Controlling the noise: A phenomenological account of Anorexia Nervosa and the threatening body

Abstract: Anorexia Nervosa (AN) is a complex disorder characterised by self-starvation, an act of self-destruction. It is often described as a disorder marked by paradoxes and, despite extensive research attention, is still not well understood. Much AN research focuses upon the distorted body image that individuals with AN supposedly experience. However, based upon reports from individuals describing their own experience of AN, I argue that their bodily experience is much more complex than this focus might lead us to believe. Such research often presents an overly cognitive understanding of bodily experience in AN, underplaying the affective, felt experience of individuals with AN, as well as descriptions of empowerment, strength and control reported in the early stages of AN. This paper seeks to enrich our understanding of bodily experience in AN as it progresses throughout the various stages of the disorder. I show how the classical phenomenological distinction between the body-as-subject and the body-as-object, as well as Leder's conception of the visceral body, can inform our understanding of bodily experience in AN. I suggest that the project of self-starvation is an attempt to overcome the noisy demands of the visceral body, which are experienced as threatening the body-as-subject, through a process of objectifying the body-as-object. By cashing out AN as a project of radical bodily control that, tragically, comes to control the individual, we can capture important aspects of the bodily experience of AN and the temporal progression of the disorder.

Keywords: anorexia nervosa, phenomenology, bodily experience, embodiment, objectification, visceral body

Introduction

Anorexia Nervosa (AN) is a complex disorder characterised by self-starvation, an act of self-destruction. It is often described as a disorder marked by paradoxes (Leder 2013) and, despite extensive research attention, is still not well understood. One of the central characteristics associated with AN is the idea that individuals with AN experience distorted body image, typically, in terms of judging or perceiving their body as larger than it in fact is. Indeed, suffering from distorted body image is one of the diagnostic criteria for AN and is influential in how AN is conceived both academically and in the media; we are all familiar with images of a painfully thin woman peering into a mirror that shows an obese figure staring back at her. As Cash & Brown (1987, p.487) put it, "this alone is suggestive of how common the belief is that perceptual distortion of body image is a hallmark of the disorder".

This paper suggests, however, that experiencing distorted body image does not exhaustively nor, in many cases, accurately, reflect the bodily experience of individuals with AN and privileges a third-person perspective of the disorder at the expense of first-person accounts. This not only hinders our *understanding* of AN but our lack of insight into the condition has therapeutic implications; AN is a potentially lethal disorder and, as yet, we have no consensus on the best way to treat patients suffering from it.

In this paper, I draw on first-person reports of individuals with AN, drawing out the reoccurring themes of experiencing their body as something volatile, threatening and demanding that needs to be controlled.[i] I suggest that the phenomenology of embodiment, with its multi-dimensional account of bodily experience, offers illuminating insights to a study of AN based upon reports of bodily experience. By introducing a multi-layered account of embodiment, we can begin to understand how

individuals with AN attempt to achieve a radical form of subjective embodiment through a radical project of bodily control.

In section 1, I provide a brief summary of AN, note that experiencing distorted body image is taken to be a central feature AN and outline why placing distorted body image at the centre of our understanding of AN is, at best, misleading and, at worst, a mischaracterization of the disorder as a 'disease of thinness'. Section 2 introduces key descriptions of bodily experience in AN. This overview highlights the role of control, power and bodily suspicion that are at play in the disorder. In particular, it reveals how an individual with AN does not experience her[ii] body simply as an overly large, inert, heavy *object*, but as a noisy, disruptive subject that threatens her own agency. This overview also brings to the fore that AN is not a static disorder but one that has numerous stages (Warin 2004, 2010). Based on this picture of the lived bodily experience of AN, I suggest that what an account of AN needs to capture is how self-starvation, an act of self-destruction, can be understood as a project of control, power and self-preservation, that often tragically subverts leaving the individual at the mercy of their own project.

It should be noted that I predominantly draw upon Hornbacher's memoir in this paper. There are, of course, limitations to drawing upon one individual's account of a disorder. However, the advantage of doing so is that we can track Hornbacher's extensive and detailed description of her experience. I use Hornbacher's descriptions to illustrate various themes that consistently resurface in reports of AN (e.g. in reports collected by or reported in: Bowden 2012, Bruch 1978, Halban 2009, Katzman & Lee 1997, Legrand 2010a,b, MacSween 1993, and Warin 2004, 2010). As such, these themes, while not exhaustive of bodily experience of AN, can be viewed as, at least, common and worthy of attention.

Section 3 sets out how phenomenological descriptions of bodily experience help us understand how a conflict between different dimensions of bodily experience might arise. Specifically, I draw on the classic phenomenological distinction between body-as-object and body-as-subject, as well as Leder's often-overlooked notion of the visceral body. In section 4, I explore the idea that the lived experience of an individual with AN involves feeling her body as radically objectified, as claimed by Bowden (2012). I suggest that the limitation of this approach is that it does not fully capture why the individual experiences her body as *threatening*. I offer a revised phenomenological account claiming that an individual with AN does not simply experience her body *as objectified* but embarks upon a project *of objectifying* the body, via self-starvation, in order to control the demands of the physical body. Finally, in section 5, I outline some therapeutic implications of my account.

1. AN and distorted body image

1.1. Diagnostic criteria

AN is classified as an eating disorder by the American Psychiatric Association (APA). It is characterized by self-starvation that leads to dramatic weight loss. The diagnostic criteria for AN, as set out in *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) (APA 2013a), are as follows:

i) a persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health);

ii) either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight); and

iii) a disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

About 1% of the general populace is diagnosed with AN and 9 out of 10 of sufferers are female (Hudson et al. 2007). AN is believed to have the highest mortality rate of any psychiatric disorder, with research suggesting that approximately 5.5% of individuals diagnosed with AN die as a result of their condition (Arcelus et al. 2011). As yet, there is little consensus among medical professionals about the best way to treat AN. Among the dominant forms of treatment is hospitalisation and in-patient treatment for weight gain. However, there is a high relapse rate; Carter et al. (2004) report that approximately 35% of individuals relapse within 2 years of leaving in-patient treatment.

AN has attracted much attention in both medical and academic circles and a plethora of theories have been offered, including: biological (e.g. Crisp 1988), psychological (e.g. Freud 1958), feminist (e.g. Bordo 1992; Orbach 1978), religious (e.g. Richards et al. 2007) and, more recently, phenomenological (e.g. Bowden 2012; Legrand 2010a, 2010b; Rodemeyer, forthcoming; Svenaeus 2013). In many ways, these assorted approaches to AN reflect the multidimensional nature of the disorder.

Due to the complexity of the disorder, I, like many others (e.g. Krueger & Osler, forthcoming; Legrand 2010b; Rodemeyer, forthcoming), endorse a pluralistic approach to AN. As such, my focus on a disruption of bodily experience should not

be mistaken for a denial that other factors are at play. Rather, I follow researchers who have sought to draw attention to the affective, visceral bodily experience of individuals with AN (e.g. Bowden 2012; Legrand 2010a, b; Charland et al. 2013; Svenaeus 2013), that goes beyond the assertion that they suffer 'a disturbance in the way one's body weight or shape is experienced' as the DSM-V suggests. My analysis, therefore, aims to provide a more fine-grained, phenomenological account of the bodily experience of AN and considers the therapeutic implications of this approach.

1.2. Distorted body image

Distorted body image is typically treated as involving an overestimation of body parts or body size (Garner and Garfinkel 1981); either in terms of having a faulty perception of one's body or forming flawed judgments about one's body. The assumption is that subjects without AN accurately perceive their bodies and/or form positive or neutral judgments about their body size. In contrast, those with AN are described as having altered perceptions of or negative judgments about their bodies that are at odds with their anatomical size; individuals with AN are thought to perceive or judge themselves to be fat when they are, in fact, drastically underweight.

To date, perhaps the most commonly agreed upon feature of AN is that it: involves "a disturbance of body image of delusional proportions" (Bruch 1962, p.188). While Bruch (1962) was the first to postulate distorted body image as the hallmark of AN, the importance given to distorted body image is reflected in the sheer number of questionnaires and studies developed to try and measure distorted body image in AN (see Cash & Brown 1987 and Cash & Pruzinsky 2004 for an

overview of these various techniques), as well as the preponderance of therapy aimed at righting distorted body image (e.g. Thompson et al. 2001; Key et al. 2001; Vocks et al. 2010).[iii]

Indeed, this notion of distorted body image is so prevalent that it is built into the DSM-V definition of AN, which states that AN involves "a disturbance in the way one's body weight or shape is experienced" (APA 2013a). This is even more explicit in the APA fact sheet on eating disorders which claims that "[a]norexia nervosa, which primarily affects adolescent girls and young women, is *characterized by distorted body image* and excessive dieting that leads to severe weight loss" (APA 2013b, my emphasis). What is more, distorted body image is widely reinforced by images of individuals with AN found in the media. As Warin (2004) wryly notes, we are all familiar with the depiction of AN as a skeletal female figure staring into a mirror that reflects her as overweight.

Notwithstanding the emphasis on distorted body image in AN research, I suggest that there are three reasons why we should treat this conception of the bodily experience of individuals with AN with reservation. Namely that:

i) scientific evidence about distorted body image in AN is inconclusive;
ii) the focus on body image in AN privileges a third-person perspective fascinated by thinness; and
iii) this approach fails to give proper attention to individuals' complex lived bodily experience of AN.

Despite extensive scientific research into distorted body image in patients with AN, results do not currently provide a coherent picture about the alteration of body image in AN. Some researchers claim that body image distortion is a common feature of AN (e.g. Garner & Garfinkel 1977; Fairburn & Harrison 2003). However,

such findings have been called into question on the basis that "many studies have failed to demonstrate a significant difference in overestimation between eating disordered patients and non-eating disordered controls" (Dolan et. al 1987, p.513; see also Delinsky 2011; Hennighausen et al. 1999). There have been few studies that have explicitly looked at body image in non-pathological cases; in particular, little attention has been given to how men perceive their body image (Dolan et. al 1987; Grogan 2016). Some studies suggest that body image disturbance, in fact, occurs both in individuals with and without AN (e.g. Dolan et. al 1987; Hennighausen et al 1999). This is additionally complicated when we take in account research done by Lee (1991, 2001) that indicates that Asian women with AN do not suffer from distorted body image, leading her to conclude that "DBI is a controversial entity that may be obvious, mild, latent or absent" (1991, p.708).

This is not to say that we must dismiss body image distortion as having no role in AN; rather, the point is to emphasise that "research results are rather inconsistent and the true nature of body image disturbance is still not very well understood" (Skrzypek et al. 2001, p.220). As such, we should be hesitant to commit to conceptions of AN based principally upon this notion.

What is more, when we privilege distorted body image as a way of understanding the bodily experience of AN, we implicitly privilege an understanding that conceives of AN as a 'disease of thinness'. The implication is that because individuals with AN have distorted body image and overestimate the size of their bodies, they enter into a ritual of self-starvation in order to reach a lower, ideal shape or weight. However, as Legrand (2014, p.186) highlights "a description of anorexia which focuses on low body weight and disturbed body representation does not make

sense from the patient's perspective, in her world, but only in the objective and objectifying world of the psychiatrist".

Why has thinness has come to occupy centre stage when addressing AN? One reason might be that the *thinness* of patients with AN is the aspect of the disorder that is available to the third-person perspective; thus, coming to stand as the visual marker of the pathology. A fixation on thinness is generated through the privileging of the outsider's gaze. Lee (2001) also highlights that this fascination with thinness is culturally valanced, as this emphasis on thinness, while dominating Western discussions of AN, is largely missing in Asian societies.

Warin (2004, p.95) suggests that it is the fascination with thinness which leads us to ignore "the profound embodied sensations of power and suffering that are central to experiences of anorexia". Conceptualising AN on the basis of what is available to the third-person perspective risks leaving aside "the subject as she experiences her body here and now" (Legrand 2010a, p.729) and leaving us with an incomplete picture of bodily experience in AN.[iv]

This seems particularly problematic when we consider descriptions of bodily experience of AN that are at odds with models that posit thinness and distorted body image as central features. Statements such as the following make it clear that the lived experience of AN goes beyond a striving for thinness or a fear of fatness: "Yes, there are days when I "feel fat," but this mostly translates to "I feel stressed." Somehow, they got linked in my mind (stress– >fat–>eat less–>less stress), but that doesn't mean the driver is for me to be thin; the driver is for me to be calm, and thinness was the result" (Arnold in Legrand 2014). Other reports explicitly undermine the distorted body image approach: "I did not think I was too fat; quite the contrary. There was a skeleton peering at me from behind the looking glass" (Halban 2009,

p.184); as well as evidence that some individuals with AN take satisfaction in their emaciated bodies.

The focus on thinness and distorted body image seems to be made at the expense of listening to subjective experiences of AN. Those with AN often do not mention the pursuit of thinness as the *only,* nor even sometimes the *primary*, motivating factor during the early stages of AN. Commonly expressed are themes of control, self-preservation and bodily distrust (e.g. Halban 2009; Hornbacher 1999; MacSween 1993; accounts reported in Legrand 2010, Warin 2004, 2010). As Hornbacher expresses it:

> [S]hrinks have been paying way too much attention to the end result of eating disorders...This end result is not your intention at the outset. Your intention was to become superhuman, skin thick as steel, unflinching in the face of adversity. (Hornbacher 1999, p.68)

The risk of focusing predominantly upon thinness is that it gives rise to the impression that AN is a form of radical dieting gone wrong resulting from a misperception or misjudgement of one's body size or shape.

It should also be highlighted that the distorted body image approach, like many other accounts, tends towards depicting AN as a static disorder (Warin 2004, p.98). By focusing upon the emaciated patient who is subject to obsessive thoughts about food and her body, we are prone to forget that AN is not just a pathology in the end stages, when someone is really thin. As I shall explore, the experience of a patient with AN might start out as one thing 'at the outset' and then transform into another by the 'end result'. Note that I am not suggesting that individuals with AN never talk about thinness and weight-size, clearly they do (e.g. reports in Charland et al. 2013). However, we need to show sensitivity to *what stage* reports of AN are

being documented at. As discussed in section 4, individuals with AN often experience increased obsession with food and thinness as the disorder progresses. If reports are taken during this stage, while individuals are in the throes of such obsessive thoughts and feelings, this does not necessarily reflect bodily experience and concerns during earlier stages of AN.

This is all to say that focusing on distorted body image risks overshadowing other aspects of bodily experience in AN. When studying AN, a bodily pathology, it seems remiss to not fully explore bodily experience of those suffering from the disorder. As such, in this paper, I follow researchers such as Bowden (2012), Charland et al. (2013), and Legrand (2010a, b) in placing the affective, bodily experience of individuals with AN front and centre in my analysis of AN.

2. Lived bodily experience of AN

For the purposes of this paper, I draw primarily upon Marya Hornbacher's book *Wasted*, which provides a detailed account of her battle with AN, as my source of experience of the body in AN. It should be noted, however, that Hornbacher's descriptions of AN are not exhaustive of the disorder. Therefore, her account should not be treated as universal. Nevertheless, I suggest that her descriptions of AN as involving a desire to assert control over her physical body, of having a deep-rooted suspicion of her body and wanting to preserve her sense of self, are reflective of numerous other accounts of the disorder (e.g. Bowman 2006; Halban 2009; accounts detailed in Bruch 1978 and Warin 2004, 2010).

In particular, I want to draw attention to the following passages from Hornbacher's account:

> It is, at the most basic level, a bundle of deadly contradictions; a desire for power that strips you of all power. A gesture of strength that divests you of all strength. A wish to prove that you need nothing, that you have no human hungers, which turns on itself and becomes a searing need for the hunger itself. (Hornbacher 1999, p.6)

> Somehow I learned before I could articulate it that the body – my body – was dangerous…*I did not trust it.* It seemed *treacherous*. I watched it with a wary eye. (*ibid.,* p.14)

> I had no patience for my body. I wanted it to go away so that I could be a pure mind, a walking brain, admired and acclaimed for my incredible self-control. (*ibid*. p.108)

> Anorexia was my Big Idea, my bid for independence, identity, freedom…You don't just get it, the way you get a cold; you take it into your head, consider it as an idea first, play with the behaviours awhile, see if they take root. *(ibid,* p.69)

In addition to these extracts from Hornbacher's personal account of AN, it is important to add that AN is a disorder of stages. In the early stages, AN is experienced as an expression of self-control and strength, a project of empowerment. As Warin (2004) notes, this stage is referred to by some as the 'honeymoon phase'. However, as AN progresses, there is a reversal; ultimately the individual "loses control over the bodily practices that were intended to further the experience of greater control" (Duesund & Skårderud 2003, p.56). In the final stages, the individual with AN can lose control over her thoughts and actions and thinking about food and the body becomes "obsessional" (*ibid.*).

Hornbacher's descriptions point to an "intolerable tension" (Legrand 2010a, p.727) experienced by the individual between the subjective and physical dimensions of her lived experience. In particular, Hornbacher describes how she experienced her body as something loud, domineering, threatening; something that she was unable to trust or block out. Hunger is depicted as something intrusive which a person with AN strives to overcome, to refuse to give in to. The act of self-starvation, rather than simply a pursuit for thinness, is described as an act of strength, of self-control.

This might strike us as somewhat paradoxical; how can an act of self-destruction be understood as an act of power, an act of self-preservation? I suggest that the phenomenology of embodiment, with its multi-dimensional account of the body, is able to make sense of this supposed paradox in the following terms: that self-starvation is an act of body-control enacted by the body-as-subject over her physical body. I will claim that the act of body-control is pursued in order to diminish the threat of the objective, visceral body to the body-as-subject. The individual with AN, as an act of self-preservation, attempts to control and silence the *noisy* demanding body in search of a radical embodiment as a body-as-subject, freed from the demands of the physical body. Capturing self-starvation as a project of control, rather than just a project of dieting, helps to do justice to the complex bodily experience of AN.

It should be noted here that the term 'project' here is not meant to imply a purely cognitive, goal-orientated project that the individual explicitly formulates and pursues but as an embodied, affective habitual pattern of behaviours. My notion of 'project of control' could well be characterised using the illuminating framework of conceiving of AN as a *passion*; a felt, affective form of organization that can seep

into all corners of an individual's life, affecting her evaluative frameworks (Charland et al. 2013, p.357).[v] While Charland et al. discuss AN as a passion for *thinness*, this approach is also compatible with the idea that AN can be characterised as a passion for *control*. I will return to this idea in section 4 in relation to how the experience of hunger changes, from the individual experiencing it as an intrusive desire of the body to a valued sign of success of her taking control of the body's visceral demands.

3. Three dimensions of bodily experience

Phenomenological accounts of embodiment provide a detailed description of the body as both something physical and subjective. As Husserl (1989) highlights, we do not just *have* a physical body (*Körper*) but we also *are* our lived body (*Leib*); the body is a physical object in the world and something subjective, that which we live through. In addition to this classical distinction, I also introduce a third, commonly overlooked, dimension of bodily experience: Leder's conception of the visceral body. These distinctions highlight the different *ways* in which we can experience the body, not a claim that we have different *types* of body (Gallagher & Zahavi 2013, p.136).

With these three dimensions of bodily experience in play, I suggest we can start to demystify the seeming paradox of starving oneself as an act of self-preservation; the individual with AN can be understood as a body-as-subject trying to protect her sense of agency and autonomy from the noisy, visceral demands of her physical object-body. Self-starvation, then, is not deployed against the *whole* body but against a *specific* dimension of bodily experience.

3.1. Body-as-object

The body is a physical object: it has spatial and temporal location in the world; it has colour and texture; it can be measured; it is subject to natural laws. As discussed above, it is the body-as-object (*Körper*) that tends to be of interest to the scientific and medical world. We, too, can experience our own bodies as objects. I can use my senses to explore my body in a way that I might explore another object in the world.

Yet, the body-as-object is not experienced in *exactly* the same way as we experience other objects in the world. Imagine leaning your cheek against your hand. You can feel your cheek with your hand, perceive it as a smooth physical surface. However, when touch*ing* a part of your body, the body also feels itself as touch*ed* (Merleau-Ponty 2012). When my hand touches my cheek, my cheek is not some inert object but *my* cheek; my cheek feels the touch of my hand. My body is not experienced as a *mere* object. The experience of my body-as-object involves experiencing it as *my* body, not as just another object out there in the world. Compare this experience of my cheek and my hand to the ring on my finger: when I push my hand against my cheek, I can feel my ring pushing against my cheek, but my ring cannot feel my cheek, nor do I experience the ring as mine in the same way that my cheek is mine. The body-as-object is not, therefore, experienced as totally devoid of subjectivity. While the body can be experienced as an object, as something that can be perceived, it is not just an object; it is also the body-as-subject, that which does the perceiving (Merleau-Ponty 2012). This highlights that the body has a unique phenomenological status compared to other objects in the world.

3.2. Body-as-subject

According to Sartre (2003, p.357), explicitly experiencing the body-as-object is an “aberrant type of appearance”. We do not regularly attend to our bodies as objects.

When I walk along the street, I am not intentionally directed toward my body-as-object, to my feet and legs moving, my arms swinging. Instead, I am caught up in my aim to get to the bus stop.

We experience our bodies as the medium through which we have a world. The lived body (*Leib*), the body-as-subject, orientates me in the world; it is the 'here' from which everything else is experienced as 'there'. This is not to say that the body is a vessel for subjectivity. Rather, "I am my body" (Merleau-Ponty 2012, p.151) and my body structures my experience of the world. I see my shoelaces as tie-able because I have hands with opposable thumbs, I see stairs as climbable as I have legs with which to walk up them. The world unfolds itself as a world of possibilities that refer to my bodily abilities; the world offers itself up to a bodily "I can" (Merleau-Ponty 2012). My physical body, therefore, shapes my subjective experience of the world. In this way, we can see that the body-as-subject, while experienced differently from the body-as-object, is not devoid of all physicality.

We are not, usually, intentionally directed to our bodies but directed towards the world, caught up in our everyday doings. It is part of the character of experiencing the body-as-subject that the body-as-object 'disappears' into the background (Leder 1990). If the body-as-object were constantly at the fore-front of my attention, our ability to get caught up in the world would be hindered. Take for example going for a walk: if I were directed toward moving my legs, my muscles, placing my feet, the whole experience would be clunky and disjointed. That the body-as-object is absent is precisely what makes walking easy, the disappearance of the body-as-object liberates us, allows us to focus on the world (Leder 1990).

3.3. The visceral body

There is, though, a third dimension of bodily experience I want to highlight. Somewhat ironically, classical phenomenology often downplays that the physical body is not an object like cups and chairs but is an *organic object*, with needs, feelings, affectivity. Leder (1990) notes that one area of bodily experience frequently overlooked is the *visceral body*. By the visceral body, Leder is referring to the inner body. Leder claims that this is an important aspect of bodily experience because it captures how the body-as-object can feature not just as something that shapes the body-as-subject or is experienced as an inert object but something that makes *demands* of the body-as-subject.

Leder captures the demanding nature of the body by giving a phenomenological description of the visceral body. He details how, when we are hungry for example, the body-as-object does not just call attention to itself as an object but makes demands upon the body-as-subject:

> I must eat, breathe, excrete, drink, sleep, at certain times in certain ways to mollify inner demands. My personal subjectivity can choose to fulfil such biological needs, eating one food rather than another. But it does not assert final autonomy. I may temporally postpone a meal, but if I engage in prolonged self-starvation, this will eventually threaten my life. When the personal subject seeks to overcome the vegetative "I must", it is the subject who is ultimately overcome. (Leder 1990, p.48)

This feature of bodily experience highlights that the body-as-object is not simply experienced as some inert object but has its own 'voice'. These demands are not neutral, cold demands but *felt, noisy demands*, as anyone who has experienced a pang of hunger will recognise.

This bodily "I must" can, as we will see, come into direct conflict with the autonomy of the body-as-subject. The bodily "I must" appears to emerge from a "different volitional space" (*ibid.*, p.47), that of the inner body. As we will see below, it is this demanding bodily 'voice' that the individual experiences (in the early stages of the disorder) as a threat to her body-as-subject; the "I must" impacts her, comes from her own body, and thus is in some sense her own (I do not, for example, mistake my hunger for your hunger, however unwanted that hunger might be), but is experienced as outside of her control and as impinging upon her autonomy. Indeed, that AN was initially labelled a *hysterical* illness suggests that the visceral, affective experience of the disorder previously received greater attention than perhaps it currently does.[vi]

3.4. Intertwinement, objectification and visceral demands

The physical and subjective dimensions of the body are usually intertwined (Legrand 2010a; Moran 2013). As Moran (2013, p.294) highlights we should be careful not to "absolutize the contrast between *Körper* and *Leib*, since my living body is always physical body too"; we should not create a false dichotomy between these aspects of bodily experience. The body-as-subject is not solely experienced as subjective but as tied to the physical world and the physical body; the body-as-object is not solely experienced as physical as it is experienced as mine, as capable of performing the switch between perceived and perceiver, but also as alive, with its demands and needs.

Nevertheless, to say that the body-as-object and body-as-subject are intertwined is not to say that they are experienced as always being in perfect harmony. These different dimensions of bodily experience can come into conflict with

one another. When this occurs, we experience a tension between body-as-object and body-as-subject (Legrand 2010a, p.727). The classic example of this is when we experience pain. Let us return to my going to the bus stop. Initially, while I am walking along, I am not directed at my body-as-object, at my feet and legs moving, at my arms swinging. Instead I am focused on getting to the bus-stop, planning my day, admiring the weather. Then, I suddenly experience a searing pain in my knee and my body-as-object is thrown into the foreground. My project of walking to the bus stop evaporates and all I am aware of is my knee. In this way, the body-as-object disrupts my bodily "I can" and replaces it with a bodily "I can't" (Leder 1990, p.85). The experience of the body-as-object being thrown into the foreground in this way is often described as an experience of *objectification*. According to Leder (1990, p.85), this is often accompanied by an experience of the body-as-object as alienated or distanced from the body-as-subject.

Another example of objectification is of Sartre's description of shame where the gaze of the Other brings our body-as-object to the fore. Here our body-as-object can be experienced as the centre of attention: I feel the blush creep up my face, feel my feet rooted to the ground, feel painfully visible and vulnerable as an object in the world (Sartre 2003, p.282).

In addition to the tension created by *objectification*, we can also experience the visceral body impinging on the realm of the body-as-subject; not by appearing as object-like but by demanding action on the part of the subject. Thus, the body-as-object can be experienced as threatening to the body-as-subject as it compels the body-as-subject through its needs. The body-as-subject's agency and sense of self-determination may be challenged by such visceral demands, setting the body-as-subject at cross-purposes with the visceral body. Indeed, we should note that even in

the classic examples of objectification, such as pain and shame, to say that we experience the body as object-like might be misleading; for we experience the body as suffused with the *feeling* of pain, the *feeling* of blushing. Even here the body-as-object is not devoid of all subjectivity or viscerality.

What these examples illustrate is how a conflict can arise between body-as-object, body-as-subject and the visceral body in everyday experience. In such instances, the physical body stands out to me, thwarts my projects, breaks my seamless engagement with the world, makes demands of me. In section 4, I discuss how a person with AN does not simply experience a conflict between these dimensions of bodily experience but experiences the visceral body's demands as encroaching unbearably upon their subjective autonomy.

4. **A phenomenological account of AN**

What do these insights offer a study of AN? As we saw earlier, the individual with AN looks to be in a paradoxical situation where (at least in the early stages) she sees her self-starvation, an act of self-destruction, as an act of self-preservation. I suggest by understanding bodily experience to be made up of multiple dimensions, we can make sense of this apparent paradox. I propose that we understand the early stages of AN as an attempt to preserve the body-as-subject through an act of bodily control over the body-as-object as a visceral body. By attempting to quell the demanding 'voice' of the body-as-object, an individual with AN seeks a radical form of embodiment as a body-as-subject, unchallenged and unthreatened by the visceral body.

In the following, I start by exploring the idea that individuals with AN experience their bodies as radically objectified. While this, I think, captures some aspects of the disorder, it falls short of capturing that the individual with AN does not experience her body as simply object-like but as something noisy, out of control and threatening. I argue that we should understand an individual with AN as experiencing her body-as-subject as threatened by the visceral demands of the body-as-object and, in order to subjugate these demands, embarks upon a *project of objectifying* the body to assert her dominance and power as a body-as-subject.

Thus, we can conceive of AN not as an attempt to disappear an objectif*ied* body but as a project of bringing the physical body under the command of the subjective one, a project that involves reductively objectify*ing* the body. A project that, eventually, reverses, rendering the individual at the beck-and-call of her obsessive habits. By bringing in Leder's visceral body, the account I put forward helps us move beyond a static account of AN towards an account which outlines the various stages and bodily experiences of AN as the disorder progresses.

4.1. AN as radical objectification

In section 3, we saw how experiences of objectification involve a conflict between the body-as-object and the body-as-subject. Objectification is marked by feelings of the body as object-like; its physicality comes to the forefront of the subject's attention. Given that individuals with AN often report feeling their bodies as overly present and visible to others, this might seem like a good characterisation of the experience of AN. Rather than the experience of the body-as-object being an aberrant way of experiencing their bodies, it is their dominant form of bodily experience.

Bowden (2012, p.233), for instance, claims that the body in AN is experienced in a similar way to how the body is experienced in cases of objectification under the gaze of the Other: “In AN, just as with shame, the body is experienced as object-like and overly present”. She suggests that because of this objectification, an individual with AN does not identify with her body: “the experience of the body is of an extra, unwanted appendage, that she is separated from and that seems to be an obstacle in her movements” (ibid., p.234). Like in shame, the experience of the body as primarily object-like is disruptive to the body-as-subject and its goals. What is more, by adopting a reflective stance on one’s body-as-object, such as through body-checking or mirror-gazing, the individual with AN might be said to contribute to her experience of the body primarily as object-like (Legrand 2010a).

However, the idea that individuals with AN experience their bodies as pathologically objectified raises some questions. The most obvious being, what is meant by objectification? Unfortunately, this is a term that is often used without precise definition. Bowden, for example, talks of objectification in terms of experiencing the body as ‘object-like’. Yet, as we have already explored, experiencing the body as a physical object in the world is part of normal experience. It is possible to experience the body-as-object without experiencing it as devoid of subjectivity, or as reducible to merely an object (Legrand & Ravn 2009; Legrand 2010a; Papadiki 2010). Moreover, experiencing one’s body as object-like is not always disruptive or unpleasant; for example, when dancing or when experiencing sexual pleasure (Legrand & Ravn 2009). Borrowing Papadiki’s term, these instances can be described as “non-reductive objectification” (2010, p.32).

It appears unlikely that Bowden means objectification in this sense as she is claiming that an individual with AN experiences her body as object-like in a

problematic manner. It seems, then, that radical objectification is intended as "reductive objectification" (Papadiki 2010, 32); objectification through which the body is experienced as an object devoid of any degree of subjectivity, as an *inert* object.

Yet, describing an individual with AN as experiencing her body as an *inert* object seems to overlook reports of individuals with AN experiencing their bodies as dangerous, that they fear the biological urges of their bodies, that they experience hunger as a base need. Hornbacher describes her body as being threatening, as something that needs to be controlled, and of her aim to overcome the physical desires and needs of her body. This is not a picture of the body as something inert, that simply gets in the way of the body-as-subject, but as something that places demands on the subject. These descriptions match descriptions not just of the body-as-object but of its visceral dimension in particular. On Hornbacher's account, it seems that experiencing the body as demanding and threatening is what prompts the individual with AN to pursue self-starvation. This hints at the idea that she does not simply experience her body *as objectified* but embarks upon a *project of objectifying* the body, via self-starvation, in order to silence the demands of the visceral body.

Additionally, the radical objectification approach, as it is currently articulated, also risks presenting a static account of AN which fails to do justice to the development of the disorder. For example, it is not clear from Bowden's paper if she intends to make a distinction between experience of AN in the early and later stages of AN nor whether radical objectification is a constant feature of AN or not. I suggest that we can enrich the account of how an individual with AN experiences her body by building in Leder's conception of the visceral body.

4.2. AN as radical bodily-control

What Leder's account of the visceral body highlights is that the body-as-object can feature in experience as directly challenging the body-as-subject's autonomy. This threat does not involve the body being experienced simply as an inert object, rather it emerges from a tension between the autonomy of the body-as-subject and the inner demands of the visceral body.

The threatening demands of the body are reflected in reports of individuals with AN in relation to their experience of hunger: "The enemy of anorexic control is appetite. Appetite is the chaos which makes discipline so necessary; appetite is the danger from which ritualised eating tries to protect the self" (MacSween 1993, p.194). Indeed, Hornbacher explicitly states that AN is an attempt to prove that you have no human hunger or needs.

What is more, this is paired with the fact that AN often takes root at times of bodily upheaval such as stress or at the onset of puberty, when the body's voice is at its loudest (and arguably at its least inert): "My body, which I felt unruly to begin with, suddenly did what I always feared it would do; it defected, without my permission, and without warning, my body began to "bloom"" (Hornbacher 1999, p.40). The visceral body does not only intrude on the body-as-subject through experiences of hunger, but also through uncomfortable, negative feelings that the individual experiences as outside her control, e.g. stress, shame, bodily changes during puberty and menopause. This visceral clamouring of disruptive and intrusive feelings leads the individual not to experience their body as simply an object but as noisily making demands from the body-as-subject and challenging the body-as-subject's autonomy.

By introducing the notion of the visceral body, we can capture how the physical body threatens the body-as-subject. What leads to the 'dis-ease' at the onset of AN is precisely that the body-as-object is not simply experienced as object-like, inert and controllable. Instead, the unpredictability of the body-as-object, its demanding "I must", is experienced as threatening the body-as-subject. Self-starvation, then, is the "magic solution" (Lester 1997, p.487). By refusing to give in to the visceral body's invasive demands, the body-as-subject reasserts control. Moreover, by asserting control over this visceral dimension of the body-as-object, by denying the autonomy of the body-as-object, we can conceive of the individual with AN as attempting to reduce the body-as-object to its purely physical, object-like dimensions. Therefore, the act of self-starvation itself can be understood as an *objectifying act* in the sense that it diminishes the threatening demands of the body.

Note that self-starvation does not simply get rid of the demand for food. Rather, the individual with AN takes control over that hunger; she dictates how and what the body feels. Hunger is experienced as a result of the body-as-subject's refusal to eat (at least in the earlier stages of AN). Instead of experiencing hunger as a challenging voice, hunger becomes an affirmation of the individual's own power over her visceral body. The very meaning of hunger is transformed, where hunger is no longer experienced as negatively valenced but as a felt reward (cf. Gillet 2009). The body-as-subject, therefore, exerts control over the visceral body, transforming its threatening demands into a validation of the subject's successful project of self-starvation. As Charland et al (2013) argue, the project of AN becomes a filter through which the individual interprets her world. Hunger takes on a new meaning in this evaluative framework as a sign of felt success.

Moreover, by turning attention to the self-inflicted feeling of starvation, other feelings (such as stress, shame, and other negative emotions) fade into the background.[vii] Thus, the visceral dimension of the body-as-object is robbed of its clamouring voice, allowing the body-as-subject to experience full agency. This also captures why thinness might not be the main goal but is still valued; thinness, in this project of bodily control, becomes a sign of success, visual proof of the body-as-self overcoming the demands of the body-as-object.

The individual with AN 'co-opts' the voice of the visceral body, making it her own. In this way, she overcomes the body-as-object's demanding and threatening nature, turning it into an object over which she has control. What this approach captures is that the individual with AN does not simply experience being alienated from her own body but that the project of self-starvation aims to reconcile the deep-felt conflict between the body-as-subject and the body-as-object's visceral dimensions. Starvation is not an attempt to get rid of the body, but to bring the physical body into line; for the quiet body-as-object can disappear into the background as she seamlessly engages with the world as a body-as-subject - a "walking brain", as Hornbacher (1999, 108) puts it. If the individual with AN were to experience a complete separation between herself and her body-as-object, we might expect symptoms that more closely match that of depersonalisation, where an individual denies that their body belongs to them anymore, rather than the tension experienced by individuals with AN.

By taking over the demands of the visceral body and rendering them an affirmation of the body-as-subject's own power, we can understand how AN is "most particularly in the early phases, experienced as a productive and empowering state" (Warin 2004, p.101). If we construe AN as a passive experience of objectification,

something that just happens to the subject, this feeling of empowerment seems unwarranted. By placing objectification in the hands of the individual subject we capture how self-starvation is an act of bodily control exercised by the person herself.

As emphasised in section 2, this *project* of control need not be conceived of in terms of a cognitive, cold project but rather as a habitual, pre-reflective set of embodied practices that the individual with AN adopts in response to the intolerable tension she experiences between her body-as-subject and body-as-object. These practices of control can also be supported, driven and scaffolded by the world around her. For instance, "developing complex, excessively intricate eating rituals (supported by various artifacts and technologies) intended to slow down the eating process and minimize consumption; regularly inhabiting online spaces (pro-anorexic websites, blogs, social media, or chat groups; image-blogging platforms like Instagram and Tumblr) for tips, strategies, inspiration, or emotional support" (Krueger & Osler forthcoming, p.5). Self-starvation, then, becomes a habitual way of being-in-the-world, supported by her world. That this project of control is not simply a faulty belief or set of judgements has important therapeutic implications as I shall explore below.

However, the project of reductively objectifying the body involves attending to the body-as-object constantly. The individual with AN continuously monitors her bodily sensations (feeling her hunger, for example) - as Hornbacher notes, she starts to *need* hunger. She also compulsively scrutinizes and weighs herself. This self-monitoring does not lead to the body-as-subject seamlessly engaging with the world but obsessively turning her gaze to her body-as-object. As such, in attempting to

take control of the body-as-object's visceral threats, she exactly prevents her body-as-object smoothly disappearing into the background.

While the project of radical body-control might start out as an attempt to control the demands of the body-as-object, AN is often marked by a reversal of this situation. Ultimately, her magical solution betrays her; "[t]he individual's use of dieting, exercise, and the like to exert control, to stabilize identity and security, lead precisely to a destabilization of these as the illness progresses" (Leder 2013, p.93). These practices become habitualised and sedimented in her way of being-in-the-world.

As AN progresses, the starving body reasserts its own control, leading the patient with AN to fixate on thoughts of food and the body. Consequently, "the original goal of the self-project [is] lost in a mire of obsession and apparently "irrational" fears" (Lester 1997, p.487). The sad irony embedded in AN is that the project of objectification, which at first liberates the body-as-subject from the demands of the visceral body, comes to constrain the subject even further. The hunger, which the individual feared and then valued, becomes all-consuming; it is constantly felt, constantly attended to, and dictates how the individual with AN engages with the world. Her world collapses into a world that entirely circles around her body-as-object and obsessive thoughts of food; her project of control, of empowerment, eventually disempowers her.

If the idea of self-starvation as a bodily project of control has some traction, I suggest that we can conceive of the lived experience of AN as broadly progressing along the following lines:

i. The individual experiences the tension between body-as-object and body-as-subject, which is part of normal embodied experience, as intolerable. The

body-as-object is experienced as threatening, not simply because it is object-like, but because of the demands of the visceral body. It makes demands of the individual with AN, constantly reminding her she is under its control, hindering her easy engagement with the world as a body-as-subject.

ii. In an effort to control the body-as-object, and thus preserve the autonomy of the body-as-subject, the individual with AN refuses to eat. Self-starvation involves denying the visceral needs of the body-as-object and taking control of what the body feels. In the early stages, she experiences self-starvation and her reductive objectification of the body-as-object as empowering. While the body-as-object is not silenced, sensations such as hunger are experienced not as invasive commands of the body-as-object but as an affirmation of the body-as-subject's successful project. Additionally, other troubling feelings are drowned out by the constant ebb of hunger. By robbing the body-as-subject of its voice, the individual with AN attempts to reduce the body-as-object to the status of inert object.

iii. However, the project of objectification contains the seeds of its own destruction. As the body is increasingly experienced as object-like, for instance through constant self-monitoring, the individual with AN loses her ability to engage with the world through her body-as-subject and feels increasingly alienated from her body and the world. Moreover, the ritualised practices of her project of self-starvation (such as food rituals, body-checking and body-weighing, constantly thinking about calorie intake) themselves

become habitual; rather than being an project that she is in control of, the project becomes her normal, inflexible way of being-in-the-world.

iv. Finally, the starved body reasserts its own control, reducing the individual to obsessive thoughts of food and the body, rendering her out of control.

Note that these steps are not intended to be clear-cut; people can progress through some (and not all) of these stages, go through periods with and without self-starvation, and, crucially, some may experience other aspects of the disorder as more prevalent than those I have highlighted here. However, what I have attempted to do here is do justice to the common experience of AN as a project of bodily control.

Based upon the classic distinctions found in phenomenology of embodiment, as well as Leder's conception of the visceral body, the seemingly paradoxical project of self-destruction as self-preservation can be reconceived as a project of control enacted by a body-as-subject over a threatening body-as-object. This seems to do justice to the first-person reports of AN as a bid for control and strength. Moreover, by focusing upon lived experience of the individual with AN, the account can present AN as a disorder of stages; this means AN can be understood as a project of control that eventually leads to the patient losing control, without falling into contradiction.

4.3. A note on the (dis)embodied self

It might strike some that Hornbacher's description of AN might well be taken as showing that the individual seeks to *destroy* her physical body entirely in order to reach a purely disembodied mind; that the attitude of those with AN is marked by a radical Cartesianism (e.g. Bordo 1992; Bruch 1978). Such a reading renders the

phenomenological distinction between body-as-object and body-as-subject unnecessary for analysing AN.

While this theory of *dis*embodiment might initially seem promising, as it captures how the individual with AN privileges her subjectivity over her physicality, I do not think that it can adequately capture the nature of the conflict in AN. As discussed throughout this paper, the individual with AN does not appear to experience her body as something totally devoid of subjectivity. Quite the contrary, it is the experience of the body-as-object as having an autonomous voice, demands and needs which disrupts the individual's experience as body-as-subject that seems to be the source of the tension. As Lester concisely puts it, it seems that "anorexia springs from the all-too-painful realization that I am my body" (1997, p.485).

Indeed, the individual with AN is consumed with thoughts about her body, she finds it suspicious, treats it as a threat to her sense of self. I suggest that it is precisely because the physical body is experienced as *her* body, as part of *her* self, that it can pose such a threat. Only by experiencing her physical body as hers can she experience it as encroaching on her subjectivity. On the same reasoning, it seems that the self that she experiences as being threatened is a bodily-self, otherwise the workings of the physical body would not be seen as somehow intruding upon the subjective realm; only a bodily-self can be threatened by a bodily-object. As such, I suggest that the experience and conflict of AN must play out on the stage of bodily experience.

Moreover, if we treat the individual with AN as seeking *dis*embodiment through the destruction of the physical body, it is perplexing why the *early stages* of AN give rise to the feelings of empowerment, strength and control. Instead, we would expect this sense of empowerment to increase as the individual's body wastes away,

becomes closer to 'disappearing'. Yet, this experience of empowerment and strength, though marking the early 'honeymoon' stage, seems to evaporate as the individual becomes subject to obsessive thoughts about food and the body. As I have emphasised, what individuals with AN are attempting to disappear is the body's noisy, disruptive demands, not the body as a whole.

5. Therapeutic implications

Providing a detailed account of the lived experience of bodily experience in AN has certain implications for treatment. Cognitive Behavioural Therapy (CBT) is the most widely used form of therapy for psychiatric disorders (Škodlar et al. 2013) and is often used to treat patients with AN. CBT is a top-down approach that seeks to reconfigure faulty or disruptive thoughts, beliefs and judgements. The thought being that if one can identify the 'faulty' thinking of a patient, this can be readdressed cognitively. We can see how the CBT model fits with an understanding of AN based upon distorted body image, for it might seem well-suited for targeting and addressing misjudgements or misperceptions about body image, weight, shape or size. However, if, as I have argued, taking distorted body image as *the* central characteristic of AN results in other key aspects of bodily experience to be left to one side, then therapy orientated around righting a distorted body image may fail to deal with the crux of the disorder.

While I am not denying that CBT may work well for some individuals with AN, there is a concern that this cognitive approach leaves aside the lived bodily dynamics of the patient. In this paper, I have highlighted how the distrust and dis-ease with her material body arises out of a *felt conflict* between the needs of the visceral body and the autonomy and agency of the body-as-subject. The individual's

need to assert control over her material body does not arise from a false belief, faulty thinking or a misjudgement about her body but from a deeply felt, affective disruption at the level of her bodily experience. As Charland et al. (2013, p. 361) point out, “the cognitive lens through which so much mental disorder is seen may be distorting our perspective too much toward beliefs and rational analysis, at the expense of the affective aspects”.

If we understand AN as involving a disruption in bodily experience, then therapy which attempts to alter the patient’s bodily dynamics may well be appropriate. Body-orientated therapy that attempts to reharmonize the individual’s body-as-subject, body-as-object and visceral body is a bottom-up approach that addresses the bodily disturbance of AN. Maiese (2016) describes bottom-up therapy as “centering on bodily engagement in such a way that it shifts bodily dynamics and feelings, so as to allow not only for significant changes in cognition and patterns of thought, but also for significant changes in embodied affect and emotion” (p. 235).

Body-orientated therapeutic techniques include, among others, dance therapy, movement therapy, yoga therapy, music therapy and animal therapy, and have been suggested for the treatment of multiple disorders such as schizophrenia (Maiese 2016), depression (Michalak et al. 2012) and autism (Krueger & Maiese 2018). However, given that obsessive exercise to control weight is a classic symptom of AN, particular care must be taken when recommending exercise-based treatment for individuals with AN. Such treatment should, perhaps, focus on how the body feels during gentle movement and not encourage over-exertion. Yoga, for instance, has been used effectively in treatment of schizophrenia as a method of restoring “bodily attunement, so that their sense of ownership and agency begin to be reinstated” (Maiese 2016, 241). If AN is marked by a clash between different

dimensions of bodily experience, such body-orientated therapies may help reintegrate these dimensions in the AN patient's experience. Through gentle movement, individuals can be encouraged to use their bodies in a way that does not reductively objectify them but allows the objective body to be experienced either as something pleasurable (Legrand & Ravn 2009) or as something that can smoothly disappear into the background (Leder 2013).

In addition to recognising the lived bodily dynamics of those with AN, if, as I have suggested, the project of controlling the noisy body is also supported, driven and scaffolded by the individual's world, therapeutic interventions should also be sensitive not only to the patient's lived bodily experience but also to how her environment and habits contribute to the disorder. Looking beyond the cognitive beliefs and judgements of such patients allows for more holistic, and potentially more sustainable, forms of treatment.

Treatment that attempts to 'normalize' bodily experience must be sensitive to what the patient's current bodily experience actually is. As I have shown, the bodily experience changes at different stages of AN. Depending on what stage the particular individual is at is likely to affect what treatment is appropriate and effective. Therapeutic approaches should, then, be sensitive to the temporality of AN and accommodate this into treatment plans. This applies not only at the moment of diagnosis but involves recognising that different treatment methods may be necessary at different stages of the treatment process.

Given the emphasis I have placed on AN as a bodily project of control, when considering therapeutic methods, we should also raise the question of how individuals with AN should be involved in their own recovery. As Carter et al. (2004) note, patients with AN are rarely consulted about what they expect or what they want

from therapy. Many therapeutic approaches involve subjecting patients to a strict regime of eating, weight gain and constant measurement. If we see AN as a desperate grapple for bodily self-control, then this style of therapy should strike us as counter-productive; it threatens to place the individual as not just a slave to her bodily drives but to other people as well. Tan et al. (2010) detail how "patients with anorexia nervosa reported considerable experience of compulsion and restriction of choice" (p.18) even when formal, compulsory treatment was not being administered, as well as highlighting that most participants "thought that going through treatment and achieving recovery required some degree of consent and cooperation" (p.16). Moreover, the constant measuring of her body, which incidentally mirrors the patient's own body monitoring behaviour, might add to her experience of her body-as-object as objectified. Such approaches, therefore, might contribute to, rather than solve, the problem at the root of the disorder.

Conclusion

Rather than primarily approaching bodily experience of AN in terms of distorted body image, a phenomenological approach to AN offers an understanding of AN that does greater justice to the bodily experience of individuals with AN. By introducing the distinction made in the phenomenology of embodiment between the body-as-subject, the body-as-object and the visceral body, I have suggested that we can conceive of an individual's self-starvation, an act of self-destruction, as an act of self-preservation; the individual seeks to control the visceral body through self-starvation, an act of the body-as-subject.

While the different bodily dimensions can come into conflict with one another in everyday experience, especially in instances of objectification and in relation to the

body's visceral demands, the individual with AN does not just experience this as a *tension* but as an unbearable encroachment of the body-as-object into the subjective realm of the body-as-subject. Based on this view, I have presented the idea that the individual does not simply experience her body *as objectified* but embarks upon a project *of reductively objectifying* the body, via self-starvation, in order to take control over the demands of the visceral body.

This project of bodily control is embarked upon with the aim of being able to smoothly engage with the world as body-as-subject, where the body-as-object fades into the background. However, in carrying out the project (and seeking signs of her success), she is subject to constant hunger, to compulsive body-monitoring and obsessive thoughts about food. Thus, the project of AN, the individual's bid for power, ultimately robs her of power as she becomes uncontrollably obsessed with food and her body, rendering her body-as-object as more salient, rather than less so.

I want to end by re-emphasising that this account of AN as a project of bodily control, that progresses through various stages, is not offered as an exhaustive account. Many other factors come into play and, as a result of focusing in on the themes of control, self-preservation and hunger, I have downplayed other aspects of the experience of AN. In particular, while I have placed control at the centre of my account, I have focused upon how the individual experiences her body's visceral nature as disruptive to her sense of autonomy and said next-to-nothing about how others come into the picture. As discussed in section 3, Sartre highlights how the gaze of others can also lead to us experiencing ourselves as vulnerable and subject to others. When this occurs, Sartre describes how we not only experience ourselves as a body-as-object but also as a body-for-others. This feeling of being subject to the other's gaze is another way in which an individual with AN may experience her body

as outside of her control (see Legrand & Briend 2015). Indeed, Englebert et al. (2018) suggest that one way in which individuals with AN seek to avoid having control exerted over them by others, is to adopt food-practices where they are in control of providing food for others, thus ensuring they are not submitted to external command and vulnerability. There are, then, additional aspects of the experience of AN that relate to experiences of being out of control and additional behavioural patterns adopted to reassert a sense of control. Developing these intersubjective aspects would complement and greatly enrich the account I have put forward here.[viii]

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[i] There is also a broader epistemic point here to be considered about which reports of AN should be believed. Addressing this concern, though important, goes beyond the scope of this paper.

[ii] Due to the high prevalence of AN in women, I will use the pronoun 'her' throughout this paper.

[iii] This focus on disturbed body image also permeates discussions of bulimia (see Cash & Brown 1987, Cash & Pruzinsky 2004) and muscle dysmorphia (e.g. Pope et al. 1997).

[iv] This emphasis on measurable symptoms might not be unique to AN. Carel (2016) argues that illness is chiefly approached from the point of view of the doctor.

[v] Thank you to the blind reviewer who helpfully drew my attention to Charland et al.'s complementary framework.

[vi] Thank you to the blind reviewer who brought this point to my attention.

[vii] It might be profitable to compare self-starvation to self-harm, which also uses the infliction of a deliberate intense sensation (i.e. pain) to block out uncomfortable and uncontrollable feelings.

[viii] Thank you to the blind reviewer who brought highlighted the role of intersubjectivity in AN.