 2004, p.108). I also described Minuchin et al's (1978) 'systemic theory' which theorized anorexic behavior as a consequence of the 'dysfunctional famil[y]' (in Malson, 1999, p.86). In light of this, it appears reasonable for Hardin (2003) to argue that women constructing 'anorexia' in this way are in fact 'reinforcing dominant psychological explanations (emotional pain, psychological distress) concerning the etiology of anorexia' (p.214). However, I would like to argue that, although Hardin's (2003) interpretation is clearly viable, an alternative understanding can also be made which situates these women as offering a counter-discourse which in fact challenges 'dominant psychological explanations' (p.214). An entry point with which to investigate this counter-discourse lies within the subject of CBT (Cognitive Behavioral Therapy). I am aware that CBT would not usually be employed as means to provide such a critique, however, I explain below why I argue it to be useful to do so in this particular study.

CBT, the most frequently used type of therapy in the treatment of anorexia, is a pillar of psychology which is based on the idea that cognitions (thoughts), affect (feelings), and actions (behavior) are inextricably linked. An example of such an interaction in the case of anorexia is as follows. The individual thinks that eating carbohydrates (bread, pasta, etc) will result in a sharp increase in weight. This 'faulty' thinking causes her to feel anxious about this food group which in turn leads her to avoid consuming foods which fall within this category. The goal of CBT, in this example, would be correct this 'faulty' thought (carbohydrate = weight gain) through education

which would then reduce or eliminate anxiety which then, in turn, would prevent her from avoiding this food group. Postulating that anorexia is solely defined by the thoughts and feelings within the individual severs the link between these and self-starving behavior. For these individuals their ‘negative’ thoughts and feelings do not always cause weight-reducing behavior³⁵. In fact, a common frustration for many on the Forum is located in the fact that their persistent and troubling thoughts are not recognized as such because they have not yet manifested consistently in their behavior or on the contours of their bodies. By severing the link between anorexic thoughts and behaviors, and the anorexic body, these individuals are challenging the ‘discursive construction of anorexia nervosa’ (Hardin, 2003, p.214) rather than aligning themselves with it. Constructing ‘anorexia’ as that which is solely defined by thought processes (and feelings), these women are reconstructing ‘anorexia’ in a way that differs from the DSM-IV category. Their accounts posit ‘anorexia’ as a ‘disorder’ which is defined by thoughts and feelings *only* rather than cognition, affect, behavior, and physicality, which criterion A,B,C, and D, each refer to in the DSM-IV classification of anorexia.

This reclassifying of anorexia can also be understood as initiating what Hacking refers to as the ‘looping effect of human kinds’ (1995a in 1999, p.34). In reference to this, I want to reiterate the question: what impact will these alternative accounts of ‘anorexia’ have on the category of ‘anorexia’ itself? (p.34). Through interacting with and later rejecting the DSM-IV’s idea of ‘anorexia’, these women have created a new way of knowing anorexia. Thus by describing their experience as such they may contribute to ‘the [former] classification[] and description[] [being] revised’ (Hacking, 1995b, p.21 in

³⁵ However, it is acknowledged that other behaviors may be linked to these ‘negative’ thoughts and feelings, such as weighing oneself or visiting the pro-ana community.

Brinkman, 2005, p.774). More specifically, by identifying their experience as ‘anorexia’, even when it may not be in ‘official’ terms, these women may seek treatment prior to the point when they meet *all* the criteria of the DSM-IV. Consequently, if and when a doctor diagnoses them with ‘anorexia,’ the ‘official’ classification will be altered and will have been adapted to incorporate their definition of ‘anorexia’. Emma’s account below illustrates this possibility,

Emma: yeah, the numbers are a ‘guidance’ for doctors but they are not the final word. I was diagnosed purging ANOREXIC and i had a BMI of around 19 (btw the hospital that did the diagnosis is an accredited ed treatment facility, Rogers Memorial Hospital, so i don’t think they are wrong that often). i had the mindset and this is the most important part of a diagnosis [...] (The Forum).

This widening of the classification to incorporate other ways of knowing (and experiencing) ‘anorexia’ has already occurred. The DSM-III criteria for anorexia requested weight-loss which led to a body weight of 25% below that which is expected (1980). In 1987, when this version was revised and subsequently became the DSM III-R, the weight criterion for anorexia was reduced from 25% to 15%. In addition, in its present format, the DSM-IV-TR which was published in 2000 as a replacement for the 1994 DSM-IV, includes amenorrhea (for three consecutive months) as criterion D for an anorexia diagnosis. It has been predicted that this will be absent in the DSM-V because research has provided evidence to ‘suggest[] that the presence of amenorrhea does not increase the diagnostic specificity of the criterion’ given that some patients will continue to menstruate at a very low weight’ (Mitchell, Cook-Meyers & Wonderlich, 2005, p.96). In other words, amenorrhea has been discovered *not* be a distinguishable aspect of anorexia and as a result will possibly not be included in the DSM-V, which is expected to

be published in 2011 or later. Regardless of the transient nature of DSM criteria, the classifications which reside in the present edition have very concrete ramifications for those whom they include and exclude. As Dias (2003) explains, many individuals with ‘anorexia’ who do not meet the full criteria fail to seek treatment due to a fear that they will be rejected (p.39). Others minimize the severity of their eating practices altogether when they learn that they fall outside of the diagnostic parameters. Through challenging the DSM-IV criteria and reconstructing anorexia as ‘mindset’ these women may be more confident that their experience is meaningful and as a result be more willing to seek treatment once they have decided upon recovery. At the very least, by defining ‘anorexia’ as a pattern of thoughts and feelings, those individuals who have not yet lost a ‘clinically significant’ amount of weight may seek treatment earlier as a result, instead of waiting until they meet the DSM-IV’s weight cut off point. This could have a large impact on recovery rates. As Dias (2003) explains, ‘the success rate of treatment programs for anorexia is very low- not solely the result of the failure of specific treatment techniques, but largely because once anorexia reaches a critical and chronic stage it is much harder to recover (p.39). The real accomplishment of these women contesting the DSM-IV will be realized when enough of them have sought treatment and been diagnosed even though they fail to meet all the criteria.’³⁶ This means that the classification will need to be adjusted in order to be congruent with their manifestation of ‘anorexia’. Without this last part of the ‘looping effect’, although these women may be more willing to seek treatment under their own ‘definition’, they may still be unable to access the services they need.

³⁶ Some professionals diagnose patients with full syndrome disorders even when they fail to meet all criteria so that the patient can access publicly funded services or receive reimbursement through their insurance coverage (Kutchins & Kirk, 1997).

As Lara illustrates below,

Lara: Anorexia (not ana, the disease, anorexia) is not a number on a scale. It's the guilt you feel for having one too many pieces of lettuce in a salad. It's the physical and emotional pain you feel when you look at yourself and see what isn't real. It's hating yourself so much you want to starve away the pain, to disappear so no one can touch you or hurt you. *It isn't "Oh look, my BMI IS 17, now I'm anorexic". That belief is why so many of us cannot get help when we so desperately want it* (The Forum, my emphasis).

It is the broadening of the diagnostic category in 'official' terms which, although 'undesirable from the vantage of third-party payers' (Mitchell, Cook-Meyers & Wonderlich, 2005, p.96) who would see an increase in the amount of treatment 'eligible' individuals, would actually mean that the individual's willingness to seek treatment would be met with *accessible* treatment options. This also highlights an important contradiction. The pro-community has been criticized mainly on the basis that it aims to promote ill-health rather than recovery. However, the fact that more women may be treated, or at least have access to treatment at an earlier stage in the illness, as a possible result of these women's efforts to expand the category of anorexia, challenges previous notions of the community as engaged in encouraging sickness as they appear to be involved in promoting easier access to treatment (recovery).

CHAPTER 7: DISCUSSION OF FINDINGS

In this thesis I employed a critical discourse analytic approach to investigate how individuals with anorexia, in the online pro-anorexia community, negotiate with psy discourse as they attempt to understand their eating disorder experience. Simultaneously, I endeavored to explore how these women's behavior was affected by how they positioned their selves in relation to this discourse. Due to the Internet providing a space which facilitates debate, in the form of discussion forums, it was chosen as source of data because it offered a collection of rich, spontaneous, and authentic individual discourses which I could explore. As much of the debates around the topic of anorexia occurred within the online pro-anorexia forums, I was drawn particularly to this community as a site of study. The transgressive nature of this community has meant that its members have been constructed in specific ways, such as, women oppressed by, or liberated from, cultural ideals of the slim body. Therefore, my ultimate goal was to use these findings to challenge previous literature on pro-anorexia, while constructing an alternative meaning of the community which recognizes, among other things, that these women are involved in rearticulating dominant discourses (beyond those which revolve around the beauty ideal), rather than being simply passive recipients of the former. Working from a poststructuralist perspective of discourse, I was given the flexibility to explore how the discipline of psy constitutes the experience of anorexia in particular ways, while simultaneously attending to the individual's own understanding of their practice and how they in turn rearticulate and create new discourses. In the sections which follow, I address

each of the abovementioned objectives in relation to my findings while also proposing suggestions for future research on the topic.

Contrary to the psychological conception of anorexia, as that which emerges from, and is maintained by, individual ‘deficits and dysfunctions’ (Malson & Swann, 1999, p. 397), this thesis highlights how anorexia is constituted by the very social and cultural backdrop from within which it manifests. In fact, I argue, one of the central facets of the contemporary context which heavily influences the subjectivity of the ‘anorexic’ is the discursive constructions of psychology itself. This fact is supported by many of the individuals’ discourses located within the Forum, which revolve around the discussion of the DSM-IV and its eating disorder classifications. Through exploring various individuals’ accounts I found that these women positioned themselves in various ways in relation to this classificatory system. Therefore, contrary to the assumption of some theorists which constitute these women as a homogeneous group, I found the community to be made up of a diversity of voices which became evident in the variety of positions they occupied as they discussed the concept of eating disorder classification. For this reason, I chose Hall’s (1993) reception model as it allowed me to explore three of these central positions which the women assumed. The women whom I described as having adopted the dominant or preferred meaning of eating disorder classification, accepted the DSM-IV’s presupposition that its categories of eating disorders resemble fixed entities and that the manual description reflects the ‘reality’ of the anorexic experience rather than one possible construction. The women in this group appeared deeply frustrated by the fact that their ‘anorexic’ experience was inauthentic according to the DSM-IV standard; a conclusion they arrived at because they had accepted the DSM-

IV as that which describes 'real' anorexia. In other words, their discontent stemmed from the lack of 'fit' between their experience and the so-called 'reality' of anorexia claimed by the DSM-IV. In order to resolve this discrepancy these women explained how they were attempting to lose further amounts of weight in order to 'fit' and authenticate their experience. The fact that these women are choosing to lose further weight from their already slight frames in order to authenticate their experience contradicts the bio-medical and psychological notion of anorexia which positions it as an illness that progresses as a result of psychological and physiological changes that occur as a result of the disorder itself. These findings are crucial because if women are worsening their health in order to become 'officially' anorexic, as Hardin (2003) argues, this 'implies volition and choice' which demands an alternate treatment approach to that which works under the assumption that the disorder is solely a result of unconscious mechanisms within the individual.

Other women negotiated their experience and understanding of the classificatory system of the DSM-IV. On the one hand, similar to those who seem to operate from a dominant code, these women were acutely aware of how the DSM-IV categories influenced their subjectivity and how their eating disorder identity was dependent on their experience fitting its criteria. However, at the same time, they also explained how the discrepancy between their 'reality' and how it is described in the DSM-IV meant they were resigned to rejecting the usefulness of its classification as a way to understand their own experience. From this position these women were left without sufficient tools with which to communicate their suffering because the restrictive character of the categories neglected the complexity of their practice. As some of the members of the Forum

explained, when speaking with others outside the community about their disorder they were forced to 'package' their experience in the simplistic categories constructed by the DSM-IV. This occurrence emphasizes the need for women to produce new discourses which attend to the specificity of their practice and which will allow them to communicate their experience more precisely. These new discourses provide a wider discursive field of possibilities which other individuals can then choose to draw upon in describing their lived 'reality'. This breaking open of discursive potentialities is what some women on the Forum were already attempting to achieve; through their complete rejection of psychology's way of classifying eating disorders they created new possibilities for talking about their experience. Although this meant that they are less restricted by the DSM-IV's terms, as they seek to frame their behavior, it also means this group of women may be at risk from rejecting the possibility of professional help due to their connecting the 'inferior' classification system with those that utilize it. In a context where it is commonly known that women with eating disorders rarely seek help of their own volition, their rejection of the efficacy of psychological terms and treatment may further dissuade them from seeking the help they need to recover.

In attending to the narratives which move beyond a discussion of eating disorder classification in general, I explored how women negotiated with the specific categories of 'anorexia' and 'EDNOS' set by the DSM-IV. The classification of EDNOS, for those who considered their selves to fall within its boundaries, was uniformly experienced as a negative label. The view of EDNOS as being 'failed' anorexia was a recurrent theme within these discussions. Individuals explained how, in a context where anorexia is viewed as a status symbol among the community, receiving a diagnosis of EDNOS was

really a label which described what the person *is not* rather than what they *are*. The feelings which resulted from this appeared to drive these women to yearn to become anorexic. In addition to this being of obvious concern due to women further compromising their health in order to achieve the label of ‘anorexic’, it also clearly highlights the productive capacity of the DSM-IV which is commonly assumed by psychology as that which describes experience and not that which creates it.

EDNOS was also constructed by women in the forum as an eating disorder non-identity. More specifically, it was understood by some to be a term which is used to describe a broad spectrum of chronic dieting rather than eating disordered practices. In a contemporary Western context where dieting is a reality for many women, the ‘catch-all’ category of EDNOS was an unwanted label by nearly all the women in the Forum. Its lack of exclusivity meant that it was interpreted as a label which neglects the specificity and the severity of their *eating disordered* experience. I argue that this is, in part, reinforced by the policies that frame treatment and access to mental health resources for those with eating disorders. It is rare that insurance companies cover the cost of treatment for eating disorders and when they do they often stipulate that a diagnosis of anorexia or bulimia be present while stating that EDNOS will not warrant funding. The broad nature of EDNOS and the fact that it is rarely an ‘insured’ illness together construct it as an eating disordered body that does not ‘matter’ (Butler, 1993) while inadvertently constituting anorexia as a sure way to produce a body that does. In this context we see women, ironically, seeking to become more ill in order to access the treatment they need to get better.

In addition, being classified as ‘unspecifiable’ was problematic for women on the Forum because they felt that without falling within a more ‘definitive’ category, such as anorexia, they were unsure how to proceed with ‘fixing’ their selves. This emphasizes how individuals today have become reliant on the knowledge of experts (Rose, 1996) who are perceived to hold the answers to recovery. For if the ‘expert’ cannot specify your problem and translate it into a precise diagnosis they cannot ‘suggest’ a route to fixing the problem. Thus, the individual is left with an unsolvable problem in their eyes because that which cannot be defined cannot be repaired. This is of central importance because if EDNOS is viewed as an eating disorder non-identity the women which fall under its heading remain unsure as to how to recover, and in some cases they questioned the fact that they were ill at all. This was also the case where EDNOS was interpreted by individuals as that which resembled a ‘posing anorexic’ identity. In other words, EDNOS was understood as describing those who pretend to be anorexic although they ‘officially’ are not. This is problematic because anorexia is again reified as the ‘authentic’ eating disorder which women seek to be classified as. Contrary to the cases above, where women were changing their behavior to fit within the category of ‘anorexia,’ the latter part of the my analysis illustrates how other women are engaged in reconstructing the meaning of ‘anorexia’ itself in order for *it* to fit with their experience.

Rather than upholding the definite boundaries of the category of ‘anorexia’ as defined by the DSM-IV one group of women were involved in ‘opening’ up the classification so that they could use the term to describe their eating disordered experience. They challenged the validity of the DSM-IV weight criterion, often assumed to be the defining feature of the disorder, and constructed anorexia as that which can also

be defined by behavior or by an individual's feelings and thought patterns.

Reconstructing anorexia in this way, Hardin (2003) would argue, illustrates that women are in fact 'reinforcing dominant psychological explanations (emotional pain, psychological distress) concerning the etiology of anorexia' (p.214). However, although this may appear to be the case at first glance, I argued through using the idea of cognitive-behavioral theory (CBT) that women are actually refuting psychological assumptions about anorexia because they are severing the connection between processes of the mind and one specific behavioral outcome – severe weight loss – which CBT, and psychological perspectives in general, posit as being inextricably linked. Importantly, the outcome of this reconstruction means that, for the women on the Forum, the category of anorexia was altered to be a more inclusive and a more accessible descriptor with which a larger number of women could associate with. Hardin (2003) argued that by opening up the category of anorexia, through describing it as being solely defined by the individual's mindset, women are illustrating how 'psychological discourses result in young women claiming and declaring their own pathology in order to be considered authentic anorexics' (p.214). However, I argue that cultural discourses, other than that of psychology, have constituted anorexia as a status symbol which denotes self-mastery, control, and perhaps celebrity standing. It is these discourses which should be identified for their role in producing women which 'declar[e] their own pathology in order to considered [] anorexic[]' (p.214). In this context, cultural discourses of the slim body are acknowledged for their negative role in promoting unhealthy dieting behavior, but also for attaching a celebrity status to 'anorexia' which paradoxically encourages women to declare that they have a problem that needs to be addressed. This process may in fact

encourage them to seek help and consider recovery. Through claiming an anorexic identity, prior to meeting official DSM-IV criteria, these women are at less risk from further compromising their health in order to meet classificatory 'standards'. Therefore, claiming the illness label ahead of meeting 'official' requirements of diagnosis is a much safer adjustment than that performed by the women, who in the EDNOS discussion, were seeking to further deteriorate their health in order to become anorexic.

The narratives of the women on the Forum clearly illustrate how the individual is inextricably tied to the discourses which constitute their experience. Whether they are involved in restructuring their behavior to fit official guidelines or reconstructing the categories themselves, their subjectivities are largely influenced by the discursive field of 'anorexia' which is dominated by the hegemonic discourse of psychology. To posit anorexia as solely a result of individual 'deficits and dysfunctions' is insufficient as it ignores the crucial role of how women and their experiences are 'always contingent on the availability of circulated discourses' (Hardin, 2003, p.13) and in the case of anorexia, influenced by the constructions of psy discourse.

It is the poststructuralist vision of 'discourse' which has enabled this program of research to access how these women's individual narratives are located within dominant socio-cultural discourses and how they negotiate their subjectivity through them. Although a poststructuralist approach focuses on the role of the social, the flexibility of the approach (Hardin, p.13) which enables the researcher to switch back and forth between the individual and master discourses means that the accounts of the individual are not merely an instrument to access something larger but an integral part of the process of inquiry. This is of utmost importance because this thesis aimed to concentrate on how

the *individual* negotiates with psy discourse, rather than focusing on psy discourse itself per se. This particular aim is in line with a critical discourse analytic approach (CDA) because the latter focuses on the welfare of ‘dominated groups’ as its motive and seeks to work in a way that is ‘consistent with their best interests’ (Van Dijk, 2001, p.96). It is only through understanding the individual experiences of anorexia that we will be able to provide better support, treatment, and resources for those who suffer from the disorder so that they will be able to regain their health.

As this thesis has provided evidence of, the pro-anorexia community provides a window into the experiences of anorexia as seen by a segment of the ‘anorexic’ community itself. It is a community which has highlighted the multiplicity of meanings which surround anorexia and illustrated the theoretical and empirical shortcomings of approaches which claim there is only one way of ‘knowing’ anorexia. This is important because how ‘people position their stories’ and the outcomes of this ‘positioning’ has concrete effects for the individual, as my analysis has illustrated (Hardin, 2003, p14). It is in this natural environment, in which individuals are freely discussing *their* realities and negotiating with dominant discourses, that there exists a largely untapped wealth of knowledge waiting for the researcher who wishes to more fully understand the specificities of what it means to be eating disordered. In light of these conclusions I argue that many of the existing discourses of the pro-anorexia community must be acknowledged for their shortcomings, and that a new way of knowing this group of women needs to be articulated.

The pro-anorexia community has been at the receiving end of a barrage of criticism from the media which has described them as ‘gruesome,’ ‘pathetic,’ and

'sinister' (Pollack, 2003, p.246 citing femail.com) and even as a group that 'supports the devil' (Graham, 2001, Chicago Tribune cited in Pollack, p.247). As a result, they are articulated as the anti-thesis of the pro-recovery community. From an academic standpoint, these women have been constructed as docile readers of cultural ideology which has placed them in a dead-end of over conformity to dominant discourses which refer to the cultural ideal of the slim body. To the same end, they have also been positioned as a group engaged in rebelling against the same cultural prescriptions; although often this battle is conceptualized as a futile one in that their health is comprised as a result. This binary positioned argument is one that has long haunted the debate of the anorexic and has been transferred to the pro-anorexic. In contrast, the variety of narratives encountered in the course of this research, illustrate the heterogeneity of the group and the multiplicity of accounts which are present within the pro-anorexia community. The diversity and depth of meaning articulated by these women shows them to be acutely aware of the role of dominant discourses in constituting their experience. In addition, the content of their accounts illustrate their ability and engagement in self-reflection. This is not to suggest that the illness behaviors they engage in are not of concern and potentially lethal but rather, to propose that positioning them as cultural dupes caught in over-conforming or resisting cultural ideals is theoretically insufficient because it neglects the complexity of their lived experience and their communication of it. In the same way, constructing this group as the anti-thesis of the pro-recovery community is equally inadequate. Positioned as the opposite of pro-recovery, this community is perceived to be made up of individuals largely engaged in the task of encouraging each other to worsen their condition and ignore important health indicators

which clearly show that they are endangering their lives. Throughout my research I found that support among these women assumed the form of helping each other deal with the emotional pain associated with their eating disorder. Often, individuals were found to be warning others not to 'go to far' and advising them how to limit the damage done to their bodies by remaining hydrated and taking vitamin supplements, for example. These findings are in line with Dias's (2003) approach which positions the community as a 'sanctuary' of support for young women with anorexia. This is not to argue that the entire pro-anorexia community is identical in this way, as there are some sites where this is not the case, rather I suggest that instead of viewing the 'pro' part of the community's label as that which suggests a promotion of anorexia it is better understood as describing a group of individuals who are actively engaged in anorexic practices. More specifically, I warn against conceptualizing all sites in the community as 'pro' anorexic simply because they are not 'pro' recovery. Perhaps, these women would be better understood as simply 'anorexic'. In transcending this structure of polar opposites it becomes evident that these women are in fact a group of individuals who are ill with anorexia who feel unable at present to partake in recovery. Thus, the pro-anorexia community provides a safe place where they can discuss their experiences in an atmosphere which is appropriate to their stage in the illness. This fact was also supported through a discussion of the Stages of Change Model (SCM) which can be used to identify that these women are in the 'precontemplation' or 'contemplation' stages of change (Zimmerman, Olsen & Bosworth, 2005, ¶4-5). This means that the pro-recovery movement is not an adequate alternative which is overlooked by these women but rather an inappropriate atmosphere given the current state of their illness. This combined with the fact that while in the initial

two stages of change treatment is largely ineffective, means that the pro-anorexia community is an important resource for these women for the support function it offers. In addition, as Dias (2003) has illustrated, the letter writing tasks and discussions these women are involved in within the pro-anorexia community mirror important exercises used in 'Narrative Therapy' which aim to externalize the 'eating disorder voice' (Epston et al, cited in Dias, p.39). The latter is utilized as a method for women to 'gain some psychological distance and recognize that the eating disorder does not define them' (Dias, p.39) which facilitates the process of healing. What this suggests is that the pro-anorexia community, frequently hoisted as that which promotes anorexia, is inadvertently involved in similar recovery processes which are enacted in a therapeutic context.

Regardless of whether pro-anorexia is understood as engaged in promoting disordered eating practices, or as a 'sanctuary' (Dias, 2003) of support for individuals with anorexia, the fact remains that these internet communities are far from being occupied by a 'pitch-fork-and-torch-bearing-mob' (Cerulean Butterfly, 2006) of misinformed individuals. To the contrary, this study shows how these women demonstrate a capacity for critically thinking as they shore up dominant discourses, such as those of psychology, and rearticulate the former while also producing new alternative discourses of 'anorexia'. In addition, due to the community being publicly located online, it provides a uniquely accessible discursive space where we can actually learn how these women are reproducing, restructuring and challenging dominant discourses, and the effects of these positionings on their everyday lives. Recognizing this as a unique offering of the pro-anorexia community is important in a context where such information may well be unavailable elsewhere. Accessing these women's discourses is a necessary

endeavor if researchers and those in the medical and psychological professions wish to gain a greater understanding of both how the disorder manifests in the contemporary context and how best these individuals are to be approached in order to be helped in their process of recovery. However, this opportunity becomes overlooked when these women are constructed as being solely involved in promoting self-starvation, because it forecloses any meaningful investigation into the community which is only possible when the latter is considered as a site which offers a diversity of individual discourses and meaning.

I began this thesis with an excerpt from a message posted by a young woman called Michele, which illustrated the struggle that exists between the anorexic individual and hegemonic discourses, one which makes for a complex relationship in which subjectivity is continuously being negotiated and constantly shifting. In the course of this research it was this discursive wrestling of Michele and other women which I sought to explore. I explained above how the way in which these women understand their experience of anorexia, in relation to psy discourse, can affect their behavior and the course of their illness. However, as these women create new alternative discourses of anorexia, they also have the potential to affect the category of anorexia itself. For example, reconstituting anorexia as a disorder defined by a particular mindset, regardless of the presence of a critically low body weight, opens up the category to enable a larger number of individuals to use the term to describe their own experience. This could mean that women in the early stages of anorexia, who fall short of meeting all criteria, may be more willing to see a professional because they do not fear being rejected (Dias, 2003). If professionals then diagnose them as ‘officially’ anorexic, and this pattern continues, the

DSM-IV category will eventually need to adjust in order to more adequately reflect the manifestation of the disorder as it is being presented. In fact some women on the Forum referred to this by explaining how they had been diagnosed with ‘anorexia’ although they were still menstruating or had not lost the full 15% of body weight required for diagnosis. There is a possibility that the DSM-IV may alter its criteria in such a case, because it has done so in the past. The DSM-III required a 25% loss in body weight for a diagnosis of anorexia to be made (1980). This was later changed to 15% in the DSM-IV (1994). The broadening of the diagnostic category of anorexia, if instigated by the many thousands of women in the pro-anorexia community, could eventually create an increase in the amount of treatment ‘eligible individuals’. This would mean that those who are willing to seek treatment would be able to access the appropriate services. The latter domino effect of these women’s discourses contradicts dominant ideas about the pro-anorexia community which position it as that which is exclusively engaged in promoting ill-health to women. The way in which these women may potentially affect the dominant DSM-IV also indicates, as Fairclough argued, that discourses are ‘socially constitutive as well as *socially shaped*’ (Fairclough & Wodak, 1997, p. 258, my emphasis). It also suggests that sociological research, which has largely concentrated on how the media and cultural ideals of beauty and thinness have affected the prevalence of anorexia, is only considering half of the social equation. This is because the impact of individual discourses on dominant discourses is largely left uninvestigated when it comes to studies on anorexia.

A critical understanding of this community, or similar communities, is only achieved by adopting a perspective, as this thesis has done, which neither romanticizes or

dismisses the content of individuals' discourses but rather, seeks to consider how these are located within a specific context. It is only in this way that we can aim to understand, and subsequently work to promote the 'welfare' of those whom we study while effecting actual change which is 'consistent with their best interests' (Van Dijk, 2001, p.96).

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APPENDIX

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Author

(Read 490 times)

KAREN

I mean, does anyone here really not care what they are - anorexic, bulimic, ed-nos, compulsive over exerciser, anorexic with purging tendencies, purple and plaid kangaroo who hoards food in her pouch?

I mean, isn't it a little silly? We've all got a problem. It's just labels.

MEMBER

lol. i agree. as long as we address the problem, who cares what we are.

MEMBER

I dont care. All I know is that I have a problem with food and how to eat it, or not eat it.

MEMBER

EXACTLY!!!!!!!!!!
I love it how most of us just kinda mix the different named boards and just post on all of em. I dunno what I am. I'm not medically ana or mia, but I don't care. At all. I'm screwed up with food and weight, and lots of stuff, and I know it. That's about it.

Logged

0000

MEMBER

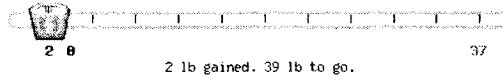
Hey,
Well I have come to the conclusion what I am is what I am. And what I am Is Fat and all I wanna do is get back down to a good weight. So I do care if Im fat ..
Dawn

Logged

0000

MEMBER

Hey,
Well I have come to the conclusion what I am is what I am. And what I am Is Fat and all I wanna do is get back down to a good weight. So I do care if Im fat ..
Dawn
[url=http://www.TickerFactory.com/]
TickerFactory.com



Logged

0000

LAURA

I don't care which 'category' of ED's I fall into. It doesn't make a difference to me, or to eating habits. There's not much point for me in pinpointing myself as something because my eating habits change daily anyway.

Logged

Pages: 1 2 3

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Author

quote

MEMBER

this is gonna sound weird but sometimes i dont think i have an eating disorder. Like technically i guess i do, but it doesnt feel like it coz i have it so well organised etc it doesnt seem disordered. Like to me its normal to go days or weeks without eating or purge if i eat, and laxatives and slimming pills are just a part of life. As well as hours of exercise a day. It just feels normal.

Logged

quote

MEMBER

I dont care. All I know is that I have a problem with food and how to eat it, or not eat it.

same for me

Logged

quote

EMILY

It seems like so much of our identity is tied up into the names and labels we fall under.

To go nameless is to be lost.

So, yeah, I guess it does bother me a little. But at the same time - if you know what you are yourself, the only time names are relevant is when you're trying to explain yourself to others. And I avoid that anyway.

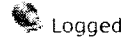
Pas de grandes choses.

Logged

JOANNE



It's a label and only a label. It's just a nice way to have everything all classified and put away in nice little boxes.
A problem is a problem doesn't really mater what it is.

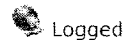


LOUISE



nah, i dont care about labels out of the ed world, so i dont care about then inside.

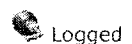
I just hold on to the labels cos its easier to understand. But my eating diorder is pretty much a dailly buffet of anorexia, bulimia, COE, and everything else in this goddamn eating disorder list. Theres no way i can posibly just choose one that totally describes my problem. Except EDnos.



MEMBER



I have tried to fall under just ana, I've tried to fall under júst mia. But I've realised that there really is no way of labelling it, I have a messed up way of thinking when it comes to food and I can't understand how my friends manage to eat normally, stay happy and stay relatively thin. I don't want to be labelled anymore, I still find it hard to admit I have any kind of disorder, it doesn't seem right that I should have.

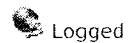




JANE

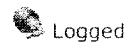
Don't label me, I'm not a soup can! 🙄

I feel like too much a poser to actually have a label. I am just sort of in the gray area of ana and mia. 🙄



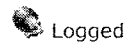
MEMBER

Label me "unhappy" with the way I look.



MEMBER

i don't know what i am. and i don't care. all i know is a have some serious food issues





SARAH

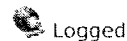
ooooo.... i wanna be a kangaroo!

wrote:

Don't label me, I'm not a soup can! 🙄

I feel like too much a poser to actually have a label. I am just sort of in the gray area of ana and mia. 🙄

yeah, a lot of times i feel like i'm undeserving of a label, as dumb as that may be. but i try not to put myself in one little box, because it's too hard to fit, and there's not much point in trying.

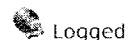


MEMBER

haha! I don't care what the hell I am!

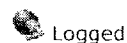
ana, mia, coe (compulsive over exercising), adderall addict...

Whatever makes me lose! Screw labels! I wanna lose!



MARIE

Actually, I do care...
not because i want a label, but because if I know **exactly** what it is maybe i can **fix** it. 🙄





Logged

MEMBER



Logged

It took me forever to even name it an eating disorder. All the other names are just confusing to me. I know that I have a problem with food, but I really don't care what the medical term for it would be. I guess many feel that way... 🙄

Logged

Logged

CATHERINE

I agree. Most of the time, when I mention it, I refer to it just as my ED, but from now on I'm the purple and plaid kangaroo!

Logged

MEMBER

Logged

I don't really care. Sometimes I switch between ED's, but I'd like to just stick w/ ana... Not that I like havin an ED, but u know what I mean...

Logged

MEMBER

Logged

i agree...but i still care

Logged

MEMBER

Logged

i certainly don't. i just call myself fucked up.

Logged

(Read 1040 times)

HEATHER



Just wondering which criteria we all fail to meet in ana/imia/coe etc. to make us "NOS".

I am not quite as underweight as would make me ana yet.

I have symptoms of a Compulsive Exerciser.

I eat more than a lot of anas (500-600 kcals per day on average).

So how about you all. Don't know how many of us are here yet. . . .



MEMBER

well.....i'm 5'8 and 145lbs due to recovery.so im not underweight...yet....lol.and i am also a compulsive exerciser.....i tend to eat more calories dialy, but i make a point of burning off every calorie i eat.....my BMI is too high to be considered ana basically



TANIA



I'm not quite ana because I'm not underweight enough. I think I am on the line between underweight and healthy though. And I eat about 800-1000 calories a day, most anas restrict WAY more than that.



MEMBER



I am really not sure, but I found a great site with myths and facts about eating disorders....

<http://www.mirror-mirror.org/myths.htm>



(Read 1041 times)



MEMBER

ya.....i get 'hunger-highs' just from not eating and then drinking soda on an empty stomach.....sadly, i love the feeling, like ive accomplished something.



REBECCA

I used to get high on sugar. Like when you have very low blood sugar then I ate a whole enormous lot of chocolate and junk, then you have way too much sugar in your blood and your brain gets high.
LOL, I called it getting high on sugar when in fact i was bingeing...

Oh and to answer the question - i ate too much 800-1000 cals and i still have my periods. So that's EDNOS i guess. Hell i hate this stuff. I'm more than specified, stop insulting my with "not specified"!!



MEMBER

☺ I defenetly know about the sugar high.... ☺ It's my nickname *points*.
at the ABSOLUTELY grossest time in my entire life... I used to eat PURE sugar... with a spoon full of butter.....
I'm almost barfing now thinking of it.
I LOVE the feeling when you're like flying... when your stomach has been empty for so long, then all of a sudden.... sweet surrender....

☺ lol



MEMBER

Yeah well I'm almost there. Unfortunatly we will soon have dinner here and i'll be forced to eat.
sigh
I still use to eat pure sugar, but then when I have to think or concentrate on something really hard, because that foggy thinking isn't good for your results.



VICTORIA

hey sorry havent read all the posts here, but something just crossed my mind... arent some of us pushing a lil harder just to be considered ana, not to be discovered or anything, but just so they have an identity, does this make any sense....

oh wait hang on, got to found out something...

yeah i found it. when i was like 13 i wrote in my diary 'i ate to much and now i have to throw it up, else ill never be bulimic' is that sick or what? well im bulimic now but still feel bad cos im not anorexic.....

not that i ever wanted to get an ed, but since ive already always had one, i wanted one that would give me the recognition ive always wanted. does this make sense? sorry if i offend anyone with this

Logged

Quote

MEMBER

Well- my situation is a little weird too.

Most of highschool I was naturally skinny at the same time I was compulsive overeating (thousands of calories a day and never gaining weight). Then my summer going into senior year I started really restricting (not intentionally- I stopped eating due to stress) and went down to 95 lbs.

Then I got pregnant, had an abortion, got depressed and started compulsive eating again. This time I ballooned upto 147 lbs.

I tried to restrict to loose weight but it really was just not working, then I started the Atkins diet and since I have lost 16 lbs and counting.

Even though I eat probably a good 1000 calories a day, and excercise moderatly (not crazy psycho all the time like i used too) I still cannot stop obsessing about loosing weight, getting back into that size zero mini-skirt i love so much, not finishing all my food, etc.

Oh well- I've always had issues with food- dating back to 6 years ago- but I really can't pinpoint my

2/18/2006

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exact ed. but the world is not exact and I'm just happy that i'm loosing weight a little more healthier than I used to.

Logged

Quote

SADIE

Distraught~

Yeah, that makes perfect sense. Striving for something just to fit in. Feeling left out is such an awful awful feeling.

Logged

Quote

MEMBER

Yeah, I get HH sometimes. I can remember a few times where I have had classes all morning and then gone into town to do some shopping and not eaten anything even though I'd been up for 6 or so hours. Then I'd buy myself a good strong coffee and I'd feel like I was tripping on drugs. The world would just float by me so fast and I'd feel like it was spinning. Its a kinda good feeling in a way. Its weird, because I think I'm always a bit spaced out too...my friends always pick up on it when I'm talking to them and I am looking totally somewhere different.

really sick. However...I don't eat full meals...ever...I cant' ..eating too much at one time will make me pass out as well...
not saying I'm right or that I know what I'm talking about...
just something else to consider
take care

MEMBER

sucks eh?...im hypoglycemic too.....i have to eat somethin small every few hours, and im on a specialized diet which blows chunks.....if i dont eat a certain way, i basically become paralyzed and end up in the ER.....
@Negative:.....i'm way too fat to be ana.....least you look thin....im too fat to even convince a therapist i have an ED..lol.....

Logged

Quote

vrote:

sucks eh?...im hypoglycemic too.....

MEMBER

It does suck...that's why I'm such a loser at fasting..I think forum members must roll on the ground laughing...for me...to go 12 hours without food...this is how I can fast...not eat after 7:00 pm and skip everything the next day until 5:00 pm...that's with getting dizzy...dropping to the ground ...trying to drive and function without blacking out..it's freakin embarassing...the only way I can even go that long is because I sleep through alot of it.. pretty dumb,huh?

Logged

Quote

MEMBER

I'm EDNOS because I go through cycles of OE (over eating) and then restricting, purdging and doing everything and anything within my power to loose weight. I go real extremes (highest weight in an OE cycle was 200, lowest weight in a Anamia cycle 125-30ish) and I mean that's within a really tiny time frame which does really bad shit to your heart and stuff I'm trying very hard to stop myself from going into an OE cycle and I want to loose a lot more weight that I have been...already dropped 10 pounds in the last week! 🙄

Logged

Quote

CAROL

I think almost all EDers are EDNOS. Only cuz that term is so fcking vague. It's like saying all pencils, pens, crayons, and markers are "writing utensils", and nothing more.

Was that a dumb analogy? 🙄

Logged

Quote

MEMBER

My period is starting to fuck up...

Logged

Quote

(Read 1043 times)

MEMBER



wrote:

I'm ED-NOS because I'm too fat to be anorexic.

amen. in addition to the fact i still get my period.



Well, I am not underweight yet, and I eat too much (have to, nursing a baby) and also I purge (but my binges are quite moderate, like two bars of chocolate or 1/2 a litre of icecream..Or just too much yoghurt..)
 BUT I do not have my period, from pregnancy and nursing or ana, I don't know, my baby is 5 months now..
 And also, I over exercise I guess..
 Oh, almost forgot, I am quite possessed with healthy food and the way the body processes it and such and got the diagnosis Orthorexic from before..
 But I mean, how healthy is it really to throw up three times a day?!



MONICA



Yeah, it's weird not to have an "identity."
 ..I wish I knew what the hell I am.
 I think about food almost all the time, but when I eat I try to purge (or on a good day; purge.) ..
 But mostly I can't get it up 😞 And then I fast..
 And I'm binging way too much. Some days I eat all the time... When I'm bored, when I'm sad, when I'm happy..
 All the time. And then I feel bad, go to the bathroom and try to purge... If it comes up I'm so happy. But if not, I have to fast for at least two days. 😞



MEMBER

im not anorexic coz im too fat and still get my period although i didnt get it when i was really low. And i dont eat more than 200cals per day and i go weeks fasting etc.

im not bulimic coz although i purge and take laxies and slimming pills, i have never binged.



MEMBER

I am a purging anorexic but still once in a while (every 2 months or so) get my period.



KIM

I'm too skinny to be 'normal' or to get my period but too fat to be anorexic. My doctor says my body's in "semistarvation mode" as opposed to "starved". Which is worrying, but just not worrying enough.



Logged



MEMBER

you know what's wierd? when i was in partial, my psychiatrist actually gave me the diagnosis of anorexia. which i thought was completely absurd because i am DEFINATELY not anywhere near being underweight (at the time i was about 130 at 5'8") granted, i do typically try to eat less than 200 cals a day and i run and burn off 300 cals a day if i'm in my restricting phase. otherwise tho, i compulsively eat like no other! so i don't know where she gets off saying i'm anorexic. i think she better go back to school!!! lol 😂

Logged

MEMBER

I guess I would qualify myself as purging ana, because I don't eat a whole lot (maybe 300 cals a day max? Around 3 pts if anyone knows weight watchers) but if I ever eat to the point where i can actually feel anything in my stomach, I have to get rid of it.



I used to think that too, "I have to throw this up or I won't be bulimic." Then i just stopped eating a lot, haha.

But I haven't stopped my periods yet, and I'm not underweight, so I guess I'm not really anorexic, technically....

Logged

NATALIE

Humm.. well. I'm ED-NOS because first, i'm not underweight and i never have been. I've already had a BMI of 19 but it's the lowest I've been. Then, I have my periods, which is obvious. Humm.. I have binge periods and restricting ones. I've used laxies sometimes, i'm not exercising a lot and I fast sometimes. I'm never vomitting. All together, it makes that I'm mainly maintaining my weight and even if I can lose 15 pounds in a short time, I'll gain them and more in an even more shorter time. My binges aren't big ones.. always about 1000-1500 cals. Most of the time, I don't purge in any way.



So I'm not bulimic and i'm not anorexic... maybe coe? I don't think! 😂

Logged

MARIE

I heard ednos whas Chronic Dieting... where you keep going on and off diets even though your weight is healthy-ish.
here... <http://www.findingbalance.com/default.asp>



Logged



MEMBER

i dont bother to care where i do or do not qualify. i just know im fucked up.

Logged



MEMBER

I think I must be an ed noser after reading the article. That was pretty informative. Thanks for posting the link.



Logged



MEMBER

i don't know if i'm ED-NOS now, but i used to be now i haven't had my period since may 2005, and my BMI is 16.7 . so now i have met all the criteria for anorexia, the only reason i was EDNOS was because i was , like someone already said, too much of a fat-ass to be anorexic. still haven't figured out if i'm restrictive or b/p tho..i can go for about a month or 2 without b/p even once, but then i suddenly can't stop b/p-ing for 2 weeks straight like right now.. i hate it, but i know i will get back on track soon...it's like i'm constantly switching AN-restrictive/ AN-b/p...i'm weird..

Logged



MEMBER

is still NOS coz i'm such a fatass!

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(Read 196 times)



MEMBER

but no i'll never be good at anything, certainly not at controlling my food. *cries* it's only past 2PM and i've already had over 1500. I hate this, i thought i had left bingeing and purging behind me - i hate when things swing out of control again. I hate it i hate it hate it... or should i say hate myself. This is the first time in 2 or 3 months, i don't know, i don't even want to know. I want to cut so badly. Sorry for the rant. I fucking have to let it out WHY CAN'T I ACT NORMAL LIKE ANYBODY ELSE?

2/18/2006

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God, something or whatever, just end my fucking life i fucking want to die!



KAREN

I'm not ana either. I've just got a few problems...
...and I'm trying to figure out how to survive and how to live.
Fuck labels.



MEMBER

He aya,
hope you feel better now!!
I had a binge today too. We'll be better tomorrow and if not tomorrow, the day after tomorrow. Keep your head up. Two or three months of no bingeing is a long time, I know you can do it again!!



MEMBER

I know exactly what you mean. Since christmas I've gained so much, i can't even think about it. if I really had an ED I would be able to just fast it of, right?
God, I hate this.

And the thing is, the part of my brain that still can think knows that I wouldn't be gaining if I hadn't screwed up my metabolism so much. Makes me hate myself even more.

blah. here's to ranting. 😞

Logged

LOUISE

i know exactly how you feel, unfortunately.
You know that my doctor doesnt believe im anorexic or bulimic?! He hays im too much at a "healthy" weight to have an eating disorder...
it makes me feel so lost. I have an Ed, i have a problem, i know it. But then sometimes i think if i really had an ed i wouldnt be such a ball of lard.
But then again, an eating disorder hays more to do about the unhealthy relationship with food, than the weight.



Logged

MEMBER

I feel the same way.. i keep losing then gaining it all back over and over again..i'm still at a

Page 4 of 7

'healthy' weight so apparently there's nothing wrong with me 😞

Logged

MEMBER

i feel the same way sometimes..you are definately not alone on that one!...

Logged

MEMBER

I cannot maintain a steady weight for the life of me. I was down to an all time low last week, and now i've gained 5 of it back!!! I cannot control myself or my weight and it sucks. I feel like I am way too fat to be considered ana as well.. I see you sexy mommas on here that weigh 50-75+ lbs less than I do! Sometimes I feel like I should stop coming here until I am thin.. or at least until I am not

Pages: 1

(Read 75 times)

quote

AGATHA.

Ok. So there is this Anorexia Clinic near my neighborhood that I wanna seek help from. (I actually called them 2 months ago.) But it says on the 'rules' that "if you are an anorexic patient you are underweight and have lost your period".

Ok, so... Im underweight but I still havent lost my period, does that mean if I seek their help I wont be accepted? It pretty much sucks and I dont even wanna find out because im afraid they will turn me down because according to the fucking medical thingys you have to HAVE or DO NOT HAVE what says on their damn 'rules'.

Page 2 of 6

I once asked people (When I was insecure) Am I anorexic? And they asked "Have you lost your period"? And I said no. And they said "Well then you are not Anorexic".

I mean, this pretty much brainwashes me into thinking I dont have a problem that needs to be fixed until I loose my period! People SUCK.

Logged

quote

MEMBER

Losing your period is one of the indications of anorexia. It does not and should not classify you as Anorexic. Health professionals realize that everyone's bodies are different and react to things in different ways. It just may be that your body, hormones, and etc have not just caught up to your low weight and eating habits.

If a person admits that they have an eating disorder and wants help health professionals are more than willing to help out. The first major hurdle of any eating disorder is getting past the denial stage, once you're there then doctors can actually help the person.

If they don't treat you then they are not true health professionals, and therefore, you should go somewhere else. I'm sure there are many places that you can go to where they would be more than willing to help you.

Best of Luck! Keep us posted!

Logged

quote

MEMBER

I still have mine, and I'm 40kg!! At my lowest, I never lost it for long. It would come and go when it

MEMBER

raising both hands



Logged

REBECCA

raises hands
what really makes me feel like a poser is i got a BMI of 18. not even 17.5, ana BMI and i am going on recovery. i don't deserve recovery i'm too fat.



Logged

A BMI of 18? I WISH! Mine is 23.



MEMBER

Feel like a poser and feel like I'm too old for this site (no offense to anyone)
BMI = 20...don't really have a right to post..but I do anyway
kathy

Logged



MEMBER

i am standing up and shouting and pointing at myself going
THATS ME IM TOO FAT AND GROSS TO HAVE AN ED!

Logged



Logged

Logged

Quote

MEMBER

vewy cwafty.....hahahahaha 😊
I like layering anyway...I for the longest time have tried to avoid drawing any attention to my shape..partly because I 'm ashamed of it...and partly because you get the attention from the wrong time of guy...i like invisible..for the most part.

Logged

Quote

BEATRICE

oh man im so glad im not the only one who feels that way! Im constantly telling myself im just a poser and im not a good enough ana 😊

Logged

Quote

MEMBER

wrote:

oh man im so glad im not the only one who feels that way! Im constantly telling myself im just a poser and im not a good enough ana 😊

I've learned at this point that eating disorders don't have a set "weight". One of my closest friends in high school was hospitalized with bulimia and she was over 300 lbs. (I went to visit her there, when she was allowed visitors.)

Logged

Quote

MEMBER

enough w/ the short jokes!! *geez* lol 😊 i'm only jokin!

hehe my mom spent £20 on a poncho 4 me 2day. aaah gotta love ponchos!! so much better than jumpers, cuz they just kinda hang off! so even tho i'm havin a fat day 2day, no one else can see how huge and gross my stomach looks! YES! 😊 they aren't that flatterin, but quite slimmin actually

MEMBER

i think...

negative~ bulimia isn't really classified as needin 2 be underweight 2 be diagnosed w/ it tho is it... stupid docs... think they kno everythin but if i told my doc i had an ED he'd probably tell me it's all in my head! haha - esp if i said it was ana! (i'm too frickin fat...)

 Logged

CINDY.

heh... at 112 i felt like a poser... now i KNOW i am!! i'm 121 now! that's an extra 9 f**kin lbs in just 3 weeks! how the f**k did i let myself gain that much? how can i even think i'm ana now?

 Logged

 Logged

(Read 1298 times)



MEMBER

i feel like a failure, i can't believe i obsess so much about my weight but i constantly sabotage myself with bingeing and purging and cancel all the restricting and working out, out. It's a stupid fight against myself that i'm loosing?! I feel like i need an ana coach to get me back on track and smartin up and quit this bingeing crap. Nicole and L.Lo have a good buddy system going on. I need to find someone as messed up as me now and get them to move in with me.*



MEMBER

wrote:

i feel like a failure, i can't believe i obsess so much about my weight but i constantly sabotage myself with bingeing and purging and cancel all the restricting and working out, out. It's a stupid fight against myself that i'm loosing?! I feel like i need an ana coach to get me back on track and smartin up and quit this bingeing crap. Nicole and L.Lo have a good buddy system going on. I need to find someone as messed up as me now and get them to move in with me.*

I totally relate...and as bad as I feel for wishing this, I often wish I had a friend who had an ed, just to be able to share it with someone, it WOULD be so great to live with someone who has an ed...at least, I wouldn't feel so alone and judged. But yeah, the poser thing...that's me! I always feel like I'm posing, especially when I gain weight...damn binge cycles!



KIM

I was scared to look at this thread because I hate thinking I don't "really" have an ED and maybe I'm just kidding myself... I'm just a fatty who's obsessed with her weight BECAUSE SHE IS FAT.

But in reality, I know I'm sick. And now my doctor knows I'm sick, too. I was kinda hoping she could say "you have [this] and we treat it like [this]." I think our situation can be trickier to get help for because there's far less understanding of EDs in general. People tend to generalize and think "anorexics have bones sticking out and bulimics throw up all the time." If you actually look up the medical definitions of anorexia, bulimia and EDNOS you start to realize the wider range of EDs. In fact, there's debate amongst the medical community of widening the definitions to better recognize people who don't fit the categories exactly. (I did a lot of research before I was actually prepared to go see a doctor about this.)



MEMBER

wrote:

i feel like a failure, i can't believe i obsess so much about my weight but i constantly sabotage myself with bingeing and purging and cancel all the restricting and working out, out. It's a stupid fight against myself that i'm loosing?! I feel like i need an ana coach to get me back on track and smartin up and quit this bingeing crap. Nicole and L.Lo have a good buddy system going on. I need to find someone as messed up as me now and get them to move in with me.*

I' your girl! We should move in together! 🤗 Would you mind moving to Norway, though? 🇳🇴

Anyway, I don't have anything to add to what you wrote, I feel exactly the same way (and judging from this post, a lot of people do). It's kind of unfair- I think about my weight 24-7, I restrict and

Logged

Quote

MEMBER

I spend WAY too much time on this site.

Logged

Quote

MEMBER

don't tell me we need 2 start a club for THAT now too?! lol

Logged

Quote

MEMBER

babes you aren't a poser. you're just ednos if you're in the normal weight range (above 15%below body average) and not ana

First of all, who are you calling "babies"? How old are you? I'm not the grandma of EDs, but I'm old enough to not be called a "baby" by some teen ana.

The term EDNOS is a bit of a misnomer. It's ridiculous to think that someone "becomes" ana when they miraculously reach a certain weight. By the time a person reaches the low weight, they are long past the point of no return. They were anorexic long before that.

I have been in and out of this ED of mine for the last 11 years. I feel ashamed to have gained over the years. I feel ashamed that I have recovered FOR OTHER PEOPLE. It was never for me. I guess that's why I'm here. Again. Losing. Again. I know how to lose weight. I'll get my 22" waist back.

That doesn't mean I'm going to "become" ana. I still am ana. I never left it... or the ED never left me. Maybe I never let go of it, but it remained inside my head, regardless of what the scale says about my current body mass.

I started this thread because I am ashamed of the state my body is in today. I am embarrassed. I feel like I SHOULD be anorexic right now. I feel like no one would consider me a "for real" ana because I'm not currently underweight. I will be. In a few months. It doesn't take me long. It never does. (And yet at the same time, it always takes too long...)

Anyway, part of why I wanted to say all of this is there are a lot of people here who think they aren't ana because they are too fat, too heavy, but it isn't about the weight. There have been threads on here discussing that. Anorexia isn't about the numbers on the scale. It's in your head. It's in your heart. It's the same way that recovery doesn't happen by making a person gain weight. That doesn't fix the problem within.

(Which is why I'm here again.... but now I'm going in circles.)

Logged

Quote

LARA

anorexia (not ana, the disease, anorexia) is not a number on a scale. It's the guilt you feel for having one too many pieces of lettuce in a salad. It's the physical and emotional pain you feel when

LARA
CONTINUED

you look at yourself and see what isn't real. Its hating yourself so much you want to starve away the pain, to dissappear so no one can touch or hurt you.

It isn't "Oh look, my BMI is 17, now I'm anorexic". That belief is why so many of us cannot get help when we so desperately want it. Calling anorexia a an eating disorder is like calling a broken leg a walking disorder. The weight is one symptom of anorexia, it isn't all there is.

Logged

quote

MEMBER

- I think you look great, I know it probably doesn't mean much, because hey, when people tell me that I just shrug. But honestly I think you are doing terrific and you are such an inspiration to us all, the fact that you just can do it, and your looking better all the time. Ana truely never leaves the person, unless the person wants her gone, you cannot heal someone who is not willing to want to be healed. It just won't work, the person has to WANT to heal for it to work, and that goes for everything. But your doing great and keep up the good work, all of you guys are doing great. 😊

- I agree with you on your whole post. It isn't a thing where it's like, hey I didnt eat today, I'm anorexic, omg. It isn't that, it is the guilt we feel for eating, for our bodies, we just want our bodies and ourselves to dissappear forever, well I do. The weight isn't all about Anorexia, usually it goes deeper than wanting to be skinny, a lot of people think, when they hear your Anorectic, they usually say, well if you want to be skinny go on a diet, but usually that isn't what it is all about. But I agree with what you both said and you both are doing a terrific JOB!!!! Good luck to you all.

Logged



neg thanks so much... i'm in no mood 2 agure the case of why i can/can't qualify to be ana... readin the post that pretty much says "you're too fat to be ana" was more than a little hurtful to me, ur reply again lifted me up... i really do appreciate it (and yea, i know u weren't just fightin 4 MY case!!)

CINDY

y'know what's f**ked up? this is a thread 4 ppl who feel like posers, to come on and be encouraged. so far, everyone has been real nice about it and realised that ana is about more than a number on the scales... it's f**ked up that ONE person comes on this thread and tells us it's all BS when actually, we're the ones who've got the whole concept of ana sussed out... cuz it's NOT about some magic number.



maybe, once you get into that IP program on Monday, your therapist will explain what anorexia nervosa (not ANA, the fad and fashion for teens) really is.



wrote:

maybe, once you get into that IP program on Monday, your therapist will explain what anorexia nervosa (not ANA, the fad and fashion for teens) really is.

MEMBER



MEMBER

Whooo! well said AK!! i second what neg said!!



wrote:

maybe, once you get into that IP program on Monday, your therapist will explain what anorexia nervosa (not ANA, the fad and fashion for teens) really is.

MEMBER

what IP program is she going to?



raises hand

Quote:

Thanks.

Welcome.

Logged



quote

MEMBER

wrote:

The term EDNOS is a bit of a misnomer. It's ridiculous to think that someone "becomes" ana when they miraculously reach a certain weight. By the time a person reaches the low weight, they are long past the point of no return. They were anorexic long before that.

That doesn't mean I'm going to "become" ana. I still am ana. I never left it... or the ED never left me. Maybe I never let go of it, but it remained inside my head, regardless of what the scale says about my current body mass.

I started this thread because I am ashamed of the state my body is in today. I am embarrassed. I feel like I SHOULD be anorexic right now. I feel like no one would consider me a "for real" ana because I'm not currently underweight. I will be. In a few months. It doesn't take me long. It never does. (And yet at the same time, it always takes too long...)

Anyway, part of why I wanted to say all of this is there are a lot of people here who think they aren't ana because they are too fat, too heavy, but it isn't about the weight. There have been threads on here discussing that. Anorexia isn't about the numbers on the scale. It's in your head. It's in your heart. It's the same way that recovery doesn't happen by making a person gain weight. That doesn't fix the problem within.

neg~ this post really encouraged me... i had a forced normal eatin day today and i felt so totally un-ana... (that make sense?) it is all in my head. i may have eaten too much today, but that doesn't make me any less ana. thanks for the encouragement... i really needed it right now!

Logged

quote

JENNY : wrote:

MEMBER

um well you know what? you aren't anorexic if you are overweight. sorry.

And you know what? If one day after you leave your teen years, anasdarling, and you gain weight and find out you still have the same ana brain that you had when you were a teenage lightweight, you'll understand what I'm saying about how it's inside and not related to your weight on the scale... and you'll probably work damn hard to get back to the low weight again, but that's a side matter. The point is, EDs are with you for life, take different forms as the years go by and it varies from going into remission and taking over, or you end up dead. That's just the way it is.

You coming onto the ED-NOS board here to tell people they aren't anorexic is kinda rude. What exactly are you trying to prove, here? That you are thinner? We know that. We've seen your pictures. Bully for you.

I'm at least a decade older than you, and I know a little bit more about EDs than you do. I've had to live with this longer.

Logged

quote

MEMBER

exactly talk to any professional at a recovery center and they will tell you that weight has nothing to do with eds!

Logged

MEMBER

Hey thats me...over here. I feel unequal to all the others on this site who try so hard and I feel soooo unable to control anything.

Its kinda funny cause I saw this girl last night walking to a gas station. She was huge and had on this metallic shiny shiny pink jacket with a pink hat and I said to my husband "she looks like cotton candy!" You all hate me now for saying that. I am so mean to people but atleast I didnt say it to her face. Im not really mean to people but it seriously disgusts me when I see how some people just let themselves go and get so fat that they cant move. If you cant move, then how do you still manage to get the food you eat? Thats what Id like to ask!!! hmmm?

Logged

quote

MEMBER

I feel so ashamed at some of the thoughts that have flashed through my head when I see a heavy person. I can't believe my heartless thoughts. I hate them... I hate being obsessed over my physical weight ...I hate this struggle that is fruitless and I feel like a failure for not losing more weight. Kind of an "all talk and no action" sort of feeling... yeah...poser material here.

Logged

quote

POSER ALERT! POSER ALERT!! OVER HERE!

RHONA

How can I say I have ED issues when I'm so f*ing fat^{???}
Pardon my implied french...touchy subject for me.

Logged



wrote:

I think everyone's is 'better' than mine...I'm still fat. 😊

MEMBER

here here!



wrote:

I think everyone's is 'better' than mine. I'm still fat. 😊

MEMBER

Hmm... Ur definately not alone in that feeling! 😊



Yep, low self-esteem, sounds familiar. *raises his hand*

ALEX .

It's stupid, really.

"I'm not anorexic. Okay. I'm not bulimic. Okay. I don't have COE anymore. Am I sick at all?"

Pff. The most irritating thing about ednos is that you're not sure whether you're sick or not. If you are, not good. If you aren't you're a poser, not good. So having ednos is... Not good? YEP.



MEMBER

you speak my mind. You couldn't have put it better. Unless you fit into these strict definitions of anorexia or bullemia or COE it's really hard to know what you are. You know your eating is wrong (by "normal" standards) but you don't get a label. Somehow EDNOS feels like a cop-out. (not meaning to offend anyone) *sigh*



MEMBER

Lo! I posted a topic just about that in the EDNOS section this morning! 😊

MEMBER

I think maybe other people are better at their ed's than me, but not that theirs is any easier or better.



Logged

MEMBER

It's a wierd thing to explain howyou can feel/think someone else is doing better with their ED. Alot of it depends on where your at. With me, ana and mia swing back and forth sometimes. I HATE the mia side, so ana always feels like the lesser of 2 evils. And here's the kicker that's so screwed up, I don't "THINK" ana is evil(even though I know that hell all too well) but I do"THINK"mia is evil and I hate that hell. It's like an internal battle ana and mia have. Does anyone else ever go through this? It's so messed up.



Logged

CINDY

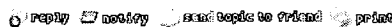
Re: My ED's better than yours, so pffft!!!
* Reply #12 on: Nov 27th, 2004, 07:31am *



I can kinda relate to that. I think the main reason I've always seen my ED as being wrong, is because that's what people have told me. To me tho, it feels right. My ED is my crutch if u like - it helps me stand and walk.

Logged

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HANNAH

Quote

im big lass and am anorexic so is it true that size doesnt matter or bmi.

Logged

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MEMBER

According to text books.... Yes it does matter and you have to fit all of the criteria to be a classic text book definition. In all honestly though.... size has nothing to do with it. Size doesn't determine how sick you are or how much the negativity in you mind controls you. I already said this in you intro but I have seen some of the most terminal/acute cases in people who were normal sized... I mean they didn't necessarily look like they had eating disorders but in reality behind the size... they were dying of self hate and just to mention... you don't have to be 80 pounds to die from anorexia. Any anorexic 80 pounds or 800 pounds can die of complications due to long term exposure to eatind disorder behaviors.

Logged

PENNY

Quote

OKAY . here is the medical definition of anorexia

- weight loss of 15% or greater below the expected weight for height
- self-imposed food intake restrictions, often hidden

PENNY
CONTINUED

- absence of menstruation
- intense fear of weight gain

so no, you are not anorexic, you just want to be skinny, and probably dont do it healthily. if people are telling you you're anorexic, they're either lying, or they believe that if you continue your current behaviour, you will become anorexic.

Logged

BETH

I know there's text book junk but it IS IN THE MIND.
 it's not a physical disease it's psychological. you can't have one without the other so if she's taking extremes to be skinny well I'd definitely say that she's anorexic. It almost feels discriminatory the way some people and doctors diagnose things or don't.
 in short, I agree with Catie 100%.
 and I know I probably don't make any sense and am way off in wording things, I just wanted to say something.

Logged

MEMBER

Is there a reason you are saying that with no information about wishingstar

Those might be the medical qualifications for it
 but doctors arent always right...
 We are more then just numbers and percents.

quote

Logged

EMMA

yeah, the numbers are a 'guidance' for doctors but they are not the final word. I was diagnosed purging ANOREXIC and i had a bmi of around 19 (btw the hospital that did the diagnosis is an accredited ed treatment facility, Rogers Memorial Hospital, so i dont think they are wrong that often). i had the mind set and that is the most important part of a diagnosis. if you have:
 lost some percentage of your body weight by restricting calories and have the intense fear of weight and all the other thoughts most docs will diagnose you anorexic. well, atleast the ones who have worked with ppl with eds and dont need to read a book in order to make their decision.

Logged

Contact

MEMBER



Re: does size matter

◀ Reply #6 on: Feb 7th, 2006, 10:01pm ▶

quote

well, just to clarify, im not talking about the mindset, im taking purely physical.
 everyone on this site in anorexic in mindset.

MEMBER

awww, sweety, give this place a chance. It's really a great supportive place, honest. There's lots of support here and great people. Don't leave okay. We want you around and you'll really like it here. You aren't judged and I believe you. It all sucks. Eating disorders suck. There's so much pain that goes along with it. I'm sorry you've been suffering through the pain you have. I was mad at my hubby because the other day he was walking by and saw a pic of someone here. The person was thin but there was nothing shocking. He said to me, she doesn't look like she has an eating disorder. I was so pissed. I said, do I? He didn't answer. I said, not everyone has to be emaciated to be suffering an eating disorder, which he should know more than anybody since he's sees everyday what I'm going through. Anyways, I hear your pain. Hang in there.

Logged

MEMBER

fair enough if some people believe me or not I do fear gaining weight and at my worst ate 15 calories per day and even felt guilty for drinking water. I have not had periods for months, and havnt told anyone about this. I dont eat in front of anyone and actually make them believe that I eat with the kids when were alone. I even fear that my children will become fat. I thought coming to people on this site I would not be judged and belived.

Logged

boohoo. you asked a question and i answered it. don't even try to make me feel guilty for my opinion.

Logged

MEMBER

fine lets just agree to disagree x

Logged

Logged

calle has adopted me what an angel x

SAM

Re: does size matter

• Reply #13 on: Feb 8th, 2006, 4:10pm •

Fuck weight. Since when were eating disorders "all about weight". No shit... weight does matter for textbook diagnosis. Who in the fucking world meets all of the criteria for either anorexia or bulimia? NOT MANY PEOPLE AT ALL. Including you Alice, you can't possibly be considered an anorexic now can you? Based on criteria.

Logged

MEMBER

This whole fucking thread hasn't left the point where it all started.

It's not cruel.

And I'm not fucking fighting.

Logged

QUOTE

MEMBER

This whole fucking thread hasn't left the point where it all started.

It's not cruel.

And I'm not fucking fighting.

No. You're just in an EXTREMELY bad mood

Logged

QUOTE

SAM

JUST FUCKING BAN ME FROM THIS GOD DAMN PLACE. SIZE DOES FUCKING MATTER AND I AM A GOD DAMN COW. ALL OF YOU ARE ALL FUCKING SKINNY AND I AM JUST ONE FUCKING HUGE DISGUSTING TUB OF LARD. YOU ALL HATE ME, I FUCKING KNOW IT. I DON'T DESERVE THIS PLACE. FUCKING GET RID OF ME.

Logged

QUOTE

MEMBER

JUST FUCKING BAN ME FROM THIS GOD DAMN PLACE. SIZE DOES FUCKING MATTER AND I AM A GOD DAMN COW. ALL OF YOU ARE ALL FUCKING SKINNY AND I AM JUST ONE FUCKING HUGE DISGUSTING TUB OF LARD. YOU ALL HATE ME, I FUCKING KNOW

(Read 153 times)



MEMBER

wrote:

I think maybe you have some serious food and eating issues, and you definitely have some symptoms of anorexia.

But maybe you aren't completely lost just yet. Weigh your options carefully. This is a miserable, horrible way to live...

TOTALLY agreed! This is just awful! I hate it... I wish sometimes that I could just stop.. but I can't. As for you, wakingupishardtoto, I agree with anakitten... you should DEFINITELY weigh your options carefully if you aren't already full-blown ana. This is NO WAY to live! It's just awful! So be careful. And if you are ana... well... be careful as well!



TRACEY

i'm sorry, i don't think i expressed myself very clearly... and believe me thankyou all so much for trying to warn me off, but it's not at the choosing stage anymore.. it was once, but i got through a year or so of making myself sick and i knew then that if i went down that path there was no turning back. i wish to god i'd had more sense, but it's too late to wish away the past.

Quote:

but one of these days you are going to cross a line, and after that point you'll be so wrapped up in this you won't be able to think of anything else....
...and you'll be miserable.

yeah.. and don't i know it. i'm sorry again for not explaining myself properly. when i first wrote the post i was feeling a little wierd because my thinking wasn't quite exactly on the lines of what i was reading... i said that losing weight wasn't always on my mind... but the preoccupation of food and my avoidance of it is.. i suspect that not eating is an extension of my SI in so far as it's almost a punishment, and hell it hurts.... so i was just wondering if anyone else did the same.. and if the other results of not eating were as desireable to anyone else, because to me they are...

Quote:

But maybe you aren't completely lost just yet. Weigh your options carefully. This is a miserable, horrible way to live..

again, i appreciate it. i honestly, honestly do. and please don't think i'm trivializing your illness into something that is a choice.. because trust me i'm not. i know it's a horrible way to live, because in some respects i exist inside my head, and i know there's no way out. no matter how hard you try, you're trapped by the fact that you know it helps you keep a handle on your life... i know without doubt i have food issues... and i use them to control my emotional space as much as my body.. more so in fact. but i hadn't really understood how much it controlled me... and i was just confused as to whether or not it was something with a label... you know, everything's easier to explain away if it has a name.

i apologize if i caused anyone to think i was about to willingly plunge into this knowing full well how crap it makes you feel.. and how life becomes a long drawn out suicide... my initial question was more of a query into thought patterns, because although mine are as persistent and painful as some of the things you have written about, at times they've got a different twist... yet also so similar that being on this site made me feel like i was almost normal again..

thankyou for not blasting me out of here for my uhm.. stunted methods of communication...

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Previous Topic | Next Topic

reply notify send topic to friend print

.. (Read 152 times)

quote

MEMBER

ok.. i've been reading posts and threads all over this site.. and i'm still wondering something.. and it may sound incredibly stupid...! but i'm not really sure if i'm ana or not. i mean.. apart from the fact i'm WAY too heavy to be.. i wouldn't say my primary aim is to be as thin as i can. i mean, i won't deny the fact that i get a major high from someone saying.. hey - you've lost weight - and inevitably there are long phases when i obsess over it..and yeah, i weigh myself SO accurately that it's like a god damn military operation but the thing is, that just being hungry is what keeps me going. you know that empty, almost painful feeling that you get.. it's like i crave craving if that makes any sense? and the fact that it's continuous.. it's not like SI where although it's much better

Page 2 of 7

temporary relief, it just wears off too quickly and you have to do it again. i don't know.. does anyone else think like that? i know it might sound crazy to some of you, but there are days that losing actual weight doesn't matter that much to me, consciously anyway .. but sure as hell i CANNOT eat....

Logged

quote

MEMBER

HA! sorry, but ur stats are better than mine! u qualify to be ana way more than i do!!

there is more 2 bein ana than weight. we all stress it over n over again and it needs to be said. anorexia itself is NOT a diet. anyone who thinks it is, well they need to get a life! it's a mental disorder as much as it is a physical one. in fact, it shows in our mindset long b4 it shows on our bodies...

and yea, u sound ana to me (i don't mean that in an offensive way btw hun!)

i love the hunger highs too, and i know a lot of the other girls on here do too. ur thinking sounds quite similar to mine. welcome 2 the site!!

Logged

quote

LARA

how much you weight doesn't determine your mental state - which is what anorexia really is (hence the name, anorexia nervosa). There isn't a magical weight that will clearly make you anorexic, though for a medical diagnosis, there is. Which is fucken stupid.

You sound anorexic to me. Remember it's all about what's goin on in your head, not on the scale.

Logged

MEMBER



Quote

hmm, thanks.. reassuring to know i'm not losing my mind completely.. not yet anyway! by the way just wanted to say this site's great.. you're all so nice to each other.. seriously i've been in other forums where there are more cat fights than in a bloody animal shelter! very cool..

Logged

Quote

MEMBER

wrote:

seriously i've been in other forums where there are more cat fights than in a bloody animal shelter! very cool..

LOL!!! haha, i kno that's not a good thing, but it made me laugh! welcome 2 the site!! (again!)

AK said pretty much what i meant to - tho, as always, she explained it better!! 😊

Logged

Quote

MEMBER

lol ah well... someone's always gonna do it better! it's a bitch, but hey that's life! hate that though..... thanks all the same 😊 made me smile!

Logged

LARA

Quote

yeah, I dont really like the other forums...I've explained why in several threads lol

People here are all supportive and there's none of those bratty self-important snots who expect to be put on a pedastool because they have a low weight, or put anyone down because they have a higher weight.

Logged

Quote

MEMBER

wrote:

People here are all supportive and there's none of those bratty self-important snots who expect to be put on a pedastool because they have a low weight, or put anyone down because they have a higher weight.

If there are, they don't stick around here too long! 😊 This isn't that kind of forum.

Logged

Quote

Worse than 95% of everyone else around, which is rather relative and comparative.

I'm hardcore in some areas - just not my eating disorder.

Quote:

I went through a phase where I didn't eat more than 100 calories...hardcore?

How long did it last? How little did you weigh? When I think hardcore, I think longterm, leading to serious endangerment of your life.

Quote:

Or... is everybody hardcore?

KAREN

The difference between a dabbler in crash dieting and a "hardcore" anorexic is like the difference between someone who has discovered he/she likes pot, and someone who's a tweaker or a cokehead.

Quote:

Can hardcore be defined by the state of mind, the ultimate state of denial that we live in?

In part. It's a mix of mindset and habit. The mindset creates the habits which create the body that results from being "hardcore". You can't be one without the other. If you have the mindset, you have the habits... and if it lasts long enough for you to get to an anorexic weight, well, that's hardcore. If you keep going, that's suicidal hardcore.

Logged

quote

MEMBER

I never really considered myself hardcore so I'm not sure if I could quite "get" the mindset. I think if I had a stronger drive...maybe...I kind of think of hardcore as being an accomplished dieter who is an over achiever and wants to get more accomplished.I know I'm going to get in trouble for saying

MEMBER

that. I wish I was more accomplished...but I know this is wrong....I can't carry on the diet to the level I want to...so I'm not hardcore. I guess I'm trying to give an example of hardcore but I'm talking in circles instead...

Logged

quote

MEMBER

i think in some ways "hardcore" could be defined as how much your e.d controls your life and how it effects what decisions you make...

Logged

quote

MEMBER

wrote:

i think in some ways "hardcore" could be defined as how much your e.d controls your life and how it effects what decisions you make...

Yes. Which makes me hardcore I guess. Nothing to strive for in general anyways.

Logged

MEMBER

i both agree and disagree with some of the definations listed here of being hard core...I agree with the fact that anytime something (like an ED) completely runs every aspect of you life, then you are hardcore. I don't agree with the fact that to be hardcore you have to be a walking skeleton. Is Andi hardcore? Absolutely but so are some other people on this site who continually restrict to about 100-200 cals a day but still weigh 130, 145, 150....They will most definately reach the "hardcore" level of sickness that Andi and some of the others have but until that point is reached, I don't think it is fair to label anyone as hardcore...does that make sense? Im on a bunch of xanies now and am having a hard time organizing these thoughts so I hope something I said was slightly profound.
Mandy

Logged

0000

MEMBER

I'm not hardcore. I've never been hardcore. I've been anorexic, but not hardcore, IMO.

Logged

0000

DANA

hardcore to me is how much it is affecting your life. someone can be hardcore bulimic and on death's door, but of normal weight. so it's not necessarily the weight as much as the behavior and how it affects your functioning.

Logged

SAM

I have no idea how to describe "hardcore". I don't think it's how you look though. Because the skinniest girl can have bones sticking out of her body left and right but you can't call her a hardcore anorexic. What if she eats A TON of food. I don't know 😊

Logged

MEMBER



Controlling your lifethat'd be something to consider. I still think of the ultra thin girls where you can see every single bone in their body. Call me old fashioned... 🤔



MEMBER



Hardcore anorexics look hardcore anorexic... and they often don't know they look hardcore anorexic.



EMMA



i guess i am a bit different. i think most people with eds are hardcore. if you purposely decide to not eat something healthy because of the calories or make yourself puke to stop calorie absorption, i would call that hardcore. i mean 500 calories may seem like a lot to us but when you think of human needs, restriction you body to 500 calories for a long period of time is hardcore.

be careful girls, we are all probably farther in to this than we wish to believe.



[reply](#) [reply](#) [send topic to friend](#) [print](#)

[quote](#)

MEMBER

Okay, stupid question number one million whatever. 😊

Why is it that people in general are so silly? I mean, just cause I'm not rail thin no one believes that I was ever ana, or even that I still could be ana.

Now, not that this is a problem atm cause I'm way too much a porker and ana really needs to become dominant again, but why can't people understand that it's the relationship to food and not the person's weight that makes them ana or not?

Page 2 of 8

Just my puzzler for the day. I'll look forward to hearing everyone's thoughts on it. 😊

[Logged](#)

[quote](#)

SASCHIA

I fully agree with what you are saying. Just because you cant see my ribs, doesn't mean that I don't have a problem. Ana is more intense than others realize. It is a lifelong suffering disorder. I swear from the moment I wake up until I go to sleep, food and my weight are what I think about the most.

[Logged](#)

[quote](#)

MEMBER

I have that problem too. But, when I am confronted about being Ana, I can say... "Do I LOOK anorexic to you?"

I guess it works that way with any "disease". Just because I dont LOOK like I cancer dosnt mean that I Dont (I dont have cancer... it was just an example).

I'm not saying Ana is a disease... 😊 It's more like a comfort blanket to me.

[Logged](#)

Logged

MEMBER

Quote:

am not ana cause im not underweight.

...sigh...

Logged

Logged

KAREN

LOL. This is the very thing anasdarling flamed me over.

Being "ana" as such is not dependent on weight. It's a mindset. The DSM-IV is very silly... and not

just on the diagnostic criteria for EDs. It's hard to meet all the diagnostic criterium for anorexia nervosa, and you might die before you even get there. Sad but true. The medical system is only ready to help people when they are so far gone it's unlikely they'll survive long...

Logged

Logged

MEMBER

Don't feel guilty about not being able to fast. I used to be able to fast for quite a while, but as an older ana, I find that the lack of food will make me vomit, blackout...or get the shakes. I will restrict to a certain type of food for several days, but straight up fasting? can't do it. I over time have upped my ability to go without food from only 3 hours to 12-16 hours..I am building stamina, but I doubt if I'll ever be able to go farther than that

Logged

Re: i'll get laughed off the site for saying this.

Logged

MEMBER

You guys make me feel SO much better. 😊 Sometimes I feel like a total cow because I eat so much more than a "typical" ana.

Actually the ONLY reason I eat is to keep my brain running. If it weren't for the need to think coherently I'd eat a lot less. 😊

Logged