

‘Why hadn’t I come across this sooner?’

Exploring the relationships between ‘feminism(s)’ and ‘eating disorders’

Abstract

This article explores discursive intersections between ‘feminism’ and ‘eating disorders’, with a particular focus on eating disorder (ED) treatment. In doing so, it draws upon two sets of original qualitative data on how women with experience of an ED responded to 1) the idea of using feminist perspectives in ED treatment 2), a 10-week in-patient group based on feminist approaches to EDs. In exploring this data, the article seeks to contribute to the body of feminist work that has explored how girls/women understand, navigate and use feminism, but *specifically* in relation to the contexts of eating problems. Whilst there is a rich body of feminist writing which seeks to give ‘voice’ to the experiences and politics of women’s eating/body distress, there has been little attempt to offer these subjects an opportunity to *respond to* the feminist discourses themselves. In interrogating this issue, the article raises questions about the historical marginalisation of feminist approaches to EDs in clinical research and practice, and suggests that they are worth pursuing as part of contemporary ED treatment. However, doing this requires careful navigation of contemporary understandings of ‘feminism’, popular constructions of the relationship between feminism and EDs, and the dominant (and often hostile) discourses of biomedical ED treatment.

Introduction

It has been suggested that feminism is currently enjoying a ‘zeitgeist’ or a ‘new luminosity’ within western culture.¹ But this visibility is both complex and uneven. Medicine, for example, has historically been understood as a lynchpin of patriarchal culture which has regulated women’s minds and bodies in oppressive ways, especially in relation to ‘disorders’ primarily associated with women.² In this regard, it is difficult to reconcile the idea of the mainstreaming of feminism with contemporary UK treatment for what are medically known as ‘eating disorders’ (EDs). As one of my research participants described when she came across the feminist work on eating problems at university:

I felt frustrated because I was like ‘why hadn’t I come across this sooner?’ ... I felt like it had been deliberately withheld from me. .. I think there is an element of truth in that.... I think [the feminist perspectives are]... such a threat to the medical establishment... It threatens their power over you...If they were to willingly acknowledge that perhaps treatment centres recreate some of the very kind of structures that anorexia fights against, they would suddenly realise that they are part of the problem rather than... the solution ... (P12) (1)).³

This impassioned response confirms Bordo’s suggestion that the biomedical model of EDs has ‘a deep professional, economic, and philosophical stake in preserving the integrity of what it has demarcated as its domain, and the result has been a frequent blindness to the obvious’.⁴ In this context, the ‘blindness to the obvious’ refers to the fact that cis-gendered females make up the *overwhelming* majority of ED ‘patients’ (despite the rise in EDs in male and transgender individuals).⁵ Yet if this connection - which is essentially ‘hiding’ in plain

sight - is not addressed, where does this leave the treatment of EDs, and the women who may live with (or die from) them?

Drawing on the interdisciplinary field of feminist approaches to eating problems, this article explores discursive dichotomies and intersections between ‘feminism’ and ‘eating disorders’, with a particular focus on questions of ED treatment. In order to do this, it draws upon two sets of original qualitative data produced by the author on how female participants with experience of an ED responded to 1) the feminist critique of biomedical ED treatment 2), a 10-week in-patient group based on feminist approaches to EDs. In so doing, the article seeks to contribute to existing scholarship in two key ways. First, it aims to contribute to empirical research on how women/ girls understand women understand, navigate and use feminism in the contemporary context,⁶ but specifically in relation to feminist conceptions of eating problems. Second, the article seeks to contribute to feminist work on EDs. Whilst there is a rich history of feminist research writing which seeks to give ‘voice’ to the gendered experiences and politics of eating/body distress,⁷ there has been little attempt to offer those living with an ED an opportunity to *respond* to the feminist discourses themselves.⁸ But if we are to understand the power and use-value of feminist paradigms in practice (bridging existing gaps between the academic and ‘popular’ feminism), such dialogue is crucial. Similarly, if feminist approaches to EDs want to play a greater role in clinical practice - and make their critique of the biomedical heard - then offering women a space to debate and evaluate these paradigms will offer an essential foundation.

Feminist approaches to ‘eating disorders’

In line with the wider development of feminist therapies emerging out of the second wave,⁹ early feminist work on EDs sought to contest medical and psychiatric constructions of eating problems, and politicise them in relation to the socially constructed nature of female identity.¹⁰ In rejecting the bid to label ‘eating disorders’ as pathologies (and medical terminology remains contested in feminist scholarship), feminist approaches situated eating problems as emerging out of the constructions and experiences of *normative* femininity.

The early feminist research – which focused primarily on anorexia - situated eating problems as the logical manifestation of a consumer culture that foregrounded dieting and calorimetry as a normal preoccupation for women. A number of feminist writers, including the later contributions of Naomi Wolf¹¹ and Susan Bordo,¹² saw the promotion of the increasingly slender female body as a ‘direct political weapon against women’,¹³ arguing that the valorisation of a thin female ideal was especially visible in periods following women’s political progress. Early feminist authors also linked eating problems to the consequences of the Women’s Movement and the resulting contradictions and pressures surrounding the female role.¹⁴ But in situating anorexia within these political contexts, the ‘anorexic’ was not simply figured as a victim of patriarchal backlash. Indeed, a number of feminist writers saw the political significance of self-starvation as highly ambivalent and contradictory – representing both a ‘hyper-conformity’ to normative femininity, *as well as* an attempt to reject feminine subjectivity by escaping into a childlike, boyish or defeminised form.¹⁵

Feminist work on EDs has expanded considerably since this early wave, particularly as influenced by the critical and discursive frameworks of poststructuralism.¹⁶ This later feminist research does not deny the significance of the media in propagating a slender ideal. However, it has also been wary of over-emphasising ‘the inscriptive power of cultural images of

thinness', and thus the characterisation of EDs as 'body image' problems.¹⁷ In moving away from a primary focus on the thin ideal, a plethora of qualitative feminist studies have attested to the highly complex centrality of gender in how girls/ women *talk about* the aetiology and experience of an ED.¹⁸

Feminist research has suggested that we should situate EDs within wider cultural contexts of gendered power - understanding them as related to sexual harassment and abuse; a desire to evade or 'opt out' of gender binaries and/or sexual availability;¹⁹ an attempt to stall transition into a heavily gendered culture in which women may *not* be able to 'have it all'; constructions of female 'appetite' (sex/ food/ career) and expectations of restraint; the overvaluation of women as nurturers; and the intersecting impacts of misogyny, racism, poverty and heterosexism.²⁰ Since the earlier period of feminist research, there has been a bid to address the privileging of anorexia as *the* key ED for feminist attention,²¹ as well as efforts to decentre the bias toward white, middle-class, cis-gendered and heterosexual subjects.²²

But in terms of the context of this article, what is important is that whilst the feminist approaches to EDs initially emerged out *of practice* (and were not primarily or 'purely' an academic pursuit), much feminist research on eating problems now takes place at a considerable remove from contemporary treatment. That is not to suggest that contemporary ED treatment as purely biomedical in nature. Treatment in the UK often takes a multi-dimensional approach that involves medical, dietetic and psychological strands and it is increasingly accepted that EDs are 'biopsychosocial' in nature – so combining biological, psychological *and* social factors.²³ But these strands are far from equal, and limited existing data suggests that questions of culture (such as gender) are now afforded *less* significance in ED treatment than ever before.²⁴

The historical and contemporary reasons for this marginalisation are complex and multi-faceted. The current emphasis on ‘evidence-based’ treatment for EDs favours masculinist discourses of ‘objectivity’ and measurable ‘scientific’ goals – narratives which prioritise the type of evidence supporting Cognitive Behavioural Therapy (CBT) for example.²⁵ In addition, existing evidence suggests that in terms of training in the field, little or no attention is paid to questions of gender²⁶. In this regard, individualised conceptions of the ‘ED patient’ are naturalised, and an emphasis on EDs as ‘biologically based, serious mental illnesses’²⁷ prevails.

In contrast to the approaches above, the feminist perspectives on EDs have been overwhelmingly qualitative, philosophical and political, and they are often counterpoised to status of ‘hard’ science. Indeed, due to the dominance of biomedical paradigms, the marginalisation of knowledge derived from qualitative research, and the critical nature of the feminist work itself,²⁸ feminist approaches to EDs now have more scholarly than clinical visibility. As such, there has been little systematic discussion about the use of feminist approaches in treatment over the last 30 years – a context which then creates its own barrier as there is a reluctance to trial interventions which are seen as having no existing ‘evidence base’.

Yet although the feminist work has produced compelling evidence about how eating problems can be situated within cultural constructions of femininity, none of the history above explains why there is so little research exploring what girls/ women *think of the feminist approaches*. Indeed, girls’/ women’s narratives of eating distress have been used by the feminist practitioner or scholar to *interpret* the role(s) played by gender, as opposed to an approach that involves them in the evaluation and construction of the feminist perspectives

themselves. As such, a key aim of my research has been to involve participants in conversations about, and uses of, the feminist approach to EDs, and its implications for their self-conceptions. Such an approach inevitably offers a more complex, contested and ‘messy’ picture of the relationship between feminism and EDs than previous approaches have addressed or allowed.

In contrast to feminist work on EDs, where feminist research *has* engaged in considerable dialogue with girls/ women about the value of feminism today is in qualitative work exploring how feminism is understood and negotiated. Over the last 20 years, there has emerged a substantial body of qualitative research into how girls/ women negotiate feminism in a postfeminist climate – which has variously been understood as a context in which feminism is repudiated²⁹ or ‘taken into account’ (with the suggestion that it is no longer needed as gender equality has been achieved).³⁰ This research has broadly suggested that young women are not keen to call themselves feminist; that they perceive the women’s movement to have done its ‘job’, and that they prioritise narratives of individual choice and biography – as commensurate with prevailing discourses of neoliberalism and postfeminism.³¹ There has been little research that has continued this work in the more recent context of heightened feminist visibility, so this changing political context represents an important terrain for further research. But analyses of popular discourse here have argued that the apparent ‘mainstreaming’ of feminism remains multivalent and complex, taking place within tacitly agreed ‘reasonable’ boundaries,³² whilst jostling for space with heightened misogyny and virulent repudiations of feminist politics.³³ These issues are directly relevant to the current study given that thinking about the relationships between feminism and EDs – particularly in terms of its use-value in treatment - requires an engagement with feminism’s *wider* status in the contemporary public sphere. In this regard, exploring how women respond

to feminist conceptions of the problem offers a crucial but under-researched terrain upon which to consider some of the complex and contested meanings of feminism(s) for women today.

Methodology

This article draws upon two sets of qualitative data that emerged from separate studies undertaken by the author between 2015-16,³⁴ and it explores themes and quotations not examined or published in this previous research. Both of these studies received ethical approval from the author's institution (General Research and Ethics Committee, UEA). The first study involved women who considered themselves recovered from an ED discussing their understandings of why they developed an eating problem, and whether or how these issues were addressed in treatment. This also involved the participants considering a prepared summary of feminist perspectives on EDs, and evaluating its relevance (if any) to their experiences of body/ eating distress.³⁵ The study recruited its participants ($n=15$) through the national ED charity Beat, which circulated the call through its social media. The study recruited fifteen participants living in different regions of the UK: four with experience of bulimia, one with experience of bulimia and anorexia, one with experience of anorexia and binge eating disorder, and nine with experience of anorexia. The ages of the participants ranged from 19-45, with the majority ($n=11$) sitting between the ages of 24-34. In terms of ethnicity, eight respondents defined themselves as white British, two as white Scottish, one as white Northern Irish, one as white British Jewish, two as white American, and one as British Asian. In terms of sexual orientation, thirteen participants identified as heterosexual, one as bisexual, and one as bi/pansexual. In addition, although respondents came from a range of socio-economic backgrounds, all had been to university, a factor that often emerged as relevant in their engagement with the feminist approaches discussed.

In second study, the data emerged from the trial of a treatment group based on feminist approaches to EDs undertaken at a private in-patient facility in the East of England. All of the patients ($n=7$) who were currently resident in the clinic took part (they could opt out if they wished), with ages ranging from 19-51 (mean age = 26). All had a primary diagnosis of anorexia, all were female, and all but one participant – who identified her ethnicity as mixed race – defined their ethnic identity as white British. The research did not collect information on sexual orientation, and this can be understood as a limitation of the study when it comes to considering questions of intersectionality.

Indeed, it is fully acknowledged here that these samples reproduce some of the dominant categories of existing research on EDs which have historically prioritised white, middle-class and heterosexual subjects. Given the range of work that has demonstrated the ways in which race, class and sexuality contribute to the construction and materiality of the body,³⁶ this is recognised as a limitation of this study. In addition, it is clear that the relationship between questions of gender and eating/body distress do not *only* apply to cis-gendered girls/ women, with wider research on EDs increasingly turning its attention to males and gender minorities.³⁷ The feminist approaches to eating problems have seldom tackled this wider landscape (a significant omission given that some of their detractors have focused on their ‘failure’ to explain EDs in males). This article works from the premise that the relationship between social constructions of gender and the development of eating/body distress is relevant to *all* groups of ‘patients’ – even if the constructions themselves will vary. But it does focus on the group which has historically dominated the demographic of ED treatment, discussing how the omission of gender in this regard is highly political.³⁸

The author of the article co-facilitated and planned the group with a senior occupational therapist at the clinic, and it was shaped by some of the key tenets of the feminist approaches

to EDs (which reflect broader principles in feminist therapy).³⁹ This included a recognition of the role that social oppressions play in creating and maintaining eating and body distress; a sensitivity to power in therapeutic/ treatment contexts; an emphasis on women's strengths and collectivity, and a commitment to empower women to challenge and critique the structures which may have repressed them.⁴⁰ The group met once a week for 1 hour for a duration of 10 weeks, and explored the potential relationships between eating problems and cultural constructions of femininity. In particular, the group was shaped by the suggestion that it may be worth reframing body image as *the* site of sociocultural significance in EDs and weekly topics moved across what 'culture' might mean in relation to EDs; gendered constructions of appetite; cultural expectations surrounding female emotion and anger; 'reading' the starved body in relation to cultural prescriptions of femininity; to the gendered dynamics of 'healthy' eating/living and fitness cultures. The primary method of data collection was the individual semi-structured interview – as undertaken by a separate interviewer (not involved in the group) two weeks after they had finished their run.

Feminist qualitative research has invested in models which seeks to reduce the power gap between 'expert' and participant, often including discussions of personal experience and reflexivity in ways which are not silenced by objectivist concerns over 'bias' and 'distortion'.⁴¹ In this regard, I chose to disclose my own history of long-term anorexia to the participants, as well as (in the second study) my own admission to the same clinic back in 2009. My self-disclosure was offered as a form of reciprocity, whilst it was also prompted by what felt congruent to me as a researcher and interviewer.

At the start of both studies, I indicated my willingness to answer any questions about my own experience of anorexia and its treatment. This was frequently taken up in the interviews in the first study, whilst some of the women in the second study also asked questions about my experience, whether within the contexts of the sessions, or via requests to speak together after

the group. In this regard, I was very aware of shifting between the position of feminist researcher and 'eating disorder sufferer' in both the interview contexts⁴² and the group setting. Yet feminist research has recognised how gender congruence and shared experience does not necessarily produce a non-hierarchical relationship between participant and researcher and that a range of social attributes - such as class, race, age and educational capital - can shape the balance of power.⁴³ As a white, middle-class woman, I shared a broad social location with many of the participants, although as middle-aged, I was older than most. But it should be noted here that – as someone bringing the feminist approaches to women who (for the most part) had never encountered them before - there was inevitably a sense of academic expertise at play, even whilst the feminist perspectives were presented as being up for debate and contestation.

In both studies, the participants were asked specific questions (see Appendix A), and the responses were analysed using qualitative analysis – particularly in terms of picking out key themes. In adopting the six-stage process for thematic analysis outlined by Braun and Clarke,⁴⁴ the transcripts were coded into thematic categories, as shaped by the prevalence of these themes within the data as a whole. The thematic categories were then analysed in detail and data extracts that represented these themes (as well as the complexities and contradictions within them) were selected for inclusion. The writing stage then involved placing these themes in relation to the literature on feminist approaches to EDs, biomedical discourses on eating problems, as well as wider qualitative work on how girls/ women negotiate feminism within the contemporary cultural landscape. In terms of the second study, although all the quotations used in this article come from the individual interviews, the research also drew upon participant observation in terms of the individual sessions themselves.⁴⁵

In the first study, many of the participants - who had self-selected to be interviewed - identified as feminist, whereas in the clinic study, the women did not. In the latter, the women's views on feminism only really became apparent in the individual interviews that followed the groups, as it was here that they were directly asked about their relationship with this term. This question was included because it was felt important to gauge how attitudes toward feminism might affect appraisals of the group. However, making these questions explicit *prior* to the groups may have set up particular expectations or resistances that the facilitators were keen to avoid. In this regard, the groups in the clinic were primarily articulated as offering 'cultural approaches to EDs' rather than 'feminist' interventions as such.

Indeed, any attempt to bring feminism into ED treatment necessarily requires navigating how feminism (which comes with pre-existing semiotic 'baggage') might be perceived by participants, whilst it also demands a consideration of how feminism(s) might be popularly understood in relation to eating/body distress. The following sections look at examples of how participants negotiated the discursive entanglement between feminism and EDs with a particular focus on 1) how feminism may 'advocate' only for women and marginalise men 2) how EDs might be positioned as somehow antithetical to feminism (due to the feminist critique of beauty and body ideals), 3) the marginalisation of gender in treatment and 4) responses to biomedical model of EDs and critiques of existing ED treatment.

But 'what about the boys?'

As with earlier research on how women/ girls negotiate feminism, when participants discussed what the term feminism meant to them, the idea of 'equality' emerged as central, and the importance of equality between the sexes was represented as 'common sense' and beyond debate.⁴⁶ But in the second study in particular, this folded into perceptions of

feminism as now ‘dated’, ‘excessive’ and ‘unreasonable’ - as it was perceived that equality had been achieved, or that feminism was (unreasonably) asking for ‘more’ than was ‘fair’. For example, this was indicated by such comments as: ‘I think... feminism takes it to the extreme - that females should have even more than men’ (P5 (2)), or that ‘To me it’s about woman’s rights but then I think it can also go borderline, you know, women are great, men aren’t...’ (P2 (2)). These responses then inevitably shaped how the intersection between feminism and EDs might be perceived, and this was also true of the first study (in which most participants *did* see themselves as having positive affiliations with feminism). As one participant from the first study commented when evaluating the summary of feminist approaches to EDs that was circulated prior to interview:

I guess if I’m completely honest when I first read it ... I didn’t like it.... I guess I was sort of worried it was very ... well, taking away from like males (P4 (1)).

This concern about excluding or marginalising males with EDs was also repeatedly articulated in the second study:

People that aren’t female get eating disorders as well... I think that men are also held to quite high standards when it comes to exercise and things like that so...I don’t know, I don’t think eating disorders really are a feminist issue (P4 (2)).

As discussed, although it is true that questions of gender are indeed relevant to the range of people who may be diagnosed with an ED, the responses above appear to be shaped by the still prescient discursive constructions of feminism as advocating ‘only for women and hat[ing]... men’.⁴⁷

In addition, the responses may also have been shaped by wider *media* discourse on the rise of EDs in boys/ men, and the apparent difficulties males face in suffering from an illness mainly

identified with females.⁴⁸ It is clearly imperative that ED treatment is gender inclusive, but such discourses about the ‘excessive’ focus on girls/women (in relation to both feminism *and* ED treatment) also do clear ideological work in naturalising gender inequities, as well as diverting attention from what this article argues are glaring omissions in ED treatment. For example, the concern over males having to face the ‘burden’ and shame of being diagnosed with a ‘feminised’ problem endorses a perspective in which the feminine is ‘naturally’ trivialised and stigmatised, and thus more ‘naturally’ associated with eating/body distress. Equally, the suggestion in academic work that males are excluded because ‘treatment paradigms’ have ‘been *geared toward* females [emphasis added]’⁴⁹ is highly problematic. As this article has explored, there is little or *no* evidence that contemporary ED treatment focuses on the relationship between EDs and cultural constructions of femininity in any systematic way. As such, the question ‘what about the boys?’ diverts attention from the efficacy and failings of ED treatment for girls/ women – the group that has actually been there *all along*.

This is not to suggest that the critiques of feminism articulated above are not legitimate (and feminist approaches to EDs could certainly have done more to diversify their focus beyond cis-gendered girls and women). Rather, it is to point out how the participant’s views on the very idea of feminist approaches to EDs are shaped by particular discursive constructions of feminism as being only for and about women. These then collide with and endorse particular contemporary discourses on male EDs which implicitly downgrade female experience, and obfuscate the ways in which treatment has failed to address the significance of (female) gender. Given that EDs are seen to be complexly bound up with gendered discourses of self-effacement self-care and entitlement (‘I don’t deserve food/ I don’t matter’),⁵⁰ this is particularly troubling and problematic.

‘A little bit like an imposter ... from the school of patriarchy’

A further discursive frame which shaped the perceived relationships between feminism and EDs relates to the feminist critique of the beauty and fashion industries. In popular discourse in particular, the idea of a ‘feminist’ identity has historically been situated as somehow antithetical to normative heterosexual femininity.⁵¹ This is especially so in terms of stereotypes of second wave feminism. Given that popular constructions of the relationship between gender and eating problems indeed focus (somewhat simplistically) on the power of the media-produced thin ideal, it is not surprising that some participants questioned the ‘fit’ between occupying a ‘feminist’ and an ‘eating-disordered’ identity simultaneously. As one participant from the first study explained:

I felt quite embarrassed for a long time in ... hanging around with people who are like very shouty out and proud feminists that ... I was.. you know ..weak and feeble enough to ... suffer so strongly from the patriarchy... I mean am I a bad feminist because I had anorexia? Like, can I even be a feminist having had one?...Can I like have a really honest conversation about how I feel pretty rubbish about my body?... I know I’m supposed to be all like shouty and happy and hey ‘I’m so proud of my female form!’ and ‘let me take up space because I deserve space!’ [we both laugh] ... But I find owning a feminist identity quite difficult... like I always feel a little bit like an imposter ... basically an infiltrator from the school of patriarchy (P11 (2)).

In articulate and passionate terms, the participant questions the simplicity of an opposition between ‘feminism’ and ‘anorexia’, whilst also indicating how such discourses have real implications for her subjectivity as a woman. The construction of the feminist as somehow rejecting gendered discourses of body surveillance is called out as unrealistic, whilst such a construct *also* helps to regulate the participant’s identification with feminism (making her feel like an ‘infiltrator’ and a feminist ‘imposter’).

Implicit within the quote is also the suggestion of how disempowering it is to be positioned as a ‘victim’ of patriarchy – a critique that has been lodged at some of the earlier feminist work on EDs.⁵² Some of the early feminist writings on EDs did appear to *polarise* anorexia and feminism: for example, the promotion of an ever more slender ideal was positioned as a direct ‘attack’ on feminism, whilst starvation was seen as rendering women voiceless and compliant.⁵³ This then led to a simplistic and unfortunate binary in which feminism could be positioned as ‘rescuing’ the ED sufferer – providing a framework in which a ‘deluded existence is replaced by a higher level of consciousness ... rejecting the anorexic/bulimic identity for a more authentic [feminist] mode of political awareness’.⁵⁴ In work that seeks to explore the value of feminism in understanding and treating EDs, it is impossible to avoid such hierarchies (however reflexively the relationship between researcher and participant are explored). But it is a useful reminder of how particular discursive constructions of feminism may make women feel ‘oppressed and diminutive’ (P1, (1)) rather than simply empowered or strong. To be fair to the earlier feminist work, anorexia was not primarily conceived in top down terms, and self-starvation had long since been explored as both a resistance to, and a compliance with, constructions of normative femininity. However, the participant above was responding to wider constructions of the

relationship between ‘anorexia’ and ‘feminism’ – a context in which this connection is seen as uneasy, tricky and troubled.

The fact that the women in the first study *did* identify as feminist, whereas the women in the clinic study did *not*, also complicates the idea that women diagnosed with anorexia are more likely to be aligned with patriarchal modes of femininity. As noted above, although some early feminist authors saw anorexia as a contradictory expression of oppression *and* resistance from the start, others framed it as emblematic of female subordination.⁵⁵ Such assumptions and generalisations are deeply problematic, and do little to capture the complexity of how women actually *talk* about the negotiation between an ‘eating disordered’ and a ‘feminist’ identity in practice. In comparison to the interviewee quoted above, one participant who identified firmly as feminist recalled how important feminism was to her recovery:

It was very helpful to me in recovery to see my struggle as a feminist one ... because I should get healthier... to make it individual to yourself is not very motivating... It was [in] my recovery that I sort of seized once again that feminist power that had become distant to me since the illness. ... I felt victimised by what the world was telling me and doing to me... But I would say that I was a feminist during [and after]... my eating disorder, and that my feminism helped me to recover. ... You know you can have an ideology and it not necessarily connect with your behaviour. So it was just reconnecting those two things up again (P7 (1)).

Although this participant *does* construct an implicit opposition between the ED and her feminist identity, she goes on to explore the inadequacy of this binary, suggesting that her feminism was there all along, eventually helping her to reconceptualise her struggle and seize back some political power.

Feminisms in treatment: ‘maybe this is not all... my fault’

The article has so far discussed some of the wider discursive frames which may shape how ‘feminism’, and feminist approaches to EDs, are negotiated and received. But as the last quote from the participant suggests, this did not mean that the participants primarily rejected feminist perspectives on eating/body distress, or spoke about them in largely negative terms. The first study provided a very strong endorsement of how cultural constructions of gender are relevant to the aetiology and experience of an ED, and why such connections should be addressed in clinical contexts. In the second study, the interview data indicated how some of the *ideas* from feminist approaches to EDs were potentially useful in ED treatment, even if the concept of (or term) feminism was seen as more ‘alien’ or problematic.

In both studies, the participants talked about the value of situating their eating problems within a wider cultural landscape that included discussion of cultural constructions of femininity. In reflecting back on her treatment for anorexia, one participant in the first study stated that:

I had absolutely *nothing* related to anything other than the food that was on my plate in front of me and that I was going to eat...To be able to put me away from this bubble of health services ... and go ‘well this is you as a young woman within the wider context of the world’, would have been *great* at the time. I think

I would have responded to that. I would certainly have responded to that now [original emphasis] (P10, (1)).

In terms of the feminist treatment group, the participants talked about how such perspectives could operate as a protective framework in recovery, enabling them to develop a more critical attitude toward societal constructs of gender which may shape EDs:

I think that in the past, that I have tried to kind of block out the fact that society had an impact, cos' I felt like it shouldn't. It's like well... magazines and models and I'm not interested in anything like that so why would that affect me? But in thinking more about just expectations society has on men and women and pressures that are put on you – that are not even like, eating disorder related - but which might help to shape an eating disorder... that can be helpful (P7 (2)).

Crucially, this participant highlights how existing and popular conceptions of the relationships between 'gender' and 'eating disorders' largely foreground the power of the media and the slim ideal. But as the response attests, this can be received as trivialising, patronising and pathologising – situating people with EDs as especially 'vulnerable' media consumers (constructions which are highly feminised and have a longer history).⁵⁶

At the same time, in shifting the locus of the 'disorder' from the individual to their *social* context, the clinic participants found the feminist perspectives troubling when situated in relation to future recovery. As one explained:

It did kind of make you think maybe this is not all... my fault. But then it kind of made you think, oh if that's how society is then what am I to do about that? Like

you can change your own views but then you just think, okay if this is normalised, then maybe it's not gonna' change (P5 (2)).

So what the feminist perspectives see as the pathologising and individualising nature of medical discourses on EDs may also be enabling for some by locating the possibility change within the *self*.

Although a key aim of both studies was to explore participant responses to feminist approaches, this also involved consideration of how they responded to biomedical understandings of eating problems. This was particularly so in the first study which interviewed women who considered themselves recovered from their ED, and who were no longer in treatment. The interview questions did not explicitly refer to biomedical constructions of EDs (but rather positioned feminist approaches as a critique of 'existing treatment'). However, the interview questions fostered the possibility of understanding biomedical approaches to EDs – and biomedical ED treatment – as a *construction* in the question 'how do you feel about EDs being understood as a form of mental illness?'. One participant explained how:

A huge part of me coming to terms with my anorexia ... was to accept that it was a mental illness that I'd been effected by just like any other... illness.. So to take a different [feminist] approach would just sort of open up all these things and questions (P4, 1).

In suggesting that she 'been effected... just like another other illness' by anorexia, the participant went on to talk about conceptions of blame – that if she had been 'struck down' by an illness then the ED was less likely to be seen as her 'fault'. This notably reflects the wider findings of stigma studies in this field. Research suggests that

biological and/or genetic explanations of eating problems are associated with lower levels of stigma, whereas sociocultural explanations (which privilege the role of the media and fashion industries in fostering EDs) are associated with higher levels of stigma, because such factors are linked with discourses of ‘choice’ and volition.⁵⁷ In a similar vein, other participants in the study talked about how biomedical – and particularly genetic – explanations of EDs had enabled eating problems to be taken more seriously by society, and that this was something that they considered important. But whilst it was clear that some participants found aspects of the biomedical model useful, others recognised that such understandings of EDs could have negative consequences for them socially. As one explained:

I’m still really incredibly cautious about telling people my background because of the mental illness stigma.... I feel like I’m a bit of a liability although actually I feel that *other people* perceive me as a liability – I actually feel much more grounded and strong with who I am now than a lot of people that I know...[original emphasis] (P5, 1).

In this response, the participant effectively recognises the stigmatising implications of biomedical conceptions of EDs in her suggestion that she is ‘still incredibly cautious about telling people’. Nevertheless, she then goes on to recognise these understandings as a construction rather than an objective ‘truth’ (indicating that they do not align with her own sense of self and subjectivity). Others similarly recognised the stigmatising – and potentially far-reaching consequences – of biomedical conceptions of EDs in such comments as ‘it [anorexia] ... can be defined as a mental illness... So I’m quite concerned that like if I tried to adopt [a child] or anything it would be a black cross’ (P9, 1).

In contrast, some of the participants in the first study specifically *rejected* medical constructions of EDs as disempowering and pathologising, and discussed how the feminist approaches gave them a means through which to critique their treatment. For example, one participant who had discovered the feminist approaches to EDs whilst doing her undergraduate degree reflected how: ‘I was told for a while in treatment that it would be like empowering for me to explain [anorexia] ... as a disease or an illness... I take issue with that now and don’t like it being seen as *disordered* and a malfunction [original emphasis]’ (P12 (1)). As this suggests, the women in the first study were speaking from a position in which they were reflecting back on their treatment - possibly with more critical distance from their eating problems. In contrast, the participants in the clinic were obviously still *in* treatment, and this clearly limited what the group could cover and how. Indeed, as the feminist approaches to EDs critique the fundamental principles of the biomedical paradigm, it would not have been ethical, appropriate nor possible (from the perspective of the clinic) to encourage the participants to openly reject the treatment they were currently in. In this regard, the clinic study did not refer to biomedical perspectives on EDs as a construction (or even a concept). Rather, the feminist (‘cultural’) perspectives were often presented by the facilitators as offering a ‘further’ perspective on EDs, possibly meaning that they stacked up rather confusingly in relation to the more individualised discourses of the participants’ wider treatment.

In fact, the difficulty of seeking to combine the feminist approaches with *existing* treatment frameworks was suggested by some of the responses in the first study. When in treatment, a couple of the participants had discovered feminist readings on EDs themselves, and had tried raising the issues posed by the books they had read. But these

efforts were dismissed and/or silenced – either because they were not seen as ‘relevant’, or because the health professional did not have sufficient knowledge to respond.⁵⁸ The interview material also indicated how the women did not just see the relevance of gender here in terms of omission and/or dismissal: existing treatment structures were described by some as actively *endorsing* scripts of gender that were implicated within EDs in the first place.⁵⁹ For example, in speaking about her experiences of in-patient treatment for anorexia, one participant drew attention to how such contexts demanded a particular ‘performance’ of femininity⁶⁰ if the ‘patient’ was to progress:

.... I didn’t feel understood, and because there wasn’t any gender stuff addressed, I... felt that I was always playing a role and that I just had to kind of toe the line and do what was expected of me because every time I opened my mouth and started questioning things it was very quickly shut down again. So it was like ‘OK so this is just another structure that I’ve got to like conform to and then I can get out and start finding out what to do ...’ (P5 (2)).

This tends to support feminist arguments that ED treatment practices - as well as models of ‘recovery’ - are structured around dominant constructions of femininity, forcing women into a ‘corseted model of femininity regardless of how tight the fit’.⁶¹ The responses also indicate the difficulty of ‘adding’ in aspects of the feminist approaches to the existing biomedical contexts of ED treatment given that the feminist approaches are such a ‘profound critique of everything to do with medicine and patriarchy...’.⁶² As a result, this clearly makes it difficult to simply ‘add gender’ (and stir).

Conclusion

The sets of data used in this article are clearly limited ($n=22$), and they primarily privilege the experiences of white, cis-gendered women. In the first study, it is possible that a research project exploring the relationship between EDs and gender may have attracted women who identified as feminist, so these results, as well as the results from the clinic study, cannot be generalised more widely. At the same time, these samples are of particular value because they emerge from studies in which women are asked to *participate in the discussion* of the feminist approaches to EDs. As such, this article has explored some of the discursive intersections between feminism and contemporary ED treatment, both as a horizon of possibility, and in terms of responses to a practical intervention. In engaging the women in debate about the purchase and value of the feminist approaches, the results are uneven and complex, whilst there are also differences between the two sets of data used here.

The different responses across the two studies may suggest that feminist perspectives are better explored further along in treatment, or in out-patient contexts in which people are not so critically 'ill'. This may well be the case, and this was something reflected on by the facilitators of the group study as the groups were progressing. But such a perspective should also be viewed with caution. Not only does it tend to 'other' and pathologise so-called 'anorexic' voices (which are often positioned as residing 'outside of the true')⁶³ but it also reaffirms a binary in which a 'deluded existence' is replaced by the 'authentic' cure of a feminist identity which brings women to 'their senses'.⁶⁴ Such a perspective also silences legitimate critiques of feminism, and ignores how many of the responses in the second study - and some in the first - dramatise a range of 'normative' discursive frames through which feminism is (still) constructed.

The differences between the two studies also raise long-standing debates about the inclusions and exclusions of feminism - especially its accessibility, and the problems of speaking for women 'as one'. Although it is fully acknowledged that the samples are limited and dominated numerically by white, heterosexual and cis-gendered women, there are also potential differences at play which are worthy of note here. In the first study, most of the women had been to university – a context in which they were exposed to feminism and often developed affiliations with a feminist identity – whereas the majority in the second study had not. This may be because in-patient clinics often treat chronic, long-term patients whose life course has been significantly disrupted or altered by their problem (although of course not everyone will aspire to go to university, and aspirations in this regard may also be curtailed by financial contexts and questions of class). Ruth Striegel Moore commented back in 1994 on the (in)accessibility of the feminist scholarship and observed how, despite its more popular roots, it was now often 'published in specialised feminist journals and read by feminists'.⁶⁵ In reflecting on the limited visibility of the feminist perspectives in clinical research, public discourse and treatment contexts today, it would seem that *not that much* has changed (even though the status of feminism arguably has). But although the dominance of biomedical approaches to EDs may have done much to marginalise the feminist work (both academically and in practice), there is also a story here about the accessibility of the feminist perspectives more widely. Not all of the feminist research offers an easy read, and there has been little or no discussion by feminists over the past 30 years about how its findings might be implemented *in practice*.

The early feminist work offered critiques of existing treatment, engaged in discussion of what feminist in-patient treatment *might* look like, and explained how they used feminist approaches within their own private practice.⁶⁶ But there has been little or no discussion of feminist interventions in ED treatment in the age of evidence-based ED practice, meaning

that these approaches may find themselves (even more) confined to intellectual debates.

Given the body of feminist work which demonstrates the *centrality* of gender to how women/ girls talk about the experience of eating/ body distress, this is both a missed opportunity and a great pity.

Clearly, if societal constructions of power and identity are implicated within EDs, this also needs to be widened to think about gender – and other identity categories – in more intersectional terms, taking in the significance of class, sexuality, ethnicity, gender identification and beyond. There are limited examples of such intersectional work, and whether the feminist approaches can encompass this scope can only be explored by practical applications. Indeed, there is an urgent need here for the construction of an active evidence base which cannot be easily dismissed by the biomedical perspectives. This will clearly involve engaging ‘patients’ in the active exploration of how social and cultural ideologies – including, but not limited to, questions of gender – may have shaped their eating/ body distress, and understanding how challenging these contexts might be productive in recovering from an ED. This will also involve navigating the contradictory construction and reception of ‘feminism’ itself, and the ways in which this inevitably shapes how such interventions might be received. But the research offered in this article, alongside a longer history of feminist qualitative work on EDs, *does* suggest that a focus on gender is urgently worth pursuing as part of contemporary ED treatment.

To end, in reflecting on the history of feminist approaches to EDs, founding scholar/ therapist Susie Orbach has recalled the excitement of mounting a challenge to medicine, as well as the ridicule she received in return.⁶⁷ In surveying the contemporary cultural landscape, she thus suggests that we should find cause for optimism and be ‘very happy to see feminism come back as a word’⁶⁸. These are indeed exciting times for feminism. But whether or how the

‘feminism zeitgeist’⁶⁹ offers opportunities for ‘feminism’ and ‘eating disorders’ to develop more sustained relationships remains to be seen.

¹ Rosalind Gill, “Post-postfeminism?: new feminist visibilities in postfeminist times”, *Feminist Media Studies*, 16:4 (2016): 610-630.

² Elaine Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (London: Virago, 1986).

³ The participants have been given the participant number they were allocated in the initial studies, followed by a (1) or a (2) to indicate which study the data is from.

⁴ Bordo, *Unbearable Weight*, 53

⁵ Beat, Statistics for Journalists, <https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics> [accessed 30 October, 2018].

⁶ Shelly Budgeon, “Emergent Feminist (?) Identities: Young women and the Practice of Micropolitics”, *The European Journal of Women’s Studies*, 8 (1) (2001): 7-28, Shelly Budgeon, *Third-Wave Feminism and the Politics of Gender in Late Modernity* (Basingstoke: Palgrave Macmillan, 2011), Octavia Calder-Dawe and Nicola Gavey, “Jekyll and Hyde Revisited: Young people’s constructions of feminism, feminists and the practice of ‘reasonable’ feminism”, *Feminism and Psychology*, 26 (4) (2016): 487-507, Christina Scharff, *Repudiating Feminism: Young Women in a Neoliberal World* (Farnham, Ashgate, 2011).

⁷ Desiree Boughtwood and Christine Halse, “Other than Obedient: Girls’ Constructions of Doctors and Treatment Regimes for Anorexia Nervosa”, *Journal of Community and Applied Psychology*, 20 (2) (2010): 83-94, Maree Burns, “Eating like an Ox: Femininity and Dualistic Constructions of Bulimia and Anorexia”, *Feminism and Psychology*, 14 (2) (2004): 269-295, Malson, *The Thin Woman*, Paula Saukko, *The Anorexic Self: A personal and Political Analysis of a Diagnostic Discourse*. (Albany: State University of New York Press, 2008).

⁸ Su Holmes, “Blindness to the Obvious”, in *Feminism and Psychology*.

⁹ Carolyn Zerbe Enns, "Twenty Years of Feminist Counseling and Therapy: From Naming Biases to Implementing Multifaceted Practice", *The Counseling Psychologist*, 21 (1993): 3-87.

¹⁰ Kim Chernin, *The Hungry Self: Women, Eating and Identity* (New York: Harper Collins, 1985), Marilyn Lawrence, *The Anorexic Experience* (London: The Women's Press, 1984), Susie Orbach, *Fat is a Feminist Issue* (London: Arrow Books, 1979), Susie Orbach, *Hunger Strike: the Anorectic's Struggle as a Metaphor for Our Age*. (London: Faber & Faber, 1986).

¹¹ Naomi Wolf, *The Beauty Myth: How Images of Beauty are Used Against Women* (London: Vintage, 1991).

¹² Bordo, *Unbearable Weight*.

¹³ 119 Abigail Bray, "The Anorexic Body: Reading Disorders", in *The Body: Readers in Cultural Criticism*, ed Tiffany Atkinson (Basingstoke, Palgrave, 2005): p.115.

Chernin, *The Hungry Self: Women*, Orbach, *Hunger Strike*, Lawrence, *The Anorexic Experience*.

Bordo, *Unbearable Weight*, Orbach, *Hunger Strike*, Lawrence, *The Anorexic Experience*.

¹⁶ See Helen Malson and Maree Burns (eds), *Critical Feminist Approaches to eating dis/orders* (Sussex: Routledge, 2009).

¹⁷ Melaine Katzman and Lee Sing, "Beyond Body Image: The integration of Feminist and Transcultural Theories in the Understanding of Self Starvation", *International Journal of Eating Disorders*, 22 (1997): 385-394.

¹⁸ See Maree Burns, "Eating like an Ox", in *Feminism and Psychology*, Su Holmes, "Blindness to the Obvious", in *Feminism and Psychology*, Malson, *The Thin Woman*, Paula Saukko, *The Anorexic Self*.

¹⁹ Bordo, *Unbearable Weight*, Su Holmes, "Blindness to the Obvious", in *Feminism and Psychology*, Malson, *The Thin Woman*, 1998, 2009, Orbach, *Hunger Strike*.

²⁰ Rebecca Jones & Helen Malson, "A critical exploration of lesbian perspectives on eating disorders", *Psychology and Sexuality* 4 (2013): 62-74, Rebecca Thompson, *A Hunger So Wide And So Deep: A Multiracial View of Women's Eating Problems* (Minnesota: University of Minnesota Press, 1994)

²¹ Maree Burns, “Bodies as (im)material? Bulimia and body image discourse”, in *Critical Feminist Approaches to eating dis/orders*, eds. Helen Malson and Maree Burns (Sussex: Routledge, 2009): 124-134.

²² For example, Susan Bordo, “Not ‘just a white girl’s thing’: The changing face of food and body image problems”, in *Critical Feminist Approaches to eating dis/orders*, eds. Helen Malson and Maree Burns (Sussex: Routledge, 2009) :46-60; Melaine Katzman and Lee Sing, “Beyond Body Image” in *International Journal of Eating Disorders*, Thompson, *A Hunger So Wide And So Deep*.

²³ Kristen. M Culbert, K.M, Sarah E. Racine & Kelly. L Klump, “What we have learned about the causes of eating disorders – a synthesis of sociocultural, psychological, and biological research”, *The Journal of Child Psychology and Psychiatry*, 56 (11) (2015): 1114-1164.

²⁴ Su Holmes, “Blindness to the Obvious”, in *Feminism and Psychology*, Su Holmes, “The role of sociocultural perspectives in eating disorder treatment”, in *Health*; Su Holmes, Sarah Drake, Kelsey Rogers and Jon Wilson, “Feminist approaches to anorexia: a qualitative study of a treatment group”, *Eating Disorders*, published 13 November 2017,

<https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-017-0166-y>.

²⁵ Andrea LaMarre, “Eating Disorders: What’s Feminism Got to Do with it?”, 25 November, 2015, <http://www.scienceofeds.org/2015/11/23/eating-disorders-whats-feminism-got-to-do-with-it> [accessed 2 September 2016]

²⁶ Su Holmes, “The role of sociocultural perspectives in eating disorder treatment”, in *Health*.

²⁷ Michael Levine & Linda Smolak, “Paradigm clash in the field of eating disorders: a critical examination of the biopsychiatric model from a sociocultural perspective”, *Advances in Eating Disorders*, 2 (2) (2014): 159.

²⁸ Niva Piran, “A feminist perspective on risk factor research and on the prevention of eating disorders”, *Eating disorders: The Journal of Treatment and Prevention*, 18 (3) (2010): 183-198.

²⁹ Christina Scharff, *Repudiating Feminism*.

³⁰ Angela McRobbie, *The Aftermath of Feminism: Gender, Culture and Social Change* (London: Sage, 2008).

³¹ Anita Harris, Harris, "MIND THE GAP: Attitudes and Emergent Feminist Politics since the Third Wave", *Australian Feminist Studies*, 26 (66) (2010), 476.

³² Octavia Calder-Dawe and Nicola Gavey, "Jekyll and Hyde Revisited", in *Feminism and Psychology*.

³³ Rosalind Gill, "Post-postfeminism?: new feminist visibilities in postfeminist times", in *Feminist Media Studies*.

³⁴ Su Holmes, "Blindness to the Obvious", in *Feminism and Psychology*,; Su Holmes et al, "Feminist approaches to anorexia", *Eating Disorders*.

³⁵ See Su Holmes, "Blindness to the Obvious".

³⁶ Bell Hooks, *Black Looks: Race and Representation*. (Boston, MA: South End Press, 1992); Bev Skeggs, *Class, Self, Culture* (London: Routledge, 2003).

³⁷ Catherine Soban, "What about the boys? Addressing issues of masculinity within male anorexia in a feminist therapeutic environment" *International Journal of Men's Health*, 5 (3): 2006: 251-267; Eric Strother, Raymond Lemberg, Stevie. C Stanford & Dayton Turberville,, "Eating Disorders in Men: Underdiagnosed, Undertreated, and Misunderstood", *Eating Disorders: The Journal of Treatment and Prevention*, 20 (5), (2014): 346-355.

³⁸ Bordo, *Unbearable Weight: 53*.

³⁹ Carolyn Zerbe Enns, "Twenty Years of Feminist Counseling and Therapy", in *The Counseling Psychologist*.

⁴⁰ Carolyn Zerbe Enns, "Twenty Years of Feminist Counseling and Therapy", *The Counseling Psychologist*, 4; Margo Maine & Douglas Bunnell, "How do the Principles of the Feminist, Relational Model Apply to Treatment of Men with Eating Disorders and Related Issues?", *Eating Disorders: The Journal of Treatment and Prevention*, 16 (2) (2008): 187-192

⁴¹ Ning Tang, "Interviewer and Interviewee Relationships Between Women", *Sociology*, 36 (3): (2002): 703-721.

⁴² Su Holmes, "Blindness to the Obvious", in *Feminism and Psychology*.

⁴³ Ning Tang, Tang, "Interviewer and Interviewee Relationships Between Women", in *Sociology*.

⁴⁴ Virginia Braun & Victoria Clarke, “Using thematic analysis in psychology”, *Qualitative Research in Psychology*, 3: (2006): 77-101.

⁴⁵ Barbara. B Kawulich, “Participant Observation as a Data Collection Method”, *Forum: Qualitative Social Research*, 6 (2): (2005): <http://www.qualitative-research.net/index.php/fqs/article/view/466/996>

⁴⁶ See also Octavia Calder-Dawe and Nicola Gavey, “Jekyll and Hyde Revisited”, in *Feminism and Psychology*.

⁴⁷ Octavia Calder-Dawe and Nicola Gavey, “Jekyll and Hyde Revisited”, in *Feminism and Psychology*. 498.

⁴⁸ Eric Strother, Raymond Lemberg, Stevie. C Stanford & Dayton Turberville,, “Eating Disorders in Men”, in *Eating Disorders*, Ulla Raisanen, & Kate Hunt, “The role of gendered constructions of eating disorders in delayed help-seeking in men: A qualitative interview study”, *BMJ Open*, 4, (2014) DOI:10.1136/bmjopen-2013-004342.

⁴⁹ Eric Strother, Raymond Lemberg, Stevie. C Stanford & Dayton Turberville,, “Eating Disorders in Men”, in *Eating Disorders*:436.

⁵⁰ Susie Orbach, *Hunger Strike*.

⁵¹ Christina Scharff, *Repudiating Feminism*.

⁵² See Stephanie Houston-Grey, “A Perfect Loathing: The Feminist Expulsion of the Eating Disorder”, *.KB Journal*, 7 (2) (2011) <http://kbjournal.org/grey>.

⁵³ Naomi Wolf, *The Beauty Myth*.

⁵⁴ Stephanie Houston-Grey, “A Perfect Loathing”, in *.KB Journal*.

⁵⁵ See Ibid.

⁵⁶ Abigail Bray, “The Anorexic Body: Reading Disorders”, In *The Body: Readers in Cultural Criticism*, Tiffany Atkinson (ed) (Basingstoke: Palgrave): 115-128.

⁵⁷ See summary in Joanna. R. Doley, Laura. M. Hart, Arthur. A Stukas, Katja Petrovic, Ayoub Bouguettaya, Susan. J Paxton S.J, “Interventions to reduce the stigma of eating disorders: A systematic review and meta-analysis”, *International Journal of Eating Disorders*, 50 (3) (2017): 1-21.

⁵⁸ See Su Holmes, “Blindness to the Obvious”, in *Feminism and Psychology*.

⁵⁹ See also Desiree Boughtwood and Christine Halse, "Other than Obedient", in *Journal of Community and Applied Psychology*; Saukko, *The Anorexic Self*; Helen Gremillion, *Feeding Anorexia: Gender and Power at a Treatment Center* (Durham and London: Duke UP, 2003);

⁶⁰ See also Desiree Boughtwood and Christine Halse, "Other than Obedient", in *Journal of Community and Applied Psychology*.

⁶¹ Rebecca Lester, "Like a Natural Woman: Celibacy and the Embodied Self in Anorexia Nervosa", in *Celibacy, Culture and Society: the anthropology of sexual abstinence* eds Elisa.J Sobo & Sandra Bell (Madison: University of Wisconsin Press, 2001): 210.

⁶² Susie Orbach, Personal interview with author, 13th May, 2015.

⁶³ Saukko, *The Anorexic Self*: 64.

⁶⁴ Stephanie Houston-Grey, "A Perfect Loathing".

⁶⁵ Ruth Striegel-Moore, "A Feminist agenda for psychological research on eating disorders", in *Feminist Perspectives on Eating Disorders*, eds. Patricia Fallon, Melanie .A Katzman & Susan.C Wooley (Guildford: Guildford Press, 1994): 446.

⁶⁶ Orbach, Hunger Strike, 161-172, Robyn Sesan, "Feminist Inpatient treatment for eating disorders: An oxymoron?", in *Feminist Perspectives on Eating Disorders*, eds. Patricia Fallon, Melanie .A Katzman & Susan.C Wooley (Guildford: Guildford Press, 1994): 251-72)

⁶⁷ Susie Orbach, Personal interview with author, 13th May, 2015.

⁶⁸ Ibid

⁶⁹ Rosalind Gill, "Post-postfeminism?" in *Feminist Media Studies*.

Appendix A

Interview schedule for study 1

- Why did you choose to participate in the study?
- Can you describe the forms of treatment that you have encountered? (ie GP, counselling, in/out patient, support group, other?)
- How was your experience of treatment? What was positive/negative/ successful/ unsuccessful?
- What is your own understanding of why you developed an ED?
- To what extent/ in what ways, was this shaped by your treatment?
- How do you feel about EDs being defined as a mental illness?
- I sent you a summary of feminist approaches to EDs. How did you feel when reading this? How would you relate / not relate the approaches to your own experience of an ED?
- Did any of your treatment engage with these ideas? If no, how do you feel about that? Why did you think that was?
- Do you think that a focus on questions of gender should be part of treatment? Why/ why not?

Interview schedule for study 2

-
- How would you describe your experience of participating in the groups and what did you see as the key themes?
 - Prior to the current group, had any of the themes covered been addressed in any previous treatment? If so what/ how/ when?
 - In terms of the themes focused on in the group - do you think this focus should be part of ED treatment? (why/ why not)
 - Did you find the group helpful? (why/ why not?)
 - Was there anything that was unhelpful?
 - Did the groups challenge / contribute to/ change your understanding of why you have developed/ maintained an ED? If so, how?
 - Did it change your view on the extent to which society/ culture may have contributed to your ED?
 - Based on your own experience, do you think these themes are best addressed in groups or in a one-to-one setting (or both)?
 - For you, what were the implications of the focus on EDs as a product of society (rather than purely 'individual' problem)?
 - What does the term feminism mean to you?
 - Has doing the group changed your idea(s) of what this term means at all?
 - Is there anything else about the groups that you would like to say that we haven't covered?