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Unbearable Weight, Unbearable Witness: The (Im)possibility of Witnessing Eating Disorders in Cyberspace

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Unbearable Weight, Unbearable Witness:
The (Im)possibility of Witnessing Eating Disorders in Cyberspace

by

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of the requirements for the degree of
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Abstract

This thesis argues that the recent erasure of digital pro-anorexia (“pro-ana”) narratives by websites such as Tumblr, Pinterest, and Instagram represents an attempt to silence female self-starvers and reify the authority of medical associations to speak for female bodies. I draw parallels between these attempts and Gayatri Chakravorty Spivak’s theory of epistemic violence, since the experiences of women are effectively discredited, through metaphors that render the thin body dangerous, to shore up professional medical authority. As an attempt to privilege the experiences of the self-starvers, I analyze one Tumblr blog with eating disorder content to listen to the letters users anonymously write to their bodies in contrast to narratives written by “recovered” self-starvers that are officially endorsed by the National Eating Disorder Association. Finally, I argue that the Internet provides us with the opportunity to foster response-able witnessing, for which Kelly Oliver has advocated. I extend Oliver’s research to argue that we must foster response-ability for all attempts to bear witness. I suggest that creating response-able spaces where others might witness their different embodied experiences can enable female self-starvers to reclaim subjectivity that medicine has taken from them. In so doing, they might learn to become response-able to their eating disorders, and, eventually, their own bodies.

Introduction

In “First It Saves Your Life, Then It Kills You,” Robert Maisel reflects on a patient named Emily, whom he treated for anorexia for two years. Emily’s struggle with eating disorders began at the age of 12, in part as a response to her troubled relationship with her parents. Her parents responded ineffectively to Emily’s disorder, as evidenced by her father’s belief that her “expressions of outrage were an outcome of demon possession” (45). Maisel also recalls, “Though her mother was of medium build, her father often expressed disgust for his wife’s body in front of Emily and made derogatory remarks about her eating. Emily was often solicited to corroborate his evaluations and moral censure” (46). Thus, Emily attempted to identify with her father through inhabiting a body that he would find more acceptable—a prepubescent, anorexic body (47). In treatment, Emily wrote poetry and journal entries to express her anger and to try to transform her experience with anorexia into a narrative. In a journal entry, she characterizes her disease in the following way:

Okay, it’s like this. You’re walking down the street and for no reason at all somebody shoots you in the back. Anorexia immediately numbs the pain, and you continue to walk down the street not knowing you’ve been shot in the back because you can’t see or feel the pain. Yes, you may feel happy, but you are going to bleed to death very quickly if you don’t do something

about that bullet hole in your back. Or maybe it's a stab wound. The bottom line is that you will bleed to death with a smile on your face. The stab wound won't kill you if you go to the emergency room and let other people know what happened so they can help you get better and help stop the bleeding. But there is a problem with this whole scenario. The gunshot wound in your back would be excruciatingly painful and you wouldn't be able to walk at all, much less walk down the street with a...smile on your face. So Anorexia comes and takes away the pain. You don't ask it to. It just does. It tells you that the pain is too great and it takes it away. Numb. Not feeling. Takes you from your body. In a sense, it rescues you. It doesn't want you to be hurt. Anorexia cares about you in the beginning. It saves your life. Then it kills you. (48)

This narrative highlights several complex feelings associated with self-starvation, such as numbness, fear, pain, and the experience of anorexia as both savior and murderer. In another piece of writing, for example, Emily wonders whether or not she is to blame for her eating disorder, or whether anorexia itself has possessed her. She refers to anorexia as a rapist that “tells you you did it to yourself and the worst part of it all is that I believed it” (53). Anorexia, for Emily, is a violent source of both self-preservation and self-mutilation. Anorexia makes the cruel demand that she face her own death with a smile.

21 years after Emily first met with Maisel, Emily's narrative is now being echoed by other self-starving women in digital, rather than professional, spaces.¹ However, websites such as Tumblr, Pinterest, and Instagram have recently threatened to expose and

¹ For the purposes of this research, since recovery rates for anorexia are so much lower than for bulimia, I have chosen to focus primarily on women who suffer from anorexia nervosa (Herzog et al. 832).

delete digital pro-anorexia (“pro-ana”) narratives in an attempt to protect “innocent” Internet browsers from “infection” with an eating disorder. Most notably, in February 2012, a popular blog hosting platform, Tumblr, released a draft of a new policy that would ban “self-harm” content that could be considered dangerous to viewers. Noting that they also reject “spam and identity theft,” Tumblr announced that they would institute a Content Policy that would prohibit any “blogs that glorify or promote anorexia, bulimia, or other eating disorders; self mutilation; or suicide” (“A New Policy”). They explained that “These are messages and points of view that we strongly oppose, and don’t want to be hosting” (“A New Policy”). The problem with such posts, Tumblr posited, is that they (1) “glorify” a lifestyle that is dangerous to other readers and (2) distract readers from healthy responses to self-starvation, such as seeking treatment from medical authorities. Beyond prohibiting this “self-harm” content, Tumblr also described plans to redirect searches for suspicious terms, such as “anorexia” or “bulimia,” to official messages from select organizations (“Follow-up”). Citing “helpful suggestions” that were provided by the National Eating Disorder Association (NEDA), Tumblr explained that they would redirect self-harm searches to a message that warned:

Eating disorders are not lifestyle choices, they are mental disorders that [*sic*] when left untreated, can cause serious health problems, and at their most severe can even be life-threatening. For treatment referrals, information and support, please contact the National Eating Disorders Association’s Helpline at 1-800-931-2237 or www.nationaleatingdisorders.org. (“Follow-up”)

In other words, the policy attempted to reify the authority of medical discourse over female bodies by ensuring that self-starvers are characterized as passive, sick, and deluded. Significantly, it also characterizes self-starving women as dangerous.

Tumblr's change of policy represents only one effort among many to silence the voices of the women who write about their experiences with eating disorders in online forums, citing danger to other viewers and distraction from treatment as justifiable causes. In 2001, under pressure from several professional organizations, including NEDA and Anorexia Nervosa and Associated Disorders (ANAD), Yahoo and MSN erased any pro-ana websites that promoted the anorexic or bulimic lifestyle from their servers (Cspike and Horne 2007; Rouleau and von Ranson 2011). However, since 2001, the websites have proliferated. In 2012, Lewis and Arbuthnott found that more than 13,245,000 Google searches for pro-ED Websites are conducted annually, with the terms "pro-ana," "thinspo," and "thinspiration" being among the most common search terms (202). More recently, following the migration of the women from Tumblr to Pinterest, and then to Instagram, the two photo sharing websites also updated their policies to ban pro-ana or thinspirational ("thinspo") images that actively promote emaciation (Gregoire, n.p.). This pattern of erasure finds its impetus in the risk-of-transmission metaphor that surrounds much of the discourse about pro-ana narratives and images. As I will discuss in what follows, websites generally erase pro-ana in an attempt to protect other viewers and appease professional organizations.

Beyond the underlying assumption that female self-starvers are "infecting" the Internet with their content—which the websites attempt to treat using policies as antidotes—concerns arise regarding the potential risk that such content poses in

influencing other women to develop eating disorders. Pro-ana websites are often considered dangerous because they offer support for disordered eating behaviors, prevent recovery, discourage other users from seeking help, and function as a type of ONESG (Online Negative Enabling Support Group) (Rouleau and von Ranson 526, Hass, Irr, Jennings, and Wagner 51). According to Codie R. Rouleau and Kristin M. von Ranson in “Potential Risks of Pro-Eating Disorder Websites,” these websites are often shut down because of concerns surrounding the “alluring quality of pro-ED websites to young girls and the potentially deadly effects of promoting self-starvation to this vulnerable population” (526). In 2010, Jett, LaPorte, and Wanchisn found a correlation between viewership of a pro-ED website and significantly reduced caloric intake for participants following exposure (“Impact of Exposure” 413). Similarly, in “Starving is the Most Fun a Girl Can Have,” a study of pro-ana subculture, Jeannine Gailey explains that she had to limit her research at times, and seek help from colleagues and friends, because the content on the websites affected her eating behaviors negatively (97). In part due to such findings, researchers often refer to the effects that websites might have on those who are experimenting with disordered eating behaviors as “contagion-like” and “exceptionally deviant and destructive” because it seems that pro-ana content itself can trigger eating disorders (Lewis and Arbuthnott 201, Whitehead 621, Reaves n.p.). This may be true in some cases, and it is important to consider which forms of content might be harmful to web users (particularly minors). However, the metaphor of infection that such considerations invoke for pro-ana conceptualizes eating disorders as sicknesses that may be “caught” immediately—not complex diseases that develop based on many causes and, often, over time. It also justifies the silencing of self-starving narratives by warning of

danger to young girls who have Internet access. Thus, the metaphor of infection that haunts eating disorder forums is implemented to discredit the women who write (about) themselves online. While such policies protect one group from potential danger, they prohibit another group's potential recovery.

The characterization of pro-ana spaces, and self-starving women, as dangerous has not been well received by the pro-ana community in general. For example, in a prominent pro-ana forum, a user recently defended pro-ana as a form of support for self-starvers instead of a digital anorexia fan club (as it is sometimes characterized).² This post instigated a series of positive responses from other users. One woman, in particular, explains:

Not ONCE in my 4 years on pro ana [*sic*] sites have I ever seen anybody say something along the lines of 'Oh you're (insert low weight here). Keep fasting without water/food till [*sic*] you die.' We don't encourage death. We don't tell people who don't have EDs that they should develop one. We're not soulless jeez [*sic*].

The woman seems personally offended by claims from Tumblr and other professional organizations that pro-ana writers are morally reprehensible. She also rejects the idea that pro-ana attempts to appeal to vulnerable populations and lure them into an eating disorder. She adds, "We don't encourage people to become ill. People would have EDS

² As an attempt to protect the privacy of women who have not posted their content to a professional website, I do not refer to specific usernames or webpage titles in quoting material from self-starving and pro-ana writers. Because I am emphasizing the importance of listening to pro-ana writers speak as they have chosen to present their stories, I do quote all writers directly. However, all of the information I include from self-starvers was found on one of several publically accessible Tumblr or pro-ana forum pages. I do name self-starvers who post information in web magazines or professional organization forums, as these writers have already chosen to make their identities publically known. For these women, I only include first names.

without us, [*sic*] we just encourage those who need support [*sic*] who already have a problem.” Another user agrees that pro-ana users do not intend for their words to hurt viewers—instead, their forums serve as spaces where self-starvers can talk to an audience that understands what they are experiencing. She writes:

It's true that I feel a little more comfortable talking with people [in pro-ana forums] and opening up without the fear of ‘triggering’ someone and abiding by a ton of rules...I won't give tips or advice on living with ana unless I know that it is someone who's been dealing with it for a long time such as myself. I try and encourage others experimenting or just starting to stop while they can. It scares me how many young kids we have here as well as when I see an UGW [ultimate goal weight] of ‘dead’. [*sic*] I don't think any of us would encourage that!

The user explains that her intentions are not to convert others to eating disorders but rather to express herself and find solidarity with those whom she knows are already struggling with anorexia (like herself).³ While she does note that self-starvers depend on each other for encouragement, she does not seem to hope for herself or others to ultimately die as a result of their starvation.

In contrast to the voices of these self-starving women, the ways in which organizations such as Tumblr, NEDA, and ANAD silence such women may be seen as more violent than the conversations that such spaces make possible. The erasure of pro-ana websites, which serves to protect the authority of eating disorder associations, in particular, perpetuates a cycle of violence that is always already done to women's ways

³ It is interesting to note that this woman views the pro-ana audience as other self-starving women, and not the entire Internet. Their messages, she insinuates, are intended for others who can relate to them.

of understanding and experiencing their bodies. In “Can the Subaltern Speak?” Gayatri Chakravorty Spivak defines epistemic violence as the process by which one way of knowing, formed by the elite class, subjugates Other ways of knowing, formed by the working class. These subjugated knowledges, furthermore, are considered “inadequate to their task or insufficiently elaborated: naïve knowledges” that may lack scientific justification and elevated status (2115). Epistemic violence, or “epistemic overhaul,” originally led Spivak, in an earlier iteration of this essay, to claim that “the subaltern cannot speak” (2115, 2120). However, she revises her earlier thesis to argue that the subaltern (woman, in particular) cannot speak because she is silenced and spoken for by dominant modes of discourse. Spivak explains, “The subaltern as female cannot be heard or read” because she will be silenced, misinterpreted, or essentialized as oppositional to the dominant figure (2123). Even when the subaltern woman does speak, then, her voice is not heard, and her ways of knowing are discredited in favor of more ostensibly credible epistemologies.

To extend Spivak’s theory, I argue that the female self-starver cannot be heard or read because her experiences of her body are silenced by discourse from professional eating disorder associations, which claim to offer support to women with eating disorders while they authoritatively speak for them. Professional eating disorder associations in general, and NEDA and ANAD in particular, must protect this authority through erasure because pro-ana and pro-ED (pro-eating disorder) self-starving women represent a threat to them in several ways. According to Natalie Boero and C. J. Pascoe, the pro-ana self-starving woman differs from the anorexic in that she “does not seek to hide her body or her disorder, often acts aggressively, actively searches out membership in a pro-ana

community, and shows ambivalence about both anorexia and recovery” (38). The visibility of the pro-ana woman, and her pride in her chosen identity, oppose images of the anorexic woman who is mentally ill, pitiable, and in need of professional intervention or treatment. Additionally, in maintaining that anorexia is a lifestyle choice, and not a disease or illness, and in insisting that traditional therapy methods for disorders (hospitalization and institutionalization) are ineffective, the pro-ana self-starver directly defies professional associations such as NEDA and ANAD. Downer, Gresham, Kirkwood, and Reynolds note that this project is part of an overall shift away from medical authority; as they explain, “‘Patients’ are beginning to examine and to question that [medical] authority...we are seeing this questioning in the emergence of the pro-ana Web sites, sites that deny the power of the medical community to label one as ‘sick’ or ‘pathological’” (93). The organizations, in turn, punish self-starving women for defying their authority in digital spaces by putting pressure on web hosting sites to erase their voices.

The discrediting of the embodied experiences of women results in more than their silence—it can result in their death when organizations recommend professional intervention and then prevent them from accessing treatment because they are not “really” or “officially” anorexic. In fact, Stephen M. Haas, Meghan E. Irr, Nancy A. Jennings, and Lisa M. Wagner claim that it is the medicalization of eating disorder issues itself that creates a stigmatization towards weight gain and loss and drives women with anorexia to form support groups in digital forums (41). Similarly, in “The Ana Sanctuary,” Karen Dias suggests that pro-ana forums are spaces where female self-starvers might seek “sanctuary from the surveillance and regulatory mechanisms of the

public sphere” (1). She draws attention to the paradox inherent within pro-ana spaces, since the women are punished for their refusal to seek treatment, but are often unable to receive it due to the “rigid criteria for diagnosis and admittance” (39). Thus, while the Tumblr policy, in particular, attempts to redirect self-starving women to professional organizations, these same women will often be turned away from the organizations when and if they do seek treatment.⁴

The implications of this shift to medicine, or professional associations, as the epistemic authorities for female bodies, are frightening. Becky W. Thompson, in particular, is critical of medical discourse surrounding eating disorders, which has “belittled” women for their ostensibly superficial illness while excluding women of color, working-class women, and lesbian women from studies, theories, and discussions of anorexia. In *A Hunger So Wide and So Deep*, she claims that eating problems first manifest as “survival strategies—as sensible acts of self-preservation—in response to myriad injustices including racism, sexism, homophobia, classism, the stress of acculturation, and emotional, physical, and sexual abuse” (2). The silencing of the experiences of female self-starvers serves to mask this trauma and abuse and perpetuate the oppression of women by making them seem passive, weak, or ill. Epistemic violence, then, represents a framework within which we might read the erasure of female self-starving cybervoices as they are silenced in favor of the dominant figures in discourse about female bodies, which institutionalize and pathologize female experiences.

The dangerous metaphor of infection is only one example of illness being exploited rhetorically to enact violence. In *Illness as Metaphor and AIDS and Its*

⁴ It is estimated that only 1 out of 10 people with eating disorders will enter treatment, due to high costs and strict definitions that exclude women from seeking help (“Eating Disorder Statistics”).

Metaphors, Susan Sontag exposes the use of metaphors to frame discussions of illness and health as they have served to incite patient-blaming and stigmatization, romanticize illness, and perpetuate genocidal and warfare rhetoric. She argues that “Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious” (76). I extend Sontag’s argument here to argue that the metaphor of infection is promoted by ANAD, NEDA, and other related groups because the writing of women with eating disorders subverts and disturbs the medical community’s authority over women’s bodies and experiences.

While a detailed description of metaphors of infection and contagion is beyond the scope of this research, Priscilla Wald’s *Contagious: Cultures, Carriers, and the Outbreak Narrative* offers an important insight into the effects that metaphors, including those that label pro-ana narratives as risky and contagious, have. She argues that:

Outbreak narratives...have consequences...They promote or mitigate the stigmatizing of individuals, groups, populations, locales (regional and global), behaviors, and lifestyles, and they change economies...It is therefore important to understand the appeal and persistence of the outbreak narrative and to consider how it shapes accounts of disease emergence among genres and media. (3)

The consequences for the “outbreak” narratives of anorexia, bulimia, and other eating disorders often include the stigmatization of women and the erasure of their subjectivity and agency. By presenting pro-ana writers, and self-starvers, as dangerous, medical and professional organizations can secure their power to speak for and pathologize female bodies.

The professional associations, in indirectly positing that the women are dangerous and unstable, directly defy the ways in which the women conceive of their disorders—and pro-ana itself. In one forum on a popular pro-ana website, for example, a user recently started a thread and admitted that she wanted to kill herself. Users responded immediately, encouraging her to call a suicide hotline, try to relieve her stress in other ways, seek professional help, go to the hospital, and try to resolve the relationship issues that were bothering her. One user, for example, writes, “I know how it feels to want to die, [*sic*] i [*sic*] know how it feels when you see no way out, [*sic*] i [*sic*] know how it feels to just want to make all the bad feelings stop once an [*sic*] for all. Your [*sic*] not alone! Im [*sic*] sorry for your pain, [*sic*] i [*sic*] wish i [*sic*] knew what to say to make u [*sic*] feel better.” The user who responds explains that she empathizes with the writer who started the thread, and she also tells her that she is not alone. Another user echoed this compassionate response, simply writing, “I love you and you will get better.” Whereas pro-ana writers tend to be characterized as abusive and dangerous, these women offer support and even love to each other in the midst of crisis. Another user offers advice to the woman based on her own experience:

I didn't have a job, I didn't have any money, my life seemed hopeless and I've been where you are now. But push through! Even if it hurts because you are strong! You may not feel it but you are! You can surprise yourself. Push through for a night, then try for the week and longer. There are things that are worth living for. They are sometimes hard to see but you just have to bare [*sic*] with it, no matter how hard (and I know, IT'S HARD), because eventually you will find them. We are always here for

support. Everyone on this site is here to help each other. Message me if you need to talk.

In this message, the user draws on her own experience to remind the woman who feels suicidal that it is possible to make it through darker moments with an eating disorder. She does not pretend that suicidal impulses can be easily managed, but she does tell the user that she is willing to help, that she can take small steps towards recovery, and that the woman herself has resisted the urge to take her own life. This example does not indicate that pro-ana always offers such support, but it does demonstrate that pro-ana can do more than expose other browsers to eating disorders. It can also create dialogue in which users save each other's lives.

Furthermore, in insisting that the women are subversive or unstable, the organizations that silence self-starving women also refuse to take them seriously as rhetors. In "Who's Really a Cyberfeminist?" by Christa Downer, Morgan Gresham, Roxanne Kirkwood, and Sandi Reynolds, Kirkwood posits that:

Through these Web sites, young women are explaining how they wish to be communicated with. They do not want to be considered victims. They do not want to be considered incapable of making decisions. In fact, these young women are fully acknowledging the consequences of their actions on themselves and the possible effects on other lives... The 'experts' directly violate the demands of the women by viewing them as helpless and misguided—even possibly stupid. (89)

While this statement might not apply to every pro-ana/thinspo forum online, their essay does offer a useful insight for thinking about the rhetorical choices that female self-

starvers employ in digital spaces, and it insists that these choices demand a response from those who might help, rather than erasure.

Several studies have attempted to acknowledge the rhetorical choices that self-starving women make as responsive to gender norms and medical discourse, which function to disempower them. These studies contend that female pro-ana writers are agentive, and this research contends for the importance of listening to their perspectives, which might be read as responsive to traditional, Western gender roles and medical discourse (Whitehead 597, Bordo 141, Haas et al. 41, Gailey 107, Boero and Pascoe 39, 42). Downer et al., in particular, acknowledge that self-starving women form these spaces in response to medical associations in order to “(re)conceptualize themselves beyond the discourse of the medical and psychiatric fields” since “[the women] refuse such labels as 'pathological' and 'diseased' and reject being 'objects of study' by claiming their own identities and positioning themselves as knowers" (90). What is missing, however, is an alternative framework within which we might begin to actively foster response-ability with these women by listening to them speak, and holding ourselves accountable for responding.

In what follows, I attempt to form one such alternative by drawing on Kelly Oliver’s theory of witnessing, which she explicates in *Witnessing: Beyond Recognition*. Oliver re-envision ethical responsibility by replacing the Hegelian model of recognition with her concept of witnessing, which encompasses both “*eyewitness* testimony” and “*bearing* witness” (16). Such a model allows Others to reclaim the agency and subjectivity that the Hegelian model of subjectivity reserves for the subject (4-6). While the emphasis is placed on opening spaces where the Other might witness her difference,

the subject bears a responsibility in the creation and maintenance of these spaces. She argues, “We are obligated to respond to the environment and other people in ways that open up rather than close off the possibility of a response. This obligation is an obligation to life itself” (15). This means that “We are responsible for the other’s ability to respond...to open ourselves to the responses that constitute us as subjects,” since it is only in opening spaces for response-ability that others can reassert themselves as subjects by witnessing their difference (19). To extend Oliver’s thesis to the discussion of pro-ana content and forums, I suggest that witnessing, rather than erasure and epistemic violence, may be a more useful model for framing the interactions between medical associations, public websites, web browsers, and female self-starvers. Forming response-able relationships with self-starving women need not involve the endorsement of disordered eating. It does, however, demand an acknowledgement that the women who write in these spaces are rhetors who make complex rhetorical choices and claim authority over their bodies, identities, and experiences that has so often been stolen from them.

I extend Oliver’s theory to wonder how the writing that female self-starvers engage in online might allow them to develop response-able relationships with their bodies that are not rooted in violence. Oliver writes, “The question is how can we witness and bear witness to oppression, domination, subordination, enslavement, and torture in ways that open up the possibility of a more humane and ethical future beyond violence?” (18). While I do not hope to offer an answer to this question, I do contend that attempts by female self-starvers to bear witness to the complex system of oppression that is enacted upon their bodies, and that they come to enact on themselves, warrants our careful response, and not our fearful silence. My thesis, then, is that we bear a

responsibility to foster spaces where women can become response-able to their eating disorders, and, hopefully, where they can develop response-able relationships with their bodies.

Chapter One:

Silencing Self-Starvers as Epistemic Violence

Introduction

In 1694, Richard Morton published *Phthisiologia or, a Treatise of Consumptions*, which became the first medical account of eating disorders (Gilman 192). Morton described the illness as “nervous consumption,” since the patients he saw for the disease resembled tuberculosis patients (9). The treatise describes various interactions with patients, one of them a twenty-year-old woman who is referred to as the daughter of Mr. Duke. The woman (who might now be diagnosed as anorexic) was ill, Morton explains, because “she was wont [to breathe unhealthy air] by her studying at Night, and continual poring upon Books” (9). The woman died shortly after being seen by Morton (Gilman 192). In the 1870s, Ernest Charles Lasègue identified the illness of “anorexia,” and he described a “diagrammatic sketch of the disease” in his article “On Hysterical Anorexia” (Gull 500; Lasègue 493). He explains that, in a “typical” case of anorexia, “A young girl, between fifteen and twenty years of age, suffers from some emotion which she avows or conceals. Generally it relates to some real or imaginary marriage project, to a violence done to some sympathy, or to some more or less conscient desire” (493). The patient chooses not to eat, he observes, because she “thinks to herself that [starvation is] the best remedy for this indefinite and painful uneasiness” (493). Lasègue conceptualizes

anorexia as a form of hysteria and a mental illness when he argues, “In comparing this satisfied assurance [with starvation] to the obstinacy of the insane, I do not think I am going too far” (495). Similarly, also in the 1870’s, William Withey Gull noted that, for anorexic women, “The inclination of the patient must be in no way consulted” during treatment since anorexia is “due to a morbid mental state” (501). This conception of anorexia as a form of insanity also shapes his idea for what constitutes effective treatment: “The patients should be fed at regular intervals and surrounded by persons who would have moral control over them” (501). Prior to the twenty first century, then, physicians described anorexia as a form of insanity and moral failing that was specific to the female sex.

It is not until 1937 that we can find a patient’s perspective of anorexia and bulimia described in her own words. This patient, Ellen West, wrote about her experiences with eating disorders and depression in letters, diaries, and poems. These words were later published in Ludwig Binswanger’s, her doctor’s, account of her illness “The Case of Ellen West: An Anthropological-Clinical Study.” In this text, Ellen describes her obsessions with food, terror of becoming fat, depression, and self-denial in vivid detail. She writes, “This is the horrible part of my life: It is filled with dread. Dread of eating, dread of hunger, dread of the dread. Only death can save me from this dread...It is useless to have analysis tell me that I want precisely this dread, this tension. It sounds brilliant, but it does not help my aching heart” (254-5). In this first recorded critique of treatment for anorexia, West argues that the psychoanalysis that she undergoes, while interesting, ultimately fails to heal her. She explains, in another diary entry, “The only work I do is mental. In my innermost being nothing changes, the

torment remains the same. It is easy to say: everything is transparent. I long to be violated—and indeed I do violence to myself every hour [L.B.’s Italics]. Thus I have reached my goal” (255). West refers to anorexia as an outlet for self-violence, an outlet within which treatment fails to successfully intervene.

West’s voice, albeit through her doctor’s publication, was heard. As West did almost a century ago, thousands of women in contemporary times are sharing their experiences with eating disorders publically in digital pro-ana forums. Whereas West’s words were originally intended for herself, her doctor, close friends, and relatives, these women can oftentimes reach an audience of other women who have eating disorders, seeking support, tips, and dialogue about their illness. Unlike West, these women are being silenced by the very groups who might intervene and help them—treatment facilities, professional eating disorder organizations, and blog hosting / photo sharing websites—for engaging in such conversations. Like West, however, many of these self-starving women will die.

In contemporary times, when self-starving narratives are shared digitally, medical facilities, organizations, and websites rhetorically “respond” to pro-ana narratives by silencing them. In large part, this response is instigated by fears that pro-ana content is dangerous for other web browsers or women who may be at risk for developing an eating disorder. The National Association for Anorexia Nervosa and Associated Disorders (ANAD), a professional organization that connects at-risk web users to eating disorder treatment services, argues that in pro-ana forums “Contradicting information [about recovery and anorexia]...may influence innocent and impressionable site users, like children, adolescents and those who already feel isolated” to develop eating disorders

(“Eating Disorders and the Internet”). This concern that pro-ana will influence others to contract eating disorders has most recently led to the erasure of pro-ana content on websites such as Tumblr, Instagram, and Pinterest. These blog hosting (Tumblr) and photo sharing (Instagram and Pinterest) websites have created policies that threaten to erase self-harm content and redirect users who search for pro-ana discussions to professional organizations, such as ANAD and the National Eating Disorder Association (NEDA). More specifically, in 2012, Tumblr gained a lot of press (both positive and negative) when it changed its policies to ban any content that would encourage users to “embrace anorexia, bulimia, or other eating disorders; or commit suicide rather than, e.g., seeking counseling or treatment, or joining together in supportive conversation with those suffering or recovering from depression or other conditions” (“Community Guidelines”). In an attempt to be responsible about the content that it hosts, Tumblr took a public stand against pro-ana (Pinterest and Instagram quickly followed suite), threatening to delete any accounts that engaged in positive discussions of eating disorders.⁵

As a response to such claims, in a popular pro-ana forum, a user recently posted a summary of an article that defended pro-ana as source of comfort for women with eating disorders. The user asked for feedback from other forum contributors, and many responded positively and agreed that pro-ana attempts to provide support for fellow sufferers. One user explains that she first discovered pro-ana while reading a book about eating disorders and entering “anorexia” into a Google search. She writes, “When I first found proana [*sic*] sites, I was eight years old...Sure, the sites taught me how to do some things I hadn't thought of. But even without the internet [*sic*] I would have been messed

⁵ It is worth noting that Tumblr will also not host: “Malicious Bigotry,” “Harm to Minors,” “Gore and Mutilation Content,” “Unflagged NSFW Blogs,” “Sexually Explicit Video,” “Non-Genuine Social Gesture Schemes,” “Impersonation, Stalking, or Harassment,” and Spam (“Community Guidelines”).

up. For sure.” The user also offers her insight into the negative public response to pro-ana:

I think the problem is when people figure out their 13, 14, 16 year old kid is starving themselves [*sic*], or throwing up, or cutting themselves [*sic*], or abusing drugs, or whatever, they want someone to blame. They don't want to take responsibility for it. They want to say ‘oh, [*sic*] obviously it's because of *x* so if we remove *x* everything will be back to normal and I'll have my little girl back’ [*sic*] Not even close. I've heard people say things about proana [*sic*] sites before after reading about them or whatever, and it really upsets me. I've obviously never spoken up and corrected them, [*sic*] gotta [*sic*] stay neutral on the topic in public.

The users’ insights into the purpose for many pro-ana forums, and the backlash such spaces encounter from parents and professional authority figures, point to a disconnect between the women who write in pro-ana spaces and their readers who react ineffectively.

Another user agrees, noting that, in terms of the positive research about pro-ana that the original poster indicates, “it's nice to see someone trying to understand pro-ana communities.” She has a hard time believing that self-starvers should be blamed when someone develops an eating disorder, and explains:

I was a little disappointed to hear that a large percentage of health professionals believe people are ‘to blame’ for having/developing an ED. Whilst I acknowledge that some people do seek out tips on 'how to be anorexic/bulimic/otherED' [*sic*] or whatever on the internet etc, [*sic*] I

could NEVER believe that anyone is responsible for having an ED.

Nobody actually chooses this. Even people who say they ‘want to have an ED’ must already be disordered to some degree. I didn’t just wake up one day and decide I wanted to go through hell. Nobody really ‘chooses’ this.

Therefore [*sic*] they can’t really be held ‘responsible’ [*sic*].

The writer’s point insinuates that Tumblr’s policies may be doing more than erasing spaces that offer companionship while a person suffers from a devastating mental and physical illness. These policies might also be placing blame on the women who suffer from eating disorders—as if they somehow chose to “catch” an eating disorder just as they chose to search for a pro-ana website.

However, these policies, and the violence they instigate against self-starving women, did not originate with Tumblr. The medical model of treatment for eating disorders in general, and anorexia nervosa in particular, instigates the violent erasure of self-starving women that finds its ultimate result in the erasure of pro-ana forums. Many women who do seek treatment will be turned away due to high costs, or subjected to failing treatment models and unbalanced power dynamics within treatment centers. Recovery rates for women with eating disorders, and particularly women with anorexia nervosa, are disturbingly low (approximately 33 percent for patients with anorexia), which indicates that treatment models for eating disorders need to be altered to better attend to the needs of patients (“Eating Disorder Statistics,” Gendall 1288, Kaplan 235, McAleavey 428, Herzog et al. 832, Maisel, Epston, and Borden 5-6). These treatment models themselves, I will argue, are epistemologically, psychologically, and even physically violent. Additionally, following medical treatment models, professional eating

disorder associations, such as NEDA and ANAD, use highly rigid and exclusionary definitions of eating disorders to recommend that users seek diagnosis and treatment from medical and psychological specialists. NEDA, in particular, goes so far as to provide guidelines for “responsibly” describing experiences with eating disorders (“Guidelines for Sharing”). Both the rigid definitions, and the “rules” for making one’s story with anorexia or bulimia “useful” are forms of destroying female subjectivity, which represents another form of epistemic violence. Finally, this cycle finds its conclusion in the material and epistemological violence that manifests in the erasure of pro-ana writing, which, as previously mentioned, is instigated by pressures from professional organizations. Thus, the cycle of silencing women with eating disorders, which begins in treatment facilities, continues with the intervention of professional eating disorder associations, and ends with the erasure of female narratives, is failing countless women.

This chapter will trace this cycle of violence that silences self-starving women without taking them seriously as subjects or providing them with alternative spaces within which they might more healthily seek support. Pro-ana communities hold the potential to offer support to women who are disenfranchised by medical treatment models for eating disorders and professional organizations (Hanna, n.p.). The experiences of pro-ana writers warrant our careful consideration, as they form communities that respond to this failing model of treatment and voice concerns that could potentially help medical providers and specialists to better account for their needs. In defending the writers as powerful rhetors and arguing that we bear a responsibility to attune ourselves to their experiences and perspectives, I do not hope to insinuate that engaging in a pro-ana community is necessarily healthy. However, I do insist that silencing the women, rather

than listening to them, perpetuates the cycle of violence that contributes to the failing system for intervention and treatment of eating disorders—and their own self-starvation. We stand to learn more from pro-ana writers than dieting tricks and tips. By taking their narratives and rhetorical choices seriously, we stand to gain insight into institutions, such as medicine and psychology, which oppress women and medicalize their bodies in highly dangerous ways.

Epistemic Violence

Many feminists, such as Iris Marion Young and Susan Bordo, have described the violence that characterizes female embodiment(s). For Young, this violence is tied to the ways in which women *learn* to inhabit their space as restricted and out of control. In “Throwing Like a Girl,” she contends that “women in a sexist society are physically handicapped” because female embodiment is characterized by passivity, mistrust, and powerlessness (42). Similarly, for Bordo, the prevalence of anorexia should come as no surprise given the extremely thin female bodies and ideals of female restraint that are celebrated in some facets of Western culture. She claims that anorexia is

merely the most concrete expression of the general rule governing the construction of femininity: that female hunger—for public power, for independence, for sexual gratification—be contained, and the public space that women be allowed to take up be circumscribed, limited. (171)

Anorexia, then, is a hyperbolic reflection of how society tells women to live in their space.

Bordo's assertion that anorexia is an extreme, physical manifestation of Western culture's demands on women, while arguably integral to any research on eating disorders, fails to adequately discuss anorexia as narrative. Bordo also does not describe the rhetorical consequences of silencing self-starvers or the epistemological ramifications of erasing pro-ana narratives. For this analysis, it will be necessary to turn to Gayatri Chakravorty Spivak. For Spivak, epistemic violence is a concept that describes (1) the violent re-appropriation of subaltern epistemologies as oppositional to imperialist epistemology, and (2) the reduction of subaltern ways of knowing into a coherent and unified epistemology. In "Can The Subaltern Speak?" Spivak explains that examples of epistemic violence are characterized by "remotely orchestrated, far-flung, and heterogenous project[s] to constitute the colonial subject as Other" and "the asymmetrical obliteration of the trace of that Other in its precarious Subjectivity" (2115). Put another way, epistemic violence occurs when the re/presentation of subjugated ways of knowing and living are assimilated into one coherent narrative that is then conceptualized as oppositional to the dominant way of knowing. This concept of epistemic violence resonates with the ways in which self-starvers are reduced to subversive, sick, and passive objects in contrast to medicine, which is (ostensibly) dominant, objective, and active. Self-starver's ways of knowing their bodies must be silenced in order to reify the power of medicine, but this results in more than a loss of narrative. For the self-starver, this erasure results in a form of violence against their identity—what Spivak describes as the "obliteration" of the Other's subjectivity (2115). As I will explain in greater depth later, when self-starvers are institutionalized, their various embodied knowledges are obliterated and they become "the anorexic."

Even when self-starvers speak, their narratives and bodies are notoriously misread. Spivak describes this problem in her example of embodied epistemic violence, when she reflects on a young woman named Bhubaneswari Bhaduri, who killed herself in 1926 because she was unable to complete a political assassination; before killing herself, she waited until she was menstruating, which meant that her suicide could not be attributed to an illicit pregnancy (2123). This suicide, according to Spivak, “generalized the sanctioned motive for female suicide [sati] by taking immense trouble to displace (not merely deny), in the physiological inscription of her body, its imprisonment within legitimate passion by a single mate” (2123). The complexity of this suicide was later dismissed by a new generation of female family members, who misinterpreted Bhaduri’s body’s message. Spivak writes, “Bhubaneswari attempted to ‘speak’ by turning her body into a text of woman/writing. The immediate passion of my declaration ‘the subaltern cannot speak,’ came from the despair that, in her own family, among women, in no more than fifty years, her attempt had failed” (2124). In some ways, self-starving women, whose bodies bear complex, and often contradictory, messages, echo Bhaduri’s suicide and embodied rhetoric. As Bhaduri’s family misread her suicide, however, we now risk the potential misreading of self-starving bodies when we silence them for being dangerous or superficial.

The concern that the subaltern cannot speak reflects a fear that the subaltern speaking, and the female body speaking, I might add, cannot be listened to. Even when the subaltern does speak, her meaning will not be conveyed (2124-5). In “Subaltern Talk: Interview with the Editors,” Spivak confirms that “even when the subaltern makes an effort to the death to speak, she is not able to be heard” (292). Thus, epistemic violence

means more than subjugating ways of knowing; it also refers to refusing to hear the subaltern as they speak. This theory mirrors the silencing of and speaking for self-starving women that medicine, professional organizations, and blog hosting / photo sharing websites enact. From Spivak, then, we can understand that the rhetorical moves of silencing and speaking for others are never innocent, but are rather violent methods for erasing subjectivity, misreading embodiment, and refusing to listen to difference.

The erasure of pro-ana websites, which discredits female ways of knowing, perpetuates a cycle of violence that is always already done to women's ways of understanding and experiencing their bodies. As an extension of Spivak's concept of epistemic violence, I posit self-starving bodies as subaltern to the extent that they are potentially able to speak but not be heard. I argue that the female self-starver cannot be heard or read because her ways of knowing herself and her body are subjugated in favor of ostensibly more credible medical and professional discourse, which claim to offer support to women with eating disorders while they authoritatively speak for and commit violence against them. This violence is perpetuated through professional organizations, which reify the authority of medical discourse over female bodies even as they advocate for self-starving women. Finally, blog hosting and photo sharing websites, such as Tumblr, Instagram, and Pinterest, enact epistemic violence against self-starvers by silencing them and erasing their narratives. I will now turn to a discussion of the implications of these three forums for/ forms of epistemic violence.

Epistemic Violence and Medical Authority

In in-patient and outpatient treatment facilities for eating disorders, there is a lack of consensus regarding which treatment methods are most effective, little discussion of development of new methods, and a lack of insight into “effective management that truly impacts on long-term outcome” (Kaplan 235). These aspects of eating disorder treatment make it difficult to generalize about common treatment procedures. However, practices that are generally used (depending, of course, on the perceived severity of the illness) include psychotherapy, group therapy, medication, the pursuit of a healthier target weight, and, in some cases, force-feeding (Treasure, Todd, and Szmukler 275-85, Brisman 41). First, psychotherapy is a practice that seeks to tease out the connections between a patient’s disordered eating behaviors as they relate to potentially disordered relationships. In particular, Christopher Dare and Catherine Crowther posit that psychotherapy often involves a therapist and patient engaging in dialogue about the ways in which, for the patient, “neediness has been distorted...into representing an invasion of her personal boundaries, a complete capitulation of her self-control and the annihilation of her self by the overwhelming power of another, who threatens almost to gobble her up” (300). Dare and Crowther also note that psychotherapy often involves discussions of self-isolation, family conflicts (especially with parents), and loss of loved ones (304-5). Group therapy is another commonly used treatment measure, particularly in the form of family intervention, which is the “only form of treatment for anorexia nervosa shown to be effective in the long term by controlled trials” (Dare and Eisler 334). Medication is also used to “correct the basic biochemical deficit underlying the condition” (i.e. depression, obsessive compulsive disorder, or anxiety disorder) and for “symptomatic

benefit” (Treasure et al. 286). While it is difficult to clearly distinguish between mental and physical treatment methods, these procedures are commonly used to treat psychological factors that contribute to eating disorders.

Psychological treatment for eating disorders, in general, can be violent when the psychological factors are ignored or rendered superficial in comparison to physical factors. In *Biting the Hand that Starves You*, David Epston reflects on his years of “active practice and consultation/research” and reveals that psychological treatment for patients is often deplorable. He writes:

In New Zealand and everywhere I traveled—Canada, Sweden, the United States, Australia, and elsewhere—women described with uncanny repetition that the hospitals to which they had been admitted as a last resort were ‘no better than concentration camps.’ Although they had physically survived the ordeals of hospitalization and the terror of their force-feedings, many felt that their spirits had been trampled upon in the process, making them even more vulnerable to a/b [anorexia and bulimia] upon discharge. (5)

The lack of attention physicians pay to empowering and listening to patients during treatment may render any physical improvements that are made temporary—even futile, if patients will leave feeling more dedicated to their eating disorder than ever. The “concentration camp” metaphor, furthermore, offers an extreme depiction of the powerlessness and psychological torture that patients experience during treatment. Epston also characterizes physician attitudes towards patients as violent: “Over the years, I heard many professionals refer to insiders [patients being treated for eating disorders] as ‘prima

donnas,' 'spoiled brats,' and 'manipulative attention-seekers,' describing them as people deserving of disdain and even loathing. At the same time, they also feared these young women" (5). Thus, not only are psychological treatment models for eating disorders inherently violent to a self-starver's sense of self (subjectivity/ identity/ sense of agency), the sentiments and motivations behind such treatment can be (and often are) violent.

In other, more physically dire situations, doctors may take control of a patient's consumption of food. According to Treasure et al., "A common approach in specialized inpatient units is for nurses to take control of eating away from the patient at first" (280). However, they note, "It is important that the nurse sees her role as a therapist rather than a prison guard" as she forces patients with anorexia to "recogni[ze] and tar[get]" their "abnormal behaviors" while they increase calorie consumption (280). When forced to gain weight, "Patients with anorexia will feel panic," particularly because they must be weighed regularly (Treasure et al. 281). The authors further claim that in some situations, information about a patient's changing health and weight may be withheld because such information is not of "value" to them (281). If these treatment options prove unsuccessful, then physicians may turn to force-feeding. Penny Lewis, in "Feeding Anorexic Patients Who Refuse Food," argues that, while it does technically maintain life, force-feeding a patient with anorexia represents "a serious intrusion into the patient's bodily integrity" and "crushes the patient's will, destroying who the patient is" (30, 33). Whereas the other forms of treatment are psychologically and epistemologically violent, force-feeding is a physical form of violence that involves forced entry of a tube into a patient's stomach or nose. All of these forms of treatment, then, may be seen as

potentially violent responses, epistemologically, psychologically, or physically, to violent enactments of anorexia.

Many women will never experience these violent treatment models at all, however, since only a select few can access treatment due to the high costs for both inpatient and outpatient care. The South Carolina Department of Mental Health's website estimates that "Treatment of an eating disorder in the US ranges from \$500 per day to \$2,000 per day. The average cost for a month of inpatient treatment is \$30,000" and "The cost of outpatient treatment, including therapy and medical monitoring, can extend to \$100,000 or more" ("Eating Disorder Statistics"). They also explain that health insurance companies do not often cover treatment costs ("Eating Disorder Statistics"). The lack of support from insurance companies, in large part, is due to the stigma that eating disorders are superficial choices rather than serious diseases, the differing care needs for various patients, and the tendency, on the part of insurance companies, to define wellness in regards to physical, rather than mental, health (Nelson n.p.). This lack of coverage, and the high treatment costs, unsurprisingly, has negative consequences for many women with eating disorders who will be told that they have a disease but cannot receive treatment. According to ANAD's website, only "1 in 10 men and women with eating disorders receive treatment" and "Only 35% of people that receive treatment for eating disorders get treatment at a specialized facility for eating disorders" ("Eating Disorder Statistics"). Thus, the violent medicalization of female bodies also fails the women who are excluded from treatment due to their inability to pay.

In a pro-ana forum, when a woman asked fellow users whether or not they were seeking treatment, one woman wrote back with an ambivalent response that speaks to the issue of expense and seeking help. She writes:

I started seeing a therapist at 16 but quit when I was 17. I stopped going because we couldn't afford it. I really wish we could, [*sic*] I felt like just talking about my problems and learning healthy coping methods worked way better than pills. None of these visits were ED or self harm related. Just for my bipolar disorder. I never felt comfortable talking about it till [*sic*] I was 18 and couldn't be forced into an institute. Unfortunately by the time I was 18 and felt safe talking about it [*sic*] my mother could no longer afford it.

Thus, as this woman indicates, treatment for eating disorders depends on many factors, and, at times, emotional readiness for treatment may not indicate financial readiness.

Even when self-starvers are able to seek and afford treatment, the success rates for in-patient and outpatient treatment are very low. Walter Kaye, Michael Strober, Daniel Stein, and Kelly Gendall argue, “It is distressingly clear that treatment interventions that may have value in the acute management of AN and BN do not guarantee longer-term maintenance of gains, and may not be optimally effective in prophylaxis” (1288). In large part, the notoriously low success rate for eating disorder treatment is due to the drop out rate of patients (sometimes due to inability to pay or the violent treatments, as previously described), the lack of long-term care, and the lack of attention professionals pay to patient resistance (Kaplan 235). More specifically, according to research compiled by the Eating Disorder Coalition, up to 20 percent of people with anorexia will die from the

disease (often due to heart failure), and the rates of recovery indicate that “1/3 recover after [the] initial episode,” “1/3 fluctuate with recovery and relapse,” and 1/3 will die (“Facts About Eating Disorders,” Ellin n.p.). In their longitudinal study of patients with anorexia and bulimia nervosa, Herzog et al. found that recovery rates were higher, overall, for patients with bulimia than for patients with anorexia. They found that “33.7% of AN subjects, and 73.8% of BN subjects achieved full recovery at some point over a median of 90 months of follow-up” (831-2). The relapse rate for subjects was significant: “Forty percent of AN subjects relapsed after full recovery. Of BN subjects, 35.3% relapsed after full recovery” (834). These recovery rates are disturbingly low given the high costs for treatment and the repeated hospitalizations that are associated with eating disorders. While these statistics do not indicate a lack of good intention on the part of medical specialists, reading the treatment models in relation to their success rates raises serious questions regarding whether the violent acts of reifying medical authority during treatment, physically and psychologically, are the most effective way to respond to eating disorders.

It is likely that specialists who treat eating disorders are well intentioned, and certainly, eating disorders are complex illnesses that must be approached differently for each patient. However, treatment models that respond to eating disorder patients in ways that reinforce the power of medical professionals risk doing further violence to patients, and may even contribute to the low success rates for treatment. Many variables feed into these alarmingly unsuccessful treatment rates, but one major flaw in treatment models for eating disorders is that they oftentimes perpetuate power relations that contribute to patients’ feelings of helplessness. In *Feeding Anorexia: Gender and Power at a*

Treatment Center, Helen Gremillion argues that medical models for treating eating disorders “directly re-create conflicts that patients and their families have been experiencing in their lives” (3). In particular, she claims that “power struggles in treatment participate in the cultural production of patients’ experience that they cannot control themselves (and that they should be able to)...therapies for anorexia unwittingly engage cultural practices and ideologies that are constitutive of this syndrome” (4). For example, Gremillion points to practices that involve constantly weighing patients and ensuring that patients’ lives are “heavily structured by eating” as reiterating some of the dangerous behaviors that they are seeking to cure, since patients can eat themselves out of the hospital, and then begin to starve themselves or attempt suicide once free (8). The danger of such practices, in part, is that they perpetuate fixations on weight, numbers, and calories while they remove control from the patient altogether.

Similarly, medical treatment models can dehumanize patients by reducing them to their illness. Dare and Crowther admit that, because the psychological and physical effects of anorexia nervosa are so extreme, “It becomes difficult to see the patient as a person: she is an anorexic. The minute body blocks the view of the woman” (301). Beyond the risk of dehumanizing female patients, doctors may infantilize or even experience attraction to a female patient, and this may influence the power dynamics within their interactions. Dare and Crowther warn that if “the patient appears as a pretty, vulnerable young woman...The therapist may be consumed by the thought that protectiveness should be offered rather than facing her up to harsh reality” (304). The unequal power dynamics in eating disorder treatment facilities, particularly when the

patient population is most often young women, can easily shift from being violent to exploitative.

As one woman shares in a popular pro-ana forum, she had a negative experience with treatment because her doctor insisted that she must overcome her anorexia using her willpower alone. She writes that all of her therapists were helpful:

Except [*sic*] for one idiot psychologist who asked me to pick up a pencil. I don't remember what i [*sic*] did but he argued that one either does or doesn't pick it up, that you can't 'try' ??? [*sic*] I argued for the entire hour that it wasn't true...he was referring to my Ana and that I either join the team and get better or I wouldn't. I still think we can try or 'want' to get better but not all at once....one CAN TRY....and what if I had some disease that made it hard to pick up the stupid pencil. [*sic*] I never went back to him. I still get fired up.

In this situation, in particular, the woman describes her experience in treatment as adversarial. The psychologist, rather than listening to the woman's perspective about her disorder, attempts to force his own opinion about recovery and ability to change upon her while she is already in a vulnerable state. As she insists, this attempt at convincing her to "pick up the pencil" backfired in more ways than one. Her current weight of 95 pounds, and her goal to weigh 86 pounds, indicates that she still struggles with anorexia.

Thus, treatment for eating disorders represents violence against self-starving women psychologically and physically, as medical facilities and physicians reify their authority to the detriment of the women they treat. The high costs for treatment also exclude many women from seeking help. Finally, the low recovery rates for patients with

anorexia, in particular, suggest that problematic power dynamics that treatment may reinforce to dominate young women may prevent them from healing.

Epistemic Violence and Defining Anorexia (Narratives)

While medical treatment models reify medicine's authority over female bodies, professional eating disorder associations function to raise awareness about eating disorder treatment, inform the public about disorders, and connect women who might be at risk to resources for getting help. More specifically, NEDA explains that their mission is to “support individuals and families affected by eating disorders, and serv[e] as a catalyst for prevention, cures and access to quality care” (“Mission and Vision”). This mission is certainly important, and the programs, as represented through their websites, may be helpful to some women who are seeking information or access to care. However, despite these admirable goals, when professional eating disorder organizations use medical definitions for eating disorders that are very rigid and exclusionary and provide guidelines for “responsibly” sharing narratives about eating disorders, they perpetuate the epistemic violence that is committed by medical authorities.

One way in which professional eating disorder associations, and ANAD and NEDA in particular, risk enacting this violence is by defining eating disorders in rigid ways that exclude many women and subsume women who meet the “official” criteria into their disorder. For example, ANAD's website defines anorexia as being “characterized by emaciation, a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight, a distortion of body image and intense fear of gaining weight, a lack of menstruation among girls and women, and extremely disturbed

eating behavior” (“Anorexia Nervosa”). They also use terms such as “obsessions,” “deteriorates,” “battle,” “illness,” “deliberate,” “irregular,” “abnormal,” “compulsive,” “excessive,” “continuous,” “refusal,” and “a very frightening experience [that] feels very real” to describe the symptoms associated with anorexia (“Anorexia Nervosa”). These definitions characterize anorexia in very rigid ways, as they insist that anorexia is characterized by absolute physical conditions and vague psychological conditions. For example, some women who know that they experience anorexia may nonetheless still menstruate, or may menstruate occasionally. Also, in using terms such as “relentless,” “distortion,” “intense,” and “extremely disturbed,” which suggest extreme degrees of psychological illness, ANAD risks the potential alienation of women who know that they experience anorexia, but not to the extent that these singular definitions suggest.

In the pro-ana forum in which women discuss their experiences with treatment, one woman speaks to the difficulty of being diagnosed with an eating disorder, even by professionals. She explains that she sees her therapist “for my non depression (apparently its [*sic*] just a ‘phase’, [*sic*] yeah right, a fifteen year phase) [*sic*] Nobody knows about my ana and I intend on keeping it that way.” Beneath her post, she engages in the common practice, in pro-ana forums, of listing height, BMI, current weight, goal weight, goal weight 2, and ultimate goal weight. She writes that she is 5 feet 2 inches, her ultimate goal weight is 70 pounds, and her current weight is 82, which means that her BMI is 15.1.⁶ Another user responds by asking, “You have been going to a therapist with your bmi [*sic*] that low and no one has said anything? Wow! Kinda [*sic*] sad on the professionals [*sic*] part.” She explains to her respondent, “My dad told them I don’t eat

⁶ According to the National Heart, Lung, and Blood Institute, a BMI beneath 18.5 is considered underweight, while a BMI in the range of 18.5-24.9 is considered normal (“Calculate Your Body Mass Index”).

much, they asked me about it and I just said I was eating health, [sic] end of story for them.” Her respondent writes back, explaining:

Well that was easy...This would totally screw with my mind bc [sic] I would feel as if I didn't look sick enough (hope that doesn't trigger you, but I am sure you have thought this) and I would want to lose more...even though I don't want help or anything I would still want someone to notice my silent screams.

When definitions for eating disorders are too specific and subjective, it can be difficult to diagnose eating disorders in professional contexts. But it also means that self-starvers can suffer in silence when others do not recognize the signs of their eating disorder, which may not match the official criteria. Even though the final writer claims that she does not want help, it seems that she does want someone to indicate concern for her condition. Clearly, even the professionals who are trained to intervene fail to do so, at least in this woman's case.

These definitions, and their inability to translate into real contexts, are problematic because the extreme medicalization of female bodies, particularly in regards to weight management, means that women must be “diagnosed” with an eating disorder by an expert before they can seek treatment. When the criteria for defining an eating disorder is this specific, as these definitions suggest, many women may be told that they are not “really” or “officially” anorexic when they nonetheless experience disordered eating behaviors or anorexic thoughts and feelings. Functioning anorexics who find that they are “not anorexic enough” to meet this definition's standards may not seek treatment if they feel that their experience of disordered eating does not meet the official criteria.

This means that many women may not be able to seek treatment until their anorexia is very severe, at which point treatment may be less effective. Thus, defining eating disorders, particularly anorexia, in very specific and extreme ways, is an act of epistemic violence because it speaks for self-starving women by defining who they are and are not.

Professional organizations, unfortunately, go beyond speaking for self-starving women—they also tell them how to speak. NEDA’s website provides a set of guidelines that encourage women to blog about their experiences, but only within specific parameters for sharing stories “responsibly.” Their guidelines for responsible sharing inform women that they “are in a unique position to offer hope” to others, and it urges them to “present your story in a *useful* way while protecting your personal well-being” (“Guidelines for Sharing”; emphasis mine). The guidelines essentially tell women that there are ways of sharing their stories that are dangerous to themselves and others. To mitigate the risks of sharing their narratives, they must follow NEDA’s directions and shape their stories in accordance with the guidelines. While this warning may be useful to some writers, it places blame on the female self-starver (in advance) and tells her that her ways of experiencing her eating disorder may be unacceptable or not “useful” in helping others. For example, in the section called “remember your reason for speaking,” women are told to “Make sure you leave your audience with the message that there is hope” (“Guidelines for Sharing”). Women are also warned to avoid “anorexia chic” and told to remind the audience that “eating disorders are illnesses, not choices” to be glamorized (“Guidelines for Sharing”). These guidelines tell women how it is acceptable to present their eating disorder to others, but they also, perhaps more importantly, tell them how to think about their disorder. Thus, whether or not they feel that they choose to engage in

disordered eating behaviors, they are told that they do not—anorexia is an illness. They are told that eating disorders are not glamorous, which assumes that the women feel that way to begin with, even though some actually find the daily realities of self-starvation to be quite ugly. Finally, being told to leave the audience with a message that there is hope may be akin to asking the women to lie, when we remember that two thirds of self-starving women will not fully recover.

These views, significantly, insinuate that responsible sharing of eating disorder narratives can only come through sanctioned channels and with sanctioned themes. In contrast to this point of view, in 2008, a Tumblr blogger who advocates for pro-ana as a lifestyle refuted several popular myths surrounding pro-ana and repositioned pro-ana as a responsible space. She explicitly contends that some pro-ana forums are actually more responsible and supportive than pro-recovery and professional websites. The blogger, responding to the claim that “Pro-ana encourages you to stay anorexic,” argues:

We don't encourage you to stay anorexic, but this is the biggest way in which we differ from the professional and pro-recovery sites. Instead of treating a disorder itself, pro-ana treats the person. We get to know the individual, what makes them laugh, smile, cry and scared to see what their world is like through their eyes. See, like I said before, eating disorders are a deep rooted problem and there is no point trying to get rid of something that will just come back again instantly. To get rid of this, one must get to the main root and work from there. Once the root is gone, the consequence [*sic*] of eating disorders are that much easier to recover from...and the

process will be a lasting one. This is why the most important part of any ed [eating disorder] forum is the journal area.

Far from glorifying or promoting self-harm, this woman demonstrates awareness of the complexity of eating disorders, the problems with treating only the physical consequences of the disorder while ignoring the underlying causes and contributing factors, and the importance of treating women with eating disorders like human beings. She expresses concern that women who seek help from recovery websites or professional organizations will have their identities subsumed in their disease. Pro-ana, she tells readers, will “get to know” them, will learn to understand their triggers, and will empathize with and listen to them in ways that professional organizations will not.

Epistemic Violence and the Erasure of Pro-Ana

Just as medical discourse’s authority over female bodies shapes the ways in which professional organizations define anorexia and “responsible” and “useful” narratives about it, professional organizations pressure websites to perpetuate the authority of medicine by erasing the digital narratives of self-starving women. The erasure of the narratives of self-starving women, as shared in digital spaces, can be read as a form of epistemic violence because it literally involves the silencing of female voices. Tumblr’s guidelines for content sharing attempt to distinguish between innocent storytelling and dangerous discussions. They explain that while they encourage discussion and dialogue about eating disorders, they will not condone the *promotion* or *glorification* of self-starvation. They write:

Dialogue about these behaviors is incredibly important and online communities can be extraordinarily helpful to people struggling with these difficult conditions. We aim to sustain Tumblr as a place that facilitates awareness, support and recovery, and to remove only those blogs that cross the line into active promotion or glorification of self-harm.

(“Community Guidelines”)

The problem with such guidelines is that promotion and glorification are subjective terms. The policy raises questions regarding what constitutes the glorification and promotion of extreme dieting and thin bodies. For example, for whom does pro-ana promote or glorify eating disorders? And does pro-ana promote or glorify disordered eating differently than Victoria’s Secret or Slim Fast, to name a few brands that arguably convey similar messages about weight loss and pursuing “perfect” bodies to impressionable audiences?

Tumblr does not supply an answer to these questions, but they do explain that the purpose for their website is the sharing of experiences so long as that sharing that will not be harmful to other users. They write: “Tumblr celebrates creativity. We want you to express yourself freely and use Tumblr to reflect who you are, and what you love, think, witness, and believe” (“Community Guidelines”). These goals for expression and witnessing, however, have their limits; in a section labeled “What Tumblr is Not For,” the website clearly states that “content that actively promotes or glorifies self-harm” will not be tolerated (“Community Guidelines”). Of course, it is difficult to speak definitively about any “self-harm” content, since it varies for each user and context, and there are arguably differences in self-harm content for anorexia and, for example, self-harm

content for cutting or suicide. However, Tumblr presents pro-ana as dangerous and risky, and insinuates that it is their responsibility to protect other “innocent” web browsers from being exposed to such content.

As an indirect response to such claims, the Tumblr blogger who refuted several popular myths surrounding pro-ana also took issue with the claim that pro-ana attempts to “teac[h] others to become anorexic,” responding:

You cannot ‘become’ anorexic, it is not something you choose like a diet, anorexia chooses you and in the lottery of anorexia winning is loosing [sic] more than you know. It's outside factors in your own enviornment [sic] that make one eating disordered, not text and pictures on a website. To those that [sic] think you can become ‘ana’...it won't happen. You may skip a few meals, fast for a few days but that does not make you anorexic at all. Much like a drag queen, you can look act talk walk and sing every bit like Cher...but you are not Cher. It's simple as that.

The writer, who self-identifies as a female anorectic, conceptualizes anorexia and pro-ana in ways that defy Tumblr’s, Pinterest’s, and Instagram’s assertions that pro-ana poses serious risks to other viewers. She argues that anorexia is not something that can be chosen due to the influence of images, words, or peer pressure and shifts the blame for eating problems to the environment that surrounds many women. But most significantly, she makes an important distinction between anorexia and dieting as they relate to the pro-ana content on websites that so many have found disturbing. Pro-ana may cause dieting, she explains, but it does not, and cannot, cause anorexia. In fact, as has been previously discussed, the rigid and extreme definitions for anorexia actually seem to support this

woman's assertion that eating disorders are not simply "chosen" in the moment upon reading web content. She suggests that the rhetorical purpose of pro-ana is not conversion, but support for women whose silent screams have been routinely ignored.

Additionally, while it may be true that viewing pro-ana content can influence some young women to engage in disordered eating behaviors, whether or not these behaviors become eating disorders, the violent erasure of this content seems reductive and unfair given expectations in dominant Western culture for women to be (extremely) thin. For example, in "Hunger Hurts but Starving Works," Krista Whitehead posits that pro-eating disorder forums represent collective identity formation that is highly, and complexly, gendered as "feminine" (597). This argument is in the vein of Bordo's "Anorexia Nervosa: Psychopathology as the Crystallization of Culture," which presents anorexia as an exaggeration of "what is wrong with" a culture (141). The pro-ana presentation of what the "ideal" female body, in hegemonic Western culture, should look like, while exaggerated, is not very different from the way women are typically presented in popular magazines, videos, and images. Similarly, Gailey argues that pro-ana women engage in risk-taking eating behaviors to maintain a sense of control over their (otherwise chaotic) lives, and she urges researchers to blame "the cultural messages that we are inundated with daily" instead of young women and their websites (107). This is an important point for a feminist framework for understanding women with eating disorders, since I would posit that self-starvers are oftentimes following cultural scripts that they have found elsewhere—and not always (if at all) in pro-ana spaces. Generally, pro-ana writing is less focused on converting others to anorexia, and more on controlling one's

own weight in the midst of a culture that constantly makes conflicting demands upon female bodies.⁷

The implication of this violent erasure of female narratives is both epistemologically and psychologically violent. Speaking about illnesses digitally represents a way in which people might seek support and attempt to find meaning in their suffering and self-violence, and in removing pro-ana content, websites may be removing this way to seek peace. In *Illness as Narrative*, Ann Jurecic explains, “If one of the consequences of modernity is that we no longer depend upon traditional explanations for suffering, loss, and mortality, and if doctors’ offices and hospitals cannot function as spaces where personal meaning can be developed, then the existential questions about human fragility and significance have to be asked and answered elsewhere” (10). For many women with eating disorders, these questions are being asked in pro-ana forums, where they can discuss painful experiences and respond to medical and cultural discourses that seek to silence and disempower them. The erasure of these spaces may keep some viewers from learning about dieting ideas and tips, but it might also prevent self-starving women from finding meaning in their suffering or having a space to grapple with its meaninglessness.

Conclusion

In “Feminist Interpretations of Anorexia Nervosa,” Matra Robertson argues, “The voice of the woman who starves herself is rarely heard in the literature on anorexia nervosa. Instead others speak about her and for her” (52). Rather than listening to the narratives and experiences that female self-starvers write and speak with their bodies,

⁷ For example, that the female body should be sexy but restrained.

their narratives are appropriated in a way that hearkens back to Bhaduri's misread suicide, to return to Spivak's illustration of epistemic violence. Anorexic bodies, when dominated by medical discourse about and treatment programs for anorexia, are subjected to still more violence when their digital narratives and forums for sharing are erased. Robertson assigns partial blame to medicine (and I would add professional organizations) for "speaking *for* the woman being treated for anorexia, who is seldom the originator of the discourse, but is instead its silent object" (54). Furthermore, Robertson makes an explicit connection between epistemic authority, anorexia, and the medicalization of female bodies. She claims, "Anorexia nervosa is part of a process of medicalization of women's bodies that has gradually assumed authority over how women are embodied and hence *how they embody themselves*" (40; emphasis mine). This last point resonates with me, in particular, as I consider the implications of the epistemic violence in the three forums that have been described as they contribute to the violence women commit against themselves when they self-starve.

Anorexia is a very violent act, in which a woman starves herself to the point of death. In some pro-ana forums, it is not uncommon to see women recommending dangerous dieting tips and purging tricks, and in such spaces, pro-ana can also enact violence against many women. But I take issue with the idea that pro-ana is the only form of violence, in the cycle that has been described, that must be responded to with erasure. First, the women who write in pro-ana forums do not instigate this violence, they merely perpetuate a cycle that occurs within medicine and professional organizations and results in the erasure of pro-ana narratives. Attacking the women who share their stories, while

reifying the power of the organizations and institutions that enact violence against them, is not an ethical way to respond to self-starving women and eating disorders.

Beyond what I consider the misdirected attacks against self-starving writers, I argue that the propensity for pro-ana to unsettle and bother us is not necessarily a bad thing. Certainly, our discomfort with reading pro-ana writing is not a justifiable cause for its erasure. The issues that the women who write in pro-ana forums bear witness to demand our attention—and as I will argue in Chapter Two, they demand and warrant our careful response. We need to be bothered by failing treatment models, institutions that tell women that they can only seek control through their body, and experiences of trauma and abuse that so often contribute to eating disorders. In large part, epistemic violence occurs because of our unwillingness to be unsettled. It occurs because we rhetorically respond to anorexia by silencing it. We silence the anorexic body. We silence the anorexic narrative. And until we stop silencing the anorexic woman when she speaks, I fear, she will continue to silence herself.

Chapter Two: Witnessing Anorexia

Introduction

In “Saving a Life: Anorexia’s Story About Kristen,” Richard Maisel, David Epston, and Ali Borden analyze a letter that is “‘Authored’ by anorexia” (66). It was supplied by Kristen, who gave it to her therapist as a representation of anorexia’s voice.

In the letter, anorexia explains:

There is something about Kristen that makes people want to hurt her. She has already been hurt by males before because she was not smart and very careless. She needs to lose weight so she won’t be hurt anymore. She is safer when she doesn’t eat because people don’t feel like they need to hurt her. They are entirely right in thinking she deserves to be hurt. She deserves to be hurt right now because she is so fat. She deserves to be hurt when she eats, especially in front of people. I’m just trying to protect Kristen. I have her best interests in mind at all times. (69-70)

Anorexia claims that it is saving Kristen by starving her, and posits that her past pain at the hands of men justifies her current suffering at the “hands” of the disease. But anorexia does more than starve Kristen. It steals her voice. Kristen’s dehumanization means that anorexia authors her narrative.

As described in Chapter One, women with anorexia are subjected to epistemic violence from medical treatment models and facilities, professional eating disorder associations, and blog hosting and photo sharing websites that destroy their subjectivity, sanitize their narratives, and silence them through erasure. The model of responding to self-starving women by silencing them is failing, and, as a result, women are losing authorship of their narratives—and their bodies, as described in Kristen’s example. The message of epistemic violence as it relates to pro-ana is that some narratives are not worth sharing, are even dangerous or risky for others, and thus deserve to be silenced.

Kelly Oliver speaks to this same issue of silenced bodies in different terms in *Witnessing: Beyond Recognition*, noting that “Within a racist or sexist culture, certain bodies are not able to legitimately question, interpret, or reflect. Those human abilities are reserved for bodies posing as disembodied neutral forces of nature or truth” (40). Certainly, women with eating disorders, to the extent that their disease highlights their embodiment by attempting to transcend it, are denied the right to question, interpret, or reflect—even to speak. However, this inability to author their narrative also results in a loss of subjectivity. Oliver claims that “oppressed people lack the ability to create meaning for themselves” since they are denied the subjectivity that is necessary to speak and “a social space within which to create meaning” (43). As has previously been described, women with eating disorders are oftentimes literally objectified or subsumed by their illness. They lose subjectivity (and agency) at the moment in which they are seen as an anorexic, and not an individual person. This lost subjectivity contributes to the epistemic violence that is committed against their ways of knowing and understanding their bodies.

Although she does not discuss eating disorders, this problem of destroyed subjectivity leads Oliver to re-envision interactions with Others through the framework of witnessing, which means both “*eyewitness* testimony based on first-hand knowledge” and “*bearing witness* to something beyond recognition that can’t be seen” such as trauma, objectification, and dehumanization (16). Witnessing is necessary because it allows objectified Others to reclaim subjectivity in the space of “tension between these two meanings” (83, 105). It is within this tension that we might “mov[e] beyond the melancholic choice between dead historical facts or traumatic repetition” (106). The tension between what women with eating disorders say and what they cannot say, what they know and cannot know, is precisely the possibility that they may reassert themselves as subjects.

Oliver’s framework of witnessing is useful to the present consideration of responding to women with eating disorders because it suggests a better way to foster conversations that might lead to healing. Witnessing opposes the Hegelian recognition model of identity because his model grants the dominant figure the power to bestow (or not) agency/subjectivity to Others and in so doing, it serves to perpetuate oppressive relations (24, 27, 36, 62). Similarly, witnessing rejects notions of performativity (via Judith Butler, in particular) that presume exclusion, because such models again privilege the dominant figure while they “put the subject in an antagonistic relation with its others” (62). This means that “Butler builds oppression and abuse into the foundation of subjectivity” (62). Such a model resonates with the framework of epistemic violence that I have used thus far to describe the ineffective responses to anorexia narratives that are shared digitally. We might, with Oliver, move beyond recognition, and its attendant

violence, towards witnessing. This would involve the decentralizing of authority on the part of medicine, professional organizations, and websites as the grantors of agency and subjectivity to self-starving women. For women who are discredited and disempowered in these three forums, witnessing might open alternative spaces within which self-starvers might reassert themselves as subjects.

Beyond restoring subjectivity to Others, witnessing insists on our mutual responsibility to open up spaces where response is possible, and our response-ability to create conditions in which “I am responsible for the other, for the other’s response, for the other’s ability to respond” (Oliver 206). For women with eating disorders, this model opens up the possibility of dialogue and invites self-starving women to share their testimony with a listening audience. Without an audience who listens to them speak, the women cannot exist as subjects. We, as digital citizens, must be the audience who listens, even if we feel unqualified or unprepared for such a serious task. Part of the usefulness of Oliver’s model of subjectivity is that it accounts for, even insists upon, the impossibility of witnessing as an imperfect and stumbling endeavor (143). Witnessing, in fact, “is always bearing witness to the necessity of its process and to the impossibility of the eyewitness” (143). This impossibility of the eyewitness suggests that there is also an impossibility of the listener—it may be impossible for us to respond coherently or perfectly to testimony, even if we are well intentioned. If it is impossible to witness dehumanization, then certainly it will be impossible to respond to it directly. This limitation to witnessing, however, is a positive element to Oliver’s theory that suggests our perpetual responsibility for maintaining response-able spaces, listening, engaging in dialogue, and “working through” the challenges that witnessing and listening entail (19-

20). Witnessing is an ongoing process to which we must attune ourselves—not a momentary engagement that we can complete or perfect.

The problem that has been discussed thus far, however, is not that women are unwilling or unable to witness their experiences in available forums, but rather, that there is not a willing audience to listen to their testimony. As anorexia takes control of Kristen’s narrative, professional organizations, and NEDA in particular, are taking control of the narratives that other self-starving women share by telling them what they can and cannot bear witness to in various contexts. The creation of an official and “responsible” master narrative for anorexia threatens to exclude narratives that characterize different experiences—and in so doing, it limits what women can share and specifies which narratives are deserving of a response. Before I describe the ways in which NEDA hinders our ability to foster response-ability with self-starving women, I will first turn to Alcoholics Anonymous (A.A.) to consider their narrative model as it may lead us closer towards a realization of witnessing for treatment forums. A.A. allows for the necessary element of witnessing, and reassertion of subjectivity, that pro-ana forums are denied: the telling of a narrative, or testimony.

A.A.’s Alcoholism Narrative

A.A., in fact, does more than create a space in which alcoholics might share their stories; it gives them a narrative to identify with. The A.A. narrative, at what is perhaps its most basic (and thus universally applicable) level, encompasses all A.A. members who identify with the Twelve Steps: “My name is _____, and I’m an alcoholic.” By giving members a sense of coherence and unity in the form of a narrative, A.A. allows

members to identify with the group, and with their common struggle against their disease. In “Twelve-Step Teleology: Narratives of Recovery/Recovery as Narrative,” Robyn R. Warhol and Helena Michie argue that “Twelve-Step programs function as a ‘coherence system,’” particularly in regards to the A.A. narrative, which is “A powerful master narrative [that] shapes the life story of each recovering alcoholic, an autobiography-in-common that comes to constitute a collective identity for sober persons” (328). In A.A., then, “the focus is a communal one, the story collective, rather than individualized; the ‘self’ in A.A. is conceived as resembling and relating to others, rather than existing in isolated uniqueness” (334). Warhol and Michie further note that within A.A. pamphlets and propaganda, the lack of personalization reflects “the ability of the A.A. master narrative to voice differences for other people, to represent and literally to advocate for all people, including those whose subject position would seem to distance them most from A.A.” (338). This represents an important way to encourage all alcoholics—regardless of race, class, gender, ability, or sexuality—to identify first and foremost as an alcoholic in the A.A. group context. The self-identification of “I” is subsumed not into the disease of alcoholism itself (as occurs so often with self-starving women and anorexia), but rather into a group of others who also have the disease, alcoholics. Thus, A.A. frames narratives for alcoholics in overtly inclusive ways that point to the connectedness of all members due to their mutual struggle.

There are three important aspects of A.A. teleology, to borrow Warhol and Michie’s term, that might enable us to better enact Oliver’s theory of witnessing as a response to pro-ana writers. First, within A.A., the erasure of difference, which Robyn R. Warhol and Helena Michie rightly remain critical of, serves an important purpose in the

A.A. narrative. They write, “Telling one’s story in conformity with the teleology of Twelve-Step programs, one embraces that totalization. The end of every Twelve-Step story is the moment of its telling or its writing: the act of telling is itself the evidence of sobriety. The ‘I’ who tells the story participates fully in the fiction of a unified self” and “‘willingly’ suspend[s] their disbelief” (348). Thus the “fiction” that everyone shares the same master narrative within A.A. (as outlined in the Twelve Steps) allows anyone to envision himself/herself as a subject to whom the recovery narrative speaks. In speaking (to) this narrative, a person might come to live it. The A.A. master narrative minimizes difference in order to invite a wide range of alcoholics to transform into recovering alcoholics by identification with a story of powerlessness, hope, and recovery.

Additionally, it is significant that this master narrative leads towards mutual *recovery* or allows members to become *recovering* alcoholics. As Warhol and Michie note, A.A. members rarely refer to themselves as “recovered,” since recovery is considered an ongoing, “endless” process (336). Furthermore, this master narrative functions as a discursive space beyond medicine and psychology. In “Codependency: A Feminist Critique,” Bette S. Tallen explains that The Twelve Traditions, “the governing principles of A.A.” serve to “distance the organization from experts and from treatment approaches, but they also address the forms of self-aggrandizement and endorsement that are seen at the core of alcoholic behavior” (313). Significantly, A.A. does not usually include medical or psychological professionals in meetings (since members should remain anonymous), and it also discourages the glamorization or promotion (to borrow terms from Tumblr) of alcoholism as an individualistic disease (313). This strikes an important balance between avoiding the medicalization of alcoholic narratives, but also avoiding

the glamorization or promotion of behaviors that are destructive and constitute alcoholism.

Unbearable Witness

Not only are women with eating disorders not being given a narrative within which to trace their process towards recovery by the organizations that claim to advocate for them, they are also told what they cannot write, say, and know about their experiences. Their witnessing is impossible, on the one hand, because it is impossible to provide testimony for the dehumanization that self-starvation and epistemic violence (from the organizations previously mentioned) entails. Their witnessing is also unbearable, perhaps in a more preventable way, because there is no one present to listen to the narratives they share *in the way they share them*. If pro-ana functions as a kind of online A.A. meeting, which I argue that it does, then understanding the official anorexia narrative as absolute and exclusionary, rather than encompassing and teleological, is an important departure from the model for A.A. which seems to more successfully foster a sense of community, response-ability, and freedom from dominant medical discourse. In moving towards response-able relationships with self-starving women, how might we better implement AA's model for valuing, and responding to, testimony in order to realize Oliver's model of subjectivity for self-starving women? It seems that the first task will be dismantling the idea, upheld by professional eating disorder organizations, that there is one master narrative for eating disorders that must be "useful" in order to be responsible.

Unlike the master narrative for A.A., which encourages members to identify as a part of a collective that shares a disease, NEDA's narrative for anorexia excludes countless self-starvers by telling them that only some stories are valid, useful, or even responsible in describing experiences with eating disorders. NEDA provides explicit directions for "Sharing Your Story Responsibly" on their website, where they invite self-starvers to share their recovery stories—but only if their stories will encourage others to seek help. They explain, "The forums are meant to be an online community where individuals can connect to others who are either struggling with an eating disorder, in recovery, or supporting someone with an eating disorder. Our forums are not a replacement for professional help, rather a place to give and receive support" ("Community Guidelines"). Narratives must follow specific guidelines, which include not focusing on "graphic images or physical descriptions of the body at its unhealthiest," being vague enough to not "provide tips" for others, avoiding "'anorexia chic,'" focusing on the role that others play in recovery so as to not "provid[e] testimony of how you 'bravely fought this illness alone,'" presenting eating disorders in a hopeful way, and providing resources for others to reference for treatment and information ("Guidelines for Sharing"). In soliciting submissions, they announce that to be accepted, posts must follow NEDA's guidelines and "focus on hope, including what helped you recover – your support system, treatment, self-care practices, etc." ("Stories of Hope"). These directions do more than insist upon particular rhetorical moves within narratives—they insist on one narrative for anorexia that may not match the lived experiences of many women. This rigid master narrative outlines the kinds of narratives that may be shared on NEDA's website, but also the narratives that will be worthy of response elsewhere. In so doing,

NEDA enacts a form of pre-erasure for anorexia narratives that deviate from this trajectory, and are therefore labeled as risky and subversive.

In order to demonstrate the contrast between the master eating disorder narrative outlined by NEDA, and the narratives written by women in “subversive” spaces, I will demonstrate differences between the narratives that are featured on NEDA’s website and narratives by self-starvers elsewhere on the Internet—particularly on a Tumblr blog.

While the posts on NEDA’s forum must follow a particular narrative form, as described by their guidelines, the Tumblr blog, which has been inactive for two years, invited self-starvers to write and submit letters to their bodies without providing any limitations.

While these narratives differ in many ways, for the purposes of this research, I will explore the differences between the ways in which these narratives approach the role that others play in recovery and the possibility of recovery itself. It is important to note that these narratives do not represent all of the writing that is available or possible in pro-ana and professional spaces. However, I hope that even this small sampling of narratives will highlight the limitations of the master narrative guidelines that NEDA dictates. My goal for this analysis is not to suggest that some narratives are more or less “true” or “valid,” but rather, it is to insist that we must denounce any guidelines, from NEDA or elsewhere, that claim to advocate for women with eating disorders while telling women that they can only share their narratives within certain parameters. The narratives all offer important insights into experiences with eating disorders, treatment, and struggles toward recovery. But the narratives written outside of the official NEDA forum complicate the master narrative for anorexia that NEDA unproblematically embraces (ostensibly because it is more hopeful) in ways that might allow us to better foster response-ability with all self-

starvers. After all, perhaps we bear a special responsibility to the women who cannot be hopeful about their self-starvation.

Methods and Ethics

In what follows, I analyze contributions to one publically accessible Tumblr blog, which contains 22 letters written by female self-starvers to their bodies. While the page has not been updated for two years, the anonymous posts serve as important contributions to discussions surrounding pro-ana content and forums. This blog was chosen for analysis for several reasons. First, the posts were added to the site before the Tumblr “self-harm” policy was created, which means that they may represent what was possible for self-starving women in these spaces prior to the change of policy. Additionally, I find the mission statement for the blog to be particularly compelling, as it states that “the goal of this project [the blog] is to offer an unbiased forum for those who want to address the current state of their relationship with their body, and to encourage healing through this expression.” Thus, the blog unwittingly attempts to become a space that fosters responsibility amongst self-starvers in a way that is unbiased, encouraging, and expressive. I do quote these passages, since listening to their narratives as they have described them is of utmost importance to this analysis. In quoting other posts, which were found in publically accessible web magazines or in NEDA’s “Stories of Hope” forum, I do provide first names for writers, as they have chosen to identify themselves publically.

In this analysis, I follow Downer, Gresham, Kirkwood, and Reynolds in noting that while I will describe the content posted by female self-starvers, I “hope not to fall into the trap of talking about these sites instead of participating in conversations with the

authors of them” (87). Eating disorders are complex enactments of violence and expressions of trauma, and it is only in listening to the female self-starvers themselves that we can begin to hear the response that their rhetoric demands.

The Role of Others in Anorexia Narratives

NEDA provides guidelines regarding the role of other people (family members, friends, and care providers) in the anorexia narrative. They explain that self-starvers should clearly describe that they depended upon others throughout their recovery process, and that eating disorders cannot and should not be faced alone. NEDA writes, “Be careful about providing testimony of how you ‘bravely fought this illness alone’ (“Guidelines for Sharing”). This message presumes, first of all, that self-starvers will want to present themselves as brave heroes who have rescued themselves from eating disorders. NEDA also asks that such testimony, even if it is true, be withheld from anorexia narratives. As they clarify: “Perhaps you did [fight the illness alone], but most do not—the vast majority of those who recover from their illness do it only with the ongoing help of trained professionals. Remember that isolation is one of the most difficult aspects of eating disorders for many sufferers” (“Guidelines for Sharing”). First, it is not productive to make sweeping generalizations about how “most” do or do not recover from an eating disorder, particularly when those claims are not substantiated with any evidence. NEDA’s guideline also implies that self-starvers should have access to treatment, that such treatment is actually helpful for patients, and that there are other people available (such as supportive family members or friends) who are willing to be involved in the recovery process. For many women, these supportive networks of family members,

friends, and caretakers may not exist, or they may be unable to care for the self-starver for financial, physical, or other reasons. Also, while it may be true that “most” do not recover in isolation, this statement strips the self-starver of her sense of agency in insisting that there is little chance that she has played a significant role in her own recovery. Finally, NEDA explains that self-starvers should “Make sure you reinforce that it is courageous and necessary to reach out for support and guidance during the recovery process” (“Guidelines for Sharing”). For the reasons previously mentioned, insisting that others should “reach out” for help is unfair given the financial and emotional restrictions that keep many women from doing so.

On NEDA’s website, nonetheless, the self-starvers do generally discuss others as a positive, motivating factor in their recovery. In a story by Ericka called “Learning How to Live Wholeheartedly,” she reveals that other people—particularly one child—ultimately led her to seek help. She explains, “It wasn’t until I became a preschool teacher that I even began to appreciate and understand what life is about. I watched one of my students battle (and survive!!) cancer. It was then that I realized that I had a critical choice to make. I could honor my body...Or I could continue to abuse it” (Ericka). This narrative is echoed by other contributors, who reveal that other people’s illnesses and their own accidents, near-death experiences, and confrontations involving others led them to realize the severity of their illness and seek help. For some, becoming response-able to another person in a crisis situation served as an intervention moment that reminded them of the importance of living.

Contributors also describe the role a supportive community played in helping them through the challenges of the recovery process. Another contributor, Meghan,

writes that her family and a friend named Sam were her motivation for healing. She notes, “My family never judged. They just loved. They also worried. Learning of the worry my anorexia and bulimia were causing for the ones I loved most became a main motivator in my later recovery” (Meghan). Significantly, other people, in this case, motivate Meghan to the point that she is made to feel guilty for her illness. In realizing that her pain touches others, she does seek treatment, but it seems that this is due to a sense of obligation to others rather than for her own benefit. Meghan also shares her future plans as they relate to her health and the family that she is creating with Sam: “A continuous motivator in beating this thing has been the hope for a happy, healthy family with Sam. I want happy, healthy children who never have to experience the horror of anorexia and bulimia” (Meghan). Even in describing the future, Meghan seems to hold herself accountable for being healthy enough to create a family and bear children. Other people, then, both present and potential, function to guilt her into maintaining her health. Another woman, Brianna, echoes these sentiments by explaining that her sister, family, and friends were integral to her ability to “beat my eating disorder” (Brianna). She reveals that she was still struggling with stress about eating pizza, however, in front of her husband and friends until she saw other attractive women who did not share her concerns. She writes, “I saw my husband’s friends’ beautiful wives and friends sitting at the table with us, ordering beer and pizza, and laughing and enjoying every minute of the moment. They were not having the same anxious thoughts that I was...I realized I wanted that. To enjoy the moment, live a little, and well, chug a beer and have pizza. And I did!” (Brianna). Here, Brianna admits that other people—beautiful women, in particular— influence her to enjoy food. Out of what seems like competitiveness, and a desire to fit in,

Brianna does partake in the food and alcohol. But in her attempt to fit in with others, her telling discomfort in the presence of food is brushed aside in the narrative. Whereas for Meghan other people serve as a source of guilt, for Brianna, other women serve as a barometer for her own eating choices.

Another writer, Debbi, describes the role her treatment facility played in her recovery. She explains that those who cared for her while she was in treatment became very important to her—so much so that her final day in their care was very emotional. She remembers that “Tears streamed down my cheeks as the therapists, staff members and other girls touched my heart when they told me how far I had come, and how I was guaranteed to be a prize to the world as long as I believed in myself and allowed my talents and passions to shine” (Debbi). She adds, “I’m so grateful for all the love and support I received from everyone—it truly showed me how lucky I was. There was even a mock funeral staged for me at the facility to prove how many people I’d be hurting if I let my disorder consume me entirely. Physically and psychologically, I was torn apart by this” (Debbi). Like Meghan, Debbi experiences guilt at the thought of hurting her family and friends by potentially dying. Unlike Meghan, however, Debbi seems unnerved by the experience of the mock funeral, and seems a bit overwhelmed by the pressure to stay healthy for so many others. Also, the phrase “if I *let* my disorder consume me entirely” reveals that Debbi views the disorder as something that she can, and should, control. Her ethical obligation to not hurt others makes her feel (perhaps unfairly) responsible for not allowing anorexia to control her. She insinuates that if she allows anorexia to control her, then she allows anorexia to hurt the people she loves. This reverses the earlier claim, on the part of NEDA, that others should be included in the narrative because they have

helped the self-starver recover. Perhaps, feeling brave for others does not differ so much from being brave and rescuing oneself from a disorder.

While these narratives focus on the roles that supportive others can play in the recovery process, the contributors to the Tumblr page describe the recovery process as much more isolated and lonely. For one contributor, in fact, the idea of allowing other people to dictate what she should do with her body prevents her from seeking help. She writes, “I know that I’ve taken it too far now and I’ve become skin and bones. I am too afraid to try to gain weight...I’m afraid of looking weak by giving in to everyone’s pleas to gain weight. I have this screwed up idea that weight gain equals weakness or lack of self-control.” For this self-starver, for whom feeling in control is paramount, feeling like she must let others dictate what she should do with her body contributes to her fear of gaining weight. She sees others, in fact, as the controlling forces that would take away her power over her body. Because this fear haunts her so extremely, she ends her letter by telling her body that “I know you deserve better, but at this point in time I’m just not trying hard enough to find that balance. I’m too concerned with my obsessions.” While the writer’s word choice suggests that she might have adopted some of the official terminology for eating disorders, she ultimately finds these words ineffective in helping her to confront her overriding fear of powerlessness.

NEDA’s guidelines also ignore the fact that for some women, turning to others for help would be more difficult—and dangerous—than turning to anorexia. Another contributor to the Tumblr page points out the role others can play in *perpetuating* eating disorders—particularly when the self-starver is in an abusive relationship. She writes to her body: “I...came across the pictures of you at your smallest. You WERE too thin!

Your friends were worried but I was just sad and abused by my boyfriend but he paid SO much more attention the smaller you got.” The switching between first and second point of view point to her disconnect from her body, but it also points to her ability to speak kindly to her body, the way she might speak to a friend. In fact, the first person term, “I,” only appears in the sentence to claim the sadness and abuse from the boyfriend. The woman becomes response-able to her body here by trying to sort out her relationship with herself apart from others. In this case, distance from others seems to be helpful in allowing the self-starver to attempt to make peace with herself. She continues to describe the abusiveness and abandonment of the boyfriend, which ultimately led her to attempt to heal her body on her own: “I thought you were fine and you weren’t...and eventually his niceness ran out (of course, it was running on about as much as you were)—and finally, after too much hurting, the mean and scary boyfriend was gone and I was just left to rebuild you.” Having space from the boyfriend, in this situation, seems to have allowed the woman to realize that self-starvation is hurting her, not making her feel better. In fact, her narrative characterizes anorexia as a coping mechanism for dealing with and seeking positive attention from her abusive boyfriend. She acknowledges that she finally found that she was hurting her body “to escape being neglected myself. It wasn’t fair and it didn’t make me happier. Getting out of that relationship did.” Thus, being forced to reflect on the positive role that others play in the recovery process may not be realistic for many women if they hope to accurately portray their experiences.

Further complicating the idea that other people should be central to narratives of healing, another woman offers a different perspective: for her, her body itself became a “friend” and ally in her struggle towards recovery. She writes, in her letter to her

recovering body, “Thank you for standing tall when I need to stand up for myself. Thank you for telling me when you are hungry. Thank you for telling me when you are full. Thank you for letting me soak in a hot bath for an hour at time; I promise to do that as much as possible, since I know that you love it too!” She addresses her body as a loyal friend, claiming, “You have put up with the changes my mind has gone through over the years, and I promise to stand by you while you go through all the changes you have yet to come.” Finally, she speaks to her body as a separate entity when she writes, “We make a pretty good team and I am glad to have such a strong, graceful and beautiful partner to go through life with” and “Truly, a girl could not ask for a better BEST FRIEND.” For some women, the most important “other” in their recovery process is their own body. Learning to view their own bodies as friends again, after years of what they refer to as abuse, complicates notions that the intervention on the part of other people can solely save women from eating disorders.

Hanna, writing for the online community of Blistree, agrees that isolation would have been a very dangerous thing for her while she grappled with her eating disorder. But her source of support was not treatment, nor family members, but rather an online ED community that withheld judgement and allowed her to speak freely. Hanna’s eating disorder “started in 2001,” a year that “coincided with the proliferation of ‘pro-ana’ websites and forums” (Hanna n.p.). She reveals that she has been involved in the online ED community since then and explains that, despite differences between pro-ana and recovery focused websites, “What all of these sites had in common was a connection to people who knew what I was going through” (Hanna n.p.). This companionship, and empathy from people who shared her disease, were invaluable in enabling her to gain the

support she needed. This was support that only other self-starving women could provide.

She explains:

One common theme among people with eating disorders is shame. There are so many thoughts and behaviors that accompany an ED that we feel we have to hide, and sometimes for good reason (in my case, I had to pretend to be recovered to avoid being kicked out of college). Only online could I tell others about the rampaging voice in my head telling me I was fat; only online could I share my guilt about stealing a roommate's food; only online could I admit to rummaging through trash bins to find scraps of food I wouldn't otherwise allow myself; only online could I share the horror of purging in the bathroom and forgetting to clean before my roommates returned. (Hanna n.p.)

Apart from professional and familial spaces, the online ED community offered Hanna a place to honestly share her experiences and to “avoid...the feeling of being alone in my struggles” by placing her in conversation with people who shared them (Olsen). The very spaces and groups that Tumblr, Pinterest, Instagram, NEDA, ANAD, and medical facilities rail against as dangerous and destructive saved, Hanna guesses, at least one life. Significantly, the spaces also allowed Hanna to begin to develop response-ability to others. Because she engaged in dialogue with other self-starvers and now manages a supportive online community for self-starvers, she writes, “Online forums have also provided me with an opportunity to look beyond my own problems in order to reach out and help others” (Olsen). Rather than being compelled by guilt to remain healthy for

others, Hanna expresses eagerness to create spaces that will help others as she has been helped.

Overall, then, the narratives that are shared on NEDA and Tumblr all claim that others are integral to experiences surrounding eating disorders. However, not all of the women view the role these others played positively. Additionally, some women explain that they turn(ed) to what NEDA might consider irresponsible or not useful sources, such as themselves, other self-starvers in pro-ana forums, and their own bodies, to seek support. In their guideline regarding the role that others must play in recovery narratives, NEDA may be erasing issues of abuse, trauma, exploitation, and enabling behaviors on the part of others who are ostensibly supporting self-starvers (such as partners, physicians, parents, friends, etc.). On the other hand, they may also be denigrating supportive others (such as other self-starvers) who play an invaluable role in fostering spaces within which self-starving women might feel comfortable sharing their experiences. Asking women to bear witness to their experiences with others as they pertain to their eating disorders is valuable work. But telling women who counts as a useful other from which to seek support, and implying that others must play a positive role in treating the disorder, threatens to unhinge the project of witnessing as it pertains to pro-ana.

Recovery in Anorexia Narratives

In addition to their implication that certain others must play a positive role in anorexia narratives, NEDA also requires that contributors reflect positively on the possibility of recovery. In a post on xoJane called “It Happened to Me: I Was a Member

of Pro-Ana Groups on the Internet,” a writer named Courtney mocks the expectation that narratives about eating disorders should end on a hopeful note. She writes:

For this story to be published in a magazine, I would probably have to end it by saying that after my recovery, I was a success, an inspiration. I would say that I have started a new organization of body image positivity for young girls, that I’m a correspondent for the White House, that I am, at the very least, an honors student at a well-known university. (Courtney)

This narrative, however, does not match her lived experience of recovering from anorexia. She explains that while her narrative may not have changed drastically as she has healed, she is proud of the fact that she still has a narrative to write. She describes her current state by noting, “None of these things are true. For starters, recovery is an ongoing process: the ‘I have recovered, never again will I etc.’ ray of light moment is a myth. I am, however, at a healthy weight, happy some of the time, on medication, and employed at a grocery store” (Courtney). Courtney’s realistic conception about the status of her recovery directly defies the guidelines provided by Tumblr, which state that anorexia narratives should end on a hopeful, positive note in order to be responsible and useful.

NEDA’s “Guidelines for Sharing Your Story Responsibly” page explains, “An effective recovery story helps lead others toward health, hope, and understanding.” As Courtney argues, the expected conclusion to an anorexia narrative, as reiterated by NEDA, is that recovery has been achieved (permanently) and that everyone might achieve this recovery. They add, “Emphasize the seriousness of eating disorders without portraying them as hopeless...Always encourage people to seek help for themselves or

loved ones who are suffering. Recovery is often a long and expensive process – but it is achievable and there are many options available” (“Guidelines for Sharing”). NEDA posits that the responsibility to provide readers with a message of hope outweighs personal goals and needs for sharing a narrative about anorexia. They write:

While it may be personally rewarding to be honest and open about your experience, remember that you have an important obligation to your audience members. Make sure you leave your audience with the message that there is hope, that recovery and freedom from food and weight concerns is possible, and professional help is available. (“Guidelines for Sharing”)

Thus, for NEDA, the sharing of anorexia narratives becomes meaningful only when it convinces other readers to seek treatment or help, and not when it is “personally rewarding” to the writer herself. Without explicitly asking writers to lie, they eschew honesty and openness in favor of what is perhaps an overly optimistic or reductive conclusion of hope for overcoming eating disorders.

Most of the writers who have featured stories on NEDA’s website abide by this guideline in their narratives. Hope, after all, seems to be the focus of the posts themselves—they are all found within a section labeled “Stories of Hope.” For example, a user named Martha, in a post entitled “Never Lose Hope,” posits that recovery is always achievable and possible for everyone, even if it takes more than one attempt. She explains that during her first treatment experience, she was unaware “of the hard work and dedication it would take to beat my disorder. I never even recognized it as much of a problem—I thought it was just how I coped with life” (Martha). Understanding the need

to recover, then, was integral to Martha's ability to successfully achieve recovery, and her inability to recover during her first stay. In fact, she points to her own lack of understanding as the reason for the first failed treatment. She reflects, "With many years of individual and family therapy, day programs, inpatient hospital stays, and residential treatments, I now know what recovery truly is. Recovery is life" (Martha). In the end, Martha offers a vaguely inspirational conclusion to her narrative when she explains:

Even in the bleakest moments, there is always hope. Hope for a better tomorrow, a day where life won't seem so dim. Hope is always with us and never gives up. As Dickinson writes, '-never stops at all.' There is hope for every single eating disorder victim and family, from long term sufferers to those recently affected. We all have the power within us to recover. Just keep hope. (Martha)

She also contends that the people she knows now "see the 'real' Martha" since "My eating disorder is no longer in control of my life" (Martha). Martha describes true recovery, here, in somewhat vague terms ("Just keep hope" and "Recovery is life"), which suggests that she feels compelled to address a process that she does not fully understand, even as she advocates for its effectiveness for every self-starver once they know what recovery means and requires (Martha). She also portrays recovery in idealistic terms, as she feels that it reveals her true self and enables her to take control of her disorder. Following NEDA's guidelines, Martha wavers between two different positions: that treatment for eating disorders is a complex process that takes time, but that every person who simply maintains hope can heal and realize their true (healthy) self.

The idea that eating disorders can be conquered, once and for all, echoes throughout many of the narratives on the NEDA page. Another writer, Lauren, begins her story with the words: “I’m Lauren. I’m 16 years old and love life. I’m proud to say that I’ve won my fight against anorexia” (Lauren). Lauren takes the firm stance that her experience with her disorder was a “fight” which she has “won”—the battle metaphor suggests that it is possible to destroy the opposition for good. After explaining her experiences with her disorder and treatment options, which she says “ended up saving me,” she claims that “My eating disorder no longer has a place in my life and I have turned to positivity to help me get through difficult times. My goal is to eventually become a therapist for people suffering with eating disorders, and I am currently working on my own self-help book as well!” (Lauren). Lauren explains that she has overcome her disorder, and that she is now doing exceptionally well; she wants to become a therapist for other self-starvers and write a book. She echoes Martha’s sentiments that hope and positivity can help self-starvers to overcome their eating disorders. Lauren’s discussion of her disorder, which, she claims, no longer affects her life, paints an extremely optimistic picture of treatment and recovery—she posits that it not only works, but that with the proper attitude, it can work forever.

Finally, another letter that reflects on recovery, written by a woman named Carly, ends with what she defines as an extremely positive outcome. She reveals that, despite the very dangerous condition her heart was in while she struggled with anorexia, and multiple treatment experiences, she has finally healed enough to find her body beautiful. She writes, “I have recently decided to participate in the 2014 Donald Trump Miss New York pageant. Yes, a beauty pageant. I am determined to redefine the definition of

beautiful” (Carly). Her desire to redefine beauty standards through a beauty pageant will also involve her advocating for the platform of eating disorders and related organizations (NEDA, in particular). She says, seemingly to other self-starvers, “I understand how it feels to be scared and to feel alone in your thoughts and worries. The fight can be won. It will take courage, persistence, and leaps of faith, but recovery is attainable if you keep moving forward and never give up hope. I want to start a new generation where men and women are proud of their bodies and love themselves for who they are” (Carly). The idea that eating disorders can be overcome, through hope, should sound familiar by now. A new point that she raises, however, is that eating disorders can be overcome socially if men and women are “proud” of their bodies and “love” themselves. While advocating for other self-starvers and taking charge of supportive online ED communities represents a fairly common response to recovery in these narratives, Carly aims to change the ways in which Western culture views bodies. Her perspective suggests that recovery has given her a sense that eating disorders are superficial illnesses caused by beauty norms, rather than psychological illnesses. Nonetheless, she reinforces the message that recovery is possible for everyone if they only believe in their ability to change. What remains to be seen, however, is whether her goal to change the world’s beauty standards has translated into her own beauty standards.

In the Tumblr forum, on the other hand, letters tend to end on a less hopeful and jubilant note. Whereas women on the NEDA website say that they have recovered, writers on the Tumblr page tend to portray their recovery as a constant struggle within their narratives. One brief letter, for example, initially seems to demonstrate humor, but betrays a lack of trust of the body that may reveal an inability to fully recover. The writer

bargains with her body when she writes: “Dear Body, Let’s make a pact...I promise to treat you well, and you promise to never come down with cancer. We’ve seen too many suffer. Deal?!” The question, which attempts to be playful, reveals serious mistrust of the body as a space that might become sick again—particularly if the writer fails to care for it by maintaining a healthy diet. This fear of the body—which may “come down with cancer”—suggests that recovery is tenuous, subject to change, and momentary, like health. It also demonstrates fear that if the writer does not treat her body well, thus failing ethically, then her body will respond to her shortcomings with cancer.

Another writer apologizes to her body for years of abuse, and she complicates notions of an easy and permanent recovery by noting that it is rather a slow and ongoing process. The contributor writes, “Dear body, I’m learning. I’m realizing now, how amazing you are...I’m discovering, albeit slowly, how to trust you. How to listen for your signals.” Reattuning herself with her body, as presented here, is a slow and stumbling process that cannot occur immediately. While recovery requires patience and time in order to be effective, the writer insists that she will never be able to guarantee that it will last. She writes, “I would be a fool if I said I would never again abuse you—but I stand here today to say that I appreciate you. I cannot promise you perfection but my pledge to you is to recognize and be forever grateful for how far you’ve allowed me to come.” This realistic portrayal of recovery, as it may not last, seems significant in allowing the writer to account for any difficulties she experiences throughout the recovery process. She seems to recognize that it would be impossible to promise that she will never relapse into disordered eating behaviors, and this allows her to take a much more tentative, and careful, approach to her recovery process and reattunement to her

body. An additional letter echoes this sentiment by explaining, “I have had a lifelong battle with my body.” Although the letter goes on to argue that the writer has “recovered” (past tense), the initial statement speaks to the ongoing nature of recovery, and the inability that most experience to ever fully defeat their eating disorders.

For some writers, recovery is not simply long, arduous, and ongoing—it is impossible for various reasons. One writer addresses her inability to recover due to her extreme anger at her body’s poor physical condition, and her anger at herself for causing it. She begins her letter with the words: “I am so angry at you for giving out on me. I took you for granted always assuming you would be there for me, taking whatever extreme measure I pushed you through.” She begs her body to “be strong again,” “not to hurt so much,” and to “work like you used to. to [*sic*] walk across the room.” For this writer, the damage that has been done to her body seems irreparable, because she senses that she and her body are two separate entities that betray each other. She asks “how could you ever return to me if I can’t forgive you. [*sic*] It feels like my anger gets in the way.” She becomes increasingly frustrated, and tells her body that she cannot forgive it for its limitations. She demands, “Forgive and accept? My difficulty walking? My low stamina? My fatigue so deep that at times it is simply a struggle to get my muscles to coordinate to maintain breathing? My quaking muscles and inability to lift my own head at times? Forgive and accept you as that?” The writer perceives that her anger at her body’s inability to bear her abuse, and its subsequent refusal to function, means that she cannot heal or overcome her disorder. In contrast to the writers on the NEDA pages, this woman expresses the impossibility of embracing her body, which, she says, has failed her.

A fellow contributor echoes this sentiment, but notes that her ability to technically recover from disordered eating does not mean that she can psychologically and emotionally recover. She illustrates this partial change by telling her body “We have lived this nightmare for thirty years. I refuse to purge, abuse or binge anymore. But, I still am a pear-shaped mess.” Even when there is a slight indication of recovery—as seen in the admission that she will not engage in overtly disordered eating behaviors—the conclusion is less than jubilant. The writer explains, further, that “I looked in the mirror today and I said to my myself. ‘Body I hate the way you look.’” Even after thirty years of struggling through what she calls a “nightmare,” the best outcome for the woman is her claim that she will no longer actively seek to starve herself. She does not, however, describe grandiose future plans, claim that she is enamored with her body, or feel emotionally healed.

Another writer’s letter represents an important complication to NEDA’s easy generalization that anorexia narratives need to be hopeful and positive. The woman describes the impossibility of seeking treatment because her comparatively “high” weight excludes her from treatment. The letter simply states, “Dear Body, Why can’t we be thin enough for treatment?” In telling women that their narratives must provide hope, and, by extension, that they must describe the role that treatment can play in recovery and finding hope, NEDA ignores the countless women who cannot seek help and are denied hope for various reasons—because they are wary of believing that they will never relapse, because they have unresolved emotional concerns that were never treated, and, as this writer reminds us, because many women cannot access recovery at all. Additionally, the guideline that women must demonstrate hopefulness implies that women who cannot

keep a positive outlook are at fault for their disorder or relapse. If we are to bear witness to self-starving women in regards to recovery, we must attune ourselves to all of their narratives—perhaps especially to these narratives that alert us to issues that prevent women from feeling hopeful.

Conclusion

To return to “Saving a Life: Anorexia’s Story About Kristen,” the way to move past anorexia as the author of Kristen’s narrative, as the author of countless narratives by women who struggle with eating disorders, is to create spaces where women can witness their struggles for authorship of their lives. Anorexia claims that “Kristen deserves to die if she doesn’t listen to me. She might as well just kill herself if she disobeys me because she’ll never find happiness. I have the answer to her happiness” (Maisel, Epston, and Borden 71). For women who listen to this narrative, and follow it closely, however, more needs to be done to ensure that they are able to speak—their attempts at witnessing must be listened and responded to.

Maisel, Epston, and Borden, in fact, echo both Oliver’s theory of witnessing (they do not reference her in particular) and her example of the Holocaust as the event that is ultimately impossible to witness. Maisel, Epston, and Borden apply this example to the eating disorder context, calling anorexia and bulimia “concentration camp[s]” and claiming that:

We cannot blind ourselves to what we have witnessed and experienced—
death sneaking its way of into the lives of young women and young men.

Nor can we drive out of our memories the agonizing screams of those who

have been robbed of all hope, or worse, the deafening and chilling silence of those resigned souls who have passed beyond despair. (3)

This excerpt speaks not to the impossibility of witnessing, but rather to the impossibility of refusing to witness. In acknowledging the spectrum of narratives from self-starvers in various spaces and forms, certainly we must move past attempts by NEDA, and other groups, to provide specific guidelines for making stories about eating disorders useful, responsible, and hopeful for others. Following A.A., as I have suggested, we might begin to re-envision narratives by self-starvers as they allow women to identify with each other as fellow self-starvers, as they reserve a space outside of pathology and medicine for women to speak, and as they maintain a narrative of inclusion rather than exclusion. Also following A.A., we must attune ourselves to all narratives surrounding anorexia—not only the ones that are hopeful and positive. Telling women that their narratives about anorexia are wrong means telling them that they are dispensable. Telling women that their narratives about anorexia are wrong, more pressingly, means that we fail countless women who attempt to bear witness to problems that need changing, and not simply positive changes that have been made. If anorexia is ever going to stop speaking to Kristen, then perhaps we should start.

Conclusion

In “Other than Obedient: Girls’ Constructions of Doctors and Treatment Regimes for Anorexia Nervosa,” Desiree Boughtwood and Christine Halse found that “in hospitals, girls’ words and actions are often interpreted in terms of a universal, generalized notion of ‘the anorexic’ rather than of diverse individuals struggling with an illness or pain or trauma” (92). They recommend that medical professionals acknowledge their lack of complete knowledge about the causes of anorexia and understand the limitations of current treatment models, while taking seriously the need to “understan[d] and addres[s] the girls’ view of hospitalization” (92). They add, “Repositioning girls in this way opens up the possibility of a new framework for involving girls in discussions about their treatment, such as the reasons for recommending particular procedures, and for establishing an open dialogue that may reduce the health risks” associated with treatment resistance (92). Such a “new framework,” which I have advocated for through Oliver’s model of witnessing, has begun to be realized in the new DSM-V, which will implement changes for diagnoses of eating disorders that have implications for insurance coverage and questions regarding which bodies get to tell their stories.

There are four major changes being made in regards to definitions and criteria for anorexia nervosa, in particular. First, the DSM-V, which will be released in 2013, will omit the phrase “refusal to maintain body weight at or above a minimally normal weight

for age and height” (Klinger). This phrase, of course, insinuates that self-starvers actively choose to starve themselves, which may not be a fair way of characterizing anorexia for everyone. Next, to the phrase “Intense fear of gaining weight or becoming fat,” the DSM-V will add the phrase “or persistent behaviors that prevent weight gain, even though at a significantly low weight” (Klinger). Third, in terms of “body image,” the DSM-V will revise the criterion “*denial* of recognition of the seriousness of the current low body weight” to “persistent lack of recognition of the seriousness of the current low body weight” (Klinger; emphasis mine). The final, and perhaps most significant, change to the DSM-V is that women will no longer have to experience amenorrhea (cessation of menstrual cycle) in order to be diagnosed with anorexia (Klinger). According to Deborah Klinger, this change means that:

women whose menses have been affected by the weight loss and inadequate nutrition but who still menstruate sometimes, women who are postmenopausal, and women whose periods are artificially generated by contraception or other hormonal interventions ... will no longer be excluded from a diagnosis of anorexia nervosa. (“Welcome Changes”)

These changes bear important implications for which women can receive treatment for their disorder, how women understand their experiences, and which women can gain proper insurance coverage for their disease. But the changes also suggest that more women’s experiences will be recognized as a way of living anorexia.

To return to Oliver’s vital question—“how can we witness and bear witness to oppression, domination, subordination, enslavement, and torture in ways that open up the possibility of a more humane and ethical future beyond violence?”—I posit that we must

begin by dedicating ourselves to foster response-ability with pro-ana writers and self-starvers (18). We might begin to do so by inviting them to witness their narratives as they choose to do so. We might ask the women to tell us their stories, and not to save other women with their stories. We must also, following Jurecic, recognize the Internet as an important space within which many women with eating disorders are making meaning and grappling with what they cannot understand about their disorders (10). We must protect these spaces as forums that deserve more than our erasure, and we must create ways to respond to women in ways that might engage them in a dialogue, offer them support, and, above all, listen to them.

Jurecic points out that many writers, in “invit[ing] readers to be attentive to the complexity of pain in lives that are embodied and social...encourage them to be rigorous and responsive, to exercise reason and emotion, to be willing to suspect and to listen, to acknowledge what is not known, and also what is” (66). I suggest, following Jurecic, that our engagement with self-starvers should reflect these same demands—demands that place us in an ongoing conversation with others, require that we interrogate our own positionality, and forefront the limitations of our collective knowledge. For the women with eating disorders being starved by the rhetorical response of silence, witnessing might reopen forums within which they might speak, and in this speaking, heal.

In arguing that we must move past metaphors of contagion that prevent women from witnessing, I want to posit a new metaphor for response-able relationships between self-starving women and their various audiences. In 2012, the same year in which Tumblr, Pinterest, and Instagram banned pro-ana narratives and images, a treatment center for adolescents and college-aged students with eating centers opened in Durham,

North Carolina. This treatment center, Veritas Collaborative, provides varying levels of treatment options that implement a variety of unique treatment approaches such as Art Therapy, Mindfulness, Body Movement and Yoga Groups, and Culinary Skills Groups (“University Program”). The programs take patient concerns into consideration, and each treatment plan considers the individual person being helped. Instead of an assembly line model for eating disorder treatment, these people are cared for based on individual needs, schedules, and hobbies. For example, the Culinary Skills Groups work with gourmet chefs and families to “Create-Your-Own individualized meal plans from foods you choose with help from a nutrition therapist” (“Culinary Program”). Veritas Collaborative explains that they want patients to be actively involved this process because “the food part of eating disorder recovery can be scary” (Culinary Program”). This focus on the patients as key members of the collaborative treatment groups, who must play a vital and engaged role in their recovery process, also translates into Veritas Collaborative’s mission. On the Veritas Collaborative blog, Chase Bannister and Stacie McEntyre argue:

Now more than ever, we hold fast to the claim that the vital enterprise of re-nourishing young bodies and young minds must be a ‘together’ sort of affair. Be it actual or metaphorical, we are *all* at the table of recovery—family members, patients, clinicians, referring providers, advocates, researchers, teachers, universities, policy-makers, thought-leaders, and friends.

As Veritas Collaborative suggests in both word and practice, perhaps this table of recovery is a better metaphor for witnessing eating disorders in both digital and professional forums. When—and if—we are all at the table, we are all embodied, present,

and response-able. When we are all at the table, perhaps most importantly, we can focus on the person sitting with us, and not solely on the disease that prevents her from eating. Perhaps when we listen and speak to self-starvers, we should remember the table where we all eat—where we all face our empty or full plates and remember our physical and mental vulnerability. This is the place where we are reminded of our common need for sustenance and our shared responsibility to sustain each other.

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