CHRISTIAN WOMEN, ANOREXIA AND THEOLOGICAL RESPONSES:

AN EXPLORATION OF LIVED EXPERIENCE

By

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ABSTRACT

This thesis argues that, for Christian women with anorexia nervosa, there is a distinct interplay between their religious beliefs and their eating disorder. This interplay can be both negative, in the sense that religious beliefs can be interpreted so as to motivate eating disordered behaviour; or positive, in the sense that faith can motivate recovery. Furthermore, pastoral care provided by well-meaning clergy and faith groups can be either an extraordinary support to aid recovery when done well, or immensely damaging if done badly.

This thesis is based on a qualitative Grounded Theory study into the way in which Christian women understand the relationship between their faith and their eating disorders. Through semi-structured interviews with nine women, I explore their lived experiences of anorexia and Christian faith. The study was approved by an NHS Research Ethics Committee and undertaken in partnership with Birmingham and Solihull Mental Health Foundation Trust.

Several themes emerge from the narratives relating to the lived experiences of Christian women with anorexia. Of these, four key themes are explored in depth in this thesis: Anorexia: Sickness or Sin?; Images of God; Models of Christian Femininity; and Pastoral Care. Finally, this thesis responds to a gap in pastoral care practice and research by offering an initial framework which could form the basis for a model of chaplaincy care for sufferers of anorexia nervosa, both in inpatient treatment and in the community.

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CONTENTS

CHAPTER 1: INTRODUCTION

1.1.1. BACKGROUND AND RATIONALE

This thesis arose initially from my experience with anorexia as a Christian woman. At 18 I developed anorexia nervosa and became seriously ill; a year later I was hospitalised for three months. At that time, I was reading Theology at Oxford University, and became aware whilst studying the Old Testament in the hospital common room that a disproportionate number of my fellow patients had a Christian faith or Christian upbringing.

Sitting in that room with a pile of theology books trying to write essays was a catalyst for a number of conversations about faith and eating disorders with other inpatients. I discovered some felt guilt for not being able to recover from their eating disorder. Several were terrified of Communion, lest the calories in the bread and wine tip them over the edge of their meagre calorie count for the day. Some were desperate to go to church but were not allowed to leave the ward until they reached a certain weight. Many of us – myself included – went to church as one of our first permitted leaves from hospital. Of all the things in the world (or, within Oxford) we wanted to do, many of us most wanted to go to church.

During my illness, I experienced both wonderful and terrible pastoral care from churches. Whilst in hospital, my friends from Christian groups showed me what the compassion of Christ looked like, bringing me things, phoning me each day and visiting

and praying with me each week. They were the ones who always came, even though I was terrible company at that point. They were the ones who never gave up on me.

Like many women in my study, I was told to 'pray my way out of it' by well-meaning church members. I was told I 'looked great' when I really didn't. I remember one occasion when a well-meaning and beloved pastor prayed with me, and asked God that I would 'gain weight quickly'. I hoped and prayed (literally!) that God would listen to my 'cancelling out' prayer! I had people from church try to feed me up. I also had unending support from my house group[1] over the following years whenever I relapsed. For all the comments I received from members of the church – helpful and really quite damaging – every single one was said in love.

I have not included my own story in the narratives or data analysis, although I would fit the participant criteria. However, it would be foolish to think that my own story and experiences have not impacted on the data. I am a liberal Methodist, a chaplain and a recovered anorexic: these parts of me will have informed the questions I asked, the ways I understand other people's stories and the elements I have emphasised. This is one reason why I have written each woman's narrative separately from my comments on it and tried to use their words and phrases in doing so: to allow their voices to come through.

[1] A 'house group' is a smaller community or sub-group of church members who meet regularly to share in food, prayer and Bible study. They are common in many Protestant churches. The Methodist Church runs a system of 'house groups' or 'pastoral groups'.

I began this work from my own experience and anecdotal evidence from healthcare professionals working in eating disorders treatment. Professionals I spoke with corroborated my observation that Christians seemed disproportionately represented in treatment and that their difficulties were often bound up with their faith in ways that were both helpful for recovery and unhelpful. As I researched further, I discovered this was indeed a link that has been made, although the exact nature of the connection between Christianity and anorexia is still disputed, as I discuss in 2.3.2.

In 2007 when I was hospitalised, I was one of 4849 patients admitted in England that year for an eating disorder.[2] NHS figures show that the number of hospital admissions for anorexia nervosa[3] (as either a primary or secondary condition) are rising year on year and by 2010-11, there were 7620 admissions. By 2016-17 that had almost doubled to 13,885. Just two years later, in 2018-19, there were 19,040.[4] This is not due to hospitals gaining capacity and taking less seriously ill patients: if anything, we are hearing increasing anecdotal evidence that suggests patients are being turned away as 'not sick enough', although it is unclear whether this is a change on previous years. Substantially

[2] "Admissions for Eating Disorders by sex and ethnic category, England," NHS Digital, last modified November 22 2018, https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/admissions-for-eating-disorders-by-sex-and-ethnic-category-england.

[3] The official name for the illness is 'anorexia nervosa', however it is often abbreviated to simply 'anorexia'. I have used this abbreviation throughout the thesis, and the term 'anorexia' can be taken to refer to the illness 'anorexia nervosa' unless otherwise specified.

[4] "Eating Disorder Hospital Admissions rise sharply," *BBC News,* January 2, 2020, https://www.bbc.co.uk/news/uk-50969174.

over half these admissions are due to anorexia, despite accounting for only 8% of all eating disorders.[5]

Mental ill-health, including eating disorders, is a growing problem in the UK. Statistics from 2018 suggest that there are between 1.25 million (BEAT statistics[6]) and as many as 3.4 million (Priory Group statistics[7]) eating disorder sufferers in the UK. Of anorexia sufferers, 80-90% are women.[8] Although eating disorders in men are on the rise and extremely concerning (approximately 25% of all eating disorder sufferers are male[9]), anorexia is still a feminist issue. Despite anorexia accounting for a small percentage of total eating disorders (approximately 8%[10]), it is the psychiatric illness with the highest mortality rate, some estimates suggesting 10% of sufferers will die prematurely from their illness, with upper estimates of 20%.[11]

This rocketing rate of eating disorders has happened against a backdrop of austerity. A 2019 report by the Royal College of Psychiatrists pointed to failings in adult eating disorders care, citing that many adults wait over 3 years for any treatment.[12] As

[5] "Statistics for journalists," BEAT Eating Disorders, accessed May 28, 2020, https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics.
[6] BEAT, "Statistics."
[7] "Eating Disorder Statistics," Priory Group, accessed May 29, 2020, https://www.priorygroup.com/eating-disorders/eating-disorder-statistics.
[8] Jane Morris and Sara Twaddle, "Anorexia Nervosa," *The BMJ* 334, no.7599 (April 2007): 894-898, https://doi.org/10.1136/bmj.39171.616840.BE.
[9] Priory, "Eating Disorder Statistics."
[10] BEAT, "Statistics."
[11] Jon Arcelus et al., "Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies," *Archives of General Psychiatry* 68, no.7 (July 2011): 724-731.
[12] "Position statement on early intervention for eating disorders," Royal College of Psychiatrists, published May 2019, https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps03_19.pdf?sfvrsn=b1283556_2.

community services are stretched, churches (alongside other services such as schools) step in to try to plug the gaps. The Theos Thinktank produced a report in 2017 on "Christianity and Mental Health: Theology, Activities, Potential,"[13] which offers a comprehensive exploration of church initiatives to support wellbeing and mental health. It also offers a balanced and thoughtful exploration of ways in which the church has failed to support mental health and even damaged wellbeing with examples such as churches rejecting LGB individuals, and the stresses placed on clergy.[14] The report considers initiatives that have worked, and those that have not, and the difficulties of judging the impact of such initiatives.

Despite the increasing body of work on Christianity and mental health in general, both in terms of theory and practical guidance for clergy working in the field, there is rather less relating to Christianity and eating disorders, specifically anorexia. Although the connection between anorexia and spirituality is becoming better documented, there is still a limited amount of work on this in the UK. One gap in the research is the area of practical, pastoral theology and anorexia in the context of the UK healthcare system and the community. It is into this space that this research fits.

[13] Ben Ryan, "Christianity and Mental Health: Theology, Activities, Potential" *Theos* (2017), https://www.theosthinktank.co.uk/cmsfiles/archive/files/Christianity%20and%20Mental%20Health%20FINAL%20COPY%20FOR%20WEB.pdf.
[14] Ryan, "Christianity and Mental Health," 46.

1.1.2. AIMS

My primary aim is twofold: firstly, to discover more about the nature of the connection between Christian faith and anorexia in Christian women. Secondly, to explore what churches and faith organisations could do to support these women, both in inpatient settings and the community in the hope of creating an initial basic framework from which a model of pastoral care for anorexia could be built. Both these aims are pursued through exploration of the lived experiences of Christian women with anorexia and how their faith informs their thought processes and actions, either positively or negatively.

1.2. ORGANISATION OF THESIS

Chapter 2 reviews existing literature in the field. This review was, as befits a Grounded Theory study, undertaken concurrently with the fieldwork detailed in Chapter 3, although due to the need for a rationale for the study for the NHS Ethics Committee, it was necessary to review sufficient literature to justify the study before the fieldwork could commence. The chapter is divided into three main sections: autobiographical literature by Christian women with eating disorders; works on the historic 'holy anorexics' of the medieval era; and finally contemporary research that considers the connection between anorexia and spirituality.

Chapter 3 outlines my fieldwork methodology. It is a qualitative study using aspects of Grounded Theory and carried out through semi-structured interviews with Christian women with either current or historical anorexia. There were two phases to the study: one in an inpatient unit, and a second in the community. This chapter also addresses the

ethical and practical issues posed by such a study. The participant information sheets, consent forms and data analysis can be found in appendices 1-8.

The women's narratives are found in Chapter 4, alongside my reflections on their stories. Due to space constraints, it is impossible to include the narratives of all eight women (the ninth did not want a narrative written for confidentiality reasons) and so I have selected the six narratives of women who have lived in the UK as this is the context on which I am focusing. I did not want to lose the narratives of the remaining two women, and therefore these can be found in appendices 9-10.

In Chapter 5, I have identified four prominent themes from the data and consider each of these in more detail. First, anorexia as sickness or sin? Second, models of Christian femininity and the role these play in developing and maintaining anorexic thoughts and behaviours. Third, images of God and how these changed or remained constant during illness and recovery, and finally, pastoral models, both successful and less successful.

Chapter 6 concludes, offering a summary of what this work adds to extant research, considering limitations and suggesting areas for further research.

CHAPTER 2: LITERATURE REVIEW

2.1.1. AUTOBIOGRAPHICAL ACCOUNTS: AN INTRODUCTION

I begin with the lived experiences of Christian women with anorexia in autobiographies.[15] The themes found in these acted as a starting point for comparison to the themes which emerged from my fieldwork, and also served as prompts in the semi-structured interviews. [16] The selection criteria were that works must be autobiographical or biographical with an autobiographical element; concerned with an eating disorder; and specifically include reflections on the relationship between the author's (or subject's) eating disorder and their Christian faith. I also narrowed the field to UK publications.[17]

There are surprisingly few autobiographical accounts of anorexia and Christian experience published in the UK; the autobiography of Emma Scrivener[18] (a vicar's wife, children's worker, recovered anorexic and Christian blogger), and an academic work by

[15] I have also discussed these autobiographical works in Hannah Stammers, "Towards a Feminist Theology of Liberation from Anorexia Nervosa," *Journal of Academic Perspectives* no.1 (2017).
[16] The inclusion of autobiographical data (i.e. an emic viewpoint) would be justified in a Grounded Theory study. Although I have not included these autobiographical narratives in my data analysis as such, it is justified to use these narratives to develop interview questions in the same way that the earlier interviews in my study also pointed to questions that I could ask in later interviews.
[17] This decision was taken as my fieldwork was to take place in a UK context and to allow a tighter focus. Although Catherine Garrett is Australian and grew up in Geneva, since her book is published in the UK I have included her story. As will be noted from the demographics of the participants, in the event, two participants in phase two were from North America which made for useful comparison, and one had lived in multiple countries including the UK. All were recruited via UK university mailing lists or friends in the UK. The narratives of the two North American participants have been excluded from Chapter 4, but included in the data analysis. The emphasis on Christian women who reflect specifically on the relationship between faith and eating problems (as this is the focus of the thesis) also excludes other autobiographical writers who are prominent in discussions of anorexia in a secular context.
[18] Emma Scrivener, *A New Name: Grace and Healing for Anorexia* (Nottingham: Inter Varsity Press, 2012).

Catherine Garrett (senior lecturer in sociology) which begins with her own narrative of anorexia and spirituality and includes biographies of others.[19] The autobiography of Jo Ind (writer and journalist)[20] also fulfilled the selection criteria, although her book concerns EDNOS[21] with both restrictive and binge tendencies. The similarities in mindset are strikingly similar to those found in anorexia and the themes Ind mentions are similar to both Scrivener's and my own experiences.[22] This justifies inclusion of Ind's narrative. I have also included the story of Catherine Dunbar who died aged 22 from anorexia, written by her mother including excerpts from Catherine's diary. Although the book does not deal specifically with the interaction of faith and eating, there is a strong sense throughout the narrative that Catherine was a deeply religious young woman, shown through her repeated pleas to God (in the prayers written in her diary) to end her suffering.[23]

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[19] Catherine Garrett, *Beyond Anorexia: Spirituality, Narrative and Recovery* (Cambridge: Cambridge University Press, 1998). Garrett's book is based on her own study into recovery from anorexia. Her primary claim is that recovery is key to understanding anorexia and that it is a spiritual experience akin to a religious conversion. She considers anorexia to be an existential or spiritual quest, and that in recovery, the self is reconnected with nature, body and society. Garrett's study is based on her own narrative and interviews with thirty-three other sufferers or former sufferers of anorexia in varying stages of recovery. Her research was conducted in Australia, and participants were recruited by advertisement and were thus self-selecting. The study took place between 1991 and 1996, and was first published in 1998. I have used the term 'sufferers' throughout the thesis rather than the sometimes preferred 'survivors' as firstly, the latter implies that the disease is over, which is often not the case in anorexia, and secondly, to describe patients as 'survivors' implies that the disease is terminal, which is not a discussion for which there is space in this thesis.

[20] Jo Ind, *Fat is a Spiritual Issue* (London: Mowbray, 1993).

[21] Eating Disorder Not Otherwise Specified.

[22] In the simplest possible terms, the thought processes behind the two eating disorders in this case (as shown in the autobiographies of Scrivener and Ind) are very alike; it is simply that the balance of binge versus restrictive phases differs, leading to a less extreme weight loss.

[23] Maureen Dunbar, *Catherine: Story of a Young Girl who died of Anorexia* (London: Penguin Books Ltd, 1986).

2.1.2. BIOGRAPHICAL COMMONALITIES

The resemblances between Ind and Scrivener's accounts are striking in terms of the religious themes they cite as having informed their eating disorders; they are also similar in genre. They come from similar backgrounds. Scrivener grew up in Northern Ireland attending a Presbyterian Church with her family. As a teenager, a friend introduced her to left wing evangelical Christianity. She feared her family would go to hell as they did not believe what this branch of Christianity presented as truth, felt out of control with the experiences of growing up and the pressure of an all-girls grammar school, and succumbed to food abstinence to regain a semblance of self-control.[24] Ind attended a rather dry Protestant Church where her father was church-warden. She too was introduced to evangelical Christianity by a friend, and felt her family were not 'real Christians'. This, combined with the difficulties of being a teenage girl and her parents' messy divorce, trapped her in a cycle of restrictive dieting and compulsive binge-eating.[25]

Garrett argues that anorexia is a form of 'spiritual quest' and that recovery is akin to the spiritual experience of conversion.[26] She strongly believes that more stories of recovery need to be told to enable sufferers to make the turning point required for their own recovery.[27] Although she explicitly states she is not interested in why her research participants became anorexic, she explains her own descent into anorexia and this is

[24] Scrivener, *A New Name,* 33–37.
[25] Ind, *Fat is a Spiritual Issue,* 15–21.
[26] Garrett, *Beyond Anorexia*, 186.
[27] Garrett, *Beyond Anorexia,* 185.

where the similarities between her story and those of Scrivener and Ind become apparent. Garrett too grew up in a Protestant family; her father was a Congregationalist minister. She too dabbled in the evangelical movement as a teenager (but rejected it fairly swiftly). There are traumas in Garrett's early life which would no doubt be identified by some as likely factors in her eating disorder: sexual abuse by a family friend, the death of her mother, a distant father.[28] What is striking is the way she interweaves her experiences with religion into her understanding of her eating disorder. All three women are explicit that their religion was, in some way, a factor in their illness – both negatively in cause, and positively in recovery. This is not to say that had they not been Christian they would not have developed eating disorders; but as Ind remarks: 'I do know that as a praying person the way I imagined God[29] affected the way I saw myself, the world and my eating disorder'.[30] Throughout their narratives, their faith and eating disorders are inextricably interlinked – and this is the point that will form the basis of my thesis. For Christian women with anorexia, faith and anorexia cannot be separated, either in cause or in hope for recovery. If we are to provide effective medical treatment

[28] Garrett, *Beyond Anorexia*, 3–12. Everill and Glenn Waller, "Reported Sexual Abuse and Eating Psychopathology: A Review of the Evidence for a Causal Link", *International Journal of Eating Disorders* 18, no.1 (1995): 1–11; Tamas Treuer et al., "The Impact of Physical and Sexual Abuse on Body Image in Eating Disorders" *European Eating Disorders Review* 13, no.2 (2005): 106–111; Christine Vize and Peter Cooper, "Sexual Abuse in Patients with Eating Disorder, Patient with Depression and Normal Controls: A Comparative Study" *British Journal of Psychiatry* 167, no.1 (1995): 80–85 all consider the causal relationship between sexual abuse and eating disorders. Brian Lask and Rachel Bryant Waugh, *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence, Second Edition,* (Hove: Brunner Routledge, 2000), 70, suggests that between 34% and 83% of eating disorders patients have suffered sexual trauma. Jerica M Berge et al*.,* **"**Family life cycle transitions and the onset of eating disorders: a retrospective grounded theory approach**"** *Journal of Clinical Nursing* 2 (2012): 9-10 discusses the prospect that bereavement can be the trigger for an eating disorder. Margo Maine, *Father Hunger: Fathers, Daughters and the Pursuit of Thinness* (Carlsberg: Gorsze Books, 1991) cited in Lask and Bryant Waugh, *Anorexia Nervosa and Related Eating Disorders,* 68–69 proposes that anorexia develops as a response to the father becoming distanced as the daughter reaches puberty as a subconscious attempt to regain her childlike relationship with her father by returning to her childlike body.

[29] The way in which Ind 'imagined God' will be discussed in more depth later.

[30] Ind, *Fat is a Spiritual Issue*, 11.

this must be recognised and reflected with holistic treatment that includes pastoral and spiritual care.

2.1.3. THEME 1: MIND/BODY DUALISM

Several themes emerged from these accounts. Perhaps the most prevalent was that of mind/body dualisms. Garrett talks of creating a pattern of living that detached her mind from her body, and notes that this theme of 'disconnection' of body/emotion/sexuality and mind/self/spirit was present throughout her research, either explicitly or implicitly. Her participants referred to their selves (or souls) as 'I' and their bodies as 'it'.[31] Ind describes hatred of her body, simply because it was a body; she had an idea that the person is divided into three parts: body, mind and spirit. These are interrelated, but with a definite hierarchy – and body belongs at the bottom. 'Holiness' for her was about not giving into the earthly desires of the body, but allowing it to be directed (i.e. ignored[32]) by the spirit. The desires of the flesh are sin, whereas the desires of the spirit are good.[33] Indeed, her church encouraged believers to 'die to the flesh'.[34] Scrivener is less explicit concerning the role of dualism in cementing feelings of body hatred, but dualisms influence her resistance to recovery. She felt God was not interested in her

[31] Garrett, *Beyond Anorexia*, 148.
[32] Although many would not consider the spirit 'directing' the body to be synonymous to 'ignoring' the body, Ind is clear that this is how she interpreted the need for the spirit to direct the body. To her, the spirit and body were so far separated as to become opposites with mutually exclusive desires: the body had only base desires which would lead to the sins of the flesh, whereas the spirit was pure and holy. She describes her understanding of holiness to be the refusal to give in to her bodily desires: 'I sinned when I gave in to my body's desires and did not allow them to be directed (ignored, squashed, suppressed) by my spirit' Ind, *Fat is a Spiritual Issue,* 76.
[33] Ind, *Fat is a Spiritual Issue,* 75-76.
[34] Ind, *Fat is a Spiritual Issue*, 36. This teaching is based on Romans 8:13 'for if you live according to the flesh you will die; but if by the Spirit you put to death the deeds of the body, you will live'.

body and thus she was within her rights to harm it: 'God owned my soul, but my body was mine'.[35]

2.1.4. THEME 2: SINS OF THE FLESH V. FRUITS OF THE SPIRIT

All three mention this theme as an important factor fuelling their eating disorder. Ind describes her body as a 'ravenous and obsessive beast' whose desires need controlling.[36] She believed her sin was gluttony – a sin of the flesh. The solution, she believed, was to learn to hate the flesh. Only in hindsight did she realise that self-love was never the root cause of her actions.[37] Garrett's story also has an undertone of sin as she lists her faults of selfishness, vanity and so on – strikingly like a reverse 'fruits of the spirit' list.[38] Self-control is 'godlike'[39] and she goes so far as to tie her discovery of self-control to Lenten abstinence.[40]

The concept of sin permeates the narratives, expressed in varying (although inevitably Christian) ways. The classical Pauline and Augustine-inspired language of bondage and weak will is apparent in Ind's and Scrivener's narratives. Scrivener associated 'sin' with her inability to maintain sufficient self-control to restrict her food intake. In retrospect she sees anorexia itself as the sin, and likens 'slavery to sin' to 'slavery to starvation'.[41]

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[35] Scrivener, *A New Name,* 124.
[36] Ind, *Fat is a Spiritual Issue*, 76.
[37] Ind, *Fat is a Spiritual Issue,* 47-48.
[38] Garrett, *Beyond Anorexia,* 7.
[39] Garrett, *Beyond Anorexia,* 3.
[40] Garrett, *Beyond Anorexia*, 5.
[41] Scrivener, *A New Name,* 121.

Ind believed that becoming godlike meant cultivating willpower. Holiness was about following strict rules; which she felt she continued to break. Her repentance felt inauthentic as she returned to confess the same sin every day. Her daily prayer of confession turned into a meditation on her own weak will and her prayers of confession became entirely about her eating habits.

2.1.5. THEME 3: IDENTITY: THE 'PERFECT' CHRISTIAN WOMAN

The language of bondage and shackles reappears in Ind's narrative relating to her struggle with the tensions between her identity and the identity she felt her religion was imposing on her. She describes the difficulty she had in accepting the Christian Union's teaching that wives should submit to their husbands; that 'good girls' do not date non-Christians; that kissing is only for when you have prayed together and made a commitment.[42] She could not reconcile her identities as an evangelical Christian and a feminist socialist. She describes her non-Christian friends as 'liberated' and does not want to 'offer them the bonds and shackles of religion'. [43]

These shackles revolve around three main issues: the requirement to be good; the image of the ideal Christian woman; and the Church's attitude towards sex. The first I have briefly addressed in 2.1.4 in the context of sin. The second, the image of a 'Christian woman' is something that both Ind and Scrivener find difficult. Ind describes 'Super

[42] Ind, *Fat is a Spiritual Issue,* 35.
[43] Ind, *Fat is a Spiritual Issue,* 25, 87.

Christian'; an image of ideal Christian femininity and role model for girls – nurturing, gentle, prayerful, in a Laura Ashley dress and always with a Bible at the ready. Super Christian is the perfect girlfriend but never appears 'sexy'. Ind struggles to relate to such a figure.[44] Scrivener has similar concerns, magnified in her role as vicar's wife. She is meant to be an 'all-feminine, all-fragrant dispenser of wisdom, hospitality and traybakes' but cannot envisage herself in this identity.[45] Both images seem to reflect the unattainable role models presented for young women in both Church and secular society. In secular society, media images of the 'perfect' woman abound,[46] and for centuries the Roman Catholic Church has made their main female role model for women someone who is both a virgin and a mother. These are impossible ideals which women can never achieve, creating feelings of guilt and inadequacy.

2.1.6. THEME 4: SEXUAL PURITY

Religious language and ideas around bodies and sexuality cause nervousness about the body and appetites, particularly the sexual body. There is a well-respected school of thought amongst psychiatrists that one factor (among others) in developing anorexia can be a rejection of a sexual body; a girl starves herself to avoid her body developing,

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[44] Ind, *Fat is a Spiritual Issue,* 52-53.
[45] Scrivener, *A New Name,* 118.
[46] For example: 'Are you beach body ready?' by Protein World depicts a bikini-clad who conforms to the Western stereotype of a (physically) 'perfect' body. This advert was met with outrage, and the UK Eating Disorder charity, B-EAT pushed for an investigation by the Advertising Standards Agency 'Beach Body Ready Advert Not Offensive, Rules Watchdog', *BBC News,* July 1, 2015, http://www.bbc.co.uk/news/uk-33340301 . Such images are also described by Naomi Wolf who coins the term 'media woman' to describe the ideal white Western woman: Naomi Wolf, *The Beauty Myth* (London: Chatto and Windus, 1990). Ideal images of women vary from culture to culture, and some of these role models are explored in Rosalind Gill and Christina Scharff, eds., *New Femininities: Postfeminism, Neoliberalism and Subjectivity* (Hampshire: Palgrave Macmillan, 2013).

either as a response to sexual abuse or as part of a fear of growing up.[47] For Ind and Scrivener, the Church's silence on the matter of sex (other than to say 'don't' and to link it with the sinful desires of the flesh, teenage pregnancy and subsequent residence in hell) leaves them unsure how to cope with their sexual bodies. Ind realises in hindsight that by compulsive eating she was avoiding accepting her own sexual body. The implication of Church teaching was that to be holy, one needed to be pure – i.e. non-sexual – and deny the desires and natural impulses of the body.[48]

This requirement for purity is reflected in terms of cleansing from sin. Scrivener describes how by starving herself she could feel 'clean'[49] and Garrett speaks of purging herself of faults.[50] Two of Garrett's participants also speak of a need to 'purify' themselves through punishment and sacrifice.[51] Although sin is not exclusive to sex, the dualisms of body/spirit; sex/chastity; sin/purity are telling: sex and bodily appetites are linked to sin.

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[47] Walter Vandereycken and Ron van Deth, *From Fasting Saints to Anorexic Girls: The History of Self-Starvation,* (London: Athlone Press, 1994), 3. The authors (a psychiatrist and psychologist respectively) describe the views held by psychiatrists as to the aetiology of anorexia based on their own experience working in the field. They do not cite any sources, however this theory is widely held in the field. For a select number of sources supporting their claim, see footnote 28.

[48] Ind, *Fat is a Spiritual Issue,* 63–66.

[49] Scrivener, *A New Name*, 66.

[50] Garrett, *Beyond Anorexia*, 7.

[51] Garrett, *Beyond Anorexia,* 96,134.

2.1.7. THEME 5: SAINTS AND DEMONS

This language of penance is reminiscent of the medieval ascetic saints, and it is notable that both Garrett and Scrivener found them inspirational in their fasting.[52] Neither specify particular saints: Scrivener merely refers to those who fasted 'in godly isolation, far removed from the chaotic desires of body and world'[53] and Garrett mentions an unnamed book of ten saints' stories, describing those who tortured their bodies as her 'heroes' who were 'serene in their suffering'.[54] She later describes being deeply moved and weeping at a visit to the relics of St. Clare of Assisi, a famous ascetic.[55]

It is worth mentioning here the story of Catherine Dunbar. Maureen Dunbar describes the spiritual support given to Catherine, a devoted Roman Catholic, by the parish priests and Sister Marie (a nun who had taught at Catherine's school). On Christmas Eve, a few weeks before her death, Father John told Catherine the story of Clare of Assisi and she found comfort in the story of a saint who had once lain critically ill in her cell on Christmas Eve longing to attend Midnight Mass. Catherine's faith is mentioned frequently as a source of comfort and strength to her – and at times, perhaps even fear. On 10th March 1978 she wrote in her diary that she would commit suicide if it were not for her faith; but she believed that 'it would be the devil' at work if she were to do so.[56]

[52] Garrett, *Beyond Anorexia,* 5 and Scrivener, *A New Name*, 56.
[53] Scrivener, *A New Name*, 56.
[54] Garrett, *Beyond Anorexia,* 5.
[55] Garrett, *Beyond Anorexia,* 13.
[56] Dunbar, *Catherine,* 32.

One incident that stands out in Catherine's story is told by Sister Marie. One night in hospital, Catherine felt a force of evil and said 'the devil is here'. Sister Marie claims she sensed a malevolent force alongside Catherine, and performed some form of exorcism, commanding the force to leave followed by prayers of healing, a pattern repeated several times over the next few days.[57] I include this incident for three reasons: firstly, many anorexics speak of a demon-like presence or voice who seems to take over. It seems significant that a Christian with anorexia should equate this force or being with the devil. Secondly, the practice of exorcism in the treatment of anorexia still continues today.[58] Finally, Catherine's fear of devil possession is reminiscent of stories of ascetic saints who forced themselves to eat to convince those watching over them that they were not fed by the devil at night.

2.1.8. THEME 6: IDOLATRY

Language of idolatry is prominent in the narratives; Ind believes her 'idol' is her stomach,[59] for Scrivener the idol is anorexia itself, asking: 'is this sickness, or is it sin?'[60] Scrivener describes the 'goddess Anorexia' viewing anorexia as a religion in itself: 'Like any religion, anorexia is built on a mountain of beliefs about what constitutes life and

[57] Dunbar, *Catherine,* 76.
[58] An example of this practice continuing is the report of an (unnamed) Spanish priest carrying out thirteen exorcisms on a girl with anorexia at the request of her parents who believed her to be demon-possessed. Ashifa Kassan, "Priest Questioned over Alleged 13 Exorcisms of Anorexic Teenager," *The Guardian,* March 20, 2015, http://www.theguardian.com/world/2015/mar/20/priest-court-exorcisms-teenage-girl-anorexia-spain.
[59] Ind, *Fat is a Spiritual Issue,* 34.
[60] Scrivener, *A New Name,* 15.

death, salvation and sin, shame and redemption.'[61] In the 'religion of Anorexia', sin is synonymous with lack of self-control. Fat is what makes one unclean and separate from the ideal (the goddess). The illness is, for her, a spiritual problem. The differences between Christianity and the 'religion Anorexia' become even more obvious when it comes to atonement: Whereas in Christianity, Christ atones for sins, in Anorexia, the victim atones for her own by punishing her body. She strives to overcome her own fallibility. Christ's broken body is replaced with her own.[62]

2.1.9. THEME 7: REDEMPTION BY WORK ETHIC

Both Scrivener and Garrett identify a 'work ethic' or 'Protestant perfectionism' as a factor in their eating disorders. It is ironic that in the Protestant tradition that began from *sola fide*, the subliminal message all three women have received is that of rules, strict morality and good deeds. Scrivener speaks of the need to 'fix' her mistakes and being 'beyond redemption'.[63] Repentance is about fear, pride, self-will and DIY salvation. The Protestant work ethic merges into the religion of the goddess Anorexia, where individuals must save themselves – it is their work, their self-control that matters. It is, as Garrett describes it, a spiritual quest for salvation.[64] However, Anorexia is

[61] Scrivener, *A New Name,* 83.
[62] Scrivener, *A New Name,* 83. A more in-depth exploration of 'Pro-Ana Religion' can be found in my previous work: Hannah Stammers, "The Theological Language of Anorexia Nervosa: An Argument for Greater Rapprochement between Chaplains and Physicians," *Feminist Theology* 28, no.3 (May 2020): 282-296.
[63] Scrivener, *A New Name,* 95.
[64] Garrett, *Beyond Anorexia*, 186.

deceptive, and instead of leading to salvation, she leads to hell. As Scrivener writes: '"Life" is what the disorder promises. Death, you see, is just a side effect'. [65]

2.1.10. THEME 8: IMAGES OF GOD

A final concern is the authors' concepts of God. Ind notes that she found it hard to relate to God, and believed God could not relate to her. She perceived God as masculine with 'masculine' stereotypes and values: spirit rather than flesh, strong, self-controlled and judgemental. She writes that this seemed the antithesis of her own feminine body and she could not fathom how a masculine, powerful God could possibly understand the difficulties she faced concerning sex, breasts and chocolate cake[66] Like her own father, God as father seemed distant, absent and busy. His love did not feel soft and comforting, but 'hard, cold, rigid and reserved for those unlucky enough to be chosen.'[67] For Ind, recovery began in realising that Christianity was not about rules, but redemption; that holiness was not about self-control and strength and becoming identical to all the other 'Super Christians', but about becoming more fully who God – who she now viewed as a mother – created her to be.[68] Her turning point led to a re-evaluation of what she now saw as skewed perceptions she had formerly held about Christianity and realising the importance of the incarnation. God is not 'up there' but

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[65] Scrivener, *A New Name*, 65.
[66] Ind, *Fat is a Spiritual Issue*, 11.
[67] Ind, *Fat is a Spiritual Issue,* 36.
[68] Ind, *Fat is a Spiritual Issue,* 68–70. Ind describes her recovery and realisation of a different image of God as 'gradual', helped by her time in prayer and meditation in a Roman Catholic monastery. She notes the irony that it was in a Roman Catholic monastery that she made the connection between 'the sublime and the sexy' and realised her new image of a creative, erotic God who helped her to accept herself and her body.

Emmanuel – 'with us'. She concluded that she could not be ashamed of her body when salvation is through a broken, human body. [69]

Garrett similarly finds her 'turning point' in recovery when she hears a poetry reading in a Benedictine monastery. The poem is about God and humanity connected; God with humanity, not a faraway 'other'.[70] Scrivener describes God as a 'bearded moralist in the sky' who was 'far too busy and important' to pay her attention. [71] She believed God to be 'disappointed' and 'disgusted' by her, perceiving him as an 'extension of the grown ups'.[72] Scrivener eventually re-evaluates her images of God, finding reassurance that she is known and valued by the God is bigger than any problem. Both Ind and Scrivener conclude that salvation lies in accepting their weaknesses and saying 'yes' to this new image of a 'vibrant, sensual God'[73] who offers unconditional grace.[74]

[69] Ind, *Fat is a Spiritual Issue*, 42–43, 54–55, 78, 95.
[70] Garrett, *Beyond Anorexia*, 16.
[71] Scrivener, *A New Name,* 35.
[72] Scrivener, *A New Name,* 77.
[73] Ind, *Fat is a Spiritual Issue,* 70.
[74] Scrivener, *A New Name,* 134.

2.2.1. STARVING SAINTS

A frequently cited corpus of books deal with the relationship between the behaviours of the female medieval ascetic saints who engaged in extreme fasting – dubbed by Rudolph Bell 'holy anorexia'[75] – and the modern disease anorexia nervosa. Three major works approach the issue from varying angles: Bell writes from the perspective of a medieval historian, but includes a psycho-analytical angle, justified by the epilogue by clinical psychologist William Davis.[76] Caroline Walker Bynum takes an historical/sociological angle informed by her interest in women's issues.[77] Both consider specific issues facing women in the medieval era, relating these to contemporary feminist theories surrounding women's eating behaviours. The final work, *From Fasting Saints to Anorexic Girls: The History of Self-Starvation,* by Walter Vandereycken and Ron van Deth (a psychiatrist and psychologist respectively) traces the historical development of deliberate self-starvation from a perspective of psychological expertise.[78]

[75] I will adopt Rudolph Bell's phrase 'holy anorexia' referring to the self-starvation behaviours of the medieval saints for the sake of simplicity and to distinguish it from modern anorexia nervosa. As will become apparent, I am fully in agreement with Bell in his use of this term.
[76] Rudolph Bell, *Holy Anorexia,* (London: University of Chicago Press Ltd, 1985).
[77] Caroline Walker Bynum, *Holy Feast and Holy Fast: The Religious Significance of Food to Medieval Women,* (London: University of California Press Ltd, 1987).
[78] Vandereycken and van Deth, *From Fasting Saints.* There are two further works which could arguably be included which I have chosen to leave out of this analysis. Firstly, Donald Weinstein and Rudolph Bell, *Saints and Society: The Two Worlds of Western Christendom* (London: University of Chicago Press Ltd, 1982, 1986), which I have omitted as *Holy Anorexia,* by one of the same authors, builds on this angle of *Saints and Society.* Secondly, Joan Jacobs Brumberg, *Fasting Girls: The History of Anorexia Nervosa* (New York: Vintage Books, 2000, first published 1988) includes a chapter 'From Sainthood to Patienthood'. However, this is not the focus of the book, rather a brief exploration of the context of the emergence of the modern disease and so I have not included it in this literature review.

Bynum dismisses any possibility that the medieval saints could be suffering from a form of anorexia, which she says is defined by 20th century causes.[79] Both Vandereycken and van Deth and Bell consider and note the limitations of retrospectively diagnosing the saints on the basis of limited (and potentially biased) material.[80] For sake of clarity, I have divided these authors into those who argue there is continuity between 'holy anorexia' and anorexia nervosa, and those who argue they are entirely distinct.

2.2.2. HOLY ANOREXIA: AN EARLY FORM OF ANOREXIA NERVOSA?

Bell asserts that we have sufficient information concerning 170 of the 261 Italian women recognised as 'blessed' or 'saint' or 'venerable' by the Roman Catholic Church from 1200 onwards. More than half display clear symptoms of anorexia.[81] He has two primary theses: firstly, to show that this group of women exhibited anorexic behaviour as a reaction to their entrapment within patriarchal structures; [82] secondly, to suggest that (although not identical phenomena) research into 'holy anorexia' could have something worthwhile to bring to modern treatment approaches for anorexia. Essentially, Bell argues for similarities and continuity between holy anorexia and anorexia nervosa. He points to not only the physiological similarities (emaciation; vomiting; amenorrhea;

[79] Bynum, *Holy Feast and Holy Fast,* 197-198.
[80] Vandereycken and van Deth, *From Fasting Saints,* 6 and Bell, *Holy Anorexia,* 16-17.
[81] Bell, *Holy Anorexia,* x.
[82] Bell uses the established diagnostic criteria for anorexia nervosa at the time he was writing: that of Feigner et al, 1972, published in John Feigner et al "Diagnostic Criteria for Use in Psychiatric Research" *Archives of General Psychiatry* 26, no.1 (January 1972): 57-62. These are (in summary): 1) Younger than 25 at the age of onset (a criteria that has now been removed, and that Bell considers – rather presciently – to be merely observation rather than criterion); 2) 25%+ weight loss; 3) No alternative medical reason accounting for weight loss; 4) Hunger overridden by desire for thinness/reward of starvation; 5) No alternative psychological disorder accounting for weight loss; 6) Any two of: amenorrhoea, hyperactivity, binging or vomiting, bradycardia or lanugo.

constipation; low body temperature) many of which could equally be a consequence of any starvation, but also to psychological similarities between the phenomena: striving to gain control; pursuit of a highly valued cultural goal (thinness or holiness); perfectionism; a sense of insecurity; and identity becoming founded on the ability to self-starve.[83]

Bell cites quantitative data on the Italian saints to support his thesis and gives lengthy examples of specific saints. Most detailed is Catherine of Siena's story. It is easy enough to understand Bell's assertion that she would fit the diagnostic criteria of anorexia nervosa: she begins fasting soon after her father's death and by 25 was eating so little as to be described as 'nothing'. It is clear she did feel hunger, suggesting there was no physiological reason why she could not eat.[84] By the end of her life, other than the host, she drank only cold water and chewed and spat out herbs. She focused intently on the host in what seems from her dialogues with Raymond of Capua to be an attempt to suppress other bodily urges.[85] As her 'holy anorexia' progressed she began to induce vomiting, which she saw as punishment for her sins. Although it is speculation, Bell's hypothesis that this is a cycle similar to the binge-purge-starve cycle practiced by modern anorexics seems a reasonable conclusion in light of the evidence.[86]

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[83] Bell, *Holy Anorexia,* 14-20.
[84] Bell, *Holy Anorexia,* 25.
[85] Bell, *Holy Anorexia,* 26.
[86] Bell, *Holy Anorexia,* 27-28. As many medieval fasting saints did, Catherine of Siena had to fight accusations from others (in particular, her superiors) that she was either a fraud or fed by the devil in secret. In order to counter this, she ate once a day in company, and Raymond of Capua describes how, although she did so under order, she could not digest anything and all she ate was vomited back. However, as he goes on to describe how she inserted stalks of fennel into her stomach to induce the

Bell's retrospective psycho-analysis can be justified in the case of Catherine Siena as we have a quantity of her own writings in which she reveals her thoughts and motivations. Bell cites *The Dialogue* and concludes that she is not attempting to rack up 'holy points' through penance, rather she is attempting to destroy 'self-will'. She writes of the value of 'holy hatred' of oneself.[87] Ironically, as is the way with anorexia nervosa, in attempting to destroy 'self-will' she uses a superhuman level of willpower and it is, in fact, her will that is winning the battle.[88] Bell concludes that Catherine's anorexia was formed in a familial context and was closely entwined in an attempt to take on the sins of her family.[89] This seems a broadly feasible suggestion, and would certainly coincide with medieval tendencies to try to imitate Christ.

Despite Bell's excellent analysis of Catherine of Siena he frequently goes too far in his attempts to retrospectively psycho-analyse. He attempts to find the cause of Catherine's holy anorexia in her childhood, and suggests (on the basis of weaning metaphors) that her plight is brought about by an unhappy mother/daughter relationship that stemmed

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aforementioned vomiting it seems reasonable to assume this was induced vomiting rather than a digestive issue (although, of course, regular vomiting could cause digestive issues). Eventually, Raymond suggested that she stop eating, since it is clearly causing her such discomfort; however, she refused on the grounds that vomiting was a punishment for her sins and thus she must continue with it.

[87] *The Dialogue of St Catherine of Siena* cited in Bell, *Holy Anorexia,* 28. The text of the dialogue can be found online: Catherine of Siena, *The Dialog,* trans. Arthur Thorold (Christian Classics Ethereal Library: 1370, digitised 1994), http://www.ccel.org/ccel/catherine/dialog.i.html.

[88] Bell, *Holy Anorexia,* 29.

[89] We have knowledge of 'bargains' made by Catherine with God, suggesting that she believed that if she gave up all wordly comforts, God would release her family from the price of their sins and hasten them to salvation. This is revealed in two different prayers: Catherine prays at her mother's sickbed 'Father this is not what you promised me: that all my family would be saved' and demands that God not 'defraud' her (cited in Bell, *Holy Anorexia,* 40). She makes another similar bargain at her father's death described in Raymond of Capua's *Legenda*; that she would take on her father's punishments now on earth to in exchange for his immediate ascension to heaven (Bell, *Holy Anorexia,* 47).

from breastfeeding.[90] Here, he speculates on issues for which we have little data, furthermore, we have no evidence for a causal relationship between weaning and self-starvation in the holy anorexics.

Bell cites several more examples, and although in the case of some, such as Veronica Giuliana,[91] there is sufficient data to justify a retrospective diagnosis on the basis of the underlying thought patterns and physiological symptoms of the saint in question, this is not always so. There are occasions when Bell appears to fill the gaps with a typical model he has created in the pattern of those saints on whom we have sufficient data. For example, Bell cites Umiliana de'Cerchi as an example of holy anorexia in a wife and mother who isolated herself in the family tower. She lived a life of service, ate only bread and water and sometimes nothing when she gave her meals to the poor; practiced self-flagellation; vomited blood and had pains in her uterus; and became 'denuded of flesh, like a skeleton'.[92] She finally became paralysed, did not eat for 42 days and died. Although there are elements of Umiliana's life that could point to holy anorexia, this is far from clear: When Umiliana ate nothing, she did so for a reason – to give her meals to the poor. The vomiting of blood and pains in her uterus imply a potential physiological reason for her fasting. All we can diagnose her with is a social conscience, asceticism

[90] Bell, *Holy Anorexia,* 48.
[91] In the case of Veronica, Bell's analysis is based on not only the testimonies of her confessors, but 22,000 pages of her own writings, including three attempts she made at writing her own autobiography. Bell, *Holy Anorexia,* 81.
[92] Bell, *Holy Anorexia,* 92.

typical of the medieval era and an unknown disease which included wasting – which may, or may not, be related to intentional self-starvation.

Although I am sceptical of some of Bell's examples, I believe he has put forward sufficient evidence to support his theory of continuity or similarity between holy anorexia and anorexia nervosa. He hypothesises that the reason for holy anorexia was a reaction to patriarchy; it was a search for autonomy in a culture that allowed women little independence or individuality. As stories of 13th century saints became well-known and lauded, they paved the way for a new model of female piety which did not place woman as the passive wife and mother in the mould of Mary. Instead, they dared to claim a personal relationship with God and a connection with Christ as his bride which overrode the orders and regulations of male clerics. In including self-sacrifice as an intrinsic part of women's holiness, they became at one with the suffering, self-sacrificing Christ, and in choosing to do so became autonomous subjects, not the objects of men.[93] By the 17th century, clerics started to question female fasters more vigorously, citing demon possession or illness. Around this time, the path for women to be holy became the path of nurturing and charitable deeds rather than active self-sacrifice, and the phenomenon of 'holy anorexia' went into decline.[94]

[93] Bell, *Holy Anorexia,* 148.
[94] Bell, *Holy Anorexia,* 148-149.

Bell does not attempt, as an historian, to suggest *what* insights may be gained from this study for modern treatment approaches, leaving this to William Davis in the epilogue. Davis concludes on the basis of Bell's work that although anorexia nervosa and holy anorexia are not identical, they are extremely similar. The primary difference (on the basis of which Bynum dismisses any link) is the pursuit of thinness in anorexia nervosa. Davis points out that if one substitutes the 'pursuit of holiness' the two phenomena are parallel. He stops short of suggesting specific alterations to modern treatment approaches, however he asserts there is something for the medical profession to learn from holy anorexia.[95]

Bell's argument is supported by two contemporaries from different fields, Rampling[96] and Corrington.[97] As a psychiatrist, Rampling starts from a different angle, looking specifically for Christian themes of asceticism in anorexia nervosa.[98] Whereas historians begin from the medieval ascetics, Rampling begins from the study of anorexia nervosa. He asks the question 'might there be a common aetiological thread linking the ascetic ideals of the saint and extraordinary motivation which appears to transcend the self-interest of the severely anorexic patient?'[99] He too looks to Catherine of Siena and

[95] Bell, *Holy Anorexia,* 180-190.
[96] David Rampling, "Ascetic Ideal and Anorexia Nervosa" *Journal of Psychiatric Research* 19, no.2/3 (1985): 89-94.
[97] Gail Corrington, "Anorexia, Asceticism and Autonomy: Self-Control as Liberation and Transcendence" *Journal of Feminist Studies in Religion* 2, no.2 (1986): 51-61.
[98] I have noted that Rampling pursues the question from a different angle; this may at first be a surprising statement as Vandereycken and van Deth also write from a psychiatrist/psychologist perspective; however, they are tracing a medical history and write, to all intents and purposes, as medical historians. Rampling's starting point for study (although he does trace a history) is firmly embedded in his 20th century patients.
[99] Rampling, "Ascetic Ideals," 89.

traces the themes which occur in both her life, and the life of the modern anorexic. These he pinpoints as: subordination of the body; a feeling of deserving punishment; striving for perfection; self-hatred and a transcendental mode of thinking.[100] Rampling looks also to 20th century spiritual figures, such as Simone Weil who died aged 34 from causes related to anorexia nervosa. He brings his argument back to the present day by referring to studies which suggest a link between religious attitudes and anorexia nervosa[101] and concludes by suggesting that there is a spiritual dimension to anorexia. The Christian ascetic tradition, by aligning the refusal of food with those parts of the personality considered 'good' and 'altruistic', has paved the way for anorexia nervosa to be acceptable, and ultimately the ascetic features of anorexia contain an 'ineradicable element of the numinous'.[102]

Corrington, writing from a theologian's perspective, also sees continuity between 'holy anorexia' and anorexia nervosa, noting the same themes (purity, eating as sin, desire to transcend a world with which the anorexic cannot cope[103]) and tracing development of these themes through Christian history, pointing to Jerome who specifically linked food and lust, and suggested that women must fast to suppress the bodily appetite. Corrington isolates key themes which can be traced through stories of starving women from the ascetic saints to the modern anorexic: striving for perfection; 'holy hatred' of

[100] Rampling, "Ascetic Ideals," 91-92.
[101] Notably, Christine J. Wilbur & Robert C. Colligan, "Psychological and behavioural correlates on anorexia nervosa," *Journal of Developmental and Behavioural Paediatrics* 2 (1981): 89-92.
[102] Rampling, "Ascetic Ideals," 94.
[103] Corrington, "Anorexia, Asceticism and Autonomy," 54.

themselves; dualisms of spirit/flesh and subsequent desire to be liberated from the body; and use of self-control to search for autonomy and self-identity.[104]

2.2.3. HOLY ANOREXIA: AN ARGUMENT AGAINST SIMILARITY TO ANOREXIA NERVOSA

Bynum takes a different approach in her study of women's religiosity and food practices in 12th-16th century Europe, and although she cites the statistics of Weinstein and Bell which show that although only 17% of saints from 1000-1700 were female, they made up 29% of those who practiced extreme austerity, she comes to an entirely different conclusion.[105] Bynum argues two main points; firstly that the nature of medieval ascetism is not a self-hating, world-denying form of self-harm and rebellion against a patriarchal society, and secondly for a new viewpoint on gender in medieval religion which does not revolve around a belief that women saw themselves as spiritually inferior.[106]

Underlying both strands is Bynum's assertion that food practices were more important to medieval women than to men. She effectively cites several examples of female saints and mystics (e.g. Clare of Assisi, Catherine of Siena, Mary of Oignes) and some male comparisons (e.g. Francis of Assisi, Henry of Suso). She takes her reader on a geographical tour of medieval Europe looking at food practices of women in different

[104] Corrington, "Anorexia, Asceticism and Autonomy," 61.
[105] Bynum, *Holy Feast and Holy Fast,* 76 citing Weinstein and Bell, *Saints and Society,* 234.
[106] Bynum, *Holy Feast and Holy Fast,* 294.

parts of the continent and considering evidence from their biographers (often their confessors) and, where possible, their own writings.

A distinct pattern emerges including extreme ascetism in the form of self-starvation, self-flagellation, desire for the Eucharist (often the only food these women would consume), food multiplication miracles and lives of service feeding or caring for others. These practices often stem from adolescence and are part of a desire to escape the perils of marriage and consequent childbirth. It is noted by their biographers that these women frequently stopped having any 'normal' excretions (including menses) and started exuding supernatural fluids (e.g. lactating virgins).

It has been previously believed widely by theologians and historians (including Bell[107]) that the practices of medieval ascetism such as self-starvation and self-flagellation have stemmed from Christian dualisms (influenced perhaps by Gnosticism or Neo-Platonism) between the body and the soul. This explanation for extreme fasting seems plausible considering the evidence Bynum herself has put forward about medieval ascetism. However, Bynum disagrees. She believes women's food practices were, rather, a way of embracing the flesh.[108] She, like Bell, recognises that fasting women believed that in suffering they were redeeming others: in the context of medieval beliefs, fasting women believed they were, literally, in purgatory – purgatory was not simply an afterlife.[109]

[107] Bell, *Holy Anorexia,* 118-120.
[108] Bynum, *Holy Feast and Holy Fast,* 274-276, 296.
[109] Bynum, *Holy Feast and Holy Fast,* 120.

Furthermore, it was only through suffering flesh that one can become one with the suffering flesh of Christ's humanity. As women in the (male) dualisms of the time were associated with 'flesh' whereas man was 'soul/intellect' this was a natural spiritual progression for women. Likewise, through eating Christ in the Eucharist, they become one with Christ. They literally fed on Christ's body; a very real image for women whose own bodies feed infants and whose social role is to provide food for men. Whereas attempts at suffering in imitation of Christ cause Bell concern, for Bynum it is to be celebrated; far from trying to escape the flesh, fasting medieval women were embracing it.[110]

Although Bynum claims that dichotomies and reversals were the thinking of men and denies they played a part in women's motivations for fasting, even here in her argument against dualism she admits that such dichotomies did, inevitably, affect women. Perhaps she has been too sweeping in her earlier dismissal of this. She herself has argued that becoming 'religious' was often an 'escape route' from the horrors of marriage and childbearing; thus, it seems women attempted to escape a 'fleshly' role for a 'spiritual' role. Such an escape would sit well with Bell's suggestion that holy anorexia is an attempt to escape patriarchal expectations imposed upon women. It seems inconceivable that with this motivation their religious ascetism could be entirely devoid of either dualisms or a desire to escape the world; at least, the world and society they lived in.

[110] Bynum, *Holy Feast and Holy Fast,* 3, 289.

The main mistake I believe Bynum makes in her treatment of ascetism is her strong assertion that medieval fasting is entirely distinct from 'the modern disease anorexia nervosa' and that it 'had a resonance and complexity that are not captured by the analogy to modern disease entities'.[111] In her earlier chapters Bynum has (like Bell) given detailed descriptions of women who, were they to produce such behaviours and symptoms today, would no doubt be labelled 'anorexic'. Her main argument for why they are not a form of the same illness is that they do not pursue thinness, which she takes as an essential criterion for anorexia nervosa. She is at odds with Davis who points out, quite rightly, that if we exchange 'pursuit of thinness' for 'pursuit of holiness' we have two very similar phenomena.[112] Furthermore, there are cases of atypical anorexia nervosa today that do not require this criterion. It is not inconceivable that a disease should adapt over several hundred years according to cultural change; but this does not make it an entirely distinct unrelated disease.

Bynum states that it is not possible to demonstrate that these women developed such an 'infirmity' (the words of Catherine of Siena, implying perhaps the women themselves did not see their fasting in quite the same light as their biographers[113]) from problems in adolescence. Although there are similarities between the two phenomena (which she lists extensively), they are not related and there are no 'direct lessons' for the modern

[111] Bynum, *Holy Feast and Holy Fast,* 298.
[112] William Davis, 'Epilogue' in Bell, *Holy Anorexia,* 181.
[113] Bynum, *Holy Feast and Holy Fast,* 168 citing Catherine's own words in Letter 19 as numbered and reproduced in Dupre Theseider, *Epistolario vol 1,* 80-82; and Raymond of Capua's report of Catherine's words in Raymond of Capua, *The Life of Catherine of Siena,* pt.2, ch5, par.74, 906.

world to learn. She goes so far as to suggest that perhaps the reason anorexia exists today is that we do not have the rich symbols and values of these medieval women.[114]

There are several problems with this analysis. Bynum requires for her 'diagnosis' of anorexia that the women have a causal problem in adolescence. As she has demonstrated this clearly in some cases (e.g. Catherine of Siena) and it is by no means an essential criterion in the diagnosis of anorexia today, this is illogical. Her assertion that anorexia nervosa is by no means as rich and complex as medieval fasting shows that she has vastly underestimated its nature. The suggestion that it occurs because we do not have symbols and values drastically misunderstands the seriousness and complexity of the illness. Bynum was writing in the 1980s when research and diagnostic tools for anorexia were less developed than today and her discussion of anorexia nervosa must in fairness be seen in that context; as we must also allow Bell his now out-of-date rhetoric about the causal impact of weaning on anorexia (holy or nervosa). However, Bynum's conclusion that they are completely distinct entities and that we have 'no direct lessons to learn' does not hold water with a contemporary understanding of anorexia. There are certainly direct lessons to learn, and her work uncovering the patterns of behaviour in medieval ascetic women is invaluable in this.

[114] Bynum, *Holy Feast and Holy Fast,* 300.

Bynum's insights on the position of women have potential to overturn Bell's theories about medieval women's discontent with patriarchy. She claims that medieval women did not feel spiritually inferior. Her evidence lies primarily in the continuity of women's symbols between their biological and social selves and their religious selves. In eating the Mass, and in suffering and fusing with Christ's suffering flesh, women simply become more fully what their culture expects them to be – 'flesh'; and in fusing with Christ they become fully flesh and fully spirit. They do not need to make drastic changes to their self-identity, because they fuse with Christ from where they are biologically and socially. This, she argues, is evidenced in that the majority of female saints in the Middle Ages discover their vocation at a young age; they do not show the major identity shift that occurs in the *vitae* of the male saints. Bynum's final point is that women's own religious images of themselves are female, albeit sometimes encompassing into the female culturally 'male' qualities (e.g. ascribing 'discipline' to a mother). She claims they are spiritual in their own right, as women. It is not that God uses them despite their weakness – God works through them because they are frail human flesh, fusing with the frail humanity of Christ.[115]

This is an excellent argument based on sound evidence from the *vitae* of female saints and the writing of the women mystics. Although Bynum acknowledges that male focus on reversal and dichotomies will affect women – indeed, her argument is based on them embracing the dichotomy of themselves as 'flesh' – she perhaps does not give it enough

[115] Bynum, *Holy Feast and Holy Fast,* 264.

weight, particularly considering her own argument relies on it. She claims that these women have not 'internalised patriarchy' but are rebelling against the moderate church that gives women a place and embracing a more severe form of life.[116] This seems a rather romanticised view of the reality of the lives of these female saints; they see themselves as 'weak flesh', albeit salvageable; they starve themselves to control their own circumstances and bodies which are otherwise at the hands of patriarchy; their religious images are based on their stereotypical position as 'food providers'. They are intelligent and spiritual women – nonetheless, they lived in a time of patriarchy and made the best of the limited religious opportunities available to them. It seems clear that they were under the influence of patriarchy rather more than Bynum implies. However, her suggestion that they do not fast in a rebellious manner but rather so as to embrace the spiritual opportunities open to them, to control their own circumstances in the best way they could is an extremely valuable insight into the lives and spirituality of medieval women. Furthermore, (although Bynum would surely not agree with me) I suggest this research could give an insight into anorexic behaviour today which does not rely on theories of adolescent rebellion. It is possible to see the parallels of intelligent and spiritual women through the ages, striving to take control of their own lives through the models put forward for them by the culture in which they live.

Vandereycken and van Deth follow the history of self-starvation, from the fasting rituals of the ancient world to the medicalisation of 'anorexia nervosa' in the 19th century. They

[116] Bynum, *Holy Feast and Holy Fast,* 218.

outline the justifications for fasting given by early Church Fathers, the rise of ascetism among the Desert Fathers, and the medieval ascetics who fasted for the expiation of sins; their own and others.[117] The authors give a fairly general overview of fasting, of necessity less comprehensive than those of Bynum and Bell. However, they take care to portray the disapproval of extreme fasting within the Church: although theologians urged self-control and many ascetics took this to extremes of self-mortification, clergy of the time were opposed to such behaviour on practical grounds that extreme ascetics became a burden on their monastery, and for spiritual reasons from fear that they must be fed by the devil.[118]

Vandereycken and van Deth do not stop at medieval mysticism; they bridge the gap between the Reformation and the current day in their description of religious ascetics of the 19th and 20th century such as Theresa Neumann. Although no deceit was proved in the rigorous testing Roman Catholic authorities inflicted upon Theresa, she was never venerated as a saint. The Roman Catholic Church had become far more suspicious of miraculous happenings (e.g. surviving without eating), and far less likely to make a public statement of support. This may be a reflection of changing ideals of female piety and the suspicion of witchcraft which began to surround the fasting saints as early as the 15th century (although accusations of being fed by the devil appeared even earlier, such as in the case of Catherine of Siena).[119] Bell too notes the changes in the way the

[117] Vandereycken and van Deth, *From Fasting Saints,* 25.
[118] Vandereycken and van Deth, *From Fasting Saints,* 26.
[119] Vandereycken and van Deth, *From Fasting Saints,* 35.

authorities viewed 'holy anorexia' between the 13th and 17th centuries: from wonder, to suspicion of demon possession, to illness.[120] I argue that in many ways the 17th century view is closer to our 21st century view, understanding it as an illness – as, indeed, it is possible that Catherine of Siena herself understood her 'infirmity' in the 13th century.[121]

Although the existence of religious fasters declined from the 17th century, fasting maidens were still a phenomenon; they were merely viewed in a different light. Although still considered 'miraculous', rather than being 'holy' they became spectacles. In the late 19th century this idea of fasting as a form of entertainment became formalised with the advent of hunger artists.[122] They were almost always male and rather than being an act of God, this was an act of human endeavour in search of commercial profit. By the 1930s this entertainment died out, as the medicalisation of fasting as an 'illness' (a process begun in the 16th century) became the dominant understanding of self-starvation. [123]

Vandereycken and van Deth review the development of medical understanding of self-starvation. Having briefly traced the 'discovery' of anorexia nervosa in the late 19th

[120] Bell, *Holy Anorexia,* 175-178. This was, of course, a gradual and not always linear progression. It is worth acknowledging that saints as early as Catherine of Siena in the 13th century were challenged with accusations of demon possession, and women were venerated as miraculous fasters as late as the 19th century (Vandereycken and van Deth, *From Fasting Saints,* 47-49).
[121] See footnote 113.
[122] Individuals who starved themselves to extremes for a paying audience.
[123] Vandereycken and van Deth, *From Fasting Girls,* 76.

century, they outline the dominant theories of cause, summarised as: biological and physiological disturbances in metabolism and hormones (although it is questionable whether this is cause or effect); psychodynamic theories (fear of growing up, desire to be asexual); weight phobia; Systems theory (disturbed family systems); and feminist theories (either rebellion against the oppression of patriarchy, or a direct effect of patriarchy's objectification of women's bodies).[124]

The authors conclude that although there are similarities, both physiological and social,[125] between the fasting saints and sufferers of anorexia nervosa, the saints were not undiagnosed anorexics.[126] They argue that many of their symptoms could be an effect of starvation due to any cause;[127] that it is absurd to attempt to post-diagnose on the little information we have about their psychosocial behaviour; and that we cannot divorce the phenomenon from its religious context without 'violating its essential meaning'.[128] Although they disagree with Bell's attempt to post-diagnose the medieval

[124] Vandereycken and van Deth, *From Fasting Saints,* 3.
[125] Vandereycken and van Deth, *From Fasting Saints,* 219-220. For example, the fasting saints showed the same physiological effects of starvation as anorexics: loss of libido, hyperactivity, loss of menses, constipation and emaciation. They also had similar food practices, such as eating in secret and allowing only certain food types. Furthermore, they often came from similar social backgrounds and showed similar motivations: they were often well born young women with perfectionist tendencies and low self-esteem who faced opposition from their parents concerning their futures.
[126] Vandereycken and van Deth, *From Fasting Saints*, 220.
[127] This assertion is supported by the findings of the Minnesota Starvation Experiment of 1944-45 in which 36 healthy male subjects were subjected to starvation in order to research the best way to rehabilitate (physiologically and psychologically) war victims suffering from starvation. The research also showed that many of the symptoms now typically associated with anorexia nervosa are a result of starvation rather than a cause: obsession with food; bradycardia; low blood pressure; hair loss; decreased concentration; irritability; unusual eating habits. Leah M. Kalm & Richard D. Semba, "They Starved So That Others Be Better Fed: Remembering Ancel Keys and the Minnesota Starvation Experiment" *Journal of Nutrition*, 135, no.6 (2005): 1347-1348.
[128] Vandereycken and van Deth, *From Fasting Girls,* 222.

anorexics, they acknowledge that in dubbing the behaviour of the starving saints 'holy anorexia' rather than 'anorexia nervosa' he has made a distinction between the two. Despite opposing Bell's suggestion that the phenomena are linked, but manifest differently depending on the cultural situation, Vandereycken and van Deth argue strongly for understanding anorexia nervosa as a culture-bound syndrome, and likewise understanding 'holy anorexia' as a product of medieval culture.[129] They conclude that anorexia nervosa has only existed for the last century, arising from 20th century cultural beliefs and practices surrounding female beauty, body and self-control, although of course, sufferers are not exclusively female[130] The authors conclude the book with no answers.

Although it is understandable that no definitive answers can be found to such complex issues, it is this that is the primary weakness of the book. Having set out in chapter one with the goal of discovering whether anorexia nervosa is a new disorder, they then refuse to answer the question, claiming it is impossible to post-diagnose, despite their own attempts to post-diagnose Lord Byron.

Vandereycken and van Deth, in my opinion, fall into the same traps as Bynum; they believe that because context is a defining issue, the only conclusion can be that holy anorexia and anorexia nervosa are entirely different. This seems to extend to not only

[129] Vandereycken and van Deth, *From Fasting Saints,* 242.
[130] Vandereycken and van Deth, *From Fasting Saints*, 228.

the causes of the fasting, but also the way it is understood by society of the time. However, I argue this does not mean they are not variants of the same illness, or connected but distinct phenomena. We are aware that in past times epileptics were considered demon-possessed. Now, we believe that epilepsy is caused by abnormality in the wiring of the brain. The argument that we cannot compare the two in the light of the differing historical contexts and the way people viewed the behaviours is absurd. On this logic, because epileptics were once considered demon-possessed, that means that all epileptics living in that time truly *were* demon-possessed. In the same vein, if we announced all anorexics today as miraculous phenomena, holy women who through Christ are able to survive on little food – they would surely *be* this, rather than being unwell.

Here it is worth referring to the work of Helen Malson, a social psychologist who uses a Foucauldian approach to consider how cultural discourses have constructed differing identities and created meaning around self-starving women throughout history.[131] She argues that anorexia is not a 'transhistorical' reality and that anorexia nervosa and the behaviour of the starving saints are not comparable precisely for these reasons suggesting 'the differences are so great as to make arguments of equivalence between the two phenomena meaningless'.[132]

[131] Helen Malson, *The Thin Woman: Feminism, Poststructuralism and the Social Psychology of Anorexia Nervosa* (New York: Routledge, 1998). A full review of Malson's work is excluded from this literature review as she only briefly references Christianity specifically and thus it does not fulfil the inclusion criteria.
[132] Malson, *Thin Woman,* 50.

This Foucauldian approach offers insights into the impact of socially constructed meaning both in terms of self-identity and society's response (e.g. treatment). Malson's point that we cannot simply add the images of self-starving women throughout history to gain a complete picture, as such, is also valuable.[133] However, I believe that Malson, like Bynum, underestimates the spiritual dimension and religious contexts of some anorexic women today and I suggest the differences are in fact not 'so great' as she believes. Although Malson is not necessarily arguing for an understanding of anorexia as a *purely* constructed idea or identity which would reject the possibility of any point of comparison between the two phenomena at all, I argue that if one were to take this post-structuralist approach to such an extreme it would go too far.

In this debate there are not merely two options: to accept that the starving saints were anorexic, or to deny any connection between the phenomena whatsoever. In between these polar positions there lies a range of possibilities and it is among this range that I believe our answer lies: whilst anorexia nervosa and holy anorexia are by no means identical due to the social contexts in which they exist, this does not exclude the possibility of similarity and continuity, and thus the likelihood that there are lessons to be learnt from the starving saints.

[133] Malson, *Thin Woman*, 98.

2.2.4. HOLY ANOREXIA: LESSONS FOR THE 21ST CENTURY

Bynum and Vandereycken and van Deth are too wary of considering that self-starvation in a religious context could be related in some way to a disorder. It is this fear of questioning the veracity of these saintly miracles of the Middle Ages that I believe has held back historians, theologians and psychiatrists alike in learning from the experiences of the 'holy anorexics'. Bell asserted in 1985 that there are lessons to be learnt from the similarities between the two phenomena, with the support of clinical psychologist William Davis,[134] an idea corroborated by Rampling and Corrington. Yet, over three decades later, there is still startlingly little work in this field. I would speculate that this is the result of wariness of the medical profession to become involved in religious issues; and the defensiveness of the Church in its quest to retain the sanctity of its saints. The prejudice apparent on both sides must be overcome if we are to make progress in this area.

Although there is a limited amount of research, it is a developing field and the findings of the above historians have been, albeit slowly, taken up by psychologists, psychiatrists and sociologists and research of ascetic features in anorexia nervosa patients has emerged over the past 30 years. Researchers from different disciplines, with different viewpoints and different questions have all highlighted the same themes and noted the striking similarities between Christian asceticism and anorexia. Regardless of the individual conclusions drawn from these emerging themes (which are, of course,

[134] Bell, *Holy Anorexia,* xii,185-187.

influenced by their research question and discipline) there is a clear pattern demonstrated which justifies the conclusion that there are indeed lessons for anorexia treatment today to be found in the stories of the holy anorexics.

2.3.1. CHRISTIANITY AND ANOREXIA NERVOSA: A POSSIBLE CORRELATION?

Since the 1980s, research into anorexia and Christianity has become a burgeoning area of interest to sociologists, psychiatrists and theologians. Questions have been asked on the nature of the link between anorexia nervosa and Christianity: does a link exist? Is it a causal link? Is Christian faith an exacerbating factor in the severity of illness? Can faith be utilised in treatment approaches, and if so, how? I take these questions in turn and set out an overview of research done so far before discussing what conclusions can be drawn in relation to my research project. Due to space constraints, I include only studies that specifically mention eating disorders and Christian faith.

The first indication of a hypothesis that anorexia may be more prevalent in women with a Christian faith (implying a possible causal link) was anecdotal evidence from several patients and medical professionals who commented that they had noticed a disproportionate number of Christian women undergoing treatment for anorexia in inpatient units. Even if this anecdotal evidence were to be supported by quantitative studies, it would not necessarily constitute evidence for a causal link; other explanations could be that Christians tend to more severe anorexia which requires inpatient treatment, or that they are more willing to accept treatment.

Anecdotal evidence does receive some confirmation in empirical research. Wilbur and Colligan noted in their 1981 study that anorexic patients in their study were significantly more likely to pray daily and read the Bible weekly than control groups (one of which had matched demographics).[135] Sykes, Gross and Subishin discovered that eating disorders (in general, not specifically anorexia) are more prevalent amongst those identifying themselves as Roman Catholics and Jews than amongst the general population.[136] However, some studies differ: Smith et al's study of 316 inpatients plus a control group, showed that although extrinsic religiousness correlated with increased symptoms of bulimia nervosa amongst their subjects, there was no clear correlation between anorexia and extrinsic religiousness. Subjects with an intrinsic religiousness were also no more likely to display eating disorder symptoms than other groups.[137]

Initial research outside the US also suggests a relationship between religion and eating disorders: Bennett et al suggest, based on a study of secondary school students in Ghana with eating disorder symptoms and thoughts, that religious fasting may be a causal risk factor for anorexia, much in the same way that dieting is thought to be.[138] King et al have carried out a general study concerning mental health risks and spirituality in the UK, and concluded that eating difficulties are more prevalent amongst people who

[135] Wilbur and Colligan, "Psychological and behavioural correlates," 89-92.
[136] D.J. Sykes, M. Gross & S. Subishin, "Preliminary findings of demographic variables in patients suffering from anorexia nervosa and bulimia," *International Journal of Psychosomatics* 33, no.4 (1986): 27-30.
[137] Faune Taylor Smith et al., "Intrinsic Religiousness and Spiritual Well-Being as Predictors of Treatment Outcome Among Women with Eating Disorders," *Eating Disorders* 11, no.1 (2003): 15-26.
[138] Dinah Bennett et al., "Anorexia Nervosa among secondary school students in Ghana," *Journal of Psychiatry* 185 (2004): 312-7.

define themselves as 'spiritual'. The authors also note this risk is heightened in cases when a 'spiritual' patient has no formal religious framework or support network. This study is somewhat generalised in that it does not attempt to consider specific religions or disorders; however, it does demonstrate that being spiritual without a religious framework can make individuals more vulnerable to developing an eating disorder.[139]

It is difficult to draw a conclusion as to the nature of the correlation between Christian faith and anorexia based on such a small number of studies, particularly when they produce conflicting results. However, all of these studies have affirmed that there is some form of link between eating disorders and faith, and thus it is an area that is well worth more exploration. On the basis of these existing studies I would advocate that there is a connection of some (as yet unconfirmed) nature.

Other studies have focused on groups with anorexia and considered whether, within this demographic, strong religious beliefs have any correlation with the severity of illness. Joughin et al questioned 851 subjects with eating disorders on a number of issues including religious beliefs and eating disorder thoughts and behaviour. With regards to anorexia, they concluded that religious subjects had a tendency to a lighter 'lowest ever adult BMI' than non-religious subjects. The lowest BMIs were seen in

[139] Michael King et al., "Religion, Spirituality and Mental Health: results from a national study of English households," *The British Journal of Psychiatry* 202, no.1 (2013): 68-73.

Anglican subjects;[140] this suggests there may be a correlation between religious views and severity of illness. The EDI 'Drive for Thinness' was comparable;[141] suggesting that desire for thinness is similar amongst those with religious beliefs and those without, but those with strong religious beliefs (particularly Anglicans) are more successful at achieving the thinness they seek. This study did not investigate whether those with religious beliefs were more likely to succumb to an eating disorder, as all participants were already diagnosed.

Rider et al note that religion has been cited as both a 'cultivator' and a 'recovery benefactor' for anorexia.[142] The paper discusses this paradox and suggests some reasons why it might be, and also reports on a study of 134 Christian women diagnosed with anorexia. The subjects answered questions on their religious style of coping. The hypothesis was that those subjects reporting a negative style of religious coping would also show more severe symptoms. This hypothesis was supported by the results. Rider et al point to other studies that have demonstrated that positive religious coping strategies tend to bring about better mental health outcomes. Thus, they conclude, it seems likely that the aforementioned paradox is due to the fact that positive religious coping strategies (seeking spiritual support; forgiveness; prayer) can be a contributing factor in recovery; whereas negative coping strategies (self-punishment; insecure

[140] Neil Joughin et al., "Religious Belief and Anorexia Nervosa," *International Journal of Eating Disorders* 12, no.4 (1992): 397-406, 400.
[141] Joughin et al., "Religious Belief," 401.
[142] Katie Rider et al., "Religious Coping Style as a Predictor of the Severity of Anorectic Symptomology," *Eating Disorders* 22, no.2 (2014): 163-179, 163.

relationship with God) can be an exacerbating factor of anorexic thought patterns and symptoms.[143]

Marsden et al similarly note that religion can present as either a hindrance or a help in the treatment of eating disorders. To this end, they undertook a qualitative study into the relationship between eating disorders and religion, and the subsequent impact on treatment. In the interviews, sufferers spoke of five main themes.[144] First, control: interviewees drew comparisons between questioning the authority of parents and the Church. Similarly, patients desired to both cling to and rebel against the rules of both family and Church. 'Self-control' in this context extended to control of emotions and moral behaviour (i.e. rule keeping), not just eating behaviours. Second, 'self-image': participants were concerned about not only body image but also moral image and felt extreme guilt for their perceived failure to live up to expectations. This guilt was exacerbated by the perception of God as judgemental rather than forgiving. Third, 'sacrifice' of self which was the punishment inflicted upon themselves for this 'sin', even for some to the point of death – the ultimate self-sacrifice, and thus in some way redemption. This seems a reversal of the Christian belief in Christ as a vessel of sacrifice; the anorexic is, in her drive for success, attempting to earn her own salvation. This leads into the fourth category, 'salvation', which produced some far more positive thoughts. Many of the participants saw God as offering salvation not just from death in the

[143] Rider et al., "Religious Coping Styles," 178-179.
[144] Patricia Marsden, Efthalia Karagianni & John Morgan, "Spirituality and Clinical Care in Eating Disorders: A Qualitative Study" *International Journal of Eating Disorders* 40, no.1 (2007): 7-12, 8.

Christian sense, but also in the sense of healing. However, this was noted to potentially have a negative effect on the sufferer's faith if healing was not forthcoming. Finally, 'maturation': the authors noted that their participants' medical and spiritual journeys followed parallel paths. Religious views developed and unhelpful beliefs were challenged as the patient journeyed spiritually. At the same time they progressed in physical and psychological recovery. There is no suggestion as to which is cause and which effect, but it is clear that the medical and spiritual journeys of the participants were interlinked.[145] The authors thus conclude that religion has the potential to be either detrimental or beneficial for recovery and in order to harness this hospital chaplaincies should contribute to patient care. The spiritual beliefs of the patient are not something that can be 'dismissed as incidental to medical treatment'.[146] These reflections build on those of an earlier paper by some of the same authors reflecting on case studies of Christian patients at St. George's Hospital in London. In this study, the authors reported that religion could be an obstacle to treatment and some beliefs needed challenging by a skilled hospital chaplain. However, it could also be a factor in recovery (note, not a cure in itself) by increasing motivation and a positive worldview. The authors conclude by calling for greater rapprochement between psychiatry and religion.[147]

[145] Marsden et al., "Spirituality and Clinical Care," 8-10.
[146] Marsden et al. "Spirituality and Clinical Care," 12.
[147] John Morgan, Patricia Marsden & J. Hubert Lacey, "'Spiritual Starvation?': A Case Series Concerning Christianity and Eating Disorders," *International Journal of Eating Disorders* 28, no.4 (2000): 476-480.

2.3.2. THE NATURE OF THE CONNECTION: HINDRANCE OR HELP?

Psychiatrists, theologians and sociologists alike have reflected on the nature of the apparent link between Christianity and anorexia. In considering this connection, it is helpful to take Rider et al's distinction of Christianity as 'cultivator' and 'benefactor of recovery'. Christianity is suggested to be a 'cultivator' of anorexia due in part to the historical origins of anorexic thinking styles in Christianity. We have already seen how the behaviours and thinking styles of modern anorexics are reflected in the holy anorexics of the medieval church. Joughin et al note that for the religious anorexic, often anorexia is presented as asceticism and justified by the sufferer's belief system.[148] This in itself not only suggests that the medical profession has something to learn from the experiences of the holy anorexics, but that careful therapeutic intervention is needed. Although it is usually considered unacceptable to challenge religious beliefs in psychiatric treatment,[149] if the religious beliefs in question are being (mis)used by the sufferer to uphold their illness, it may become necessary to do so in a sensitive and informed way.

Huline-Dickens reviews a swathe of articles on the subject and locates several religious themes which appear repeatedly (although not necessarily consistently) in research into anorexia. [150] She notes apparent influences of both Roman Catholic tradition (medieval

[148] Joughin et al., "Religious Belief," 404.
[149] Joughin et al., "Religious Belief," 404.
[150] Sarah Huline-Dickens, "Anorexia Nervosa: Some Connections with the Religious Attitude" *British Journal of Medical Psychology* 73 (2000): 67-76.

ascetic saints; themes of penitence and self-denial) and Protestant tradition (puritan character, guilt, a feeling that life should be full of hardship, and a constant need for self-control). An interesting insight comes from Jacoby, whose 1993 study suggested a higher prevalence of anorexia in Protestants and bulimia in Roman Catholics: he suggests that this could be linked to the Protestant work ethic and the internalised need to drive and control oneself.[151] Certainly the classic anorexic trait of perfectionism would fit with this hypothesis.[152] Huline-Dickens draws on Jacoby's study and notes further religious themes in anorexia: dualism of body and spirit; traditional religious female roles; sin as a female concern traced back to Eve; gluttony as sin; abstinence and mortification of the flesh as penitence and the means to redemption; and a link between chastity and purity. It is striking that these themes are the same as those which emerged from the review of autobiographical material earlier in this chapter.

Other themes seen in 2.1 are noted by Grenfell, who suggests that religious conservatism is a risk factor for developing an eating disorder. She cites a possible reason for this as the increased difficulties for young women in communities which attempt to stand against the secular world. These women receive conflicting messages concerning gender roles and female images ('good girl' or sexual being?); and receive a distortion of Christian teachings ably assisted by patriarchy. In response to this, Grenfell

[151] G.E. Jacoby, "Eating Disorder and Confession: Is there a correlation between the type of eating disorder and specific religious affiliation," *Psychotherapy, Psychosomatic Medicine and Psychology* 43 (1993): 70-73.
[152] Corinna Jacobi and Eike Fittig, "Psychosocial risk factors for eating disorders," in *The Oxford Handbook of Eating Disorders* ed. W. Stewart Agras (Oxford: Oxford University Press, 2010), 123-136.

suggests a feminist pastoral theology of healing, which will be discussed in more detail later in this review.[153]

Banks undertakes in-depth case studies of two contemporary anorexics who both come from what she terms 'religiously fundamentalist' families. Once again, the aforementioned themes emerge, and Banks consequently asserts that religious beliefs about food and the body are still important in the subjective experiences of anorexic women today (both as the conscious way they understand their illness and potentially any subconscious motivating factors[154]). Thus, these religious beliefs should not be overlooked by the medical profession.[155] Like Grenfell, she argues that that religious fundamentalism could be an exacerbating factor for anorexia suggesting this is literal interpretations of texts which highlight dualisms between the spirit and the body.[156] Banks' argument is limited as she fails to adequately define 'religious fundamentalism' and makes vast generalisations concerning fundamentalist Christian traditions. Her argument lacks both evidence and explanation as to why a literal interpretation would highlight dualisms. However, she puts forward sufficient anecdotal evidence in her case studies to justify this as a connection for further contemplation and study. Certainly her

[153] Joanne Grenfell, "Religion and Eating Disorders: Towards Understanding a Neglected Perspective," *Feminist Theology* 14, no.3 (2006): 367-387.
[154] Banks, "'There is No Fat in Heaven': Religious Asceticism and the Meaning of Anorexia Nervosa" *Ethos* 24, no.1 (1996): 107-135, 108. It is worth noting that Banks does not definitively argue for religious unconscious motivations; the important point to note here is that she distinguishes between the unconscious motives and the way in which anorexics give conscious meaning to their experiences. It would be perfectly possible to have non-religious motives understood through religious language and symbols.
[155] Banks, "No Fat in Heaven," 124.
[156] Banks, "No Fat in Heaven," 129.

assertion that treatment models need take into account women's own cultural values and subjective meanings (she suggests a failure to do so has resulted in the failure of treatment in chronic cases) is extremely pertinent: there is little to be gained from an unrelenting emphasis in therapy on a desire to be thin, when for some women (as in Banks' case study) the conscious motivation for self-starvation is a desire to be holy.[157] Banks poses a further useful question as to which cultural ideals are, in fact, involved in anorexia nervosa? Anorexia is widely defined as a 'culture-bound' syndrome[158] but there is no agreement as to which (Western) cultural values are involved. Some scholars have suggested patriarchy and a subsequent search for autonomy; others consumer culture and emphasis on women's bodies as commodities – but only when thin and 'beautiful'; others the media for promoting this image; and others still lay the blame in Western family structures, in particular mother-daughter relationships.[159] Banks quite rightly points out that equally implicated could be the *religious* cultural values of the Western world – i.e. aspects of Christian tradition. This is a view supported by Griffin and Berry, who suggest that media use of religious themes in advertisement of food and diet products have helped perpetuate a 'modern day holy anorexia'.[160]

[157] Caroline Banks, "'Culture' in Culture-Bound Syndromes: The Case of Anorexia Nervosa," *Social Science and Medicine* 34, no.8 (1992): 867-884, 869.
[158] Banks, "Culture," 867.
[159] There is no space in this thesis for a full extrapolation of these psychological models, however, please see Banks, "Culture," 871-873 for a fuller discussion.
[160] Jennifer Griffin & Elliott Berry, "A Modern Day Holy Anorexia? Religious Language in Advertising and Anorexia Nervosa in the West," *European Journal of Clinical Nutrition* 57 (2003): 43-51, 51.

2.3.3. WORKS IN FEMINIST THEOLOGY

2.3.3.4. FEMINIST THEOLOGY AND DIET CULTURE

Isherwood writes concerning the body-shaming of overweight women, and proposes a liberating 'Fat Jesus'. Like others, she implicates themes from Christian heritage in disordered eating: connections between fat and sin; sex and shame; and centuries of subjugation of women and their bodies. She writes at length concerning the damaging US biblical diet phenomenon which explicitly informs women they must be thin, beautiful objects for the male gaze. Isherwood furthermore argues that this problem is compounded by our individualistic consumerist society and the Protestant emphasis on individual experience over communal liturgy. Therefore, Isherwood proposes that it is necessary to embrace the incarnate, fleshly Christ and to reject the androcentric, disembodied God of the patriarchal church. By embracing the fleshliness of Christ (who does, after all, share his flesh and blood with all at the Eucharistic feast), women can also embrace their own flesh as sacred and enjoy food as God's bounty. [161]

I concur with the majority of Isherwood's argument: certainly her shrewd analysis of body-shaming traits in Christianity's heritage is pertinent. Her juxtaposition of the fleshly Christ and communal Eucharistic table with individual fasting sheds light on an ironic twist in the consciousness of some Christians. Her scathing attack on the US religious diet culture is amply justified and beautifully articulated. However, there are limits within her work in this area: Isherwood is writing primarily about overweight women

[161] Lisa Isherwood, *The Fat Jesus* (London: Darton, Longman & Todd Ltd, 2007). I have also written about this aspect of Isherwood's work in Stammers, "Liberation from Anorexia Nervosa," 5-6.

and 'disordered eating' rather than 'eating disorders' in the sense of a serious psychiatric illness. As such, she does not deal with the depth and distortions of anorexic thinking – because this is not what she has set out to do. At one point she condemns individualistic culture and the appeal to a 'me-me God who cares about ME personally but does not seem to notice the starving'[162] but this argument cannot successfully or morally be extended to sufferers of anorexia. Anorexics are acutely aware of the nutritional needs of others, and the need to be self-sacrificing is of high importance.[163] A call to perspective around food by citing famine around the world leads simply to more guilt, more shame and a spiral of further food refusal, rather than the jolt of perspective intended.

Hannah Bacon draws attention to the theological discourse underlying secular weight-loss groups. The unnamed diet group in her qualitative study uses the term 'syn' to relate to 'danger' food which must be counted and rationed carefully. Although the diet group is not restricted to women, it is clearly marketed to a female audience.[164] She notes not only the relationship between 'syn' and 'sin' and ancient Christian theology's suspicion towards food, fat and female flesh – but also points to other theological underpinnings of the group's philosophy: the use of moral language; the talk of a 'Fall' or 'slipping' if

[162] Isherwood, *Fat Jesus,* 75.
[163] Rachel Bachner-Melman et al., "The relationship between selflessness levels and the severity of anorexia nervosa symptomatology," *European Eating Disorders Review* 15, no. 3 (2007): 213-220.
[164] Hannah Bacon, "Fat, Syn and Disordered Eating: The Dangers and Powers of Excess," *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 4, no.2 (2015): 92-111 and Bacon, *Feminist Theology and Contemporary Diet Culture: Sin, Salvation and Women's Weight-loss Narratives* (London: T&T Clark, 2019).

one fails and eats too many syns; the eyeballs given to put in lunchboxes to remind that someone is watching as you eat; the public confessionals; and the path by which members are encouraged to work for their own fulfilment (i.e. salvation).[165] The language of 'paying' or 'saving' syns is reflective of ideas of debt or ransom theory, and the concept of working for one's own redemption can be compared to the Protestant work ethic – or indeed, medieval indulgences, although she does not explicitly make the latter link. Bacon notes clear parallels with Augustinian theology in the form of concupiscence, the divided will, sin and the Fall. Here, as in Christian theology, all women are framed as an 'Eve' who sins through eating, through giving in to desire and fleshly appetites.

Bacon identifies that 'salvation emerges as a spurious form of theosis as women's efforts to remove their weight and freeze their bodies in time forge their bodies in the image of the phallic God'.[166] Bacon draws attention to the underlying dualisms and suspicion of female flesh that stems from the Church Fathers and takes its place in today's secular weight loss industry. 'Salvation' (i.e. wholeness, transformation and self-fulfilment) is understood as an escape from the female body. In shrinking their bodies, women attempt to remove the signs of female puberty, maternity and ageing – the very things that make bodies female are seen as standing between women and salvation. The

[165] Bacon, "Fat, Syn and Disordered Eating," 96-101; Hannah Bacon, "Expanding Bodies, Expanding God: Feminist Theology in Search of a 'Fatter' Future," *Feminist Theology* 21 (2013): 309-326, 311-315.
[166] Hannah Bacon, "Dieting for Salvation: Becoming God by Weighing Less," in *Alternative Salvations: Engaging the Sacred and the Secular,* ed. Hannah Bacon, Wendy Dossett & Steve Knowles (New York: Bloomsbury Academic, 2015) 41-51, 42.

search for salvation is in attempting to transform oneself into a weightless, bodiless, un-female God.[167]

Bacon does identify redeeming features in the programme: the use of 'syn' can be considered liberating as well as restricting since 'Syns' are allowed, albeit rationed.[168] The group provides space where women can create their stories and forge connections and friendships.[169] The salvation metaphors employed have meaning in terms of the women awakening to a 'new self' with increased confidence, and thus can be liberative.[170]

Bacon therefore argues that feminist theology must respond to use of traditional Christian theology to 'feed' the secular weight loss industry by re-claiming these concepts. She reconsiders the concept of sin, which she defines as anything which prevents God's intentions for us to flourish, fully and relationally. Under this definition of sin, we can name as sin the following aspects of diet culture: sizeism, victimisation of food (i.e. the concept that foods are 'good' or 'bad') and the divided self which leads women to attempt to carve away flesh and diminish themselves. Bacon considers 'sin' to refer to destructive patterns and structures in society rather than merely individual

[167] Bacon, "Dieting for Salvation," 48-50.
[168] Bacon, "Expanding Bodies," 315-317.
[169] Bacon, *Feminist Theology and Contemporary Diet Culture,* 184, 210.
[170] Bacon, *Feminist Theology and Contemporary Diet Culture,* 161.

culpability. Here, it is the damaging structures of diet culture and the Western pursuit of thinness that form the 'sin'.[171]

Bacon calls for a theology of 'sensible eating' in the sense of women allowing themselves to use the sense of taste and touch, thus trusting and honouring their bodies. Such an action is daring, because women who taste and touch are considered dangerous, as they allow external elements to cross the boundary of their body. This, Bacon argues, is actually a good thing: When Eve eats, her eyes are opened to knowledge – she has refused to 'be good' and broken the boundaries positioned by society to hold women's bodies in place.[172] A 'sensible' approach to eating, Bacon describes, combines the delight in God's gift of food found in Ecclesiastes with Jesus' ministry of food which he uses to form relationships and overcome boundaries, inviting in those on the margins of society. Such an approach balances finding pleasure in God's gift of food with recognition that global food dynamics are not simple, and that pleasure in food should not be enjoyed in isolation from social action that enables all people to have access to such nourishment.[173]

Finally, Bacon applies diet culture to the concept of Sabbath. The Sabbath is an opportunity for rest from ordinary work and anxieties. Drawing on the work of Walter

[171] Bacon, *Feminist Theology and Contemporary Diet Culture*, 194-207.
[172] Bacon, "Expanding Bodies," 321 and Bacon, *Feminist Theology and Contemporary Diet Culture,* 244-245.
[173] Bacon, *Feminist Theology and Contemporary Diet Culture,* 230-239.

Brueggeman, Bacon suggests that Sabbath Living can offer women a respite from the 'anxious productivity' of the pursuit of thinness. 'Sabbath Living' is both individual in those moments of 'micro-salvation' but also communal. The communal element draws on the beneficial aspect of the slimming group as a safe space for women to escape domestic routines and focus on themselves. She suggests women's groups could be formed that do not polarise 'God' and 'fat' and create their own liturgies and rituals to celebrate fat bodies, including touching their flesh; dancing; eating and drinking together.[174]

Bacon does not look at eating disorders in depth – so we must be wary of making too many assumptions from her work. I am also unconvinced by some of the 'redeeming features' she points to in the slimming group's programme: they seem tenuous, and indeed one is concerned with the beneficial nature of women breaking the group's rules.[175] However, her insights – like Isherwood's – into Christian underpinnings of the secular weight loss industry which are marketed at women and seep into women's very consciousness are invaluable. If anorexia is, as Lelwica describes,[176] the extreme end of a continuum of women's eating habits; and if anorexia is indeed a culture-bound syndrome which feeds on aspects of Western culture, these connections demonstrate how the more harmful aspects of Christian theology on food, female flesh and sin has fed into women's body consciousness and pervades even in our increasingly secular age.

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[174] Bacon, *Feminist Theology and Contemporary Diet Culture,* 261-306.
[175] Bacon, *Feminist Theology and Contemporary Diet Culture,* 259.
[176] Michelle Lelwica, *Starving for Salvation: The Spiritual Dimensions of Eating Problems Among American Girls and Women* (New York: Oxford University Press, 1999) 5-6.

Bacon's insights into the aims and intended effects of the pursuit of thinness – to rid the female body of its identifying characteristics of flesh, breasts, and signs of maternity – is reminiscent of both the medieval ascetic saints who avoided the risks of childbirth via the path of asceticism,[177] and theories that young girls develop anorexia as a means of staving off puberty and the development of an adult female body.[178]

2.3.3.5. FEMINIST THEOLOGY AND ANOREXIA

Lelwica describes the spiritual dimension of eating disorders to be a 'neglected piece of the puzzle' in typical understandings of the disorders. [179] She suggests women and girls are undergoing a 'spiritual crisis', a search for meaning expressed through the symbols and rituals available to them. In a consumer culture, the available symbol/ritual is the secular 'salvation myth' of diet and bodily appearance. The rise of this secular myth, she argues, is not only down to the historical shift away from religion, but also due to the legacy of anti-body, misogynistic ideals left by traditional religion itself. Lelwica's book emphasises the diverse nature of women's experiences: she is scathing of the media presentation of a white, middle-class woman as the face of eating disorders, pointing out that anorexia (most prevalent amongst white, middle-class women) is statistically the least common eating disorder. [180] In my view, Lelwica's quest to sound the hidden voices of women from other ethnicities and classes and to provide an anti-reductionist

[177] Bynum, *Holy Feast and Holy Fast,* 18.
[178] Hilde Bruch, *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within* (London: Routledge and Kegan Paul, 1974) 277.
[179] Lelwica, *Starving for Salvation,* 10.
[180] Lelwica, *Starving for Salvation,* 4-10.

view of eating disorders, although admirable and necessary, at times leads her to belittle (and, ironically, over-generalise) experiences of white middle-class women (of whom she is one), describing it as merely the manifestation of their disappointment that the cultural ideals they bought into did not bring fulfilment.[181] This, to me, is the downfall of Lelwica's book. Her main points – highlighting the missing element of spirituality in understanding of eating disorders and raising the profile of women with eating disorders from diverse ethnicities – are important, and it is worth remembering that this was a more radical undertaking in the 1990s than it is today; but she overstates her dislike of the story of the 'white middle-class anorexic' and thus ends up demeaning these women's experiences. She misses the point that the reason anorexia gains the most press is not merely because it is typically 'white middle class' but because it is also the psychiatric disorder (of all psychiatric disorders, not just eating disorders) with the highest mortality rate.[182]

Lelwica explains the self-inflicted nature of eating disorders through Foucault's view of 'disciplinary power' as a form of social control sustained through formal hegemonic 'knowledges': they are so normal to us they feel natural, and therefore are taken for granted. It is a form of cultural control that women are taught to self-discipline, and thus perpetuate their own subordination. Another of these 'knowledges' that Lelwica

[181] Lelwica, *Starving for Salvation,* 102-103.

[182] Arcelus et al., "Mortality rates." This study analysing 50 years-worth of research showed that sufferers of anorexia nervosa have a six-fold increased risk of death compared to healthy controls: four times the death risk from major depression, twice the death risk of schizophrenia and three times the death risk for patients with bipolar disorder. Anorexia sufferers diagnosed in their 20s had an eighteenfold death risk compared to healthy controls.

argues plays a part in body dissatisfaction is science. We have learnt to analyse and measure our bodies, and to size them up, quite literally, against an objective scientific ideal. Eating disorders, Lelwica claims, are merely the extreme end of the continuum of women's eating behaviours: many self-destructive food habits practised by women along the spectrum are socially approved, and even encouraged in what she dubs 'Culture Lite'.[183]

Lelwica calls for a move away from the traditional (secular) causal models that imply sufferers to be passive victims and exhorts a move away from the 'politics of blame'. However, she simultaneously calls for a challenge to the cultural logic and historical legacies of patriarchy that have helped create the situation: thus, it would seem that she does not in fact want an entire shift away from causal models – merely a new perspective.[184] Lelwica concludes by suggesting that to break free from the cycle of disordered eating and self-discipline, women must find other means of fulfilling their symbolic-ritual needs. She looks to religion to provide this; however, as her work is intentionally broad and aims to include women of all demographics, she can only point to general ideas within different religious traditions.[185] Although a useful springboard for further researchers, it is too vague to offer anything concrete to women searching for these symbols.

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[183] Lelwica, *Starving for Salvation,* 34-43, 74 with reference to Michel Foucault, *Discipline and Punish: The Birth of the Prison* translated by Sheridan, A. (London: Penguin, 1977). First published in French as *Surveiller et Punir* (Gallimard: Paris 1975).
[184] Lelwica, *Starving for Salvation,* 126.
[185] Lelwica, *Starving for Salvation,* 139-147.

Although White does not explicitly build on Lelwica's work, she does fulfil this call for an alternative means for women to fulfil symbolic-ritual needs, drawing on feminist and body theologies and thealogy. White asserts that anorexia is an extreme version of what she dubs the 'slender performance' (building on Judith Butler's 'gender performativity' and Foucault's 'docile body') and results from the disconnect that women experience between their selves and their bodies as a result of living in a patriarchal dualistic society.[186] Although she notes the etiology of anorexia is multi-faceted, she lays much of the blame on constructions of femininity based on gender stereotypes and notions of female flesh as weak and vulnerable. Anorexia, she describes, is a reaction (not a rebellion) to living in patriarchy which conforms to these ideals to the extreme. In this way, it reflects the earlier 'female' disorders of hysteria and agoraphobia.[187]

If patriarchy is to blame for anorexia, White argues, then we must reject Christian religion with its patriarchal trappings. Instead, she turns to the work of Marion Woodman on rituals of transformation and Naomi Goldenberg's search for the 'Lost Goddess'.[188] Drawing on this thealogical framework, White proposes that Goddess Feminism offers the possibility of subverting patriarchal norms and liberating women

[186] Emma White, *The Spirituality of Anorexia: A Goddess Feminist Thealogy* (London; New York: Routledge, Taylor and Francis Group, 2019) 70-78.
[187] White, *Spirituality of Anorexia,* 97-102.
[188] White, *Spirituality of Anorexia,* 79-88. The author draws on Marion Woodman, *The Owl was a Baker's Daughter: Obesity, Anorexia Nervosa and the Repressed Feminine* (Toronto: Inner City Books, 1980); Marion Woodman, *The Pregnant Virgin: A Process of Psychological Transformation* (Toronto: Inner City Books, 1985) and Naomi Goldenberg, *Changing of the Gods: Feminism and the End of Traditional Religions* (Boston: Beacon Press, 1979).

from the slender performance – and at its most extreme, anorexia. Goldenberg observed four commonalities between Goddess feminism and Object-Relations theory: history as source of meaning; the need to deconstruct patriarchal authority figures; formation of the individual within a community; and fantasy or imagining as a structure for rational thought. On the basis of these, White suggests that a Goddess feminism could be a flexible therapeutic framework, arguing that it could offer women alternative liberating and empowering symbols in the image of the Goddess.[189] This challenge has three main mechanisms: firstly, the challenge to patriarchal discourses of disembodiment which enables women to reconnect with their feminine bodies as sacred in light of an immanent Goddess image; secondly the creation of myths drawing on matriarchal pre-history which are central to the healing experience; and thirdly the development of rituals – individual and communal – which create safe space for reflection and healing.[190] White further argues that the ultimate goal, for her, is that Goddess feminism should become mainstream and disrupt in its entirety the discourses and gender norms that create the 'slender performance' for all women, not just anorexics.[191]

White thus offers a potential therapeutic framework that enables women to view their own bodies as sacred, and looks to deal ultimately with not only the symptoms of the 'slender performance' but also its primary cause. Such a framework clearly has an

[189] White, *Spirituality of Anorexia,* 142-155.
[190] White, *Spirituality of Anorexia,* 167-168.
[191] White, *Spirituality of Anorexia,* 144-147.

important place in the pantheon of spiritual frameworks for anorexia recovery. In particular, potential for a healing framework for those women and girls who participate in the cult of the 'Goddess Anorexia' is extremely promising and I was surprised that White did not reference such quasi-religions in her work.[192] However, there are two points of concern. The first is merely a limitation which requires further study: it is abstract, based on psycho-analytical theories and thealogy with little reference to 'real-life' anorexics other than one small section quoting an autobiography concerning rituals. More research with demonstrable practical application is needed to develop this work.

Secondly, her dismissal of mainstream religion and assertion that such a Goddess Feminism be the primary healing framework is unrealistic. For some women who reject mainstream religions and are searching for such symbols it is undoubtedly beneficial; however, many anorexic religious women do not want to reject their religious framework: thus this cannot, and should not, be a universal solution. Although she notes that a 'bespoke' model would be needed within this 'malleable' framework,[193] it is still within the confines of a framework that rejects traditional mainstream religions and thus will not be appropriate for all women – nor could it be more than an 'option' for spiritual treatment within a healthcare setting. Solutions must also come from within mainstream religions.

[192] See Stammers, "The Theological Language of Anorexia Nervosa," 289-290 for a discussion on these quasi-religious Pro-Ana frameworks.
[193] White, *Spirituality of Anorexia,* 170.

2.3.4. CHRISTIANITY AS AN AID FOR RECOVERY

Turning to the role of Christianity as a help in recovery, I have already mentioned papers by Rider et al, Morgan et al, and Marsden et al suggesting that certain aspects of faith (prayer, community support, motivation, forgiveness and a feeling of self-worth) can aid recovery. These suggestions are upheld by other researchers, including Hsu et al who describe the case study of a patient who felt supported by God and understood medical treatment to be an answer to her prayers.[194] Henderson and Ellison suggest that religious commitment lessens the effect of eating disturbances on other aspects of mental health, such as depression, although their study does not specifically look at eating disorders.[195]

A leading contributor to this field is Scott Richards, psychologist and Director of Research at the 'Center for Change', a specialised eating disorders unit in Utah. Richards and his colleagues have devised a spiritual treatment model for eating disorders. In summary, a theistic model of eating disorders 'may encourage their clients to explore how their faith in God and personal spirituality may assist them during treatment and recovery' and includes encouraging prayer, liaising with religious leaders, suggesting bibliotherapy and discussing theological concepts.[196] Such a model offers ample opportunity for

[194] L. K. George Hsu, Arthur Crisp, John Callender, "Recovery in Anorexia Nervosa – The Patient's Perspective," *International Journal of Eating Disorders* 11, no.4 (1992): 341-350, 347-348.
[195] Andrea Henderson and Christopher Ellison, "My Body is a Temple: Eating Disturbances, Religious Involvement and Mental Health among Young Adult Women," *Journal of Religion and Health* 54 (2015): 954-976, 954.
[196] P. Scott Richards et al., "A Theistic Spiritual Treatment for Women with Eating Disorders," *Journal of Clinical Psychology* 65, no.2 (2009): 172-184, 173.

research into the spiritual dimension of eating disorders. Richards et al, like others, point to spiritual misconceptions at the heart of eating disorders and argue that it is vital for recovery to address these misconceptions. I will not describe here the 'misconceptions' observed, as many are the same as those already noted by other researchers. However, it is worth briefly listing the concepts that arise for comparison to other studies (including my own): negative images of God; guilt; problems with self-identity; the 'good girl' image; anorexia as an idol or religion in itself; and a sense of alienation from God and others.[197] The authors suggest that challenging misconceptions leads to spiritual healing and a renewed relationship with God. This, in turn, acts as a catalyst leading to improved mental health and relationships with others, and thus physical and emotional healing.[198]

This assertion is justified by a study in which 251 women with eating disorders completed multiple assessment questionnaires in order to examine whether spiritual wellbeing could predict outcome of treatment.[199] The most significant finding was that the women who improved in spiritual wellbeing throughout their treatment improved most in other areas including eating attitudes, body image, psychological symptoms and their relationships with others.[200] Due to the recent nature of this emerging treatment model there are at the time of writing no studies concerning the longevity of a spiritual treatment approach in comparison with other approaches. Although this study alone is

[197] Richards et al., "Theistic Spiritual Treatment," 174-177.
[198] Richards et al., "Theistic Spiritual Treatment," 181-183.
[199] Taylor Smith et al., "Intrinsic Religiousness," 18-19.
[200] Taylor Smith et al., "Intrinsic Religiousness," 24.

by no means indicative of a causal relationship, in the wider context of research in this area it seems justified to conclude there is likely to be an element of causality (or perhaps a dialectical relationship) between spiritual well-being and recovery from anorexia.

2.3.5. TREATMENT MODELS

Many researchers are calling for greater liaison between psychiatrists and religious practitioners, and/or greater inclusion of religious awareness in treatment models.[201] However, there is not necessarily a consensus on what form this should take. Joughin et al, for example, suggest that medical professionals should consider challenging unhelpful religious beliefs sensitively, even though it is usually considered unacceptable to do so.[202] I would argue that, with the greatest respect to psychiatrists and psychologists, the challenging of people's religious belief structures is not necessarily something that they are capable of and it is unreasonable to expect them to provide theological advice. To do this support and pastoral input from a trained hospital chaplain should be sought. Likewise, it is unreasonable to believe that chaplains alone would be capable of treating an eating disorder solely by spiritual means without the input of psychiatrists/psychologists. This view is also held by Morgan et al and Marsden et al, who comment that clinicians are not necessarily comfortable stepping into a

[201] Joughin et al., "Religious Beliefs"; Morgan, Marsden and Lacey, "Spiritual Starvation"; Marsden, Karagianni and Morgan, "Spirituality and Clinical Care"; Taylor Smith et al., "Intrinsic Religiousness"; Richards et al., "Theistic Spiritual Treatment"; Grenfell, "Religion and Eating Disorders".
[202] Joughin et al., "Religious Beliefs," 404.

spiritual domain, and may have their own conflicting beliefs.[203] The sensible solution is to have a multi-faith hospital chaplaincy team working closely with the clinical team – even as part of the clinical team – in a multi-disciplinary treatment model.

Huline-Dickens is wary of such a treatment model. Cognitive therapy into the themes of guilt, shame and self-denial are needed, but she is wary of involving religious practitioners, saying 'there are many difficulties with this collaboration and it is argued here that religious beliefs should be examined rationally'.[204] Her implication is that a religious practitioner could not possibly examine beliefs 'rationally'. Her wariness of bringing religious belief into treatment settings is an example of the side-lining of spiritual dimensions of anorexia and demonstration of the false idea that medicine and religion must always be at a dichotomy.

Despite my concerns with Huline-Dickens' generalisations, there is an important point to be made. The risk of well-meaning clergy attempting to get involved in treatment of anorexia with no mental health training is as horrifying as the idea of well-meaning medical professionals trying to get involved in religious counselling with no theological training (there may be some individuals who are both theologically and medically qualified, however, this is both a rarity and an unreasonable expectation). There is very little written by chaplains concerning pastoral care in eating disorders. A journal search

[203] Morgan, Marsden and Lacey, "Spiritual Starvation," 479 and Marsden, Karagianni and Morgan, "Spirituality and Clinical Care," 11.
[204] Huline-Dickens, "Connections with the Religious Attitude," 74-75.

produced only two papers with pastoral reflections on anorexia. One, by Dayringer, dated to 1981, and I was alarmed to discover how different both hospital treatment and pastoral care was four decades ago. Many of the suggestions made would no longer be considered appropriate, and in several instances prohibited due to safeguarding regulations and privacy concerns.[205]

The other paper is by Grenfell, a CofE priest involved in student chaplaincy, who calls for a feminist pastoral theology. As already noted, she believes that anorexia correlates with religious conservatism, and suggests this could be due to a combination of body image ideals promoted by society; changing female roles and identity both within and outside the church; and the central role of food in Christian tradition. The struggle to define a religious community as one that sets itself against the secular norm is often played out in the bodies of young women as they struggle with their individual and community identities – which may often seem to conflict.[206] Grenfell responds by calling for a pastoral response from churches to address the issues of shame, identity and alienation from self, community and God that are being played out in the minds and bodies of young women.

[205] Richard Dayringer, "Anorexia Nervosa: A Pastoral Update," *Journal of Religion and Health* 20, no.3 (1981): 218-223. Examples of the pastoral suggestions that I consider to be inappropriate were a suggestion that before meals the author (i.e. the chaplain) would pray (aloud) with the patient that God would 'give her appetite' for her meals; the suggestion he would visit at mealtimes; and the suggestion that he would 'observe' the family eating together and how they interact and potentially 'intervene'.
[206] Grenfell, "Religion and Eating Disorders," 368-9.

Grenfell suggests that this pastoral response should be feminist, as she believes that patriarchal emphasis on the male sacramental body and traditional gender roles has played a key role in the development of a confused female identity and thus, in some women, anorexia. Pastoral responses should aim to re-evaluate misinterpreted Christian ideas about the body, including issues surrounding purity, sexuality and guilt. The Church needs to consider images of the 'ideal woman' promoted by the Church and indeed, portrayed in the Bible itself: an effective pastoral response would challenge the idealisation of virginity, domesticity, obedience and bodily shame. Ultimately, she concludes (alongside others, secular and religious) that the overriding culprit is patriarchy, and we must 'see the problem as part of a wider setting of institutional culture in a variety of Christian churches which tends to find it difficult to be open and honest about the limits of its patriarchal system and the costs which women pay for inclusion in that system'.[207]

Grenfell appeals for the Church to reflect and respond in a pastorally appropriate way, but does not give many concrete suggestions as to how this would work in practical terms. She suggests prayer and reflection on Biblical passages such as the wilderness narrative of the Exodus and a community exploration of female identity. However, she is wary of the risks and ineffectiveness of an 'outsider' challenging, or asking the sufferer to challenge, the traditions and structures of her own community. The solution Grenfell proposes is to journey with the anorexic, rather than ask her to challenge her beliefs.

[207] Grenfell, "Religion and Eating Disorders," 380.

However, as Grenfell has already asserted, misinterpretations of Christian ideas can be at the heart of the eating disorder, and it seems to me in these cases they must be ultimately be challenged and further study concerning how Grenfell's model of care could facilitate this is needed.[208]

Richards et al have written comprehensively on what a treatment model incorporating spirituality could look like, basing their model on that used at the Center for Change. A fuller explanation can be found in Chapter 5. The efficacy of a spirituality group model was tested in comparison to cognitive and emotional support groups for eating disorder inpatients, and findings suggested that those patients treated in the spirituality group (who attended a weekly 60-minute group and individually followed a spirituality self-help workbook in line with the Christian tradition[209]) improved more in spiritual wellbeing and had reduced psychological and eating disorder symptoms at the end of the study compared to those in the other groups. This was particularly noticeable over the first four weeks.[210] The authors however comment that this is a very specialised centre and the findings could not necessarily be generalised as most of their patients are religious.[211] This is an important caveat; not only due to patient demographic but also due to the ability of the practitioners at the centre. Although the psychologists at this centre are clearly both capable and willing to engage with spiritual treatment

[208] Grenfell, "Religion and Eating Disorders," 381-2.
[209] Scott Richards et al., "Comparative Efficacy of Spirituality, Cognitive and Emotional Support Groups for Treating Eating Disorder Inpatients" *Eating Disorders* 14, no.5 (2006): 401-415, 404.
[210] Richards et al., "Comparative Efficacy," 409-411.
[211] Richards et al., "Comparative Efficacy," 412.

models, it would not be practical, nor ethically acceptable, to expect a roll-out of this model in general to all psychologists. The ethical issues appear from both medical and religious points of view. On the medical front, it is unfair to practitioners who are trained and employed as psychologists/psychiatrists to insist they also train in specific religious beliefs and become sufficiently comfortable to engage with and even challenge them. To do so may also conflict with the personal beliefs of the practitioners. From a religious perspective, it appears risky to ask non-specialists to delve into what is currently unchartered territory for them (and potentially also for the patient) of spiritual well-being – unsettling a vulnerable patient's faith could do more harm than good.

Ultimately, the understanding of religion in general, and Christianity in particular, as both a help and a hindrance in the treatment of anorexia leads logically to the conclusion that spiritual and pastoral care should be incorporated into, or administered alongside, traditional medical treatment programmes. I will return to this in Chapter 5.

CHAPTER 3: METHODS

3.1. AIMS AND RATIONALE

To fulfil the aims set out in 1.2.2, I undertook semi-structured interviews with individuals in an acute eating disorders unit. A second phase of the study involved interviews with recovered women. This was necessary due to the low participant numbers on the ward.[212]

This research, as a small qualitative study, is not designed to further an argument for the existence of a link between Christian faith and anorexia nervosa; rather it is intended to deepen knowledge of how anorexia and faith can interact for women suffering from anorexia who are (or have been brought up) Christian. Although I identify trends and themes to pinpoint areas for further research and give suggestions for pastoral care, the relatively small sample size cannot justify generalising the same feelings and experiences to all Christian women with anorexia.

3.2. RESEARCH DESIGN

The research paradigm needed to lend itself to qualitative research, be in accordance with feminist principles and relevant to the areas of study: health and social sciences, women's studies and pastoral theology. Any research model is not an absolute: Miller and Crabtree define the qualitative interview as a 'craft'; there are no set rules and a

[212] The reasons for low participation are discussed in 3.2.3.

large part is down to situation and intuition of the researcher.[213] In practice, the research process is fluid and may take characteristics from different models and paradigms.

Having reviewed four competing paradigms described by Guba and Lincoln (positivism; post-positivism; critical theory and co-constructivism)[214] and adaptations of these models such as Reinharz's 'experiential analysis'[215] and Tillman-Healy's 'Friendship as Method'[216] I decided to use a feminist paradigm within which my research design could adapt as fieldwork progressed. In terms of research aims it seemed the most appropriate for interviewing women with the aim of retelling their deeply personal and potentially sensitive stories.

The key practical elements of a feminist research paradigm include researcher subjectivity; equality between researcher and participant; reciprocity of disclosure; and emphasis on the importance of researcher empathy. Practitioners are thus aware of the messy politics of women's experience and mental health. The interviewee becomes 'subject' rather than 'object' and the interview a joint enterprise,[217] enabling inclusion

[213] William Miller and Benjamin Crabtree, "Depth Interviewing," in *Approaches to Qualitative Research: A Reader on Theory and Practice*, ed. Sharlene Hesse-Biber and Patricia Leavy (New York: Oxford University Press, 2004), 185–202, 199.
[214] Egon Guba and Yvonna Lincoln, "Competing Paradigms in Qualitative Research," in *Approaches to Qualitative Research,* ed. Hesse-Biber and Leavy, 17–38.
[215] Shulamit Reinharz, "Experiential Analysis: a contribution to feminist research," in *Theories of Women's Studies,* ed. Gloria Bowles and Renate Duelli Klein (London: Routledge, 1983), 162–191.
[216] Lisa Tillman-Healy, "Friendship as Method," *Qualitative Inquiry* 9, no.5 (2003): 729–749.
[217] For example, Ann Oakley, "Interviewing Women: A Contradiction in Terms," in *Doing Feminist Research,* ed. Helen Roberts (London: Routledge, 1981), 30-62 and Tillman-Healy 'Friendship as Method'.

of constructionist elements in which meaning is created in the dialogue between the interviewer and participant.

Within this paradigm, I used the framework of Grounded Theory: Grounded Theory has its origin in healthcare sociology and the model I used was developed by Charmaz within a feminist constructivist paradigm. Charmaz described Grounded Theory as 'systematic yet flexible guidelines for collecting and analysing qualitative data to construct theories "grounded" in the data themselves'.[218] The original characteristics of Grounded Theory research, as proposed by Glaser and Straus[219] are: simultaneous data analysis and collection; no preconceived hypotheses; theory is developed at every stage of the research process; memo writing is used to explain categories and identify gaps in data; sampling is taken to enrich data rather than represent the population; and literature review is undertaken after analysis to prevent pre-conceptions. Although the earliest forms of Grounded Theory could be described as 'positivist' (Glaser) and 'post-positivist' (Corbin and Strauss), Charmaz's later model moves into interpretive tradition, looking for an 'imaginative representation' of the subject(s).[220] It emphasises processes and human interaction; accepts there is not always one objective 'truth'; and looks to legitimise, compare and understand people's realities and the processes by which they make meaning.[221] This model is known as 'Constructivist Grounded Theory': data and

[218] Kathy Charmaz, *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis* (London: Sage, 2006), 2.
[219] Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory* (Chicago: Aldine, 1967).
[220] Marilyn Plummer and Lynne Young, "Grounded Theory and Feminist Inquiry: Revitalising Links to the Past," *Western Journal of Nursing Research* 32, no.3 (2010): 305-321, 307.
[221] Charmaz, *Constructing Grounded Theory,* 125.

analysis are constructed by interactions between researcher and participant, neither of whom are detached from the process or the data.

Plummer and Young detail areas in which Constructivist Grounded Theory dovetails with and is enhanced by a feminist approach: appeal to personal narratives; creation of knowledge within a social framework; derivation of meaning from subjective interpretation; rejection of subject-object dualism; and the ultimate aim to promote social change. Appeal to subjective experience does not come 'risk free': Scott asserts that appeal to 'autonomy of experience' can in itself undermine the desire for social change that such paradigms seek; when we promote the idea that people from different demographics have different experiences and that these are all valid 'truth' without considering the 'politics of production' which cause different experiences, we often forget to question why there should be difference in experiences in the first place.[222]

I took Grounded Theory as a framework of principles rather than a set of absolutes, and have adapted it to fit my research. It was necessary that the model evolved as the research developed and I reflected on what worked best for my study. I have had to be flexible in certain areas due to requirements of the NHS Research Ethics Committee, time constraints imposed by the length of my course and availability of participants. Some initial reading had to be done to fulfil the 'rationale' aspect of the NHS REC requirements; and the rest of the literature review was completed in tandem with the

[222] Joan Scott, "Experience," in *Feminists Theorize the Political,* ed. Judith Butler and Joan Scott, (New York: Routledge, 1992): 22-40, 37.

final parts of the fieldwork. These are well-acknowledged issues; Henwood and Pidgeon point out that all researchers are well-read and come with preconceptions and instead suggest 'theoretical agnosticism' in which the researcher is aware of earlier theories but treats them cynically.[223] Charmaz notes that often a mini literature review must be completed for grant bids or research ethics proposals, and recommends setting it to one side whilst undertaking the study: effectively, try to forget what you have read and instead look for what emerges from the data.[224]

3.2.2. SEMI-STRUCTURED INTERVIEWS

To collect narratives I used semi-structured interviews. Miller and Crabtree suggest semi-structured interviews are appropriate when the following conditions are met: the scope of the enquiry is relatively narrow; the aim is to discover themes and create narratives; it is culturally appropriate; the interviewee is used to communicating in this way and there is a shared context between the interviewer and the interviewee.[225] All of these are pertinent to my research, and although I could not be sure the participants would be used to communicating in this way, it was probable that they would have experienced one-to-one therapy and thus not be disconcerted by a one-to-one interview. The semi-structured interview is a vehicle to hear the voices of the marginalised and a way to gain insight into the lived experiences of others.[226] An

[223] Karen Henwood and Nick Pidgeon, "Grounded Theory in Psychological Research," in *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design,* ed. Paul Camic, Jean Rhodes and Lucy Yardley (Washington DC: American Psychological Association, 2003), 131-155.
[224] Charmaz, *Constructing Grounded Theory,* 166.
[225] Miller and Crabtree, "Depth Interviewing," 188.
[226] Sharlene Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," in *Feminist Research Practice, A Primer (Second Edition),* ed. Sharlene Hesse-Biber (California: Sage Publications, 2014), 182–232, 186

unstructured interview would not have been appropriate as participants might have expectations of guidance from the interviewer.[227] This proved an accurate assumption: in the event all participants needed some guidance and the semi-structured interview allowed me to respond. Furthermore, as this was an NHS study, a level of clarity on the content of the interviews was required in advance to gain ethical approval.

The way interviewees are accustomed to communicating is worthy of further consideration. Minister argues that although women communicate in a different way to men, researchers all too often impose 'male'[228] research models on research of women.[229] A sensitive researcher needs to consider how women usually communicate and adapt accordingly, rather than expecting the subjects to adapt to research methods.[230] Minister suggests three ways of making the interview more appropriate to women: firstly, the interviewer should be a woman and thus more likely – although not guaranteed – to use the same methods of communication. Secondly, it is necessary to equalise any perceived power difference between interviewer and interviewee, and thirdly, to have reciprocity between interviewer and interviewee.[231] Minister also

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and Karl Nunkoosing, "The Problems with Interviews," *Qualitative Health Research* 15, no.5 (2005): 698–706, 699.

[227] Reinharz, "Experiential Analysis," 184.

[228] Minister speaks of 'male' research models. This choice of language makes a generalisation of typically male and female communication methods of which I am wary. Inevitably some men will use 'female' communication methods and vice versa. However, her point that those communications methods generally seen as 'masculine' by society, and more usually used by men are the methods prioritised in research models is still valuable. There are questions as to the validity of generalisations in describing methods of communication to be 'male' or 'female', however, as society tends towards these gendered descriptions, in this context her point is still valid.

[229] Kristina Minister, "A Feminist Frame for the Oral History Interview," in *Women's Words: The Feminist Practice of Oral History,* ed. Sherna Berger Gluck and Daphne Patai (London: Routledge, 1991), 27–42.

[230] Minister, "Feminist Frame," 31.

[231] Minister, "Feminist Frame," 35–37.

suggests that the interview should not be within a time frame, and there should be freedom to get to know each other beforehand. By allowing time and by indirect rather than direct questions, the story can emerge and grow in dialogue as the interviewer nurtures and assists the interviewee to develop her story, using women's typical methods of communication – intonation, laughter, nods and other non-verbal signs.[232] I endeavoured to follow Minister's advice – essentially, to talk and listen in the way women (typically) talk and listen to each other. For a week at the start of the study I was available on the ward to answer questions and get to know participants before interviewing. Minister recommends not setting a time frame, however, when working within the constraints of NHS goodwill this is not possible.

3.2.3. SAMPLING AND RECRUITMENT

Participants were selected purposefully for their insights and experience of the topic being studied.[233] Patton describes purposeful sampling in qualitative research: 'logic and power of purposeful sampling lies in selecting information rich cases for study in depth'.[234] Sampling was selective in inclusion criteria, and for phase one, the research site: an inpatient eating disorders unit. To fulfil the research aims, inclusion criteria for the semi-structured interviews were that participants must be female; over 18;

[232] Minister. "Feminist Frame," 36–37.
[233] Such an approach is typical for a qualitative study. Michelle Cleary, Jan Horsfall and Mark Hayter, "Data Collection and Sampling in Qualitative Research: Does Size Matter?" *Journal of Advanced Nursing* 70, no.3 (2014): 473–475, 473.
[234] Michael Patton, *Qualitative Evaluation and Research Methods,* (California: Sage, 1990), 184.

diagnosed with anorexia (including any sub-type); and be either a practising Christian or have had a Christian upbringing (any denomination).

Anticipated benefits of undertaking the study on an inpatient unit were the on-hand pool of participants and possibility of concurrent observation of the chaplaincy team's work. However, due to a shortage of inpatient participants, phase two was added. This shortfall was due to: severity of the illness of patients which meant they were unable to engage; patients under 18; and ward timetabling. The primary issue was that I was denied access to the day patient ward, despite having ethics and consultant permission to interview there: the nurses were understaffed and felt they could not cope with additional activities; and they were wary having recently had a bad experience with a researcher. One day patient heard of the study and joined phase two after she was discharged. This 'gate-keeping' was inevitable in an NHS setting. Gate-keeping on the inpatient ward, however, was advantageous to recruitment as the chaplaincy team identified eligible patients who might wish to participate and distributed information sheets and consent forms (appendices 1 and 2) two weeks prior to the study.

Cleary, Horsfall and Hayter discuss the importance of balancing sample size in qualitative research – too few participants can lead to a shortfall in data, both in depth and breadth; too many participants can generate too much data to systematically analyse.[235] I aimed to interview between six and twelve participants for the in-depth interviews, calculating I would need at least six narratives to generate sufficient data, but more than twelve

[235] Cleary, Horsfall and Hayter, "Data Collection and Sampling" 473.

would make the data unwieldy. Over both phases a total of nine narratives were analysed.

Participants for phase two of the study were recruited via 'snowball sampling' using social media, word of mouth, and university mailing lists. This no doubt had an impact on the demographics of the participants: all participants had completed further education and all but one (mixed race Caucasian/Asian) were Caucasian. This is a 'typical' demographic for anorexia sufferers.[236] Six participants were from the British Isles; two from the USA and one had lived in several countries including the UK. Participants expressed interest by email, having been told about the study by friends or seen it on a mailing list. They were sent information sheets and consent forms leaving them to contact me if they wished to participate. I recommended that any participants still in treatment should inform their treatment provider of their participation, and gave them an information sheet to pass on including my contact details.

I had intended to use theoretical sampling towards the end of the study to fit in with a Grounded Theory framework: sampling to further explore specific themes or categories that had emerged in the research thus far.[237] This transpired to be impossible, as I could not ascertain which categories my participants would deepen for me until the interview:

[236] A 2019 study showed that 92% of anorexia nervosa sufferers in the UK were of white ethnicity, slightly more than the 86% white shown in 2011 census statistics. The predominance of white women in anorexia statistics is predominantly due to its nature as a 'culture-bound' syndrome. Hristina Petkova et al., "Incidence of anorexia nervosa in young people in the UK and Ireland: a national surveillance study," *BMJ Open* 9, (2019): e027339.

[237] Charmaz, *Constructing Grounded Theory,* 100.

I discovered early an interesting theme of exorcism and how participants understood demon-possession in the context of mental illness. This was scarcely an appropriate screening question to ask before interview, so I continued to interview based on the initial sampling criteria but paid particular attention to specific categories identified in earlier interviews.

3.3. THE INTERVIEW PROCESS

3.3.1. INFORMED CONSENT

There are multiple issues surrounding informed consent in a study with vulnerable participants: providing sufficient information; continuous consent; coercion; and capacity to consent.

Byrne suggests several aspects to include in an information sheet and/or consent form in order to qualify for 'informed consent': explanation of research purpose, rationale behind selection of research subjects; research process; benefits, risks and 'discomforts'; discussion of anonymity/confidentiality; non-coercive disclaimer; explanation of how to withdraw; option to consent to partial disclosure; explanation of any alternatives; and opportunity for the potential participant to ask, and have answered, any questions.[238] I included as many of these as possible for both phases of the study. Research goals, inclusion criteria; explanation of the process; reassurance that participation was voluntary and separate to medical treatment; possible risks and

[238] Michelle Byrne, "The concept of informed consent in qualitative research," *Association of Operating Room Nurses Journal* 74, no.3 (2001): 401–403, 402.

benefits (and contingency plan should distress occur); and assurance of confidentiality were explained on the information sheet or consent form. Plans for dissemination of the research were explained, as was the process and timescale for withdrawal. Participants were assured they did not have to answer questions they did not want to (fulfilling Byrne's criteria of 'incomplete disclosure'[239]). Information sheets were distributed at least a week prior to interview to allow time to consider participation.[240] Examples of the types of interview question were also included.[241]

Informed consent was developed in a face-to-face meeting (phase one) or email conversation (phase two) with opportunity for questions.[242] Consent was given by signing a consent form, repeated verbally at the start of the interview. Several researchers discuss the issue of prior consent in qualitative in-depth research[243] arguing it is impossible to know in advance what themes and issues will arise, and thus impossible to consent to discuss them in a fully informed way. At the beginning, the researcher does not know themselves what questions may be asked. Therefore, these researchers advocate a process of 'continuous consent'. Seibold suggests participants should sign the form after the interview so they really are 'fully informed' as to what

[239] Byrne, "Informed Consent," 402.
[240] As recommended by Helen M. Richards and Lisa J. Schwartz, "Ethics of qualitative research: are there special issues for health services research?" *Family Practice* 19, no.2 (2002): 135–139, 137.
[241] As recommended by Roger A. Boothroyd and Katherine A. Best, "Emotional reactions to research participation and the relationship to understanding of informed consent disclosure," *Social Work Research* 27, no.4 (2003): 242–251, 249.
[242] As recommended by Boothroyd and Best, "Emotional Reactions," 249.
[243] Carmel Seibold, "Qualitative research from a feminist perspective in the postmodern era: methodological, ethical and reflexive concerns," *Nursing Inquiry* 7, no.3 (2000): 147-155; Lorraine Smith, "Ethical issues in interviewing," *Journal of Advanced Nursing* 17, no.1 (1992): 98-103; Linda Bell "Ethics and Feminist Research," in *Feminist Research Practice,* ed. Hesse-Biber, 73–106; Richards and Schwartz, "Ethics of Qualitative Research"; Nunkoosing, "Problems with Interviews,"; Byrne, "Concept of Informed Consent".

they are consenting.[244] In theory this is a sound idea, however there are practical problems, not least requirements of NHS Research Ethics, which applied to my study. In order to accommodate the changeable nature of the research, I included elements of 'continuous consent'. Firstly, I explained in the information sheet and at the start of the interview that there was no obligation to answer any particular questions. Secondly, I typed the transcript of the first interview and either gave it to the participant at the second interview (phase one) or via email follow up (phase two) at which point the participant had the opportunity to remove any data.[245] Some took up this offer, primarily to clarify things they felt had been unclear rather than to remove information.

One of the main issues in informed consent is the possibility of coercion. Coercion can occur when there is a perceived duty or debt to the researcher, for example, when the researcher is also the healthcare provider.[246] Although participant information sheets were distributed by the chaplaincy team in phase one, it was made clear research was by an external researcher with whom the potential participants had no previous connection. No incentives were offered for participation (financial or otherwise) and it was explained that choosing not to participate would not affect their care. In phase two, I emphasised there was no obligation to participate when I sent information sheets, and participants had to make the first contact.

[244] Seibold, "Qualitative Research from a Feminist Perspective," 149.
[245]As recommended by Nunkoosing, "Problems with Interviews," 703 and Seibold, "Qualitative Research from a Feminist Perspective," 149.
[246] Byrne, "Concept of Informed Consent," 402.

The final issue to consider is capability to consent. Inevitably, due to the inclusion criteria of a diagnosis of anorexia, participants are considered 'vulnerable', particularly those in treatment at the time of the study. Those at very low weights could be considered incapable of consenting to participate by virtue of their consequent cognitive impairment. Boothroyd and Best demonstrated that participants with mental health symptomology have a less 'informed' understanding of research.[247] As their study was amongst welfare recipients and did not distinguish between different mental health problems, this is not necessarily helpful; indeed, Koivisto et al suggest that unless a potential participant is openly psychotic or suffering from long-term psychosis they can usually be considered capable of understanding and consenting to research.[248] Sufferers of anorexia are typically highly educated, intelligent and articulate – well able to understand the information sheets.[249] There is an argument that patients who were not admitted to hospital under Section 3 of the Mental Health Act, were in hospital of their own accord voluntarily consenting to treatment. If they have capacity to consent to treatment, it follows that they have capacity to consent to research.

Saukko discusses the issue of capability to consent in her research with anorexic women. She points out that it is important not to patronise sufferers of anorexia, especially since the aim of such research is to allow the voices of those who have 'traditionally been

[247] Boothroyd and Best, "Emotional Reactions," 246.
[248] Kaisa Koivisto et al., "Applying ethical guidelines in nursing research on people with mental illness," *Nursing Ethics* 8, no. 4 (2001): 328–339.
[249] Carolina Lopez, Daniel Stahl and Kate Tchanturia, "Estimated intelligence quotient in anorexia nervosa: a systematic review and meta-analysis of the literature," *Annals of General Psychiatry* 9, no.40 (2010).

silenced as disordered and incapable' – to be heard.[250] Although there are issues in assuming capability of vulnerable patients, it equally cannot be assumed by a researcher that they are not capable. Following the advice of Koivisto et al[251] I decided to assume that the potential participant was capable so as to avoid prejudice, but to ask the medical staff to consider each patient on a case-by-case basis. The consent form included a request to inform the participant's doctor of their participation, and created a separate information sheet for the healthcare team (appendix 3) with a request for the doctor to contact the chaplaincy team or researcher if he/she had any concerns about the participant's capability to consent or any increased risk to the patient should they participate. All participants in phase two described themselves as 'recovered' either fully or to a great extent. When a potential participant still in treatment requested information about the study, I asked her to discuss it with her doctor before making a decision on participating.

3.3.2. INTRODUCING THE INTERVIEW

Each interview began with a preamble to ensure the participant was fully informed.[252] I ensured the participant understood she did not have to answers any questions that made her uncomfortable and that we could pause or stop at any time. In phase one the chaplaincy team were available if needed. I reiterated that she was free to withdraw

[250] Paula Saukko, "Between Voice and Discourse: Quilting Interviews on Anorexia," *Qualitative Inquiry* 6, no. 3 (2000): 299–317, 300.
[251] Koivisto et al, "Applying Ethical Guidelines," 332.
[252] As recommended by Rosanna F. Hess, "Postabortion research: methodological and ethical issues," *Qualitative Health Research* 16, no.4 (2006): 580–587, 583 and Seibold, "Qualitative Research from a Feminist Perspective," 149.

from the study at any time up to six months after completion of interviews. I asked permission to record the interview to transcribe later and explained I would give her a copy of the transcription and we could discuss it at second interview or via email, when she would have the chance to remove anything she was uncomfortable with or felt I had misinterpreted or misrepresented.[253] I also checked she was agreeable to me making brief notes in addition to the recording to help me transcribe it as accurately as possible. Finally, I explained the arrangements for secure storage of data, confidentiality and pseudonymisation and asked if the participant had any further questions.

At this juncture, I felt I should acknowledge my own motivations for undertaking this research; partly in order to equalise any perceived power difference and acknowledge my 'insider' status and partly for the sake of openness in accordance with feminist research practice. Many of the phase two participants asked outright why I was undertaking this research. The main purpose of this disclosure was to reassure the participant of a level of empathy and understanding; I was aware that this was a sensitive research topic[254] and that some details about the illness may be embarrassing, and wanted to put the participant at ease. I was careful not to disclose my views on faith and anorexia in order to reduce possibility of bias to the data, although when participants asked for the premises of the research I gave a brief overview of the studies which provided the rationale. In this, I took the advice of Seibold who also undertook

[253] As recommended by Seibold, "Qualitative Research from a Feminist Perspective," 149.
[254] Defined as has 'the potential for threat to those involved' Hess, "Post-abortion Research," 580. Hess gives examples of sensitive research, including bereaved people, health care users, substance abusers and others. It is clear that any research into anorexia nervosa would fall into this category.

feminist research from an 'insider' position[255]: she suggests when confronted it is best to emphasise what is only opinion to avoid setting oneself up as an expert, and to cite sources where possible.[256] This approach fitted better with the NHS Ethics requirements than any model involving co-construction of meaning. I left the possibility for a more reciprocal dialogue (as suggested by Oakley[257] and Tillman-Healy[258]) in the second interview (phase one), or after the formal interview (phase two).

3.3.3. INTERVIEW TECHNIQUE

Many feminist researchers purport that a good relationship between interviewer and interviewee leads to good data.[259] However, this is not the only factor in achieving a good outcome;[260] it is also necessary for the interviewer to have skills of interviewing.

A semi-structured interview provides a balance between structured (a list of set, often closed questions) and unstructured interviews.[261] The former is not conducive to gaining a rich understanding of the subjective experience of the participant; rather, it looks only for what the interviewer wishes to see. The latter does not provide the necessary focus

[255] Seibold, "Qualitative Research from a Feminist Perspective," 148.
[256] Seibold, "Qualitative Research from a Feminist Perspective," 150.
[257] Oakley, "Interviewing Women".
[258] Tillman-Healy, "Friendship as Method".
[259] This view is illustrated by Oakley, "Interviewing Women," 47; Nunkoosing, "Problems with Interviews," 698 and Tillman-Healy, "Friendship as Method".
[260] By a 'good interview outcome' I mean that the participant has a positive experience and the researcher gathers sufficient relevant data.
[261] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 186.

to fulfil research aims nor provides the necessary structure for interviewees who are expecting a straight 'question and answer' style interview.[262]

I used extant autobiographical texts by Christian women with eating disorders as a starting point. They effectively acted as 'initial interviews' from which my first themes emerged. I have chosen not to include them in the data analysis, and instead to present them in the literature review, returning to them as comparisons for my data analysis. The interview began with straightforward, factual questions designed to provide basic data and to break the ice[263]; such as age, occupation and faith e.g. 'do you identify as any particular denomination or attend a particular church regularly?' For the main 'grand tour'[264] questions, I began with broad 'domains of inquiry'[265] before focusing on different aspects, depending on participant direction. I identified themes from the literature review as a starting point but left them sufficiently open to allow participants to tell their own story and create their own meanings rather than biasing the narrative to my preconceived ideas.[266] The questions were phrased to be clear but open-ended, although I did have prompts in case a participant 'froze'. I ended with questions less likely to evoke an emotional response (based on previous responses) to allow the participant to emerge gently from the depths of emotion before returning to the ward or their normal life.[267]

[262] Reinharz, "Experiential Analysis," 184.
[263] Miller and Crabtree, "Depth Interviewing," 192.
[264] Miller and Crabtree, "Depth Interviewing," 192.
[265] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 193.
[266] The Interview Guide can be found in appendix 7.
[267] As recommended by Miller and Crabtree, "Depth Interviewing," 199.

I anticipated that the research design and the questions would develop over the course of the interviews as categories emerged. The intention was that the topic guide would be fluid and evolve as the study progressed to encompass emerging themes and take into account participants' own ideas and responses, as is fitting for an exploratory research study in a Grounded Theory framework.[268] Early participants mentioned difficulties around Christian celebrations, such as Christmas, so I incorporated this into later interviews, asking "Some people have mentioned…. Does this resonate with you?" as recommended by Charmaz.[269] There is a fine line between following emerging categories and asking loaded questions, so before asking questions which emerged from earlier interviews I reiterated that they may not be relevant and that the participant should feel completely comfortable saying so. In the event I was glad I asked such questions as, returning to the exorcism theme, one participant had forgotten her experience until I prompted her, at which she remembered major events in detail (perhaps suggesting she had pushed the memory aside, akin to a traumatic experience).

Moving from broader themes to more specific questions I looked for 'markers' in the participant's response, to follow their own unique story and feelings. It was these that determined which themes I pursued. These 'markers' could be things half said, things avoided, or emotions or events slipped in which needed expansion. David Karp[270] describes these as part of his interview style and suggests that if the right question can

[268] Seibold, "Qualitative Research from a Feminist Perspective," 147 and Charmaz, *Constructing Grounded Theory,* 16.
[269] Charmaz, *Constructing Grounded Theory,* 16.
[270] David Karp, cited in Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 207-208.

be found, the interviewer needs do little more, as the narrator will tell their own story. In some interviews, participants needed little more than a thematic prompt question before weaving their own story. Others needed more direct questioning.

Several feminist researchers suggest a good researcher should be empathetic, reciprocal, and yet remain sufficiently distanced to avoid biasing the results with her own views.[271] She should assist the participant in creating and interpreting her story by gently guiding her as co-participant in the research. Finally, the researcher should listen, not merely to what is said, but to how it is said and what is not said.[272] I concluded that the research interview should be treated like the texts I was discussing, using a hermeneutic of suspicion to reflect on the subject's own underlying motives and conditioned beliefs about what is acceptable to say and what is not.

Kathryn Anderson's reflection on her own research practice was particularly helpful. She describes how, in her research with rural farm women, she heard only what they said at face value in an effort to keep to her research agenda and missed the subtext of their responses, including their emotions and the meanings they gave to their experiences.[273] Dana Jack notes that also important was the need to consider 'meta-statements' when the participant commented on her own thoughts and what she had previously said.[274]

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[271] Some examples include Seibold, "Qualitative research from a feminist perspective," 147-155; Ellen S. Cohn and Kathleen D. Lyons, "The perils of power in interpretive research," *American Journal of Occupational Therapy* 57, no.1 (2003): 40-48; Oakley, "Interviewing Women"; and Hesse-Biber, "Feminist Approaches to In-Depth Interviewing".
[272] Kathryn Anderson and Dana Jack, "Learning to Listen: Interview Techniques and Analysis," in *Women's Words,* ed. Gluck and Patai, 11–26, 15-16.
[273] Anderson and Jack, "Learning to Listen," 12-17.
[274] Anderson and Jack, "Learning to Listen," 21.

As this was to prove extremely helpful in interpreting narratives, I actively encouraged such self-reflection, particularly in follow up interviews in which we discussed the first interview transcript.

I found the use of probes helpful to gently encourage the subject to explore and create her own story. This technique is suggested as a method to encourage and support the subject without interfering and thus biasing the results. Hesse-Biber describes four types of probes. First the 'silent probe', essentially non-verbal encouragement to show interest, e.g. nodding. Next, the 'echo probe' where the researcher repeats previous words of the subject and asks for clarification or development; this helps search for new meaning and keeps momentum without changing the direction of the conversation. Third the 'uh-huh' probe, once more an encouragement or affirmation of the subject's story – this time verbal. Finally, the 'leading probe' is a tool for the researcher to lead towards a particular line of inquiry or research topic by bouncing off the subject's described experiences; gently changing the direction of the conversation.[275] For example, if a participant spoke about their experiences of church services, I could lead them with: 'So how do you feel about taking communion?' This strategy walks the fine line between fulfilling research criteria and allowing the subject to be in charge of her own story.[276] It was clear from reading back my own transcripts that on occasions I got this right, and on others I missed obvious prompts and had to return to the issue in the follow up.

[275] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 198.
[276] Anderson and Jack, "Learning to Listen," 24.

One of the key difficulties in sensitive researching of an emotionally charged topic is finding a balance between creating a space for the subject to tell her story, guiding her through this process, and encouraging her to discuss traumatic issues.[277] Unfortunately, there can be no set rules on how to avoid this conundrum – a process described by Miller and Crabtree as 'unpredictable and collaborative storytelling'[278] – empathy and intuition had to be my guide as to when a participant did or did not want to discuss an emotive issue.

3.3.4. PILOT INTERVIEW

As this was my first experience of interviewing, I carried out a pilot interview.[279] To simulate the 'real' study and uncover as many flaws in the research design as possible, I asked a friend (Abby[280]) who fulfilled the inclusion criteria. The pilot interview was carried out over Skype, so I could practise picking up on non-verbal markers, such as body language and expression. I used a draft of my interview guide and explained that rather than noting her answers, I would note how she responded to questions: did she understand them? Were they appropriate? Were any distressing? During the interview I practised looking for markers and using probes.

[277] Anderson and Jack, "Learning to Listen," 14.
[278] Miller and Crabtree, "Depth Interviewing," 199.
[279] This is recommended by Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 194 and also demonstrated by Hess, "Post-abortion Research," 582.
[280] A pseudonym.

I asked whether she would recommend any amendments to the questions and concluded that they were adequate; I had been concerned question 10 asked about too many issues at once: 'Are there any Bible passages or church teachings that make you feel uncomfortable, either about eating, body image or gender?' Abby assured me that the choice to talk about 'eating, body image or gender' was welcomed, as the general, open-ended nature of the question allowed her to discuss issues important to her and also reduced the likelihood of participants having nothing to say. One area Abby queried was the Protestant nature of some questions: I had written them using Protestant terminology, 'Communion' and 'Bible passage'. For Abby, a Roman Catholic, the word 'Communion' was confusing and I had to 'translate' it to 'Mass'. She was puzzled by the expectation that she would know Bible 'passages'; she used the language of 'readings' or 'stories'. I changed the question to 'Bible stories or church teachings' and determined to ask questions about Communion/Eucharist/Mass as applicable (or not at all), depending on the denomination specified at the start. Finally, she suggested some of the language was complicated; I had initially asked 'how do you envisage God?' This confused Abby, as she did not know whether I meant in character or literally in terms of picturing God, so I amended it to 'how do you understand God's character?'

In terms of level of distress, Abby did not admit any discomfort from the interview; however, I could tell the questions were, at times, challenging and she noted they required her to reflect on issues she had not previously considered. I discovered my decision to use a feminist paradigm rather than a positivist one to be realistic, as I found it very difficult not to be drawn in emotionally (particularly when she spoke of her suicide

attempt). This can partly be attributed to our friendship. However, in many ways it was harder with study participants as I was hearing their stories for the first time, whereas none of Abby's narrative was new.

3.3.5. DATA COLLECTION

Data was collected primarily through audio recording. The method was described on the participant information sheet and discussed at the start of the interview. Participants gave verbal consent for recording. Where possible, and where relevant, I made notes about body language, for example, pulling faces. This proved harder in the Skype interviews. Two participants requested that we did not use a Skype video, just audio: both stated it was due to not having a webcam or a broken webcam rather than a preference. The audio recording generally worked well, but in one interview (Rose), the recording cut out twice resulting in missing data and she filled in the gaps afterwards via email.

I kept a research journal during phase one on the ward, and during phase two I emailed my reflections to my supervisor after each interview. This was to note emerging themes and to reflect on my own experiences and interview practice. When mentioning participants only initials or pseudonyms were used.

3.4. ETHICAL ISSUES

3.4.1. BENEFITS

The primary benefit of the study is based firmly in its aims: to further understand the link between Christianity and anorexia, and to learn about patients' experiences of anorexia and pastoral care in order to help health professionals and chaplains better respond to sufferers in the long-term. There is also scope for considering religious belief as a risk factor for anorexia which could assist in future illness prevention or early intervention. As an initial exploratory study; it is difficult to gauge the long-term benefits as it is hoped future studies will build on the findings, but in likelihood the benefit will be greater understanding and therefore improved pastoral care for future sufferers of anorexia.

The study aims to benefit future patients rather than participants. However, many researchers suggest simply taking part in in-depth qualitative research can provide benefits. Researchers have cited the therapeutic benefits of having someone listen in a non-judgemental manner: Hess describes the 'therapeutic value of disclosure'[281] in her research with women post-abortion; Murray speaks of development of self-understanding in interviews[282] and Nunkoosing acknowledges that in-depth interviews can be therapeutic, whilst warning that it 'should not be considered as therapy'.[283] The process of creating one's own narrative through storytelling is described by both

[281] Hess, "Postabortion research," 583.
[282] B. Lee Murray, "Qualitative Research Interviews: therapeutic benefits for the participants," *Journal of Psychiatric and Mental Health Nursing* 10 (2003): 233–236, 234 demonstrates the therapeutic value for adolescents of having someone to talk to about their experiences of parental alcohol abuse.
[283] Nunkoosing, "Problems with interviews," 703.

Ganzevoort and Cooper-White as the way we formulate our identities. Interviews help the narrator make sense of his or her own experiences.[284] Cooper-White describes narratives as a way of making sense of painful experiences; it is through retelling and sharing one's story that sufferers find meaning, and from this healing.[285]

Although the overwhelming opinion seems to be that telling one's story to someone willing to listen non-judgementally can have benefits, I believe Nunkoosing is right to be wary. For a healthcare professional or chaplain undertaking research, boundaries could be blurred. For a researcher untrained in counselling or pastoral work, it is even more important to avoid embarking on any attempt at 'therapy'. It seems there are possible benefits to participants, but these cannot be guaranteed. Furthermore, it is extremely important to emphasise that the interview is not to be seen as a therapeutic encounter. The researcher should be an attentive and compassionate listener, but must not slip into the role of therapist.

Koivisto et al reported that participants in a study of psychiatric patients' experiences found they were pleased someone was interested in their experiences.[286] Biddle et al report similar findings in research into self-harm[287] and that patients were keen to assist research that might help other patients in future; for the majority of patients even if

[284] R. Ruard Ganzevoort, "Investigating Life Stories: Personal Narratives in Pastoral Psychology," *Journal of Psychology and Theology* 21, no.4 (1993): 277–287, 277.
[285] Pamela Cooper-White, "Suffering," in *The Wiley-Blackwell Companion to Practical Theology,* ed. Bonnie Miller McLemore (Chichester: Wiley-Blackwell, 2011), 21–31, 29.
[286] Koivisto et al, "Applying ethical guidelines," 336.
[287] Lucy Biddle et al., "Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research," *Journal of Affective Disorders* 145 (2013): 356–362, 359.

distress was experienced they found the research experience overall to be good as feelings of distress were outweighed by the fulfilment they gained.[288] It is, however, important to recognise that feelings of guilt and desire to be self-sacrificing associated with many mental illnesses, including anorexia, may contribute to the wish to participate and must not be exploited in recruitment.[289] Consequently, I reiterated that the research was entirely voluntary at every opportunity.

3.4.2. RISKS

Every research study carries some level of risk to participants. Richards and Schwartz pinpoint possible risks to participants that are pertinent for health services research: anxiety and distress; exploitation; misrepresentation; and identification of the participant in published work.[290] I use these as headings for the following discussion, plus one further issue – risk to researchers.

3.4.2.1. ANXIETY AND DISTRESS

Research has shown the more sensitive the topic researched, the more likely a participant will become distressed. In a study by Biddle et al of self-harm patients, 22% found the interviews contributed to a lowering of their mood.[291] Hess also describes the pain participants in her research about abortion experienced in reliving their own

[288] Biddle et al., "Qualitative Interviewing," 360.
[289] Koivisto et al., "Applying Ethical Guidelines," 333.
[290] Richards and Schwartz, "Ethics of qualitative research," 135.
[291] Biddle et al., "Qualitative interviewing," 358.

experiences.[292] My study, asking patients to discuss their experiences not only of a deeply personal illness, but their faith, is undoubtedly 'sensitive' and therefore liable to cause distress. They may be telling their story for the first time and thus reflecting on issues they have not considered before. On opening up their lives and innermost thoughts to a stranger, they are making themselves vulnerable.[293] The topics covered in interview could open a 'can of worms'[294] causing the participant to question her own experiences and identity,[295] or causing distress by reflecting on emotional pain.[296] Boothroyd's synthesis of health-related qualitative studies shows 2% of participants become depressed and 5% experience some distress. He further suggests there are increased levels of distress amongst patients with mental health difficulties.[297]

Byrne proposes that 'information regarding participants' sexuality, intelligence, personality traits, or beliefs related to social, political or religious values'[298] should be avoided. I strongly disagree with Byrne; it is this very attitude standing against the combination of spirituality and healthcare which has led to the failure of many healthcare systems to consider the individual holistically – we cannot bracket out such an important part of the lives of people and still expect the best possible chance of

[292] Hess, "Postabortion Research," 584.
[293] Nunkoosing, "Problems with Interviews," 700.
[294] Virginia Dickson-Swift et al., "Doing sensitive research: what challenges do qualitative researchers face?" *Qualitative Research* 7, no.3 (2007): 327–353, 338.
[295] Richards and Schwartz, "Ethics of Qualitative Research," 136.
[296] Barbara Johnson and Jill Clarke, "Collecting sensitive data: the impact on researchers," *Qualitative Health Research* 13, no.3 (2003): 421–434, 430.
[297] Boothroyd and Best, "Emotional Reactions," 243.
[298] Byrne, "Concept of Informed Consent," 402.

recovery, particularly in the field of mental health. However, these are very personal areas of discussion, and should be dealt with sensitively.

Boothroyd and Best recommend a risk assessment into the emotional impact on a participant, taking into consideration likelihood of distress and potential level of distress.[299] The very nature of semi-structured interviewing is that we cannot know what issues will arise in advance and thus cannot accurately predict risk.[300] Due to the possibility of greater risk for some participants, I ensured in phase one that ward doctors were informed about the study and asked to raise any concerns on a case by case basis.[301] None were.

It is the responsibility of the researcher to consider potential risks to participants, and the suggestions above of emotional distress are in many ways a 'worst case scenario'. Other researchers argue that, although these risks must be addressed, in reality they are far less likely than the literature implies. Corbin and Morse cite their 50 years of experience in qualitative research, in which they have never had any incidents of emotional distress.[302] They argue the very format of unstructured interviews (and similarly semi-structured interviews) makes it possible to manage risk as the direction of the interview is largely in the control of the participant.[303] They point out that,

[299] Boothroyd and Best, "Emotional Reactions," 242.
[300] Johnson and Clarke, "Collecting Sensitive Data," 423.
[301] Koivisto et al., "Applying Ethical Guidelines," 332.
[302] Juliet Corbin and Janet Morse, "The Unstructured Interactive Interview: Issues of Reciprocity and Risks when Dealing with Sensitive Topics" *Qualitative Inquiry* 9, no.3 (2004): 335–354, 336.
[303] Corbin and Morse, "The Unstructured Interactive Interview," 337.

assuming consent was sufficiently informed and no coercion has taken place, a participant who does not want to talk about an issue will not volunteer for the study.[304] This final point I find laissez faire in attitude; it is perfectly possible someone would want to talk but still find it difficult. Nonetheless, handing the control of the interview to the participant goes a long way to mitigate the risk of emotional distress.

I concluded emotional distress to participants was unlikely, but should be prepared for. I left interview questions broad so that participants did not have to answer anything they did not want to, and reiterated at the start that all questions were optional. Although I picked up on 'markers' and used prompts to gain more detailed information, I also took the advice of the literature and tried to avoid pressurising any participant holding back.[305] In the event, only one participant became distressed and she quickly recovered. I was reassured that her partner was collecting her from the interview.

One issue that needed considering was the possibility that participants would reveal something that might need to be passed on for the sake of their own safety (e.g., self-harm). To avoid issues with confidentiality, the consent form included a clause which allowed such information to be passed to the healthcare team, with the knowledge of the participant. In phase two, this was not practical, but I planned to encourage the participant to seek help. A further issue was how to respond should a participant say something clearly negative about herself (an issue experienced by Saukko in her work

[304] Corbin and Morse, "The Unstructured Interactive Interview," 338.
[305] Anderson and Jack, "Learning to Listen," 25 and Smith, "Ethical Issues in Interviewing," 102.

with anorexic women[306]). If a woman described herself as 'fat' or a 'failure' should I react? Or should I take that as her 'authentic voice'? I concluded that, in such a situation, the risk to the participant of saying nothing (and thus seemingly agreeing) was greater than stifling her 'authentic' voice which told her negative things about herself (it could also be argued that this is not the authentic voice of the participant, but of anorexia), and thus I decided I would (and in the event, did), without interrupting, query any such self-harmful negative statements at a suitable point in the interview. This only occurred with Tracy, who was still in treatment.

According to Boothroyd and Best, 92.8% of participants have 'good' experiences of research and it is the minority who experience distress – 95% do not.[307] Saukko concludes that, although some women found it 'hard' to read their own stories, the majority 'had a fairly undramatic if friendly approach to my work. This is a healthy reminder that describing scholarship in terms of either exploitation or empowerment may in most cases be exaggerated, and that we should humbly acknowledge that our research…. often plays a minor role in the lives of those we study.'[308]

3.4.2.2. EXPLOITATION

There is a risk of vulnerable patients being exploited for the researcher's own ends; essentially treated as a source of data rather than a human being. Although this is, to a

[306] Saukko, "Quilting Interviews," 299.
[307] Boothroyd and Best, "Emotional Reactions," 243, 248.
[308] Saukko, "Quilting Interviews," 315.

certain extent, mitigated by appropriating a feminist paradigm based in equality of researcher and researched, this raises other issues. By developing a friendly rapport with the participant,[309] does the participant then feel duty bound to disclose more? Is this in itself a form of exploitation?[310] The relationship between researcher and participant and the power dynamics therein are worthy of longer discussion.

The issue of exploitation is also raised in the methods of selecting participants; phase one of my study was on an inpatient unit. Helgeland describes concerns in her study of prisoners that she is taking advantage of the situation of her participants; they are captive in one location, and have nothing else to do. Is it exploitation to take advantage of their boredom?[311] This was a very real possibility in my research. I know from my own experience that life on an inpatient eating disorders unit is predominantly mind-numbingly boring: I certainly took part in studies as recreation for a lack of anything better to do. It could be (tenuously) argued that this is a benefit for participants – research as recreation. However, what participants give in terms of allowing the researcher into their lives is hardly equal to an hour less boredom. It was difficult to ascertain how to avoid this conundrum, and to a certain extent impossible – however, it was necessary to be aware of this to ensure that participants were fully aware of what the study entailed and willing to participate, rather than agreeing for the sake of it.

[309] As suggested by Tillman-Healy, "Friendship as Method," and Oakley "Interviewing Women".
[310] Cohn and Lyons, "Perils of Power," 45.
[311] Ingebourg M. Helgeland, "Catch 22 of research ethics: ethical dilemma in follow-up studies of marginal groups," *Qualitative Inquiry* 11, no.4 (2005): 549–569, 560.

Voyeurism is a concern in research of vulnerable groups. Both researchers and readers can have a tendency to sensationalise the lives of people they study.[312] This is of particular risk in the study of anorexia; in general people find the illness a fascinating phenomenon and the attention the media has paid to it in recent years has cemented this. Connected is possible invasion of privacy; a very real risk in any mental health research, perhaps even more so in one that also researches religion. Koivisto et al, in their study of psychosis patients state that to do so causes harm and thus contravenes the principle of nonmaleficence.[313] Mental health patients are often sensitive to the views of others and eager to please due to low self-esteem: this could result in either a participant feeling they ought to participate, or lead to over-disclosure and invasion of privacy.[314] I attempted to be aware if participants were uneasy about disclosing and gave them the opportunity to permanently delete anything from the transcript before analysis ('veto rights'[315]).

Finally, there is the issue of the therapeutic encounter. It is possible some participants may find the interview therapeutic which can lead participants to reveal more than they intend and forget that what they say is being recorded.[316] It can also allow the participant to have expectations of a therapy session, which will not be fulfilled. This

[312] Josephine Ensign, "Ethical Issues in Qualitative Health Research with Homeless Youths," *Journal of Advanced Nursing* 43, no.1 (2003): 43–50, 48.
[313] Koivisto et al., "Applying Ethical Guidelines," 334.
[314] Koivisto et al., "Applying Ethical Guidelines," 334.
[315] Ensign, "Health Research with Homeless Youths," 48.
[316] Richards and Schwartz, "Ethics of Qualitative Research," 136.

risk was greater in a hospital environment, but was somewhat mitigated as I was not taking on a dual role of healthcare worker and researcher.[317]

3.4.2.3. MISINTERPRETATION

One of the aims of feminist interviewing is to provide a channel for the voice of a (usually) silenced minority.[318] However, ultimately it is the researcher who tells the story, chooses what to include and which words and quotations to use.[319] Although the researcher has an obligation to protect participants and to tell their story authentically,[320] even with the best intentions this can sometimes not work out – we cannot but help hear the story in our context, from our own viewpoint.[321] However, the very point of research is for the researcher to bring their own knowledge and concerns to interpretation of the narrative[322] – and this is a right (albeit also a responsibility) that few researchers would want to relinquish. The task is to find a balance which keeps the authenticity of the narrator's voice and allows her to be in charge of her own story whilst interpreting it in a (sensitive) manner which also fulfils research aims.[323] In this way, the interpretation of the researcher, rather than detracting and contradicting the narrative, deepens and enriches it.[324]

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[317] This issue will be returned to in section 3.4.3.
[318] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 184.
[319] Cohn and Lyons, "Perils of Power," 41.
[320] Cohn and Lyons, "Perils of Power," 40.
[321] Katherine Borland, "That's Not What I Said," in *Women's Words* ed. Sherna Berger Gluck and Daphne Patai (London: Routledge, 1991), 63–76, 64.
[322] Borland, "That's Not What I Said," 73.
[323] Anderson and Jack, "Learning to Listen," 24.
[324] Borland, "That's Not What I Said," 73.

One way to do this is to be aware of our biases and to reflect on them.[325] Hesse-Biber speaks of first and second level meanings: the words of the narrator and interpreter respectively.[326] We need to carefully distinguish between the two and take care not to belittle the narrator's own words. Reinharz suggests that one way is to interpret the narrative together with subject (in the style of a participatory model), although this does mean undertaking data collection and interpretation simultaneously.[327] Thus, I followed up with each participant after sending her the transcript: I put forward my suggestions and the participant put forward hers. In this, I aimed to reach agreement, although this was not a guaranteed outcome. Cohn and Lyons strongly advocate 'member checking' of either the completed work or the transcript.[328] The risk of only having the transcript checked is that the researcher's interpretation has still not been included. The risk of checking the completed work is that the participant can disagree, and then where does this leave the research? To what extent should the researcher leave his/her own interpretations and to what extent should he/she bow to the narrator's self-understanding?

In writing the narratives, I took inspiration from Paula Saukko's work with anorexic women. She uses a 'quilting' approach in which she weaves together stories and her interpretations. She constructs her text as dialogic between narrator and reader, switching between first and third person for the story (including direct quotations) and

[325] Borland, "That's Not What I Said," 65.
[326] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 190.
[327] Reinharz, "Experiential Analysis," 182.
[328] Cohn and Lyons, "Perils of Power," 45.

her interpretations. Although the third person voice suggests that she is outside looking in, the way it is weaved into the texts shows she 'wrestles with [the stories] personally and theoretically'.[329] By doing this, she makes clear what is her perspective and which are the words of the subjects. By weaving the stories together she adds multidimensional layers, considering influences of cultural discourse on participant's understandings of themselves and their illness.[330] Finally, she is careful not to dismiss any of their words as 'anorexic thinking' or 'bad'.[331] To label or dismiss their thoughts as such would be to put herself in a position of power and to defeat the purpose of her own research – to empower the lost voices of those traditionally considered 'disordered'.[332]

I adopted Saukko's method, weaving my own interpretations into the narratives, and attempted to distinguish first and second level meanings by use of italics and direct quotes in the narratives. I adopted her method of organising material thematically in the data analysis. However, I left the narratives as whole units in themselves to allow an uninterrupted flow of the narrator's 'voice'. This method also fulfilled Cohn and Lyons requirement for 'transparent' analysis and interpretation in order to equalise the power differential in the interviewer/interviewee relationship.[333]

[329] Saukko, "Quilting Interviews," 303.
[330] Saukko, "Quilting Interviews," 304-305.
[331] Saukko, "Quilting Interviews," 304.
[332] Saukko, "Quilting Interviews," 300.
[333] Cohn and Lyons, "Perils of Power," 46.

There is a balance to be struck between preserving the subject's authentic voice and looking beyond what is said. What if the subject's 'authentic' story is hidden within the fog of cultural discourses and what is considered 'acceptable' to say? Anderson and Jack recommend that, whilst allowing her space and freedom to tell her own story, a feminist researcher should also be looking at underlying factors and stories behind the face-value narrative which may unconsciously adhere to dominant (patriarchal) frameworks.[334] In my study, is the narrator unconsciously adhering to popular medical discourses, or media portrayals of anorexia? Is she telling the story she thinks she should tell, rather than telling her story as she really feels it? Ganzevoort writes of Ricouer's understanding of developing an identity through narrative interpretation (hermeneutics).[335] I suggest we should interpret such narratives using another of Ricoeur's tools – hermeneutic of suspicion.[336] In a similar way to Fiorenza,[337] we need to appropriate this hermeneutic of suspicion for feminist research, and question the dominant worldviews which colour our narratives – both in what is said, and in what is not said. However, it is important to heed the warning of Nunkoosing, who notes the importance of being open to new meanings and avoiding leaning towards one's bias, and instead bracketing our preconceptions.[338] Ultimately, it is the researcher who holds the power balance at this point in the process, and it is necessary to be cautious of this and engage in sensitive, reflective interpretation.[339] This I have attempted to do.

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[334] Anderson and Jack, "Learning to Listen," 11.
[335] Ganzevoort, "Investigating life stories," 277.
[336] Paul Ricoeur, *Freud and Philosophy: An Essay on Interpretation* (Yale: Yale University Press, 1970).
[337] Elisabeth Schussler Fiorenza, *In Memory Of Her: A Feminist Theological Reconstruction of Christian Origins* (New York: Crossroad, 1994, first published 1983), xlvii.
[338] Nunkoosing, "Problems with Interviews," 702.
[339] Cohn and Lyons, "Perils of Power," 46.

3.4.2.4. IDENTIFICATION: CONFIDENTIALITY AND ANONYMITY

In a study of this nature it is difficult to guarantee confidentiality or anonymity.[340] This is, firstly, in the instance that something disclosed must be shared for safeguarding reasons, and secondly, risk of identification of the participant by others from the finished work.

The question of when confidentiality should be broken is a subject raised by many researchers.[341] Information shared with the researcher is shared confidentially and is often of a sensitive nature. The sensitive nature of the information makes it imperative that the researcher should maintain the trust this gives them: however, it also makes the disclosure of something the researcher feels necessary to share more likely. In phase one of my study, it was possible that participants might disclose harmful behaviours or suicidal thoughts. A study by Wiles et al concerning confidentiality showed that the majority of researchers said they would not report illegal activities, but would feel duty bound to report risk of harm.[342] This is in line with the 'ethics of care' suggested by Bell.[343]

As part of an NHS study it was essential that any such disclosures were passed on and so I included a clause in the consent form stating that such information could be passed

[340] Ensign, "Health Research with Homeless Youths," 47.
[341] Johnson and Clarke, "Collecting Sensitive Data," 427; Rose Wiles et al., "The Management of Confidentiality and Anonymity in Social Research," *International Journal of Social Research Methodology,* 11, no.5 (2008): 416–428*,* 419–421; Ensign, "Health Research with Homeless Youths," 47.
[342] Wiles et al., "Confidentiality and Anonymity," 419.
[343] Bell, "Ethics and Feminist Research," 82.

on to the healthcare or chaplaincy teams in phase one. There was also a clause stating it could be seen by staff at the University of Birmingham before anonymisation (should I need to discuss anything with my supervisor); and the NHS REC also requested that information could be viewed by 'any other regulatory authorities' who may ask for it.

Risk of identification from the final work was of more concern. The consequences of possible identification for participants are difficult to predict: depending on what was included in their narratives some content could cause a rift with family members or friends; at the very least identification could cause the participant to feel her privacy had been invaded. Although pseudonymisation and the changing of some characteristics made identification by a stranger impossible, some characteristics needed to be kept to preserve the integrity of the data – and these could allow a family member, friend or other participant to identify the narrator. Peer recognition in particular is a problem; it is unlikely a family member or friend would go looking for an academic publication or thesis unless the participant had alerted them to it. Another participant in the study, or staff, would be aware of the individual's participation and more likely to read the findings.[344]

To alleviate these risks, in addition to veto rights, names were removed before transcription and reduced to initials.[345] These were amended to pseudonyms after the follow up. Hess recommends removing irrelevant details.[346] This is not as simple as it

[344] Johnson and Clarke, "Collecting Sensitive Data," 426.
[345] Hess, "Post-abortion Research," 585.
[346] Hess, "Portabortion Research," 585.

sounds; how should one judge what is 'irrelevant'? After the first interview I considered which details would be possible to change without corrupting the data. I discussed these with the participant (as recommended by Wiles et al[347]) at the second interview and gained her agreement.

Wiles et al note that the 21st century culture of individualism means that many people (in particular young people who are au fait with sharing details of their lives on social media) desire to have their story told and may not welcome anonymity.[348] I was wary of this, as identification of one participant from phase one would release information about the exact date the research was undertaken and who else might have participated. It is then possible to reveal more identities by a process of elimination, a risk heightened with such a small sample size.[349] I decided to explain to participants that it would not be possible to retain their identities in publication in this instance.

3.4.2.5. RISKS TO RESEARCHER

Dickson-Swift et al recommend that risk assessment for research should include risks for the researcher.[350] Although physical risk from violent participants was not a concern, there were emotional risks to be considered. Dickson-Swift et al describe researching as 'emotion work' involving caring behaviours. It is a role in which 'ethics of care' is important. The researchers in their study advocated the importance of 'being human'

[347] Wiles et al., "Confidentiality and Anonymity," 424.
[348] Wiles et al., "Confidentiality and Anonymity," 426.
[349] Richards and Schwartz, "Ethics of Qualitative Research," 138.
[350] Dickson-Swift et al., "Doing Sensitive Research," 328.

– of relating to, and being with the participant in the story of their suffering. This, however, has an impact on the researcher.[351] 'Compassion' comes from the Latin 'to suffer with'. It is no surprise that studies have shown that researchers identify the same feelings identified by the people they study – anger, helplessness, frustration.[352] This is not only a risk in the interview, but also in the process of transcribing, the point at which they 'hear' the story and absorb the impact.[353] Subsequent risks are emotional exhaustion and feelings of guilt at 'using' participants for data and the helplessness of the researcher to alleviate the participant's suffering.[354] In my research, as a recovered anorexic, there were further emotional risks in that the study could bring back painful memories; or that I could over-identify with participants.

The measures recommended to avoid emotional risks to the researcher becoming reality are: debriefing after interviews; allowing breaks between interviews and sensible timetabling; good supervision; and emotional support, both informally and formally.[355] These suggestions were followed, and daily debriefing occurred with a member of the chaplaincy team in phase one and with my supervisor after each interview in phase two.

The question of the researcher's background has also been raised; are some researchers less prone to emotional distress than others by virtue of their background?[356] I was

[351] Dickson-Swift et al., "Doing Sensitive Research," 335–336.
[352] Dickson-Swift et al., "Doing Sensitive Research," 329.
[353] Dickson-Swift et al., "Doing Sensitive Research," 337.
[354] Dickson-Swift et al., "Doing Sensitive Research," 343-344.
[355] Dickson-Swift et al., "Doing Sensitive Research," 345.
[356] Johnson and Clarke, "Collecting Sensitive Data," 433.

warned that some patients were very ill and that many people find their skeletal appearance to be a shock. However, I had been in that situation myself and seen those around me. I have supported friends through suicide attempts and am a secondary school teacher (also 'emotion work'[357]). Although I felt sympathy (and empathy) for patients, I was sufficiently desensitised to the anorexic mind and body and not shocked by either their physical or psychological conditions. However, I was distressed to discover that one lady who had enquired about the study (although did not participate) had died before the study was over.

3.4.3. POWER AND RELATIONSHIPS

Much has been written on the balance of power in the interviewer-interviewee relationship; it has been suggested that the interviewer taking a position of power can minimise the voice of the interviewee, rather than empower as intended.[358] Feminist researchers such as Oakley[359] and Reinharz[360] advocate a model based on equality, trust and openness, with self-disclosure and genuine empathy from the interviewer. Others suggest it is not possible to remove the power imbalance and that reciprocity is the best that can be achieved.[361] I attempted to take the feminist position of equality between researcher and participant: to my mind, both have power; as the researcher I set the

[357] Dickson-Swift et al., "Doing Sensitive Research," 336.
[358] Cohn-Lyons, "Perils of Power," 40.
[359] Oakley, "Interviewing Women," 48.
[360] Reinharz, "Experiential Analysis," 181.
[361] Nunkoosing, "Problems with Interviews," 699.

theme and ultimately will write the final narrative. The participant owns the story, can choose whether to consent to participate and what to share.

I was wary of entirely embracing the 'friendship as method' model suggested by Tillman-Healy and (although not by that name) Oakley.[362] As the women I was interviewing were vulnerable, it might be difficult to ensure that friendship did not lead to exploitation by accidentally encouraging over-disclosure. I was also aware it would be difficult to walk away at the end of the study. Although this worked in phase one, in phase two it was not realistic. Some participants were friends of friends or already known to me, so I decided to relax this rule for phase two. It did not feel as necessary, as participants were predominantly recovered and so not as vulnerable, and refusing existing friends the opportunity to take part was both unnecessary and would risk missing some rich material. In the event, I discovered it was the participant I knew who was most comfortable asking me to remove or clarify things she had said – possibly a response to 'over-disclosure' to me as a friend rather than a researcher, and thus I felt there was a sufficient safety mechanism to prevent over-disclosure reaching the final data.

Hesse-Biber[363] and Minister[364] recommend equalising perceived power differences. There were few differences between us in terms of education and background, and I could reveal myself as an 'insider' by disclosing my own past in the hope it would enable to participants to relate to me and know I was genuinely interested and empathetic.

362 Tillman-Healy, "Friendship as Method," and Oakley, "Interviewing Women."
[363] Hesse-Biber, "Feminist Approaches to In-Depth Interviewing," 199.
[364] Minister, "A Feminist Frame for Oral History," 35.

This is not without problems; my status as an 'insider' would affect the information they shared and they might assume I had prior knowledge of something I did not.[365] Some researchers suggest that self-disclosure, whilst building a good rapport, can also increase the possibility for unintentional exploitation.[366] Others suggest it makes the researcher unnecessarily vulnerable.[367] I needed to be careful that, although willing to answer questions about my experiences, the interview was about the participant's story, not mine. Thus, I decided I would disclose my motives at the start of the interview, and answer questions at the end, but ensure the focus was on the participant at all times during the interview. The second interview could be more reciprocal, whilst still emphasising that my thoughts were merely opinion.[368]

There are differing opinions as to how much a researcher should disclose. Some suggest full reciprocity and mutual self-disclosure.[369] Others suggest as little as possible, particularly when it is a sensitive topic.[370] I fully agree that with such subject matter full self-disclosure may not be appropriate. I also disagree with the 'as little as possible' stance. If I am asking someone to share intimate details of a sensitive topic, I cannot refuse them the same courtesy if they ask (assuming the answer was not likely to cause them distress). Therefore, other than a brief summary of my background and motivation, I did not volunteer information, but did respond if asked, as far as

[365] Cohn and Lyons, "Perils of Power," 42.
[366] Bell, "Ethics and Feminist Research," 91.
[367] Dickson-Swift et al., "Doing Sensitive Research," 334.
[368] Seibold, "Qualitative research," 150.
[369] For example, Tillman-Healy, "Friendship as Method"; Oakley, "Interviewing Women" and Saukko "Quilting Interviews" all suggest mutual disclosure.
[370] Dickson-Swift et al., "Doing Sensitive Research," 332–333.

appropriate. With phase two interviewees it was difficult not to form friendships, as we were similar and had we met in 'normal life' we would no doubt have been friends.

Avoiding the therapist role was not necessarily straightforward, although easier than the literature suggested. It helped that many interviewees were a similar age and stage of life to me; and/or acquaintances or put in touch by mutual friends. More difficult was to avoid sharing my experiences and thoughts, particularly in phase one when Tracy described similar feelings, thoughts and experiences to those I felt as an inpatient. As Saukko notes, there is a balance between demeaning the participant's voice and acting as 'expert' and allowing her to say things that are a product of typical 'anorexic thinking'. [371] The balance between remembering her emotional vulnerability and wanting to allow her the space to tell her own story was a difficult one and ultimately came down to intuition.

Many feminist researchers recommend a fully participatory model.[372] This is frequently unrealistic and requires participant input at all stages of research – design, co-collaboration in interview, analysis and interpretation. My research was time-limited and I did not have access to participants until after the design had been approved by an ethics committee. However, some equalising of power can be gained by ensuring that the participant fully understands the purpose and nature of the research and has given

[371] Saukko, "Quilting Interviews," 299.
[372] For example, Hesse-Biber describes the researcher and participant as 'co-participants' in "Feminist Approaches to In-Depth Interviewing," 184.

informed consent.[373] I incorporated elements of a participatory model in keeping with the constructivist Grounded Theory model, particularly in the follow up in which we discussed the transcripts and our interpretations of them.

3.5. POST-INTERVIEW

3.5.1. FEEDBACK

As discussed above, participants had the opportunity to 'member check' the transcript and to discuss their own thoughts on my initial interpretations.[374] In order to ensure that the participant was not distressed and to thank them, it seemed appropriate to follow up with a phone call, visit or email. In phase one, a member of the chaplaincy team spoke with Tracy after interview and I sent a thank you card. In phase two, I sent a follow up email the next day to check participants were not distressed and thank them for taking part.

3.5.2. DATA STORAGE

After interviews, data was stored on an encrypted memory stick. All data which could be linked to an individual needed to be destroyed or suitably anonymised within six months of the end of the study according to the NHS REC. I was advised by the chaplaincy team that consent forms could not be destroyed at such an early stage, so signatures of participants on the forms could link them to the study. To resolve this

[373] Cohn and Lyons, "Perils of Power," 42.
[374] Cohn and Lyons, "Perils of Power," 45.

problem, the chaplaincy team retain the consent forms, and I retain the data at a different location. Therefore, consent forms could be produced if requested by authority but names could not be connected to data. University regulations require the data to be kept for ten years; at odds with the requirements of the NHS. To fulfil both regulations, data was anonymised within six months before permanent storage.

3.5.3. DATA ANALYSIS

As data analysis and collection were undertaken concurrently, I was able to adapt questions in later interviews to include emerging themes,[375] and discuss possible interpretations with participants either at second interview or via email. The first step of data analysis was to listen to recordings and write a transcript. This was done as soon as possible, in order to give the participant the transcript.

I began data analysis with line-by-line coding. I considered using specialist computer software to code data but decided against it, partly because I could not find a suitable programme to sort qualitative data, and partly because the process of sorting the data thematically was, for me, a useful part of the process.[376] I found it helpful to store codes in a spreadsheet and move them into groups via 'copy+paste'. After line-by-line coding three transcripts I sorted codes into larger categories. Data was colour-coded by

[375] Miller and Crabtree, "Depth Interviewing," 200.
[376] Hesse-Biber, "In-Depth Interviewing," 225. Sharlene Hesse-Biber, "Unleashing Frankenstein's Monster? The Use of Computers in Qualitative Research" in *Studies in Qualitative Methodology Vol. 5*, ed. Robert Burgess (London: JAI Press, 1995), 25-42. Sharlene Hesse-Biber, Paul DuPuis and Scott Kinder "HyperRESEARCH: A Computer Program for the Analysis of Qualitative Data with an emphasis on hypothesis testing and multimedia analysis," *Qualitative Sociology* 14 (1991): 289-306.

participant. Subsequent transcripts were added to these categories. Further categories were added, and existing categories refined or broadened, and links started to emerge between categories. For example, it became clear that 'self-worth' and 'identity' were linked, and that in turn the search for identity was linked to 'inspiring women as role models'.

As categories became fuller and major codes emerged, I took the most prevalent and/or rich categories and turned them into memos using flashcards. Although I had read about possible methods for memo-writing,[377] in the event I used my intuition and simply set out themes in a way that made sense and enabled me to see links. The idea of memos is to initially refine and fill out categories; and later to compare data and identify underlying assumptions of beliefs and processes. Memo-writing forces the researcher to explore the data – according to Charmaz they should be spontaneous, not mechanical,[378] and so my intuitive approach seemed appropriate.

I added to these memos as data came in, then sub-categorised themes as interviews progressed.[379] After I had identified themes and sub-categories, I put them into a diagram so I could see connections between themes.[380] Finally, after fieldwork was complete, I considered emerging themes in conjunction with existing theories,[381]

[377] Notably, Charmaz suggests the possibilities of 'Clustering' and 'Freewriting' in *Constructing Grounded Theory,* 85-92.
[378] Charmaz, *Constructing Grounded Theory,* 80-81.
[379] Seibold, "Qualitative Research," 151.
[380] Laura Abrams, Katrina Dornig and Laura Curran, "Barriers to Service Use for Postpartum Depressions Symptoms Among Low-Income Ethnic Minority Mothers in the United States," *Qualitative Health Research* 19, no.4 (2009): 535–551, 539.
[381] Dickson-Swift et al., "Doing Sensitive Research," 330.

returning to the autobiographical extant texts from which I had drawn my initial ideas for the interview questions. It was with these themes and theories in mind that I wrote reflections on the narratives.

Identifying when I had reached 'saturation point' and should stop interviewing was difficult. After around seven interviews no new themes were emerging and patterns were repeated: however, that is not necessarily the definition of saturation. Saturation point is when categories identified do not continue to develop with each interview.[382] After the ninth interview I concluded that not only were new categories not emerging, but I was also not discovering any new line-by-line initial codes. Furthermore, the data was becoming unwieldy and there was a real risk that the voices of participants could be lost under its weight. I concluded it was time to stop and survey the data as a whole, albeit leaving the possibility to interview further at a later date. I did return to some existing participants in order to ask further questions and develop richer data.

3.5.4. CREATING THEORY FROM DATA

The final methodological stage of a Grounded Theory study is to create theory from the data. Charmaz describes a constructivist theory as focussing on the importance of the phenomena, and the processes by which the participants of a study make meaning. The theory is contextual, and evolves from the situation in which it is constructed: as such, neither participant nor researcher is detached from the theory, nor objective.[383]

[382] Charmaz, *Constructing Grounded Theory,* 113.
[383] Charmaz, *Constructing Grounded Theory,* 131.

Charmaz is deeply critical of Grounded Theory researchers who do little more than pinpoint recurring themes in a descriptive fashion rather than producing a true 'theory'. She recommends considering actions and processes within the research, for example, the process by which participants make meaning of their situation.[384] It is then necessary to ask: 'What is the significance of this?' By doing this, researchers can bring out implicit arguments. This technique worked well with my intention to bring a 'hermeneutic of suspicion' to the narratives. However, it seems the line between 'description' and 'theory' is blurred. At what point does discussion of an emerging theme become 'theory' whilst simultaneously avoiding sweeping generalisations? If I explain how participants understand the role of the Church community in their recovery from anorexia, is that a description of their experiences, or a 'theory'? Ultimately, I suspect there is little difference, but to encourage as much theory creation as possible, I focused on processes my participants underwent during recovery where appropriate, for example, the change in their perception of God as they recovered. There were some themes in which 'processes' were less obvious: I disagree with Charmaz that this is a reason to exclude them, as this could risk discounting rich and meaningful data. In an emerging research field, it is necessary to first describe what is occurring in order to then analyse. To do so also supports recommendations for further research.

[384] Charmaz, *Constructing Grounded Theory,* 136.

CHAPTER 4: NARRATIVES

4.1. INTRODUCING THE NARRATIVES

This chapter contains the narratives of six of my participants. Two are in appendices 9-10, and Mhairi, the final participant, did not want her narrative written up for purposes of anonymity although she agreed to her data and words being included in the analysis. The narratives use pseudonyms and some personal details have been left vague to preserve anonymity.

The stories are formatted in italics, with direct quotations in normal font; within these sections, unless specified otherwise, images used are the participants' own images and ideas, albeit sometimes paraphrased. Although I have structured each story and to a certain extent 'grouped' their ideas and images to make the narrative a coherent whole, I hope these narratives allow the authentic voices of the participants to come through. Each narrative is followed by my reflections on their stories, drawing out themes which I thought dominant and noting recurring themes. These themes form the basis for the thematic analysis in Chapter 5.

4.2.1. TRACY

Tracy developed an eating disorder in her early teens. At the time I met her, she was in her mid-20s, and an inpatient in a specialist eating disorders unit. Tracy fits the stereotypical characteristics of an anorexic in terms of demographics: she is a university graduate; high achieving; white British and from a middle-class background. Before her

admission she was a teaching assistant specialising in the arts. Her eating disorder began as a series of insecurities that she took out on food, and continued at a low level for around ten years. For much of this time, she didn't realise she had an eating disorder, as she knew she was thin and was not consciously trying to lose weight – she just found security in those behaviours. These behaviours set in slowly and became more severe, and at the time of the interview, she had been in and out of hospital with anorexia for five years. This was her fourth admission.

Tracy was brought up a Quaker, but had explored several other religions. She described experiences of Hinduism and Buddhism during travels in her gap year; and had attended or worked at both Christian and (predominantly) Sikh schools, attending worship with staff and pupils. Although she regularly attended the hospital chapel, she had never wanted to commit to Christianity due to the 'rules that you have to commit to as well'. *Ultimately, she felt she still held a Quaker outlook. She understood the basis of her faith to be '*seeing the light of God in everyone'. *My overriding impression of Tracy's faith was that she was a pluralist: she regularly attended church but was equally comfortable with any of the religions she had encountered. She described all religions as '*equally brilliant*' but was wary of cultural issues and practices she felt got in the way of the actual faith. She focused extensively on rules attached to religions (predominantly Christianity in her experience, although she acknowledged that all religions are similar): '*I think the essence of Christianity and any religion is doing the right thing because it's unconditional, that's what you want to do. But quite often, these … practices that you're meant to do in your

everyday life almost become sort of a set of boundaries that you mustn't break and you get more hooked up in following the rules than you do in actually being spiritual. So, that's why I guess I've shied away actually proclaiming belonging to any particular faith'

As a child, Tracy saw God in the way typical of most children: an old man in the sky who lived on a cloud, possibly in a cave – a sort of cross between the Giant in Jack and the Beanstalk and Zeus. She described him as 'wise and a bit scary' – 'one of those people who you don't quite know or trust because they're just too powerful'. *However, she came to see God not as a wise scary man but as a divine spark which can be found in everyone and everything.*

As Tracy's eating disorder was so long-standing, she felt it had become tied up with all different aspects of her life and being. At times in her illness she felt there had been a strong connection between her eating disorder and her faith, and at others not at all. She spoke of friends who found the notion of an all-loving God immensely helpful in their recovery. For her, although she had at one time found going to a Gospel church helpful in an escapist way, she stated that she had never really had any support from a Christian community or found it helpful. The benefit that spirituality had given her was the reminder of how special life is, and that it is worth holding onto. In the context of an eating disorder, she described it as allowing people to 'step outside…. The torment you have in struggling with yourself'. *She found in her visits to Sikh gurdwaras, she could put her eating disorder aside and partake in the Karah Parshard given to visitors. She saw it*

as a blessing and a welcome that she could not shun, and so could eat without guilt. Tracy's understanding of spirituality was not restricted to organised religion, but included being in touch with nature and other people – for her the giving of Karah Parshard to welcome another person was as much a part of spirituality as worship itself.

*Tracy described how she had seen, both in her experience and that of friends, the way faith could become both '*something to hold onto' *in recovery, and also something that could in a more sinister fashion be used by the eating disorder against the sufferer. For one of her friends, the all-loving, all-forgiving God who wanted her to be alive and healthy, and the supportive church community around her, became her lifeline. For others, Tracy felt the rules of Christianity, when combined with the low self-esteem typical in anorexics, could worsen existing perfectionist traits, thus feeding the disorder. Christian ideals are '*hooked into' *by the eating disorder and* 'get twisted up into something that can be so binding it ends up destroying you'.

*When I asked if there were any Church or biblical teachings that troubled her in the context of her eating disorder, her immediate response was to turn to those that subjugate or discriminate against women. She pointed to the discrepancy in biblical laws on adultery and punishments for men and women; and the command that wives should always obey their husband, and children their parents. What if the husband was abusive? These are examples of the 'rules' she focused on – rules that she described as '*born out of trying to live out this unconditional love for one another' *which nonetheless*

when transplanted from one cultural context to another can become absurd, or even harmful.

The story she found most concerning was Eve eating the forbidden fruit. In a culture where women are pressurised about their body shapes and size from all angles, any teaching based on a story in which the first sin came into the world via a woman eating is not helpful, even to those without an eating disorder. For sufferers of anorexia, she describes the story as 'dangerous' *and '*horrendous'*. Tracy felt churches do not give enough emphasis to the metaphorical nature of the account or think deeply enough about the underlying message such stories give in the context of Western body-conscious culture.*

The second story Tracy found difficult was the Crucifixion. A key part of her eating disorder was the need to punish herself, and the guilt for everything she had 'messed up'. *The crucifixion – Jesus left to bleed to death on the cross – spoke to her of God self-harming, of madness, of the belief that sins must be punished no matter how great the cost – and that it is this punishment, or penance that leads to forgiveness. '*You start heading into dangerous territories… everything should carry warnings that it is metaphorical'.

During her time in hospital, Tracy attended chapel every week. She described one reading she had heard recently which she had found positive: Jesus calming the water. Like other stories, Tracy interpreted this metaphorically: she empathised with the disciples panicking when the storm stirred up the waters in a treacherous torrent and likened this to how she felt inside. Her eating disorder raged inside her. Jesus speaks and the water is calm. For Tracy, this represented the possibility of just letting go of the storm – if you believe it will be calm, it will.

Tracy illustrated her understanding of God as a divine spark found in everyone, and how she had found this image helpful, with a story she had heard about a prisoner who had committed terrible crimes and was in a high security prison. Whilst there, he managed to turn his life around and started to write poetry. When he was out in the community again, someone asked 'How do you carry on, knowing what you have done?' He replied 'I absolutely hate about 99.9% of me, but there's this little seed in me that's good, and I just focus on growing that, that's the little bit of me I want to hold onto.' This was another idea that Tracy could empathise with – even when she felt anorexia was taking her over, and she hated herself, she could find hope in that tiny spark of the divine which she could grow. Even when the anorexia told her she was worthless and worse than everyone else, the idea that all people are equal and have a spark of the divine in them reminded her that her life was worth living.

4.2.2. REFLECTION ON TRACY'S NARRATIVE

Interviewing Tracy was difficult in some ways, as she was so unwell at the time. In others, it was easy as she was happy to talk. Tracy seemed to be in a paradoxical relationship with religion: she was in some ways an 'insider' brought up a Quaker and attending hospital chapel regularly; and in other ways looked at Christianity from the perspective of an 'outsider', as someone who avoided committing to any religion. It was interesting she had reflected as much on her friends' experiences of Christianity and anorexia as she had on her own.

Three things stood out for me. Firstly, her conviction that Christianity was all about 'rules'. These rules were, in her words, 'boundaries' that hem you in. When she spoke about the 'rules' of religion, and in particular cultural rules to do with control and submission of women, she spoke about them in the same language she used to speak of her eating disorder: although she shied away from being contained by any bonds or shackles of religion, she could not rid herself of the internal shackles of her eating disorder. She was searching for control, but not able to get rid of the thing that was controlling her.

Secondly, Tracy's spiritual journeying. Within this Tracy made distinctions between culture and spirituality. She attributed a lot of the more punitive and controlling elements of religion – particularly those to do with women and their bodies – to culture, rather than religion. Tracy was very positive about religion or spirituality, and perceived

it as a positive force; but she was deeply negative about the boundaries imposed by culture (particularly those specific to women), and the authority which these ideals received when packaged as religious ordinances. Although she seemed averse to a lot of the 'cultural' elements of religion, it was within the cultural element of Karah Parshard that she found the 'blessing' of the Sikh community that enabled her to eat. Similarly, she described how stepping out of Western culture when she travelled into a world in which food is scarce and celebrated as such, meant she was able to eat without guilt.

It seemed that Tracy was engaged in the kind of spiritual quest of which Lelwica writes. Her exploration of so many different religions, and different denominations within Christianity despite her wariness of committing, suggested that something kept drawing her back. She spoke of how friends had found faith 'something to hold onto' in times of difficulty. Perhaps she was looking for something to hold onto too – or perhaps spirituality was holding onto her. Although Tracy claimed she had never had the support of a Christian community, this was at odds with what I saw of her involvement with the hospital chaplaincy team: perhaps she did not associate the chaplaincy team with the 'Christian community'. However, she had regular extensive conversations with the Chaplain; attended the spirituality group which she found very helpful and enjoyed; and she attended chapel weekly and found comfort in the stories and teachings she heard there.

The final thing that struck me – particularly in the second conversation we had – was Tracy's concern that Biblical texts could in some cases exacerbate disordered thinking. As explained above, she was particularly concerned with the story of the crucifixion. This was one of the times her status as an outsider looking in to Christianity was evident: as such, she could see that in a culture in which we have effectively domesticised the cross and teach the story to children with little explanation, it can easily be misunderstood to encourage the qualities that lead to mental health difficulties: self-sacrifice; punishment; willingness to endure and inflict physical pain on yourself.

4.3.1. DEBORAH

Deborah was in recovery from her eating disorder when I interviewed her. The previous year she had spent two months in an intensive day patient therapy programme in a specialist eating disorders unit. As a Theology graduate and Methodist Local Preacher, Deborah had already thought deeply about the interaction between her faith and her illness.

*Deborah grew up in an Anglican/Presbyterian family, attending a Church of England parish church and Primary School. She described her parents as open about their faith: they discussed it freely at home, and encouraged rather than forced Deborah and her sister to attend church. Her mother's side of the family she described as '*austere Protestant' *and heavily involved in the United Reformed and Presbyterian Churches. The*

*main aspect she noted about her family's religion was their '*progressive and socially liberal' *attitudes.*

When Deborah was 14 a friend invited her to a very different type of church – an evangelical 'mega-church' with a conservative theology and vast congregation of over 1000 members. Despite not feeling particularly comfortable, Deborah attended this church until she went to university. It was during her time at this church, at 17, that she developed severe OCD and depression. By the time she left, Deborah felt thoroughly disenchanted with the emphasis on sin and unworthiness, and her self-esteem had dropped – something she put down primarily to the teachings of the church.

At university, Deborah 'church shopped' for a while, and found peace in the beauty and anonymity of choral evensong at the cathedral three or four times a week, a place where she did not need to deal with the people and politics of the church and could recover from her recent experiences of church. She found her way to the Methodist Church in the final year of her undergraduate degree through the Methodist Student Society. She met her husband at university, and married soon after graduating.

Deborah's OCD developed into anorexia in her early 20s, shortly after her marriage and graduating from her Masters. After a suicide attempt, she was admitted to a general psychiatric unit. Despite the bad press general psychiatric units get amongst the

*anorexic community, Deborah felt that, with her complex difficulties, it was exactly what she needed at the time, and the result of the admission was that she spent the subsequent nine months relatively free from anorexia. Unfortunately, a year after her admission, her father died and she relapsed. Around six months later she was admitted to the intensive day patient programme. During this time, she described having to '*give up everything just to think about meals' *as the programme reinstated order into her life. She struggled briefly after discharge but felt able to pick herself up using the management techniques she had been taught. A year on she described herself as in a '*safe place'*: with some difficult days and difficult foods, but no longer on the edge of a precipice.*

*When I asked Deborah about the interaction between her faith and her eating disorder, she could pinpoint an exact causal incident in the mega-church she attended as a teenager. She described the youth leader pouring a glass of water and putting in a drop of ink which spread through the water and turned it black. That, the youth leader told them, is what happens when you have a drop of sin inside you. Deborah developed an intense fear of '*religious and mental contamination' *which in time became the driving force of her OCD. Even after leaving that church and its theology behind, she still could not shake her fear of contamination:* 'I still…remained obsessed with that idea of contamination and that's really where my eating disorder came [from]. Umm, feeling contaminated by food.' *Food became a source of contamination, and she describes herself as feeling 'physically contaminated' and dirty. She took the overriding message*

that she was worthless – that all humans deserve hell – and felt she should hate herself. Amidst these emotions, it became part of an attempt to take back control to deny herself food – and her self-hatred fuelled by her belief that she deserved nothing better than hell made this task easy. Eventually it escalated into a genuine fear of food.

*At that time in her life, Deborah described her image of a God who was '*out to get her'*. Her overriding emotion when thinking of God seems to have been fear. She describes the Calvinist beliefs of the mega-church that all deserve to go to hell, are innately evil and should be punished as the root cause of this belief. She believed God would be '*well within his rights' *to* 'turn on her at any time' *due to her inherent sinfulness. She attributes her self-harm as a teenager as an attempt to put off punishment from God by pre-emptively punishing herself for her own worthlessness. Due to this paralysing fear, she felt unable to question these teachings and learn more about God.*

*Deborah described her (Methodist) church community at the time of her admission to be extremely supportive: emotionally, spiritually and practically. It seemed important to her that as well as praying for her and listening, her church family also encouraged her to engage with medical treatment – even to the extent that the Minister offered to pay for private treatment if it would get her seen sooner. The morning she began day treatment she went to early morning Communion at her church and gained support from the small community there: '*I felt really supported by people at my church and my minister who've… known what's happening the whole way through and have … gone

out of their way to check on how I am….to let me know that they're praying for me, but also to really encourage me to engage with treatment as well'.

Despite the supportive response from her own church community, she saw less helpful responses from others. A fellow day-patient who was Christian spoke of anorexia as a sin that needs repenting for, something you have agency over. Even though that was not a belief Deborah shared anymore, she was scared how much of a hold this idea still had on her – the idea this was a choice: sin, rather than sickness. She also noted her difficulties with Emma Scrivener's book A New Name. *Although she found the account honest and relevant, she struggled with the never-quite-said implicit understanding of anorexia as a choice of one's own way over God's way. At the end of the book, Scrivener describes how she prayed and recovered. Deborah eloquently described the idea that this is how anorexia works as* 'bullshit'. *She felt the two aspects of medical treatment and prayer need to be held in tension: prayer, spiritual support and the demonstration of compassion from her church family were immensely important in Deborah's recovery. However, she strongly believed that they are not a replacement for medical care.*

I asked Deborah whether anyone at her church had attempted to stop her descent into anorexia. She replied she thought that Methodists – perhaps just the British – were essentially too polite, and particularly in churches are determined not to judge to the extent they can ignore problems. They sat and watched her eat a plate of cucumber at a harvest lunch without commenting. When I asked whether she thought it would have

helped if anyone had commented, she was unsure – perhaps some days it would have, but others it would have made things worse.

Deborah spoke of how uncomfortable she felt about the greater narrative of many churches in their attitudes to women, particularly evangelical churches. She described feeling a pressure to look good to be a good wife, despite no pressure from her parents or husband ('my husband literally couldn't care if I was wearing a small sack!'). *She felt that as long as churches side-line women and prevent them from fulfilling their God-given callings, confining them to supporting roles, then women will search for another way to define themselves. In her case it was through anorexia and starvation. She was particularly concerned about the way that religious dieting, a major phenomenon in the States, could play into this narrative.*

Deborah traced this narrative of women's search for agency and modes of religious expression in fasting back to the Middle Ages, which she had explored during her degree. She described it as an ongoing religious and political struggle for women's liberation: 'there's this kind of great political and religious struggle for women, and there has been since the beginning of the church, and women have always been looking for ways to exert agency… there's something about the spirit of women and women pushing to live out their religious vocation even in the most difficult of circumstances, and I find that quite inspiring.' *She pointed to Catherine of Siena as one of her great inspirations. Catherine showed all the socio-cultural and diagnostic markers for anorexia, but*

Deborah believed her story is one of manipulating her circumstances to live out her calling as best she could in a transformative way – and food has been a currency in that struggle for women's agency throughout the ages. Catherine also showed a remarkable insight into her condition, citing in letters that she had become ill and entreating novices to not fast to such extremes – and yet despite her struggles, she still played out her calling. Deborah looked to Revelation for the end of this narrative of struggle to the fulfilment of time when every tear is wiped away and there is no more suffering – no more struggling.

When I asked Deborah whether she thought Catherine of Siena had lived out her calling through anorexia, or in spite of it, she responded that it was perhaps a bit of both. Had she not started down the path of self-destruction and extreme religiosity, she would have been married and probably died in childbirth. In her historical and cultural situation, Catherine followed the only path available by which she could follow her calling and achieve what she did. However, Deborah warned of thinking that anorexia is the answer, or the way God chooses for sufferers. She herself thought anorexia was the answer, and found it to be empty and lacking. She described that there was certainly no scroll in heaven with the writing 'Deborah shall have anorexia' – it didn't have to happen, but it happened, and God worked through that for good.

Deborah described a love-hate relationship with the writings of St Paul. She struggled with the idea that God disciplines us (in the sense of punishment) when we do wrong,

and with the rhetoric of self-control, perseverance and character-building through suffering. Although positive about the idea that God can use suffering and we can grow through suffering, she felt Paul implies that God makes us suffer on purpose. However, she could relate to Paul in many ways: she saw aspects of mental health difficulties in St. Paul's anguished writing and felt that he would have 'had some contact with psychiatric services' *if he lived today. His self-awareness that he 'does the things he does not want to do' struck a chord with Deborah: she described him as '*everything about humanity that is confused and muddled and doesn't understand'.

Whilst at university and struggling with depression and OCD, Deborah refused to seek medical treatment or go to the university's counselling service. However, she did feel able to talk to the Methodist chaplain. One question he asked was 'who do you identify most with in the Bible?' The melodramatic side of her wanted to say 'Mary Magdalene' because she felt herself a 'terrible woman' *who need to be forgiven much. On reflection, she identified more with Peter: the apostle who tries really hard and yet gets it wrong. She felt Jesus' response to Peter – patience, kindness, firm yet gentle – was the same response Jesus gave to her with her struggles.*

The same chaplain lent her a book which she found life-changing in her understanding of God: Good Goats: Healing our Image of God. *The book focuses on the idea that God, as a parent, chooses to take responsibility for us and loves us. If all the things Deborah had believed about God were true, then he would be an abusive parent. God is a loving*

parent, there are no black and white absolutes about the way he sees us: all of us sometimes get things right (like the sheep of Matthew 25), and all of us sometimes get things wrong (the goats). Ultimately, we are God's good goats. Deborah described escaping those Calvinists trappings as liberating. She initially struggled: maybe we just don't understand? Perhaps God, as God, has the right to be an abusive parent? Perhaps when God does it, that's perfection? Eventually, she freed herself from these ideas and realised that God gives us human relationships as a reflection of his love. He is the perfect parent – and the perfect parent is not abusive.

As Deborah's image of God changed to a loving God who cares about her recovery and is proud of her when she makes progress, she found recovery became possible. She could see herself through God's eyes and recognise that she was worthy of recovery. She said 'that gives me a better identity than identifying myself by the number on the scale'. *Although Deborah was clear that faith is not a replacement for medical intervention, she recognised the strength her faith gave her in recovery, through prayer and community support, and through* 'the sudden realisation that God does really love me and is proud of me… when I do good things in recovery and all the rest of it.' *She felt that, had she still felt scared of God, she would not have reached a meaningful recovery: even if she had forced herself to eat out of fear, there would have been no mental healing.*

Deborah described a turning point whilst she was in day-patient treatment. At the end of her day in hospital, she had a driving lesson. Her instructor, an evangelical Christian,

knew she was a Christian too. She described angrily driving round, and reacting sharply to his simple question about the hospital 'how's it going, is it working?' At the end of the lesson, he asked if he could pray for her. The prayer began in a way that made Deborah feel uncomfortable, as he prayed that the demons of anorexia would leave her ('this isn't prayer, it's an exorcism!'). *However, as he continued to pray for her doctors, her family and friends supporting her, and that she would know God loved her, she described a lightbulb moment. As he prayed she realised she had pushed God away and returned to the place where she believed God hated her – and that actually he did love her and care about her recovery. That realisation, and the compassion and support shown by her driving instructor, a man who didn't know her well but cared enough to pray with her, gave her motivation in her path to recovery.*

When I asked Deborah how she felt about the idea of anorexia as a demon that needs exorcising, she expressed frustration at any literal belief in this. She was concerned that such a view leads to attempts at faith-healing based programmes of recovery that 'completely destroy people'. *She was more open to the idea of demon possession as a metaphor for anorexia, in the sense that anorexia feels like a negative force that wholly overwhelms you and takes control. She mentioned the Bible story of the man who lives amongst the tombstones and is possessed by demons. He lives amongst the dead. This, she felt, is a profound way to talk about mental illness.*

I asked Deborah what might be the best way for Christian communities to help sufferers of anorexia. She reiterated that the most important thing is walking alongside the sufferer, in the same way that Christ does, no matter how many times they seem to turn back to old ways. The value of being constantly reassured that one is worthy and precious and loved cannot be overestimated. For those sufferers who had been unwell a long time and find their self-identity in an eating disorder, she believed the church has another answer – an identity in Christ. Deborah was concerned that many churches which would never even consider suggesting that faith-healing and prayer is a solution for a physical illness, such as cancer, might be more inclined to promote this as a 'solution' for mental illnesses and by this cause deep rooted illnesses such as anorexia to become more entrenched as sufferers avoid psychiatric interventions.

For Deborah, everything in Christianity comes back to 'compassion'*: compassion from God and compassion for each other. For that reason she found hope in the parables of the Prodigal Son and the Good Samaritan. Whenever she started to question whether anorexia was a sin; to feel she was far away from God and had forsaken him, she remembered that God doesn't actually care about any of that – he just loves her, wants to be with her, and is halfway down the road to meet her with arms wide open.*

Deborah interprets Christ's life and death as the ultimate act of compassion, as he walks alongside each person and endures all the most difficult parts of being human. In a very literal way, Christ is with all people in their suffering. She reflected on Jesus' time fasting

in the wilderness: 'that speaks of all the horrible bits of anorexia: like the being hungry and the feeling sick and your hair falling out'. *She described a visit to a church in Brussels where she saw an old and eroded statue of Christ. Due to the way the statue had decayed, it looked like he had scars all the way down both arms – a self-harm Christ. It spoke to her of* 'a God who in every way has suffered the same things we're suffering'.[385]

4.3.2. REFLECTION ON DEBORAH'S NARRATIVE

Deborah's interview was very pertinent: as a Theology Graduate, she had thought about the issues I was researching, and her self-awareness and understanding of the underlying causes of her eating disorder were startlingly acute. It was notable that Deborah had far more clarity and order in her story than the prior interviewee, Tracy, primarily I suspect due to the difference in health. Whilst Tracy was in the midst of her eating disorder and her thoughts – though abundant – spilt chaotically into a narrative filled with confusion and shadows, Deborah had had time in the year since the most severe part of her illness in which to construct her own narrative and reflect on her story in a way that made sense to her. Deborah's well-developed thoughts made for an interview overflowing with rich data – and in length was, along with Mhairi's, the longest interview – I have attempted to summarise the six main points which stood out.

[385] I have also discussed this image elsewhere: Stammers, "Liberation from Anorexia Nervosa," 16-18.

Firstly, Deborah was very clear about the negative impact of certain types of teaching from the church she attended in her youth, and – without overgeneralising – could see how this could be a common theme amongst other women. These unhelpful teachings which stayed with her and impacted on both her OCD and eating disorder were: obsession with contamination by sin and the overwhelming feeling of being unworthy and undeserving; the image of an angry God who wants to punish her; what she described as the 'Calvinist' emphasis on total depravity; and subjugation of women and restrictive Christian models of femininity. Part of the latter includes an emphasis on looking good,[386] and Deborah was angry about promotion of Christian dieting that exacerbated the message that 'thin = holy' and 'fat = sinful'. I was intrigued by Deborah's description that 'almost everyone' in her youth group had a mental health issue, in her view, due to the requirement to have a problem that God could help you through. This is an interesting insight into a church community which may have been trying to encourage teenagers to be open about problems and ask for help, and begs the question: at what point does this cross the line between encouraging openness, and (with the inevitable help of peer pressure), encouraging brokenness?

The second key element of the interview was her deep concern with her own sin manifested not only in OCD and a fear of food, but in feelings of unworthiness and low self-esteem – a common trait or risk factor in anorexia. This tied into her perfectionist

[386] Although this is perhaps not the first quality that springs to mind as part of a Christian model of femininity, considering the suspicion of beauty in much of Church history, Deborah was not alone in this experience: similar thoughts emerged from other participants and autobiographical material.

traits: in discussions after interview she described how she has also felt pressure to be the 'perfect Christian', which, in Pauline terms, has included being filled with the fruits of the spirit (particularly self-control and discipline) and free from the sins of the flesh. Deborah picked up on the point that Scrivener does not fully deal with the question 'sickness or sin?'. Deborah was most adamant of all interviewees that anorexia is not a sin, and that to think it is was a strangely compelling and extremely dangerous belief. The feeling she was living under sin when living under anorexia must have felt an impossible situation: she was scared of food as a contaminant, and yet the rule she was living under to avoid that contaminant of sin was itself sin.

Thirdly, in her striking and concise reflection on demon possession as a metaphor for anorexia. Deborah's deep understanding of the historical and cultural context of the New Testament came to the fore in her reflections on the nature of demon possession as medical issues not yet understood in Biblical times, her picture of the man living amongst the tombstones as a 'profound way to speak about living with mental illness' struck me as one of the most poignant images of the interview, resonating as it did with her own experience of life with mental illness.

Regarding the fourth emergent theme, when Deborah and I discussed the interview transcript later, I asked if it would be accurate to say that the way the church has damaged women is one of the most important issues for her. She concurred actively linking women's mental health – and in particular, illnesses that tend to affect

predominantly women such as anorexia – and the treatment women have suffered at the hands of the church throughout history. The 'damage' she spoke of seemed to be summarised in two elements: firstly, side-lining of women in ecclesiastical and public arenas, such as refusing them ordination and historical theological traditions that imply women are spiritually inferior.[387] This, Deborah felt, had forced women to look for their identity elsewhere. The second, linked element is the Christian model of femininity: that of the 'good girl' and 'good wife' who is morally good, subservient and beautiful. Once again, this ties into the identity of women and the feeling of those who do not fit this mould that they must look elsewhere. Deborah's exposition of the life of Catherine of Siena was interesting – whereas I had expected her to see Catherine of Siena as a tragic figure, or an influence to starve, Deborah saw her as a strong woman searching for identity in a church and society that restricted her to certain roles, and who found it both in religiosity and in starvation. For Deborah, rather than a woman who suffered at the hands of patriarchy, Catherine of Siena was an inspiration in allowing God to bring good out of even the most difficult situations. Deborah reflected that her eating disorder was not 'planned' by God, but that he had certainly brought good out of it in her life.

[387] There is no shortage of such teachings on the inferiority of women, although whether such teachings intend to imply spiritual inferiority as well as material and social inferiority is ambiguous. The basis for such arguments can be found in the New Testament, including in the Pauline or Pseudo-Pauline household codes in Colossians 3:18-25 'wives, submit to your husbands' and Ephesians 5:21-6:9 'wives, be subject to your husbands as you are to the Lord'. Christian traditions that imply – or even outright state – the inferiority of women include the teaching of St. Augustine, *De Trinitate,* 7.10 concerning women that "separately in her quality as a helpmeet, which regards the woman alone, then she is not the image of God, but as regards the man alone, he is the image of God as fully and completely as when the women too is joined with him as one." Another example is Tertullian's statement to women that they are 'the devil's gateway': Tertullian, "On the Apparel of Women" Book 1, Chapter 1, trans. S. Thelwell, revised and edited by Kevin Knight. www.newadvent.org/fathers/0402.htm.

Fifth, despite negative teenage experiences of church, emerging equally clearly from Deborah's interview were her positive experiences of a church community in her current (Methodist) church. It is relevant that the Methodist Church in Great Britain is progressive, amongst other things, in the role of women, and Deborah speaks of the support she had from both male and female ministers, and her own vocation as a Local Preacher. Deborah was clear that pastoral and spiritual support were essential for her in her recovery, but they did not – and should not – replace medical care. The support from her church came in the form of compassion, 'walking alongside', continued prayer and gentle reassessment of the ideas she had from her previous church about God.

Finally, crucial to Deborah's understanding of her recovery from her illness was her reflection on the compassion of God. Her descriptions of 'healing our image of God' ties in well with literature which suggests a distorted image of God as an abusive father can be a feature in the religious thinking of women with anorexia. This is of no surprise, as abuse from a father figure can be a risk factor for anorexia, although this was not the case for Deborah.[388] Her reflections on God's compassion manifested in Christ as the blueprint for the church community were central to her understanding of God and scripture. Deborah reflected on the 'COMpassion' in Christ's 'passion' as he suffers with humanity, so very literally in broken human form, starving in the desert and bleeding on the cross. This is summarised beautifully in her own image, the 'self-harm Christ'. Like the Female Wisdom, the Black Messiah, and the revolutionary Christ of other liberation

[388] See footnote 28.

theologies, this is a Christ who comes to people where they are and who suffers with humanity – literally, 'com-passion' – the very same sufferings, and through that, enables liberation from those sufferings.

4.4.1. ELOISE

Eloise was brought up in a non-religious family in Northern Ireland. Her eating disorder developed when she was around 14, but throughout school she was very secretive and 'managed' *it herself. At 16 she became a Christian and attended an evangelical church. When she left home for university two years later, she found life much more stressful and her eating disorder became more severe (she believed as a direct consequence) – however, she still managed to hide it from friends and family. Around the time she left university, her eating disorder spiralled and she was diagnosed with EDNOS[389], in her case, a combination of anorexia and bulimia.*

At the time of interview, almost four years after her diagnosis, Eloise was in her mid-20s, married and back living and working in Northern Ireland. She described herself as having been fully recovered from her eating disorder for around a year previously. Eloise was working as a youth worker and had previously worked in this role in the Church of England. Despite having worked for the Church of England, Eloise preferred to attend independent evangelical churches which she described as 'younger, more charismatic'.

[389] Eating Disorder Not Otherwise Specified

*Initially on diagnosis, Eloise received counselling from an NHS hospital, which she described as good but ineffectual. Had she not had a Christian therapist who agreed to bring faith into their sessions, she thought she would not have engaged with treatment. When Eloise's eating disorder was at its worst, she was working for the Church of England. She described her faith as ultimately the reason for her recovery, but at the same time as a Christian woman she felt a profound guilt about her eating disorder. Although she would tell the children she worked with about God's love for them, she couldn't seem to apply it to herself. As someone from a non-Christian background, she felt that to be a good Christian and set an example to her non-Christian family, she ought to have everything '*sorted'. *At the same time, a close non-Christian relative was encountering similar difficulties with eating and Eloise felt a* 'responsibility' *to* 'be strong because I had a faith… and to uphold that and say "look, this really does make a difference in my life"'.

Eloise described a lack of understanding in her church as a barrier to seeking enough support. Christian friends would tell her that 'God is bigger' *and encourage her to gain perspective on her life. They didn't seem to understand that she was sick, and prayer was not going to be an entire cure. As a leader in her church, she found it difficult to seek support, especially with the mission-focused attitude of the churches she attended:* 'You're supposed to be finding people who are outside of your church who are hurting and broken. And you're like, but I'm hurting and broken, and… I don't… I don't think people are very tolerant to it particularly when you are well-known in the church.' *She*

described feeling that the church members felt that if she didn't 'have her life sorted' *then she should step down as a leader.*

*Eloise also experienced excellent pastoral care from the Church of England parish she was working in, both before she left and through continued letters and communications whilst she was in treatment '*Just before I went, they were really understanding about me leaving for that reason and they tried to accommodate me… the last couple of months were a mess and they really accommodated me when I couldn't come in. Yeah, I'd say they were brilliant. But I don't think it would be the same if I was at the church that I was at before. They were a little bit less, sort of… patient…'

Eloise described finding some Bible passages dual-edged. Sometimes she found them a source of comfort, and at other times frustrating. She described passages on honouring your body; passages on the fruits of the spirit; and the extract from the Sermon on the Mount when Jesus exhorts his followers to 'not worry' and to be like the lilies of the field and the birds of the air. Sometimes when she read these passages she felt like a failure, as she was unable to 'not worry' and it didn't make her feel any better: 'Sometimes I would come away from those messages and think, like, either I'm not listening to God right because this isn't sinking in, or basically they're just words and they're ineffective…'

*Another passage she described as difficult was Proverbs 31. It was a really important chapter for her, for what she wanted to be as a wife, and for what is really important in life: '*That last verse where it says "the woman who is to be praised is the woman who fears the Lord" and it's what's important, your looks fade, and sometimes that again is really helpful and I'm like, yes, I know what's important. But in the bad moments, sometimes I'm like, I'll never be like that. Am I not worthy enough to be a Proverbs 31 woman and am I never going to be that good?'

After months of NHS counselling and no progress, Eloise heard of Mercy Ministries, a home based in Bradford for young women with life-controlling issues of all kinds, she applied and went there for three months. She described it as 'the best thing I could have done'. *Mercy Ministries has a rigid, structured programme, with Bible study every morning, worship in the afternoon, monitored meals (and after meals for bulimics), one-to-one counselling and more group Bible teaching in the evening. Phone calls were only allowed on Saturdays for 15 minutes.*

The help Eloise got at Mercy Ministries, through Bible teaching, prayer and meeting with God paved the way to healing for her. She described finding belief in Bible passages that had previously seemed 'just words'. *She said it made her realise* God really is the only person that can genuinely say something to you and make a difference to your heart'.

*'Mercy' is a theme that runs through Eloise's recovery and still means a lot to her today. She spoke of the difference between mercy and grace, and the comfort she found in the knowledge that God's mercies are new every morning, no matter what she has done wrong the days before: '*maybe because I know there's been so many things that I have needed countless days of His mercy for, and you know, that [verse] where it says His mercy is new every morning, like, yeah, I messed up every day… for so long.. and every morning waking up… and being able to go "right, today is another day when His mercies are new" was definitely something that was helpful to my heart.'

Eloise found Psalm 139 particularly important. She described having taught the children at her church that they are 'fearfully and wonderfully made' *by God and that He loves them – but she could never quite accept that it applied to her as well. Reading over the Psalm at Mercy Ministries, she found a new comfort in those words:* 'that's a really comforting verse, like, he knows exactly what He was doing, like I was not a mistake, He knows every little bit about me and it is good. And it took me so long to actually even take a glimpse of that and believe that it was truth…but I think it was probably the most helpful words for me.' *Eloise now has a tattoo of the words 'fearfully and wonderfully made' as a reminder to herself of the truth of those words.*

Eloise mentioned how inspiring she found parts of the Old Testament. She referred to a passage in Deuteronomy, that God 'puts before you life and death, blessings and curses. Choose life that you and your descendants might live'. *She had this verse written on her*

*wardrobe and every morning when she got dressed she asked herself '*Are you going to choose life today, or death?' *For her, it was important she recognised that an eating disorder was a choice that she made: although she was unwell, she could make choices to become better. God could help, but ultimately she needed to choose life. Other Old Testament passages also inspired her to make these choices. She looked to the metaphor of a battle, and to passages in Kings when God tells his people he will fight for them, if they will just step into the battle. For Eloise, making that step* 'into the battle' *was choosing to recover from her eating disorder and letting God work in her life.*

Building on the theme of choice, I asked Eloise whether she thought an eating disorder was a sin. She responded: 'What's the definition of a sin? A sin is anything that is opposite of following God. And it's definitely not following God. But at the same time could I have helped it? Like I couldn't help myself. So, I just don't know.' *She had come across non-religious people who believed firmly it was nothing but illness, and Christians who suggested it was a sin, or even a demonic possession. She described the question as a* 'grey area' *in Christian circles that even today she doesn't know the answer to. I asked how she felt about the suggestion of demon possession. She responded that the suggestion to her, as a leader in her church, was* 'insulting' *and implied she should step down from her post. Even the concept of demon possession as a metaphor seemed insulting to her. Although she didn't absolutely reject the idea, she suggested that* 'things are a little more realistic than that… my recovery has certainly not been demons being released.'

When I asked Eloise how she viewed God's character, and how this had changed before and after recovery, she described Him primarily as a father and protector. Her positive view of God as father was consciously influenced by her good relationship with her dad 'I think I really like the idea of Him as father, and as Daddy, and as that loving protector, but I think I am also quite realistic about his wrath and sort of what hurts him. And I think I hold quite a balance of knowing that he is much much greater than us and holds a lot of power, and knowing that – well, maybe believing that – he could be pretty angry if he wanted to be. But also that he loves us more than that. Umm, maybe before Jesus he would have been extremely angry with me, but has so much grace and mercy now that – having gone through that that he can kind of overlook it.'

For Eloise, her view of God did not change after her recovery so much as her understanding of how God viewed her. When she was ill she thought God 'pitied her' *and was* 'maybe a bit bored and kind of done with me'. *During her time at Mercy Ministries she came to a genuine belief of God's love for her – she described God loving her 'so so much' 'like a daughter'. This was something she had taught and preached in the past, but never truly believed for herself.*

Eloise summarised the importance of her faith in her recovery as her 'complete saving grace'. 'I just think if you have a faith and it's strong, not bringing it into your recovery… it's never going to work. Because if God's the most important thing in your life, and your eating disorder's the other most important thing in your life, then they have got to be

married before you could ditch one. And I didn't ever know which one I would ditch to be honest, both were so strong for me…probably in equal measure. And God… if I hadn't brought him in to just completely take over I would never have got better.'[390]

4.4.2. REFLECTION ON ELOISE'S NARRATIVE

When Eloise described the difficulties she had as an anorexic Christian woman, I got the impression her chief concerns arose from worries about other people's perceptions of her. As a convert to Christianity she clearly felt like a representative of what it means to be a Christian to her family, and felt guilty any time she did not live up to her own idea of being the perfect Christian woman who 'has it sorted'. To admit or to convey weakness in her eyes was to let down God.

Similarly, Eloise seemed concerned about the perceptions of members of her evangelical church – and with good reason, as she was on the receiving end of direct comments about her health and whether she was fit for her position in the church, and even suggestions that she was demon possessed. In our interview she mentioned twice that people seemed to think she should 'step down' if she didn't 'have her life sorted' and she was defensive about her capabilities as a youth leader. It was her position in leadership that made the direct comments more hurtful, although it was unclear whether this was because she felt them more keenly or because people were more

[390] Some of Eloise's words are also discussed in my 2017 article: Stammers, "Liberation from Anorexia Nervosa," 18.

direct than they would otherwise have been. This was a concerning attitude to hear about and seemed not only to highlight lack of pastoral support for leaders in the church, lay and ordained, but also to show distinct lack of compassion from fellow church members. It was telling that her evangelical church was more interested in prioritising outsiders, who were allowed to be 'hurting and broken' but that pastoral care once in the church became minimal. It seemed strange that Eloise still preferred this environment to the less evangelical and charismatic Church of England church she had attended which, by her own admission, was far more understanding to her, and much kinder and accepting of her 'brokenness' despite her position of leadership.

Eloise obviously had a model of what it meant to be the perfect Christian woman, and the perfect Christian wife. I wondered whether this was more important to her having grown up in a non-Christian family, and also whether it was more idealistic having not grown up with a realistic role model of a Christian woman in the household. When we talked about Proverbs 31, she had quite a literal understanding of the passage as a list of expectations that Christian women should achieve. This seemed to me a potentially damaging and unrealistic expectation.

For Eloise, the issue of 'sickness or sin?' was clearly pertinent. She spoke of still being confused about the nature of anorexia. For her, it was a sin – by not following God – and yet a non-volitional sin. She could not help it, and yet it was her choice. Her confusion over this reflected the 'grey area' she felt mental health inhabits within church

circles. Ultimately, for Eloise, to understand anorexia as something she had agency over allowed her to 'choose' to control it and to recover – even though she could not help it, perhaps explained in theological terms by a fallen or 'broken' human nature, she could choose to recover, to 'choose life' in the words of Deuteronomy. This Bible verse was one I too found inspiring when suffering from anorexia – that I could choose to recover and to fight this illness. Whereas for me it was clearly a choice to fight an illness, for Eloise it seemed, despite her confusion, to be much closer to a choice to turn away from sin. Her assertion that she had 'messed up every day' and needed 'countless days of his mercy' strongly implied she was closer to 'sin' than 'sickness' in her understanding. In contrast to some participants, she had not changed her ideas about God although her understanding of how God viewed her had changed during her illness. Although she recognised him as loving, she was 'realistic about his wrath'. I was struck that this was a theology of which Deborah, my previous participant chronologically, had been extremely concerned. Deborah had felt that an image of an abusive, angry God had led her to a vicious cycle of self-punishment in anticipation of his anger. For Eloise her understanding of God as steadfastly loving and merciful yet also wrathful, did not seem to hinder her recovery in the same way.

Eloise's insights on pastoral care were striking. She had experiences of extremely poor and thoughtless pastoral care, ranging from downright hurtful comments to superficial suggestions of Bible verses or prayers. In this, her account was similar to Grace's – the idea of 'band aid Bible verses', which did very little. However, Eloise also experienced

in her Church of England the compassion of 'walking alongside' shown by the vicar's wife who continued to write to her in hospital. In Mercy Ministries, she found comfort and recovery in a much deeper study of the scriptures in an immersive spiritual programme combined with practical support for recovery. This twofold approach was interesting, clearly Eloise, like Deborah, found much comfort in the scriptures – but not when used superficially. Perhaps part of the reason for this was the 'dual edged' nature of the scriptures for Eloise: they could either be sources of inspiration and comfort; or a cause of guilt and feelings of failure. To prevent the latter, they needed to be explored in depth in a structured and supportive pastoral environment. It was apparent that for a true recovery, the spiritual element needed to accompany a practical element (albeit in this case not a fully medical environment), and vice versa.

I found the idea of Mercy Ministries extremely interesting, having not come across them before. The work they do is, in my opinion, very important and I was glad to hear that their help had changed Eloise's life. There is an obvious risk that such programmes could disconnect from conventional psychological treatments and encourage vulnerable women to eschew much needed care, and individual programmes of this type would need to guard against this. I do feel that a caveat must be made that such programmes, whilst much needed innovations, are not medical programmes and so are not an alternative for women who are seriously ill and need medical care alongside the pastoral

and psychological support. For this reason, Mercy Ministries sets a minimum BMI of 17 to enter their programme.[391]

4.5.1. CAT

Cat was diagnosed with anorexia when she was 19, shortly after she started at university and about a year after her difficulties with food began. She was diagnosed when she visited the doctor concerning an injection, and discovered she was too underweight to be given it. She was put on a waiting list for eating disorders services and had her first outpatient appointment shortly after the start of her second year at university. She was treated as an outpatient, seeing a doctor or nurse therapist fortnightly, before eventually going into the hospital as an outpatient at the end of her second year. She was in hospital for 3 months over the summer holidays. She insisted on remaining at university to complete her end of year exams before admission: her perfectionist tendencies caused her to prioritise academic studies above treatment: 'To be honest, the only reason I decided to go in was 'cause I had nothing else to do and I was a bit tired of being anorexic, but to be frank if I'd got an internship or something I probably wouldn't have gone in. It's sad, but it's the truth!' *She received further therapy as an outpatient for another 6-9 months.*

[391] All information on Mercy Ministries is taken from my conversation with Eloise or their website www.mercyuk.org, accessed August 22, 2019.

Cat was in her late 20s when I interviewed her. She has a PhD, and works in scientific research. She describes herself as almost entirely recovered, with occasional 'bad days' *still. Cat was brought up a Roman Catholic, but her family were not particularly devout – she describes her parents as* 'lapsed Catholics'. *She attended Sunday School and Roman Catholic schools, and although she could not pinpoint specific religious thinking behind her eating disorder, she felt that due to her upbringing* 'faith shaped a lot of my thinking… it sort of seeped in.' *When Cat went to University, she made a conscious effort to attend Mass every week, as well as some social events put on by the Catholic Society. Although she would not take time out of her studies for much, and felt she did not see enough of her friends as she was busy studying, she would always make time to attend Mass. She said '*I guess I wanted to use that time for reflection and stuff. I knew I was ill but didn't really know what to do about it. I was stuck in a bit of a cycle'.

The main interaction between Cat's faith and eating disorder was the lack of provision at the hospital for her to practise her religion. She describes the doctors as exaggerating the facilities available – perhaps to persuade her to come in – she had been told there would be internet access; that she could stay in touch with people; and that there was a chapel. She had expected it would not be a Roman Catholic chapel, but was happy with a CofE or ecumenical service she could attend on Sundays. On admission she discovered the description of facilities was not entirely true – mobile phones were allowed, but it was before smartphones, and not only were there no internet access facilities, but access to the internet was strictly forbidden. There was also no evidence of a chapel, although

she later discovered that it was being rebuilt. The hospital did not seem to have a chaplain.

Cat describes 'my distinct memories of… sort of attempts to… I guess continue with my faith were quite.. awkward.' *She describes one attempt to go to church: after several weeks patients could put in a request to go out for a few hours. She requested to go to church, and permission was granted. As she did not know the area, a nurse looked up the nearest RC church for her.* 'It took me longer than I thought it would have to walk there – because I was quite skinny and slow – but when I got there, I mean it probably was a Catholic church, but it was an African American church and I felt like an outsider because it was such a close-knit community. It wasn't, you know, a student church. Where students would go and they're used to a nice influx of population. So I didn't really fit in very well. I felt like I was intruding on something to be honest.' *Halfway through the service Cat felt an overwhelming anxiety and had to leave. She was also struggling with OCD, and found many aspects of the service difficult due to her fear of germs: she did not want to bless herself because she would have to touch the holy water everyone else had touched; and she found the sharing of the Peace excruciating* – 'I just wanted to wash my hands after shaking hands with people!'

I asked Cat how she felt about taking the Mass. She responded that as she had not been to Confession for a long time, the problem had not arisen as she just went forward for a

blessing. She generally did feel nervous about the idea of taking Mass – not just in terms of calories, but even more about germs in the shared cup of wine.

On another occasion, after several weeks of requests from other patients, the opportunity arose to see a Roman Catholic Chaplain, a friar, and she and a friend were taken to the sitting room to meet the chaplain. Cat describes the experience as 'weird'. 'Because I don't normally have priests talk to me on my own, I just talk to them in Church. It was a bit like we were getting a weird spiritual lap dance from this priest. And he was doing… he was talking about you know, his priestly stuff… and it was just to us, and it was way too direct and weird. He didn't really talk priest. What he did was ask us how we were. Which under the circumstances was a reasonable thing to do, because you don't just want to God at someone. Equally, if you're not a medical professional, you don't want to start quizzing them about their eating disorder. I can't remember it very well, but I think he just sort of asked us how we were, you know, gave us his blessings and asked if we wanted to talk about anything, and we were both a bit awkward like… it's just you don't…. I'm mean do people like getting lap dances when they're sat next to their friends? I suppose some people do. But this was sort of… you're sat next to someone you know and you've never really talked about your faith to each other, even though you know you're both Catholics, and now you've got a chaplain in front of you and he's – you've never met this guy before and you weren't expecting him and he's asking if you've got anything to talk about and you're both like 'aaah' yeah. It was just like, it would have been nice if we'd just had a Mass!'

*Cat described the chaplain as having '*the best will in the world' *and doing the best he could in difficult circumstances, but the situation was awkward: she had no warning of the chaplain's visit; there was no service of Mass or prayer which she would have liked; and he was not a trained hospital chaplain and had no expertise in mental health. I asked Cat if she had any support from the Catholic Society at university: however, she had not told them of her illness, and as it was the summer holidays the chaplaincy centre was not open and no one would miss her. She also had not attended enough events to be known personally to the University's Catholic Chaplain, although she felt had she opened up about her illness the community would have been very supportive.*

Cat attended a collegiate university, and did have some interaction with the College Chaplain. Unfortunately, it could only be described as a 'bad experience' *– so bad that she nicknamed the College Chaplain* 'Satan'. *Cat had heard from other students that the Chaplain could not be trusted with confidential information – they had been to talk to her in confidence and she had talked about them with other members of staff without their permission. Shortly after Cat had been discharged from the eating disorders service, she attempted suicide by slitting her wrists. When she sliced into the first wrist, the skin and flesh fell away and she could see bone amongst the blood. She panicked, changed her mind, and sought help. An ambulance came and took her to hospital, and the College authorities sent the Chaplain to see how she was. Cat described this as a* 'bizarre' *idea as she had never met the Chaplain, didn't attend Chapel, and had no rapport with her. She didn't want to talk to her, as the Chaplain's reputation for*

gossiping preceded her. She said 'I think the best thing she did was she gave me a fiver so I could actually catch the bus home.' *Having assured the Chaplain that if she needed pastoral support, she would seek it at the Catholic Chaplaincy, the Chaplain left.*

Unfortunately, the 'bad experience' *was not to end there, as the Chaplain visited Cat's home the next day. Cat was not there having gone to stay with a friend whilst waiting for plastic surgery on her arm. Her flatmates described the visit to her later: the Chaplain told them what had happened, which Cat felt was acceptable to do, however* 'I think she talked to them about it more that she was supposed to'. *The Chaplain then looked at* 'black humour' *posters in Cat's room and remarked they were* 'inappropriate'*. It was apparently difficult to get her to leave, even once Cat's friend had explained she was not there, and that the posters were* 'just a joke'*.*

Cat didn't think there were any specific Bible teachings that made her feel uncomfortable about eating; however, she did get a general sense of discomfort around eating which she thought 'came from the Bible taken in the context of the society we live in'. *She pointed to passages such as Eve eating the forbidden fruit and the command to* 'give up everything' *with the association of 'poor and hungry' = good; and 'rich and gluttonous' = bad, which put an association in her mind between food and sin. More difficult she found issues of gender in the Bible: all the apostles are male; all the lectionary readings are about men;* 'all the good people are men'. *She also found some of the descriptions of women's subordinate roles uncomfortable, for example, St. Paul's teaching that a wife*

should obey her husband. She recalled reading Hosea when she was 16, and feeling angry at the portrayal of Jerusalem as a whore – the idea that to portray something as having been ravaged and lost its way, it must be portrayed as a woman, and a sinful one. Her response was 'what the fuck is this people? How did this even get published?'

Cat pointed to the difficulties anorexia sufferers can feel with the central focus on food in Roman Catholicism, particularly in the Mass: 'it's kind of an inescapable thing about Catholicism that we're eating Jesus'. *If we get good things through consuming Jesus, Cat asked,* 'Do we have to watch what else we eat? Can you eat, like, Satan….?' *The central importance of eating in the sacramental theology of the Catholic Church* 'puts it there as an important thing, beyond "you need to eat to survive"'. *The subject seemed unavoidable – not only was food a central aspect of the Mass, but so many Bible stories revolve around food.* 'I mean like: Eve eats an apple, that's how all this shit began. Or on the final night Jesus feeds his friends and says "you are eating my flesh and blood" and that's a central, really important thing. Or Jesus going in the desert to fast. That's like an important part of the story. And just, there's loads of things that are centred around eating, and/or not eating… more so than just "Jesus happened to be having dinner with his friends", it's the eating comes as an important plot point.' *Although this does not necessarily give food negative connotations, it did mean for Cat it was not something she could ignore. As an anorexic who spent all day every day thinking about what she was going to eat next and how many calories she had already consumed, this*

prevented church from being the necessary escape from food obsessions that she needed.

We got onto the subject of religious fasting. Cat described it as a 'strange' *concept. She could not understand why fasting is meant to better yourself, or bring you closer to God:* 'why, why is that a holy thing to do?' *She could understand helping the poor; going on pilgrimages and prayer – but not the point of fasting. She thought it strange to encourage children to do in the form of Lent or sponsored fasts. As a child Cat had enjoyed Lent as not only did it help her realise she didn't need a particular food, but also encouraged her to try new foods instead. However, when she was anorexic, it became a trigger point. It was difficult, as if you have already given up everything except vegetables and fat free yoghurts, what else is there to give up?*

Even more difficult than the fast was the feast that came after it. Although not technically 'religious' per se, religious festivals are steeped in traditions revolving around food – Easter chocolate and Christmas dinner. Cat described accepting these special days as a 'write off' *when for one day she permitted herself to eat. However, in preparation she would starve herself to extremes in the days beforehand, and would be very distressed in the days that followed.*

Cat described the ‘catch 22’ *of the juxtaposition of religious or Biblical teachings that exhort us to take care of our bodies as a gift from God or* ‘temples of the Holy Spirit’ *and yet elsewhere glorify self-starvation. Cat’s overriding sense was she was failing everybody, including God, and that he would be judging her harshly. In hindsight, she recognised this was probably shaped by the way she was spoken to by judgemental doctors and other figures of authority. At the time she felt she was failing in her academic work (she wasn’t) and in her personal life. People kept telling her she was sick which made her feel she had done something wrong, even more of a failure. Her perfectionist response was to work harder and starve harder. In* ‘a stupid way’ *she was succeeding, but* ‘I think people made me believe that I was somehow failing because they kept telling me I was failing’. *This perpetuated a cycle of self-destruction.*

4.5.2. REFLECTION ON CAT’S NARRATIVE

Much of Cat’s narrative provided an account of ‘how not to chaplain an eating disorders patient’: her bad experiences of chaplaincy and church whilst in hospital stood out as important in her attempts to cling on to her faith in her time of need. There were three elements: the bad relationship with the college chaplain, largely based on the chaplain’s reputation preceding her and a lack of tact; the attempt to attend an unfamiliar church where she felt an outsider or intruder; and the visit of the friar who Cat assumed had no experience of eating disorders chaplaincy.

There are some useful points in this on how pastoral care of eating disorders patients could be improved. In terms of the college chaplain, as a chaplain working with students and primarily young high achieving students at risk of ensuing mental health problems, it is startling that she did not show a more sensitive approach: it is perhaps a reminder that the black humour employed by some mental health patients as a coping mechanism is not familiar to all people engaged in pastoral care. It is clear there were concerns regarding confidentiality with the chaplain in question: as a Chaplain, I can recognise that cases of breaking confidentiality Cat had heard about may have been serious safeguarding situations which the Chaplain had felt duty-bound to disclose to college officials. Nonetheless, someone had broken confidentiality and a relatively small college is a place where gossip spreads. This highlights the importance of the chaplain-patient relationship in pastoral care; and indeed of the need for continuing professional development and training for chaplains and others working with vulnerable populations on what to do in sensitive situations.

It was also clear that the hospital had not been honest about facilities, as it transpired that renovation of the hospital chapel was a long-term pre-planned project: this leads me to speculate whether they wanted to encourage Cat to go in as an inpatient and so exaggerated? Or perhaps healthcare professionals involved were unaware of facilities on the ward and in the hospital in general? The trip to a church which was an unfamiliar style, despite being nominally the same denomination, where Cat felt an outsider, was a lovely gesture by a well-meaning nurse: but one that could have had a far more

successful outcome with proper chaplaincy input to arrange an alternative sacred space whilst the chapel was undergoing renovation, or a more organised outing to church. It was interesting that Cat mentioned feeling like an 'outsider'. Isolation from the means to practice her faith is a theme throughout her narrative, yet she simultaneously isolated herself by not telling anyone at the Catholic chaplaincy about her illness.

I sense an implicit concern of boundary transgressions in Cat's narrative. In church, she was worried about germs from the holy water and chalice and about the handshakes for the Peace; as if these traversed an invisible bodily boundary. Her use of the metaphor of 'lap dancing' for the visit from the friar also implied an invasion of privacy or crossing of boundaries. She uses a sexual metaphor to express an uncomfortable and intense situation full of 'awkward' pauses and 'direct' questions. The issue of sharing this situation with fellow patients again seems to cross boundaries of sharing her private faith and baring her soul: once again, Cat's own shields seem to be isolating her from others. Although Cat was scathing about the success of the visit (despite admitting he had the 'best will in the world'), from an outside perspective – although possibly a little underprepared – the friar did not seem to ask anything unreasonable, simply 'how are you?'. It is Cat's perception and subjective experience that this felt 'too direct'.

Aside from Cat's experiences of pastoral care, she had interesting insights into the interaction between faith and her eating disorder: particularly her assessment that the way faith 'seeped' into her thought processes was subliminal but shaped the way she

saw the world. Her recognition of tension between Biblical narratives and the values of the contemporary world was pertinent: in particular, issues to do with gender; the sin of Eve (eating) and gluttony more generally; and the subjugation of women. Interestingly, she again selected a passage with a sexual metaphor (Hosea).

Cat also highlighted areas in which it can be extremely difficult for an anorexic to be Christian: the risk of Lenten fasting and promotion of such behaviours; difficulties surrounding large feasts; the confusing juxtaposition of caring for your body and fasting; and – most importantly perhaps – the central importance of food, particularly in Catholic worship. For an anorexic who finds food preoccupies her thoughts, church cannot be a good escape route when it centres around the Mass – literal eating and drinking. It seems from her narrative, and desire to keep attending church even when she made no time for anything else, that for Cat a church service was a time for reflection away from work and the troubles of the day. However, when it came to the troubles of food, they were also waiting for her at the altar, in Bible readings and in the very fabric of the Church.

4.6.1. GRACE

From four years old, Grace was a dancer. This 'controlling environment'*, being constantly* 'in front of mirrors' *and growing up in the US*[392] *aware of societal pressures around body image made her conscious of her body from an early age. When she was 13 she saw a film that changed her life: 'The Best Little Girl in the World'. It was the story of a dancer, who wanted, and was expected, to be good at everything. Her family argued regularly around the dinner table and her solution was to eat and make herself vomit. Grace saw this and thought it an easy solution to the pressures in her life, particularly the difficult family dynamic – so she imitated the behaviour she saw on screen. At first it was occasional, making herself sick when she felt she had eaten too much, but after a series of successive family traumas, at 18 or 19, she began to restrict food severely. This swung back to a bulimic phase aged 21, in a typical* 'bulimirexic'[393] *pattern of restricting/binge-purging. She also exhibited other self-destructive behaviours, drinking and drug-taking.*

After Grace's father died her eating disorder became 'out of control'*. At its worst the longest she went without the binge-purge cycle was three weeks, which she described as a* 'huge milestone'*. At the time, aged about 24, Grace worked in a shop. She worked closely with the manager, who was a friend, and one day mentioned that she did not*

[392] Grace has lived in several different countries, including the UK and elsewhere in Europe. I have not given much detail concerning her international moves in order to protect her identity.
[393] 'Bulimarexic' is a colloquialism for a binge-purge subtype of anorexia nervosa, so called because it combines elements of both bulimia and anorexia. It is the term Grace uses to define her eating disorder.

believe that her 'problem' *as she called it would last for ever:* 'I believed God was going to heal me one day… I'm not going to die from this.' *Her friend, who came from a charismatic background, mentioned he knew a pastor with a healing ministry who could pray with her. Grace described that she* 'knew, literally knew, that I was going to be healed.' *Grace, her best friend and the friend who had made the recommendation went to see the pastor. Grace said: '*And, all I know is I went there that night in total faith that I was going to be free of this, and they prayed for me, like, it was a long evening of prayer and talking through what had led to this thing, and by the time I left there I was free of this.'

When questioned about that evening, Grace described going to the pastor's house where her best friend told him her story, as she was crying too much to do so. The pastor gave her an image which she has never forgotten, in the form of a story. He described two men walking down a road from opposite ends, towards each other. One carries blocks of gold, the other carries manure – that is his living, his identity, how he carries himself through life. They bump into each other in the middle, and the man with the gold says "If you put down that manure, I'll give you some of this gold. You will never have to carry manure again. You'll be taken care of". The man with the manure protested: this was his livelihood, how would he survive without it? The man with the gold replied "If you just trust me, put down that manure and take this gold. You won't need that manure any longer". The image of trust spoke to Grace and she felt she had to put down her burden, her eating disorder, and trust she wouldn't need it to cope with life any longer:

'I'm either going to die, or I'm going to put this down'. *The pastor asked if she was ready to lay it down, and she was. Grace emphasised that it wasn't like being forgiven of a sin, or a conversion – she was already a Christian, and wouldn't have got to this point if she wasn't. It was a laying down of a burden by trusting in God.*

*The pastor and her friends laid hands on her and prayed. Grace described that she wasn't comfortable in such settings: '*But I do believe in healing and I do believe there is a demonic force in the world. And the guy, he laid hands on me and was praying, and he was pretty much calling things out…a kind of casting out. He was naming things I hadn't even told him about my life. It was a kind of… a lot of it's a blur because I was crying so much it was so intense.' *She described herself as feeling* 'freed' *and having an incredible* 'sense of peace'*, describing it like a spring clean – someone coming and sweeping your house out whilst you are out and setting it all back to order. Her friend described it as though a heavy dark cloud had lifted from her. From that day on, she never again restricted food with the aim of weight loss or made herself sick, nor wanted to. That night was 24 years ago at the time of interviewing.*

Later in life, Grace went through difficult times: she was in an abusive relationship and developed chronic health difficulties. She developed a number of allergies which made her relationship with food difficult for different reasons and made it hard to eat. Although there were times when eating was hard, she never reverted to disordered thinking about eating. She used food as a tool to get her life back on track, tackling her

extreme tiredness with healthy eating. She is a musician, actor and life coach and helps people with health problems improve their health through good diet.

Grace has moved around a lot and attended churches of many different denominations. She grew up in a Catholic/Protestant family with an ecumenical ethos and feels comfortable in different churches. Her parents never forced her to go to church, rather she chose to because she saw how her father lived out his faith in his life. At the time of interviewing she was attending an evangelical Lutheran church with an international congregation. Previously, she had attended an Anglican church in the UK; and a non-denominational church in the US, which she described as having evangelical worship with lots of artistic expression, but less conservative theology than many 'typical' *evangelical churches.*

Grace found two Bible stories resonated with her experiences. One was the story of the woman stoned in adultery. She described shame as being at the centre of addictive behaviours, particularly eating disorders. She describes feeling that Jesus stands between the woman and the crowd, metaphorically covering her shame and defending her. For Grace, Jesus stands between her and the voice in her head (which she described as an external 'outside' *voice) that shamed her into starving herself, or binge-purging, defending her and daring the voice to* 'shame her'.

The second story was the haemorrhaging woman, desperate to touch the hem of Jesus' cloak, believing 'if I could just touch him, I would be well'. This desperation and faith in

Christ's healing mirrored Grace's experience: 'that story, even today, when I read it, it feels like my story.'

Grace believes that anorexia/bulimia is a demonic external force that was spiritually oppressing her. She used the analogy of being in a pit and having something with its hands round her throat, trying to stop her singing. The day she was healed she was 'lifted out of the pit'. *She felt that when churches view anorexia as a sin it is not helpful – instead it should be viewed as* 'something that attached itself to you due to what you've been through'. *Although she* 'takes responsibility for her own actions' *she believes that to call it a sin puts pressure on the sufferer to solve the problem and implies they have the ability to stop it – that pressure, she believes, is the real sin.*

*Grace felt eating disorders, and mental health difficulties in general, are a taboo subject in the church. After she gave testimony of her experiences, many congregation members came to talk to her about their experiences, or experiences of relatives – which previously they had not spoken about. She suspected they felt they would not get a helpful response if they unburdened their problems, but would be told to memorise a '*trite Bible verse' *or that* 'God works all things to the good'. *This kind of response from pastors and other Christians, she described as* 'not just unhelpful, it borders on insensitive'. *Grace was also sceptical that Christians who* 'hadn't gone through anything' *were really being honest with themselves – after all,* 'everyone goes through something'. *She said* 'when they see someone who's honest about their struggle they don't know what to do with that so it's

easier just to say "Oh, Romans 8:28". Well, thank you, thank you for not really understanding what I'm going through!' *Grace described verses such as this as being beautiful in context, but not when they are used as* 'Band Aid Bible verses'.

I asked Grace about her experiences of taking the Eucharist, and whether she had struggled, either with the calories or eating in public. She replied that this had never occurred to her, and even now she does not worry about the gluten content of the bread (she is gluten intolerant) because in her Roman Catholic influenced theology, it becomes the body of Christ when she takes it. It is therefore not 'food' in the usual sense and even though she at one point struggled with eating in public, this never extended to the Eucharist.

Grace described her image of God as remaining steadfast throughout her childhood, illness and later life. In her childhood, Grace's father shared healing stories from his Catholic background, and it is on these she based her understanding of God. She never saw God as 'shaking his head at me in disappointment'. *Rather, she saw God as a healer, protector, defender, strength, shelter and rescuer. She said* 'I honestly think that… I don't know that without that image… I don't think I would be healed. I don't think I would be better as I wouldn't be able to believe in healing if I didn't see God in that way.'

4.6.2. REFLECTION ON GRACE'S NARRATIVE

Grace's story was particularly complex. I was fascinated that she describes a 'healing' or 'deliverance' from her illness. The question of how she understood her anorexia puzzled me: she could understand anorexia as an 'external force' and yet still insist on 'responsibility for her own actions' with regards to her eating disorder. When I asked about this, Grace confirmed that although she was not entirely comfortable in that environment, she did feel that 'something demonic was holding me hostage' that she could not explain: she could only reply, like the blind man 'I was blind, but now I see'. She was reticent to put a definite 'yes' or 'no' to the question of possession, preferring to use the language of 'deliverance'. She also noted that although there was an external 'possession' there is also a question of internal 'oppression' which enabled her to reconcile the tension between her own responsibility and ability to make choices about her illness, and the 'external force'. She still primarily described anorexia as an 'illness' and compared the question as to whether she believed she was demon-possessed as akin to asking a cancer sufferer who had been healed whether they were demon-possessed. She described anorexia as an illness, a mental struggle, a demonic external force, an addiction and a coping mechanism. Although it can be difficult to reconcile these multiple rationales from an outside perspective, for Grace, they were not contradictory.

I was interested in Grace's life after healing: she still did not feel comfortable in a Pentecostal environment – and spoke of spiritual abuse she witnessed in the six months

she attended a Pentecostal church – and especially discordant for her was the assertion that she had 'been saved' when she knew she was already a Christian at the time of her healing. Grace never again felt the desire to starve herself: her healing was complete. However, it was striking that she still follows an extremely restrictive gluten free, vegan diet of raw fruit and vegetables for health reasons and works as a nutritionist. This could raise a certain level of scepticism about her 'recovery', or alternatively as it is related to physical health problems, it could be a sign of how successful her recovery is that despite these extreme restrictions she did not lapse back into an eating disorder. From an 'outsider' perspective to her life, it is simply impossible to know which of these it is. It was interesting that she spoke of depression post-healing, and that her physical health problems were triggered initially by difficult times in her life emotionally (specifically abuse). The theology constructed in Grace's story implies that God can intervene to heal on one occasion, but chooses not to on others (which in itself is not an uncommon theology). This framing of her narrative also suggests that the 'anorexia' was something distinct from her later mental health problems rather than progressing manifestations of her illness or alternative coping mechanisms for the same difficulties.

I thought Grace's position on pastoral care that suggests a 'trite Bible verse' was particularly apt, and was a theme reflected in other participants' stories. Similarly, her feeling of isolation and stigma around mental health as something that is not talked about came through in other participants' stories – this was pronounced in those who

lived in the US at the time of their illness, whereas those living in the UK felt there was excessive stigma in church circles, but less so in non-religious contexts.

Like Eloise and Deborah, despite Grace's scathing comments on insensitive pastoral care and 'Band Aid Bible verses', she too found meaning and support in some Bible texts when she studied them more deeply. Like other participants, she pointed to texts about women. Grace's interpretation of the story of the adulterous woman focuses on 'shame'. Like Rose[394], she described how Jesus intervened to protect her, but whereas Rose described Jesus as speaking to her telling her not to 'judge herself', for Grace, when Jesus addresses the crowds, he shields her from an external force rather than from herself – in this case, the external voice in her head. To take the analogy further and build on Grace's concerns about societal pressures and body-shaming, one could suggest that Jesus not only stands between her and the eating disorder, but also the shaming voices of the world.

The image Grace spoke of in the haemorrhaging woman which she felt mirrored her own story seemed to me to speak very much of anorexia in today's society. It is an illness of women (primarily), and it is an illness of shame which is little understood by the culture we live in. The haemorrhaging woman has nowhere to turn in her female illness of shame, and likewise anorexics today have few places to turn for understanding support

[394] For Rose's story, see appendix 9.

and treatment. Ultimately, it is unsurprising that Grace turned to the church for healing, as she had no medical input for her eating disorder at all. When I hear Grace's story I am deeply aware – as was she – that her story is by no means common, and that miraculous faith healings are rare.[395] Other participants were concerned about the implications of faith healing, suggesting as it does that the church is an 'alternative' to modern medicine or in some way polarised to it. They felt this a dangerous path to tread, and one that was far more of a risk with mental health than physical health. Grace was similarly concerned that faith healing should not be seen as an alternative to seeking medical help. As Jesus not only shields the adulterous woman but shows her compassion and helps her, perhaps the time has come for the church to lead the way on a more compassionate and proactive response to eating disorders in conjunction with, rather than in opposition to, medical practice.

[395] There is debate concerning the validity and success of faith healing, particularly in terms of the effect of prayer on physical and mental illness. Studies show that people who partake in religious activities or who know they are being prayed for have better health outcomes, as discussed by Basak Coruh et al., "Does religious activity improve health outcomes: a critical review of the recent literature," *Explore (NY)* 1, no.3 (May 2005): 186-191. However, blind studies concerning prayer and healing which attempt to remove any possible psychological benefit of prayer are notoriously difficult to undertake, controversial and often it is impossible to account for all other potential factors, as discussed by Chittaranjan Andrade and Rajiv Radhakrishnan, "Prayer and Healing: A Medical and Scientific Perspective on Randomised Controlled Trials," *Indian Journal of Psychiatry* 51, no.4 (2009):247-253. It is also worth noting that there is no formal documentation or validation of accounts of faith healing. Candy Gunther Brown, *Testing Prayer: Science and Healing* (Cambridge, MA: Harvard University Press, 2012). Finally, it is noteworthy that much of the literature concerning prayer and faith healing does not refer to miraculous one-off instances of deliverance such as that experienced by Grace, but rather a beneficial aspect or improvement that is often in addition to medical healing and describes an ongoing process of motivation and/or peace. On this basis, the belief that both Grace and I hold that such miraculous occurrences, whilst not unheard of, are rare can be justified.

4.7.1. CLARE

Clare was in her early 60s, in a same-sex marriage and working as a writer when I interviewed her. She was brought up a Roman Catholic by devout parents who were converts. They attended church every Sunday and she went to a Roman Catholic school. Clare remembered being brought up reading saints' stories – before bed, she would be allowed one storybook, and one saint's story. Although she found the storybooks more enjoyable, she remembered a lot of saints' stories about young women who wanted to follow God but were married off by their fathers, like Saint Penelope who was tied to a wild horse. Another story was about a saint who, as a child, accepted a sweet offered by a pagan gentleman visiting her father on business. She threw the sweet in the fire, to symbolise to him how his soul would burn in hell. Clare described how, although she was read these rather extreme stories before bed, her mother would cross out parts she felt were modelling bad behaviour and write 'rude' *in the margin.*

*Clare spoke a lot about the importance of '*good' *and* 'bad' *behaviour when she was growing up, and she described this as part of who she was and how she interpreted the world in the lead up to her eating disorder. She told me how she attended early morning Mass with her mother in her teens and how it made her feel she was* 'being good' *and following the rules. During her teens, Clare's grandmother committed suicide which she felt was an early cause of her psychological difficulties.*

Clare didn't remember feeling at odds with her religion as a child or teenager; although she remembered finding elements of it somewhat boring. In hindsight, she said she now felt uncomfortable with a lot of the Roman Catholic Church's teachings, especially those to do with 'controlling of women's bodies by the patriarchy embodied in the Roman Catholic Church'. *At the time she was largely unaware of or did not fully understand such teachings on, for example, abortion or sexuality. She did describe how the ritual fasting of Lent and Advent played into the pursuit of self-control:* 'my first experience of learning to control my appetites'. *She and her siblings kept charts of achievements, or jars to fill as they did good deeds. There was a conscious link between* 'doing good deeds' *and* 'fasting' *which created a lasting connection.*

When she finished school, Clare spent a year working in a care home, and during that time she began to diet as she (and her mother) both felt she was becoming 'chubby', *although in hindsight she realised she was a healthy weight. After her gap year, Clare left home for university, and it was there that she developed anorexia – a little known condition in the 1970s. She described her illness as to do with control, a way to deal with her unhappiness and loneliness and a search for how to 'be* good'. *Whilst at university, she searched desperately for something to help and found herself looking for solace in attending Mass each day. She described this as helpful because it made her feel she was* 'being good'. *Clare was involved in the Catholic chaplaincy at university, and a lot of her memories of the activities revolved around food. She remembered how she and other students did a three day fast sleeping on the chaplaincy floor for Oxfam which she did*

not find it difficult because of the control she had over her appetite. Clare also described how she would allow herself to eat at chaplaincy events: once a week there was a chaplaincy meal where she would let herself eat as much as she liked. This was connected to her feeling that she should not spend money on herself, including food, as she did not feel she was worth it.

Clare described the professionals who tried to help her at that stage in her life: the campus doctor encouraged her weight loss, despite her obvious illness; and a counsellor was supportive but could not understand or attempt to unravel the religious perspective in which Clare's illness was rooted. The University Catholic chaplain tried to be helpful, but did not have the knowledge or skills needed. However, he invited her for student meals at his house once a week, and gave her a book of Psalms to read. Before she finished her course, Clare attempted suicide and went home to live with her mother.

It was during this time living at home – when she also developed bulimic tendencies – that Clare detached herself from Catholicism. She described how 'intensely needy' *she was of her mother during that time: '*And it was her focus on me…. and that… really helped me to come through it at that time, and her listening to me. But there was a time before that when she was saying… she was going out of the house and just saying 'I can't. You just have to give me space. I can't.' *Clare remembered one incident that she still found emotional now: her mother had gone to the church to do some charity*

work as usual, and the priest said to her 'Go home, Clare needs you more'. *Clare cried at her recollection of this.*

Clare had said that she 'went home to live with her mother'. *I asked about her father at this time. He was living at home with them, but in a difficult position himself having been made redundant: this, Clare described as* 'contributing to the family precipice situation'. *She described him as a* 'background figure' *in the family, who was sympathetic and suffered a lot of despair himself. However, he did not know how to respond to her illness '*other than to be sympathetic… give me a hug every now and then'.

Clare spent almost a year in hospital in a psycho-therapeutic ward. There the doctor queried 'do you think your problem is that you've never grown up?' *which she thought* 'sounded to me as good an explanation as any'. *Whilst there she came across the term 'anorexia' for the first time. In hospital she returned to eating regular meals, however when she left her eating patterns became chaotic again and she was plagued by anorexic behaviours and thoughts for several more years. In her late 20s, when she was* 'entirely fed up', *Clare went to see an acupuncturist, who was a good listener. The combination of acupuncture, being listened to, and being ready to* 'do the impossible' *was the turning point for Clare and over a year of treatment she recovered.*

I asked Clare how she had understood God growing up and how that image changed during her illness. She responded that she had always been very aware of the Trinitarian split, with God the Father a 'distant traditional in the clouds figure' *and the Holy Spirit* 'supposed to be this dove communicating between the Father and the Son'. *The only member of the Trinity who felt really real to her was Jesus:* 'I suppose I believed and still do believe much of what he said in the Bible'. *She felt that God the Father had* 'no interest in me whatsoever' *and although she said prayers to Jesus, it began to feel '*like sending a signal out there somewhere… not really feeling that I was having any communication'. *By the time she went into hospital, she stopped believing in God altogether, as did her mother.*

Clare now describes herself as 'spiritual' *rather than religious. She described the role she believed religion had played in her illness. Clare could consciously trace its origins in religious ideas: in particular, her desire to work out how to* 'be good' *and the models of womanhood she felt she needed to follow. She struggled with the seeming contrast in the saints' stories of either following God or living an earthly life and having a relationship. Clare felt that her mother was the model of what it meant to be a good woman, that she should marry and have children. She described what she believed were her mother's hopes for her: to pass exams and go to university, as the first woman in the family to do so, but ultimately to marry and have children. Clare felt her mother thought she was a* 'failure' *for not having a boyfriend in her teens. Clare took on this feeling of failure, believing that to have a boyfriend would be the* 'first step to being the woman I

should be'. *It seems no coincidence that one reason Clare began dieting was because her mother felt she should lose weight. There were contradictions in what it meant to be* 'good' *that confused Clare; during her gap year she gave a large amount of the money she had earned to charity – something she had been brought up to understand was* 'good' – *and her mother was* 'shocked' *and asked* 'what if the family had needed that money?' *This strange contradiction of her mother – her model of 'goodness' – responding negatively to her 'good' act was a source of confusion. Not eating was, according to Clare, likewise part of this quest to* 'be good' *by denying herself in the way her religion and the saints' stories had taught her.*

Clare described the importance of 'winning grace' *when she was growing up. Church did not seem to be about an understanding of or relationship with God; it was all about behaviour, and rituals such as Confession or All Souls day prayers that would win you grace. She described how that was similar to counting calories: you could count holy points and see how* 'good' *you were at winning grace; likewise, you could count calories and count how 'good' you were at abstaining from food.*

When Clare reflected on her experiences of anorexia and bulimia, she described anorexia as 'something that was strange and positive… in that it did give me a handle on life. It gave me a way of controlling things that seemed uncontrollable'. *For her, the experience with anorexia, although* 'dangerously self-destructive' *was also* 'a survival tool, in a contradictory way'. *It gave her reassurance that she was able to be in control, to have*

autonomy and to do things she set her mind to. When she returned to university, she put this to use in studying rather than dieting.

She was less positive about the bulimic element of her illness which she understood as sinful in a way that she had not felt about the anorexia – she 'had a sense that it was very wrong indeed… it was directly wasting food'. *She had been taught at her Catholic primary school that to waste food was morally wrong, as there were people in the world who were starving.*

Later in life, at a time of stress, Clare had another 'breakdown'. *Once again, her worries about not being* 'good enough' *arose, but she did not return to anorexic patterns of behaviour: she said that she '*knew it wouldn't work a second time because I could see through it' *and it did not really control anything.*

4.7.2. REFLECTION ON CLARE'S NARRATIVE

Clare was one of only two women in the study reflecting on their story from the hindsight of several decades. Not only did this mean her understanding of her own narrative had had time to mature, but also meant that with regards to the social and cultural influences on her eating disorder, she was reflecting on a different time to the younger participants: the culture of the 1970s rather than the 2000/2010s.

The overriding feature in Clare's story seemed to be her emphasis on 'being good'. This was what she came back to repeatedly throughout the interview, and the explicit connection between 'fasting' and 'being good' suggests that her religion was one of the direct causes of her eating disorder. Clare's desire to be the 'good' girl seemed tied in with the expectations upon her. It was telling that when I asked what she meant by 'being the woman I should be' she responded 'I suppose I felt I should be like my mother'. Her mother was her role model of womanhood; and Clare seemed to feel keenly the occasions when she 'disappointed' (or perceived to disappoint) her mother, such as by being 'too chubby' or by not having a boyfriend. There is a clear connection with her eating disorder here, as it is her mother's influence that encouraged her to start dieting as a way to fulfil the model of womanhood that was presented to her. Interestingly, although when I asked Clare did not see a direct connection between her sexuality and her illness, as she says that not having a boyfriend was part of her failure in attaining this model of womanhood, I suspect that her sexuality and ensuing lack of romantic interest in men may have contributed to her feelings of failure.

Clare clearly had a close relationship with her mother and it was interesting her second breakdown in later life was during the time she was caring for her unwell. It is perhaps this close relationship which meant Clare felt so acutely when she did not fit the same model of womanhood. Clare's emotions concerning her mother were fraught, and it was at the recollection of her mother's care of her when unwell that Clare became distressed during interview. It is noteworthy that Clare's mother encouraged her to 'be

good' with her annotation of saints' stories and the good deeds and achievement charts in Lent. It struck me that perhaps Clare's emphasis on being and doing good could spring from her desire to fulfil her mother's expectations and/or example.

I was also interested that Clare spoke of 'winning grace' and counting it up in the same way that she had stored up her deeds in a jar as a child, and counted her calories as a young woman. There is a definite theme here of 'salvation by starvation' – or at least, 'salvation by being good', and part of 'being good' is to fulfil that model of womanhood that requires a perfect figure, a husband and children – but ideally with a degree first, of course. Despite Clare's experience occurring in the 1970s, in many ways it was not very different to the expectation and pressures placed upon young Christian women today.

Other than Clare's ideas of Jesus, her relationship with Christianity seemed to be based primarily on typically childlike ideas about God in the clouds and stories. As she spoke of her experience at the university chaplaincy, I had the impression that her Christian faith never moved on from that – rather, her current position as 'spiritual' seems to have been her natural progression. I was struck that, unlike other participants who spoke of Mass as a comforting, reflective time, for Clare the only comfort to be gained from church services and rituals was that she 'felt good' – in other words, she clocked up holy points. It was interesting that Clare allowed herself to eat when it was 'validated' by religion through a chaplaincy event – as if to do so was acceptable, 'good', but to eat at

other times was immoral. The pastoral care at the chaplaincy, although well-meaning, was clearly inadequate. The priest – a single man – had little understanding of her condition and her underlying struggles with becoming the 'woman she should be'. This is unsurprising for the 1970s, when even healthcare professionals did not understand anorexia well. Partly, it seems the natural consequence of having pastoral care only supplied by a celibate, single, man: through no fault of his own, he could not possibly hope to truly understand the issues Clare was facing.

Clare's understanding of her illness as a 'strange and positive' 'survival tool' was interesting. She was very clear that for her, anorexia was a coping mechanism – not just for her struggles with identity, but with the relationships in her family and her grandmother's suicide. I found it telling that Clare had felt comfortable from a religious perspective with anorexia, which fulfilled her religious values of 'being good, 'fasting', 'self-control', 'selflessness'. Bulimia, which 'wasted food' came firmly under the category of 'sin' and so was a less acceptable coping mechanism in her eyes. Clare's recognition that it 'wouldn't work a second time because I could see through it' presented anorexia almost as a façade, a trick which made her think she could control things she couldn't. This paradox of a 'successful coping mechanism' and a 'trick that made her think she was coping' presented the mixed feelings Clare had towards the nature of her disorder. She did not present anorexia as sinful, nor so much as an illness or an external force and rather as a vague psychological phenomenon which she termed as a 'breakdown'.

CHAPTER 5: THEMES

SECTION A: SICKNESS OR SIN?

5.1.1. PERCEPTIONS OF INTENTIONAL SELF-STARVATION

As noted in the literature review, anorexia nervosa in its modern form is, by definition, a time-bound syndrome constructed as a medical disorder in the 19th century.[396] I have argued that there are distinct lines of continuity between the modern 'illness' and earlier patterns of self-starvation and thus it is relevant to consider the different paradigms in which intentional self-starvation (not due to food shortages) has been understood in different contexts.

Fasting for religious purposes is an ancient practice documented in several cultures. It is not a peculiarly Christian or even Abrahamic tradition, although for the purpose of this enquiry I trace its roots within Christian tradition. Fasting practices are referenced frequently in the Hebrew Bible.[397] It is clear that fasting (communal and personal) is an established practice in Jewish tradition long before the advent of Christianity.

In their account of the journey 'from fasting saints to anorexic girls', Vandereycken and van Deth describe two primary motives for fasting amongst early Christians (in particular, the Church Fathers). Firstly, an increase in supernatural power, for example, to intensify prayer or ask God's favour.[398] Secondly, for penance: asceticism, including

[396] Vandereycken and van Deth, *From Fasting Saints,* 25.
[397] Deuteronomy 9:18-19; Jonah 3:6-10; Esther 4:15-16; Matt 3:4.
[398] The authors use the relatively vague term 'supernatural power' to cover a range of religious traditions which undertake fasting practices. In a Christian context, fasting was intended to give an 'inner purity' by dint of not ingesting any external substance. This was considered to in some way ready

fasting was a feat of self-discipline and attempted to weaken 'sinful flesh' whilst strengthening the soul. Neo-Platonist overtones of dualism are conspicuous, and echoes of these beliefs and practices resonate throughout subsequent centuries in the practices of medieval saints.

It is amongst these early desert fathers that we find some of the earliest examples of extreme personal fasting in the Christian tradition. The desert fathers were predominantly male; however, the second 'wave' of extreme fasting came primarily from a different demographic. During the Middle Ages the number of female fasting saints increased, and by the late Middle Ages,[399] fasting became (as Bynum argues) far 'more central to women's spirituality that to men's'.[400] The motives of 'holy anorexics' are not certain as we have little of the women's own writings, and the subtleties of motives are debated; however, there are clear similarities to those of the desert fathers. We see fasting as penance for sin (in the life of Margaret of Cortona[401]); asceticism as self-punishment (Angela of Foligno[402]); as an escape from family ties instead binding oneself fully to God in devotion (Orsola[403]); as a way of expressing female autonomy in a male-dominated society and church (Catherine of Siena[404]); to prepare oneself for God

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the believer for a meeting with or religious experience of God both by purifying oneself and demonstrating devotion. Vandereycken and van Deth, *From Fasting Saints,* 15-17.

[399] The Middle Ages in Europe generally refers to the era from c.500AD to c.1500AD. The late Middle Ages is generally considered to refer to the 14th and early 15th centuries.

[400] Bynum, *Holy Feast and Holy Fast,* 69.

[401] Bell, *Holy Anorexia,* 93-99.

[402] Bell, *Holy Anorexia,* 100-112.

[403] Bell, *Holy Anorexia,* 66.

[404] Bell, *Holy Anorexia,* 15-40.

in the Eucharist (Hadewijch [405]); and as part of a supernatural magico-religious framework (the medieval mystics).[406]

The motives and thought-processes – whether disordered or not – are multifaceted and complex. More accessible (largely because they were recorded by male clerics) are the responses of Church authorities and society at large to such virtuoso fasts. Some extreme fasters were met with awe and considered to be those whom God favoured, giving them supernatural powers to fast and the visions that often went with them.[407] Others, particularly in the late medieval period, were met with scepticism from Church authorities. Such extreme fasting did not align with prescribed fasting regulations set out by the Church, thus undermining clerics' authority. Furthermore, there were theological objections that such fasts were nothing more than 'self-exaltation'.[408]

The medieval church did not look kindly upon acts of self-aggrandisement. It was not uncommon for the church to carry out a 'trial', particularly in cases which aroused much publicity or reverence. During these trials the subject was watched closely by clerics. In many cases the ascetic was claimed to have been discovered consuming food, resulting in at best public defamation, and at worst – as in the case of Elizabeth Barton in 1534 – execution.[409] Although the primary explanation for miraculous fasting in the medieval

[405] Bynum, *Holy Feast and Holy Fast,* 153.
[406] Bynum, *Holy Feast and Holy Fast,* 153-165.
[407] Vandereycken and van Deth, *From Fasting Saints,* 25.
[408] Vandereycken and van Deth, *From Fasting Saints,* 26.
[409] Vandereycken and van Deth, *From Fasting Saints,* 27.

period was either holiness or pretence of holiness, there were alternative understandings in some cases: demonic powers, or – more mundanely – illness.

The multi-faceted understandings of 'holy anorexia' in the medieval era come together in the case of Catherine of Siena. She writes of her 'infirmity' and says she tries to force herself to eat every day.[410] Her confessor, Raymond of Capua, although not describing her inability to eat as an 'illness,' describes how it becomes 'impossible' for her to eat, her body vomiting back any food forced down it. It is clear there is recognition from Catherine at least, of an 'illness'. Others saw things differently. Her earlier confessor, Tommaso, suspected her lengthy fast had a demonic source, and her letter to an anonymous cleric in Florence responds to a similar concern. She, too, believes in the possibility of a demonic source, writing that 'I myself also tremble with fear of a demonic trick'.[411] By others, she was accused of trickery, witchcraft, and lying. Ultimately, she convinced those around her that her behaviour was holy – perhaps even more than she convinced herself, as until the end she saw her inability to eat as a 'penance' or 'infirmity' whereas her confessor and hagiographers go on to write her into history as a holy miracle – whether because of, or in spite of, her eating habits.

From the 15th-17th centuries, the popular understanding of self-starvation was that it was due to either possession, or witchcraft. However, it was often complicated: Veronica Giuliani, an extreme faster in a convent who was prone to episodes of binging

[410] Bynum, *Holy Feast and Holy Fast,* 168.
[411] Cited in Bell, *Holy Anorexia,* 22.

was reported by one of the Sisters to be in the grip of the devil. Veronica's own view was that the Sister in question was having visions sent by the devil of her binges to convince the Convent she was an imposter – whereas she herself was genuine. Twenty-year-old Jane Stretton from Hertfordshire was initially considered to be unwell, but later believed to be under a spell from a local witch whose husband Jane's father had insulted.[412]

From the 16th-17th centuries, noted accounts of such phenomena began to dwindle, in part due to the Reformation, and in part due to a background of Papal efforts to reduce the number of canonisations, including strict regulations regarding such fasts laid down by Pope Benedict XIV with the aid of physicians in the 18th century.[413] Despite growing scepticism, a few such 'miracles' did still occur in both Catholic and Protestant traditions, through to the 'miraculous maidens' of the 19th century.

By the late 17th century the modern phenomenon anorexia nervosa emerged, with the first medical description of the illness typically attributed to Richard Morton in 1696.[414] In the 1860s tension between a belief in miraculous fasting and the interested scepticism of medical men came to a head in the case of twelve-year-old Sarah Jacob, a Welsh

[412] Vandereycken and van Deth, *From Fasting Saints,* 33-46.
[413] Vandereycken and van Deth, *From Fasting Saints,* 30. It seems unlikely that there was only one cause of the Roman Catholic Church's changing views concerning sainthood and the new stricter regulations were likely a combination of several factors including a feeling that there were already sufficient saints and a desire to preserve their special status and the increasingly medicalised understanding of the body, and thus, fasting. There is nothing to suggest that the stricter regulations on fasting was intended to prevent the canonisation of female saints specifically, but as extreme fasting was a typically 'female' form of piety this decision inevitably had gendered consequences.
[414] Brumberg, *Fasting Girls,* 46. Brumberg disagrees with this position and suggests that Morton was mistaken in his diagnosis.

fasting girl. Her parents, encouraged by the local vicar, were convinced she was a miraculous case and as news spread pilgrims came to visit this case of 'anorexia mirabilis'. In 1867, Dr Robert Fowler came to visit the girl and diagnosed hysteria. Locals, including her own family, protested at the diagnosis, and it was agreed that a team of nurses from Guys' Hospital should be sent to take care of her, keep watch, and determine the authenticity of her miraculous fast. After six days the girl became weak and her body began to shut down: the nurses appealed to doctors and the parents to call off the watch and feed her. The doctors agreed, the parents refused, sure in their belief that God would take care of their daughter. Ten days into the watch, Sarah Jacobs died of starvation. Her father was convicted of criminal negligence.[415]

At around the same time, two doctors in England and France: William Gull and Charles Lasègue, independently came up with similar definitions of an illness which Lasègue denoted as 'l'anorexie hysterique'. Both doctors drew on their observations of young women among their own patients who were presenting with symptoms of self-starvation. Gull rejected Lasègue's name for the disorder and instead presented 'anorexia nervosa' – a lack of appetite of nervous origin. Gull treated his patients with a nutritional programme, ideally away from home and under supervision of trained nurses. By the end of the 19th century he had defined anorexia nervosa as an illness, and self-induced fasting moved out of the realms of the miraculous, out of the insanity of the asylum, and into mainstream medical discourse.[416]

[415] Brumberg, *Fasting Girls,* 67-69.
[416] Bruch, *Eating Disorders,* 211-214.

In the late 19th and 20th century, although the primary understanding of self-starvation in the Western world has been as an illness, it would be remiss to omit other, less mainstream, understandings. The 'miracle' trope continued but in a non-religious format in the form of commercial spectacles of 'hunger art' into the 20th century.[417] The political element of the self-starvation seen in the medieval female saints is reflected in the hunger strikes of the suffragettes in the early 20th century: a characteristic response from women asserting their own autonomy via the only means available to them.[418]

In the secular sphere today, although there is still stigma surrounding anorexia, the overwhelming perception of self-starvation is as a mental illness. However, it appears that in Christian circles it is no more straightforward than it was in the Middle Ages. Although there is no longer any suggestion of anorexia being a miracle or a blessing, participants mentioned feeling 'good' by reaching such peaks of self-control, and there were suggestions that some felt starvation was a dutiful thing to do to punish themselves for their own sins. Despite these glimpses of anorexia being seen as a 'good' thing in the mind of the anorexic Christian, such views are rarely openly discussed or held in the community. Within Christian circles there appear to be two main conceptions of anorexia, set out in Scrivener's question 'is this sickness, or is it sin?'[419]

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[417] Such hunger artists would lock themselves in cages and demonstrate their stoicism in not eating as they endured hunger in front of crowds. Bruch, *Eating Disorders,* 13. An account of such a starvation spectacle can be found in the short story by Franz Kafka *A Hunger Artist* first published in 1922. An English translation of this work can be found online: Franz Kafka "A Hunger Artist," trans. Ian Johnston, accessed August 10, 2020, http://www.kafka-online.info/a-hunger-artist.html

[418] Rudolph Bell's assertion that there is a political element to the fasting of the 'holy anorexics' is discussed in more detail in Chapter 2, 2.2.2. Bell asserts that holy anorexia was a means by which women searched for autonomy in a patriarchal society.

[419] Scrivener, *A New Name,* 15.

Is anorexia a sickness, a non-volitional, tragic occurrence, or is it something anorexics choose to do themselves which leads away from God? Scrivener never fully comes to a conclusive answer in her book. This question was one that had been considered by all participants in my study, albeit with varying answers.[420]

5.1.2. THE CASE FOR SIN

Four participants – Deborah, Brigid, Eloise and Clare – felt during their illness they were committing a sin by starving themselves, although later Deborah and Brigid at least came to actively view their illness as sickness rather than sin. It is not difficult to see why Christian women with anorexia might view their illness as sinful: as Eloise noted, if 'sin' is defined as 'the opposite of following God' (her own definition), how can to starve oneself be anything but a sin?

Anorexia poses a paradox for Christian sufferers. On the one hand, as Deborah notes, St Paul (and the Church ever since) encourages followers to deny themselves, to set aside 'sins of the flesh' (including, of course, gluttony). Sin came into the world via a woman eating. To eat – even more for a woman to eat – is evermore connected with sin, this concept solidified by the writings of the Church Fathers. The connection made by early Church Fathers between sex, food and sin is described by Lisa Isherwood, who

[420] I added the question of 'sickness or sin' to the interview schedule after the first three participants independently spoke about this issue. Although later participants were explicitly asked the question, it was something that all of them said they had thought about before.

notes that Jerome describes how the sin of food led to the development of Adam and Eve as sexual beings, and thus, humankind's fall from Eden.[421]

Ideas such as these, and Biblical passages concerning 'self-control'[422] made it easy for my participants to justify their eating disorders with their religious beliefs – especially so in times of prescriptive fasting such as Lent. However, such passages are, as Eloise said, 'double sided'. To think all day of calories and food over God – is to commit idolatry, a sin. Both Cat and Rose referred specifically to 1 Corinthians 6:19-20, the command that 'your body is a temple of the Holy Spirit, therefore honour God with your body'. Cat described this as a 'Catch 22' of the Bible: should we honour our bodies, or mortify our flesh and deny ourselves? For Rose, the question was: does this passage justify my obsession with my weight, or does it tell me that I sin when I hurt myself?

For my participants, the comments that other Christians made about their illness contributed to their own understanding. Deborah made explicit links between her (evangelical) church's emphasis on sin and her own spiralling mental health difficulties, and directly attributed her early understanding of anorexia as 'sin' to their teachings. She noted a similar implicit understanding of anorexia as 'your way' over 'God's way' in

[421] Isherwood, *Fat Jesus,* 38. Isherwood offers a fuller explanation of other Church Fathers who contribute to this connection: Basil of Caesarea describes the pleasure of taste as akin to sexual pleasures; Tertullian concludes that the close proximity of the stomach and genitals suggests they must be linked; and Clement of Alexandria likewise exhorts his followers to keep tight rein on their stomachs and the organs beneath.

[422] Examples include 1 Corinthians 7:9, 1 Corinthians 9:25, Galatians 5:23, 2 Peter 1:6. Although participants specifically mentioned St. Paul in relation to self-control, St. Paul only uses the words εγκρατεια and εγκρατευομαι three times, which suggests that the emphasis on these specific passages may be coming from within the churches my participants attended.

Scrivener's book, well-loved in evangelical circles. Eloise noted comments that she was not worthy to be a leader in the church if she was following the path of anorexia rather than the path of God, and even in recovery she described herself as 'needing mercy' from God because she kept 'messing up'. An interesting distinction between Deborah and Eloise's experience is that whereas Deborah found the understanding of anorexia as a sin as deeply hurtful, Eloise – despite being offended by suggestions she should step down from her post – felt that understanding anorexia as a sin meant that she had agency over it. If anorexia was something she had chosen to do, it was also something she could choose not to do. This question of whether anorexia is an internal force we have agency over versus an external element such as an illness also emerged in Grace, Brigid and Clare's narratives.

The four participants who understood anorexia as a 'sin' during their illness were from two denominational backgrounds: Clare and Brigid were Roman Catholic; Deborah and Eloise (at the time) were both attending independent evangelical churches. Nothing can be drawn from these individual cases concerning different denominational understandings of sin and eating disorders, but it is interesting to consider the public teachings emerging from these churches concerning eating disorders in order to reflect on the environment in which the participants' understandings of anorexia developed.

The 'independent evangelical' churches are not a homogenous group with an official centralised doctrine (other than the Evangelical Alliance, of which many independent churches are not members) so it is difficult to pinpoint a 'typical' evangelical teaching.

However, a vlog post by prominent and controversial American evangelical pastor, Mark Driscoll, addressing this exact question 'Is Anorexia a Sin?' gives an insight into how some evangelical pastors understand and counsel anorexics.[423]

Driscoll's vlog, dated 16 May 2018, responds to a letter from a 28-year-old Christian woman with anorexia, who asks him whether anorexia is a sin. It becomes apparent fairly soon into the video that Driscoll has a limited understanding of anorexia as he cites the causes as 'social media and pornography' which is simplistic to say the least. In fairness to Driscoll, he declares that he is 'not in a position to answer this question'.

Unfortunately, despite this assertion, Driscoll goes on to say: firstly, that to find out if something is sin, question whether it involves behaviour that goes against the scriptures. If so, repent, and you will find your behaviour and desires changed. This is a concerning assertion: if one looks hard enough it is always possible to find something in the scriptures that anorexia, in literal terms, 'goes against'. Participants in my study cited passages such as Matthew 6:25-34 'Do not worry about your life, what you will eat…' and 1 Corinthians 6:19-20. To suggest 'repentance' is the answer, and that true repentance is shown by an instant change in desires leaves sufferers feeling they are sinning and cannot be truly repenting because their illness does not vanish. Driscoll goes on to say that anyone following something other than God, putting food, or body type first, is committing idolatry – and therefore, sinning. Having begun the talk by stating he would not make a stand on whether anorexia is a sin, he is clearly doing so.

[423] Mark Driscoll, "Is Anorexia a Sin?" May 16, 2019, https://markdriscoll.org/is-anorexia-a-sin/.

Further into the vlog, Driscoll speaks of 'Oppression and Deliverance'. He suggests that thoughts such as needing to punish or starve oneself are put in the sufferer's head by Satan. He suggests that sufferers should consider whether such thoughts are in the second person, and if so, there might be a demonic being living within them. At one point, he even suggests that 'generations of women in your family might be under this demonic possession'. This responded to her explanation that her mother and sister had suffered from anorexia too; ignorant of course, of the well-documented research that suggests there are genetic and socio-cultural factors that leads anorexia to run in families.[424] It is easy to trace the potential route by which an understanding of anorexia as a sin may have developed in these church circles.

The relationship between the RC Church and eating disorders is a difficult one, with well-documented historical descriptions of fasting saints or 'holy anorexics'.[425] None of my participants were aware of any official teaching on eating disorders, although Cat, Brigid and Clare struggled with the glorification of fasting in the Catholic tradition. For Cat and Brigid it was not official doctrines that shaped their thinking, but more general patterns that 'seeped in' (Cat). For Brigid, her overwhelming 'Catholic guilt' did not develop directly from formal Vatican statements, but rather was a worldview she absorbed from her Catholic environment which framed the way she saw the world and her place in it. One official doctrine Brigid called attention to is the Roman Catholic position on suicide. Brigid described anorexia as essentially a slow form of suicide, starving oneself to death.

[424] Greg Dring, "Anorexia Runs in Families: Is this due to genes or the family environment?" *Journal of Family Therapy* 37 (2015): 79-92 offers a review of the extensive literature concerning this research.
[425] See Chapter 2.2.

The RC Church Catechism (Part 3, Section 2, Chapter 2, Article 5: 2280-2283) is clear that suicide is 'contrary to the moral law'.[426] It was pointed out to her directly by members of her church community that she was committing a sin.

The suggestion that anorexia is a sin, comes down to an understanding that it is a choice to starve oneself. Although some participants (Mhairi, and in recovery Brigid and Deborah) were strongly against this suggestion, others felt there needed to be an element of choice and individual responsibility for recovery to take place (Eloise and Grace), and that an understanding of anorexia as 'sin' enabled them to have agency over their own choices towards recovery.

5.1.3. THE CASE FOR SICKNESS

The majority of the participants, in recovery at least, tended to view anorexia as an illness rather than a sin. Mhairi was adamant that it is 'non-volitional'. To be anorexic was not a choice, and therefore could not be a 'sin', but an illness caused by a variety of factors – biological, psychological and socio-cultural. Rose and Grace were likewise adamant that it was not a 'sin', with Grace going so far as to suggest that to call anorexia a 'sin' was in itself a sin.

Although Deborah and Brigid had felt anorexia was a sin when they were in the grips of their eating disorder, on recovery they believed that this view had been incorrect,

[426] "Catechism of the Catholic Church", Part 3, Section 2, Chapter 2, Article 5: 2280-2283. Accessed September 8, 2019. http://www.vatican.va/archive/ENG0015/__P7Z.HTM.

caused by a combination of their own tormented thinking; church teaching on sin; and societal stigma around mental health. Both came to view the understanding of anorexia as a 'sin' deeply unhelpful, and recognising it as a sickness enabled them both to seek medical treatment. Deborah in particular was critical of suggestions that anorexia is a sin rather than a sickness, as she was concerned that in her experience this meant churches believed that prayer could heal, and that modern medicine could be shunned. This approach to anorexia, she eloquently summarised as 'bullshit'. In her view, anorexia is an illness, and proper medical care should be sought and complemented by the support and prayers of the church community. Even Eloise, who remained unsure of the sin/sickness dynamic of anorexia even after recovery was critical of the implication that one could repent one's way out of anorexia with prayers.

Recognising anorexia as a sickness is the official medical position in the US and UK, defined in the Diagnostic Manual of Mental Disorders.[427] Although the etiology of eating disorders is widely debated and unclear, current opinion is that they are caused by a range of factors including biological factors such as genetics; psychological factors such as previous sexual abuse; and social factors such as Western ideals of beauty. This is a very simplified explanation of the 'bio-psycho-social' model which involves a number of factors from each of the three elements, and allows for complex interaction of these

[427] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Edition 5* 2013.

factors to create the conditions for someone to develop and sustain an eating disorder.[428]

Although it should be clear that by its very definition anorexia nervosa is an illness, Eloise described how it was more of a 'grey area' in church circles (referring to her experience of charismatic evangelical churches). Although UK participants described a stigma within the church and the suggestion that their illness was 'sin', this stigma was in contrast to outside the church, where anorexia was deemed an 'illness'. On the other hand, although US participants similarly noted the complex understanding of anorexia within the church, they also suggested they had met with more stigma outside the church as well, with anorexia a shameful secret of which one should never speak (Grace, Rose). This is, of course, no basis to suggest a distinction between UK and US culture due to the nature of the study as a small qualitative study, but it does raise questions concerning whether anorexia is truly viewed as an 'illness' by the general public.

Stigma concerning eating disorders is well documented in available literature, and according to Attribution Theory, arises principally because the illness is attributed to things which the sufferer can control (food intake and exercise). In one Australian study, two thirds of (female) respondents believed that sufferers of anorexia were responsible

[428] Guido Frank, "The Perfect Storm: A Bio-Psycho-Social Risk Model for Developing and Maintaining Eating Disorders," *Frontiers in Behavioural Neuroscience* 10, no.44 (March 2016), doi: 10.3389/fnbeh.2016.00044.

for their illness.[429] The effects of this kind of stigma (essentially, blame) can be devastating, as sufferers may hide their illness and not seek help; feel shame and self-disgust which further fuels the disorder; and isolate themselves from their support network.[430] The reason for this stigma is lack of understanding concerning eating disorders and widespread belief they are 'self-inflicted' rather than non-volitional; and belief that eating disorders are simply about physical appearance and therefore nothing but selfish vanity.[431]

Stigmatisation is common in mental illness, with a 2003 study discovering mental health is second only to HIV/AIDS for stigma and discrimination.[432] Recent campaigns such as the 'Time to Change' campaign have fought this stigma, and 2015 statistics suggest there is improvement in understanding of mental health conditions in the UK, with a 4% positive increase in attitudes from 1994-2014 according to the National Attitudes Survey.[433] There is still a way to go, with only 78% of people surveyed (up from 74%) believing that 'mental illness is an illness like any other'.[434]

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[429] Kristy Zwickert and Elizabeth Rieger, "Stigmatizing Attitudes Towards Individuals with Anorexia Nervosa: An Investigation of Attribution Theory," *Journal of Eating Disorders* 1, no.5 (2013), https://jeatdisord.biomedcentral.com/articles/10.1186/2050-2974-1-5.
[430] Gina Dimitropoulos, "Stigmatization of Eating Disorders" National Eating Disorder Information Centre (2008), http://nedic.ca/sites/default/files/files/StigmatizationOfEatingDisorders.pdf.
[431] Arthur Crisp et al., "Stigmatisation of people with mental illnesses," *British Journal of Psychiatry* 177, no.1 (2000): 4-7.
[432] Carol Roeloffs et al., "Stigma and Depression among Primary Care Patients," *General Hospital Psychiatry* 25, 5 (2003): 311-315.
[433] "Attitudes to Mental Illness 2014 Research Report" Prepared for *Time to Change* 2015, https://www.time-to-change.org.uk/sites/default/files/Attitudes_to_mental_illness_2014_report_final_0.pdf.
[434] "Attitudes to Mental Illness."

Thus, although it should be clear that (in contemporary Western understanding at least) anorexia is a mental illness, so by definition 'sickness', it would appear it is not merely within the church where this is a 'grey area' but in wider society. An interesting dynamic can be found between the agency and responsibility for change which comes with suggestions of 'choice' and thus an element of 'sin' or 'blame' and the non-volitional illness which is 'an illness like any other'. Viewing anorexia as an internal choice or an external illness can vary how patients approach treatment. Many participants struggled with this dynamic, and even those who believed it to be an illness felt there needed to be an element of self-responsibility. This could perhaps be solved by viewing anorexia as a multi-faceted illness which can be both sickness and choice; or alternatively by viewing anorexia as an illness, but one's response to it (to seek or avoid treatment) as an autonomous choice. This raises the question of autonomy within mental illness, which is beyond the scope of this thesis. Nonetheless, an official definition and understanding of anorexia as an 'illness' is not contradictory to agency and choice with regards to one's treatment and choices; and to view anorexia as an 'illness' rather than a 'sin' can have benefits in reducing stigma and increasing access to mental health treatment.

5.1.4. DEMONS: LITERAL AND METAPHORICAL

One of the most surprising moments of the research was Grace's description of her 'deliverance'. Although Grace mentioned she did believe in a demonic force in the world, it was initially unclear whether she really believed she had been exorcised of a

demon, as she insisted on using language such as 'healing' and 'illness'. Even when asked directly she was vague on this point and did not seem to recognise it as 'demon possession' in the traditional sense, but spoke of an external force which 'held her hostage' and a resulting 'internal oppression' which she understood as the illness and her own decisions around it. By viewing her anorexia as a multi-faceted phenomenon, she was able to understand her own deliverance from the external powers of evil without relinquishing her own agency. Once again, the question of the tension between autonomy and non-volitional behaviours is raised.

The pastor who conducted her healing is not alone in his beliefs that anorexia is caused by demonic possession. Prominent American televangelist Pat Robertson who hosts popular right-wing show 'The 700 Club' on the Christian Broadcasting Network, in 2015 during a discussion about Karen Carpenter claimed that eating disorders 'can be treated as demonic possession' and that 'it needs to be rebuked and cast out'.[435] He does, however, acknowledge that a full rehabilitation programme is required, presumably to change the conditions which have allowed the demon to take up residence. The 700 Club is estimated to have approximately 1million viewers on a daily basis. This view of eating disorders is similarly reflected in Mark Driscoll's vlog, as already discussed. This is not a belief restricted to the US: a simple internet search reveals UK Christians with similar views, such as the author of the blog 'Fighting the Demon Anorexia' who believes

[435] Michael Stone, "Pat Robertson: Treat Eating Disorders as Demonic Possession," May 19, 2015, https://www.patheos.com/blogs/progressivesecularhumanist/2015/05/pat-robertson-treat-eating-disorders-as-demonic-possession/.

that her daughter, who suffers from anorexia, has a demon named 'Ana'.[436] In 2014-2015 in Spain, an official exorcist of the Roman Catholic Church was the centre of controversy as he, along with her parish priest, was arrested for the 13 exorcisms which he had carried out on a girl who suffered from anorexia. He faced charges of gender violence, mistreatment and causing injury, and it was claimed the exorcisms left the girl feeling suicidal. The Archbishop of Burgos defended the exorcisms, on the grounds that it is a traditional rite of the Catholic Church which is open to all the faithful, and was requested by the girl's parents, who believed she was suffering from demon possession.[437]

It is perhaps unsurprising that anorexia is sometimes viewed as the work of a demon. A number of online 'Pro-Ana' sites use the framework of a goddess religion 'The Ana Religion' which is cult-like in its framework.[438] Sufferers of anorexia frequently speak of the illness as a separate person (often named 'Ana'), and in some mainstream therapies sufferers, especially children, are encouraged to name their anorexia in order to separate it from their own identity.[439] The theme of demon possession emerged in the biography of Catherine Dunbar and the subsequent exorcism-like ceremony performed for her by Sister Marie (see 2.1.7.). This trope has its roots far back in the attitudes towards some of the 'holy anorexics' and their own understandings of their self-

[436] "Anorexia, Lucifer and Demons," posted January 30, 2017, https://fightingthedemonanorexia.wordpress.com/2017/01/30/anorexia-lucifer-and-demons/.
[437] Hannah Raissa Marfil, "Spanish Priest Performs 13 Exorcisms on Anorexic Girl," Catholic Online, March 23, 2015, https://www.catholic.org/news/international/europe/story.php?id=59239.
[438] Stammers, "The Theological Language of Anorexia Nervosa," 289-290.
[439] James Lock et al., *Treatment Manual for Anorexia Nervosa* (New York: Guildford Press, 2016)

starvation. It is reiterated today in popular culture: Mark Bernard points out that contemporary demonic possession films 'bear an uncanny resemblance to narratives of anorexia'.[440]

Grace was not the only participant to have had the suggestion of demon possession put to her. Eloise, who believed in a literal demonic possession, was deeply offended by the suggestion, particularly as a church leader: she felt that in suggesting that she was possessed, the suggestion was that she should stand down. Eloise also felt that to see anorexia as a wholly external force such as demon possession removed autonomy and thus the possibility of recovery. This contrasts with Grace's understanding of her own autonomy despite the external element.

Deborah spoke of her driving instructor praying that the 'demons of anorexia' would leave her. Although she was surprised by this incident, she was not offended as she recognised that his prayers came from a place of compassion. She understood 'demon possession' not as a literal concept, but an historic way that first century Jewish and early Christian communities understood illness, including mental illness, and therefore felt that demon possession was a good way to metaphorically articulate mental illness. This is corroborated by Tracy's comment that she felt the eating disorder was 'taking over' her personality and that she, Tracy, was shrinking to make room for it. Although there is no literal demon, what we have historically understood as demons articulates

[440] Mark Bernard, "Disorderly Eating and Eating Disorders: The Demonic Possession Film as Anorexia Allegory," in *Food, Media and Contemporary Culture: The Edible Image,* ed. Peri Bradley (London: Palgrave Macmillan, 2016), 164-182.

well the reality of living with anorexia nervosa. Deborah's comment on the man who lived among the tombs and was possessed by demons (Mark 5) as a 'profound way to speak of mental illness' reflected her own reality of living with anorexia: she felt that she lived among the dead.

Brigid, who took a similar view to Deborah as to the origin of our conception of demons, felt this was not a helpful suggestion. However, she was aware that a fellow patient who truly believed she was demon-possessed had a right to believe that if it helped her recovery – and as we have seen, for Grace the feeling of being delivered was curative. This did not, in Brigid's mind, mean that it was appropriate to suggest to other vulnerable patients that they were demon-possessed. This raises questions concerning subjectivity: when many people say they believe anorexia is a 'sin' or a 'demon' or an 'illness', they are making an objective claim about anorexia in general, not merely making a statement about how they subjectively relate to their own condition (indeed, many people making these statements do not have anorexia). There is a difficult line to tread which honours the subjective experiences and voices of those who are suffering, and their right to understand their illness in whichever way they find most helpful without validating them as generalisable truth claims to the detriment of others.

5.1.5. SUBJECTIVITY

How we perceive self-starvation has never been as straightforward as perhaps it first appears, and my participants are by no means the first to understand their situation in diverse – and seemingly conflicted – ways. As I have noted in the literature review, I am averse to Bynum's suggestion that we should accept any construction of the phenomenon in the context in which it occurred, as such a suggestion would imply that Jane Screeton really was under a witch's spell; that all medieval women fasting were 'holy' or 'demon-possessed' and that, among my participants, Grace was demon-possessed, Mhairi was ill and Eloise was sinful. We need to find a balance between allowing for diverse subjective understandings of one's own situation within their own unique context and accepting the pervading paradigms of the era (both medieval and contemporary) as objective fact. If we veer too far to the former, we risk enabling disordered thinking. Too far to the latter, we risk over-simplifying and excluding women's own voices. This, today as in the Middle Ages, is a difficult line to walk, reconciling the multi-faceted causes behind anorexia and the varying paradigms that arise within our cultural context. In the light of my research I argue that for Christian women in the 21st century there is an additional layer of complication added by the culture which, despite accepting modern medical advances, in many instances retains religious frameworks of penance for sin and demon possession, which modern medicine may have thought were consigned to the past.

SECTION B: CHRISTIAN MODELS OF FEMININITY

5.2.1. MODELS OF FEMININITY AND IMAGES OF WOMANHOOD IN CHRISTIAN THOUGHT

As noted by Gill and Scharff, there is surprisingly little literature considering constructions of femininity, with much research preferring to look at 'women and girls' as the female equivalent to 'masculinities'.[441] This does not mean models of femininity have not traditionally existed; rather, they have been framed as models of womanhood (such as the Biblical womanhood movement) or have been implicit understandings of what it means to be a woman rather than an explicit exploration or construction. Christian traditions do not tend to theorise a 'femininity' in the same way that secular feminists do, as there is an assumption that 'woman' is a stable concept with only one model. Following Sonya Sharma,[442] I argue that – although the terms 'woman' or 'female' can be considered a stable sexed category with a biological definition – 'femininities' including Christian images of 'womanhood' are always constructed. In choosing to call these scripts or models 'femininities' I propose that they are – despite some Christian groups' assertions to the contrary – social constructions around the concept of womanhood, rather than an essential definition of 'womanhood' itself.

It became clear from the autobiographical texts in 2.1.1. and the interviews with participants that models of femininity presented by the participants' religious

[441] Rosalind Gill & Christina Scharff, "Introduction," in Gill and Scharff, *New Femininities*, 1-17, 2.
[442] Sonya Sharma, *Good Girls: Bad Sex: Women talk about church and sexuality,* (Halifax: Fernwood Pub., 2011). Sharma likewise argues that Christian models of womanhood are social constructions and thus can be labelled as 'femininities'.

communities promoted questions surrounding identity (such as 'what kind of woman should I be?' and 'how should I be as a woman and a Christian?') and a drive for perfectionism in fulfilling these models. It is not surprising this would be the case, considering the implication of perfectionist tendencies in development of anorexia.[443] Questions surrounding identity are often one of the factors in developing anorexia, particularly implicated in cases developing in the late teens when sufferers are on the cusp between adolescence and adulthood.[444] Despite slight differences between constructions of 'ideal' femininity between participants from different denominations and nationalities, the images all had a core element of the 'good girl'.

Scripts of femininity, whether secular or constructed within a religious tradition, go beyond body image and appearance to all aspects of life – family, work, social activities and moral character.[445] Young women living in the UK and US in the early 2000s, like the majority of my participants, would have been exposed to models such as Naomi Wolf's 'media woman' or the slightly later 'supermum'.[446] Gill and Scarff's *New Femininities* offers exploration of femininities developing within different cultures in the

[443] Jacobi and Fittig, "Psychosocial risk factors." Marion Woodman, *Addiction to Perfection: The Still Unravished Bride* (Toronto: Toronto Press Inc., 1982).
[444] Kelly Klump, "Puberty as a critical risk period for eating disorders: a review of human and animal studies," *Hormones and Behaviour* 64, no. 2 (July 2013): 399-410. The author summarises existing theories on the psychosocial risk factors concerning puberty and eating disorder development before going on to consider additional genetic and biological risk factors in puberty. See also Bruch, *Eating Disorders,* 277.
[445] For a more detailed description, see Stammers, "Liberation from Anorexia Nervosa".
[446] Wolf, *Beauty Myth*. PYL Choi et al., "Supermum, Superwife, Supereverything: Performing Femininity in the Transition to Motherhood," *Journal of Reproductive and Infant Psychology* 23, no.2 (2005): 167-180.

postfeminist era.[447] There is still relatively little written specifically concerning Christian femininities. There are a few exceptions: Felicia Cordoneanu's exploration of Orthodox femininity,[448] and Sullivan and Delaney's exploration of the religious development of the neoliberal model of femininity which claims women can 'have it all' in the context of the prosperity Gospel.[449] Tina Beattie also offers what could be construed as a Roman Catholic femininity in the form of women always 'becoming', although she does not use the term 'femininity'.[450]

Nonetheless, there are clear images of womanhood within Christian tradition, often centring around the characters of Eve and Mary: Eve seen in traditional teaching as the passive helper of Adam and the woman who brought sin into the world through the act of eating, leading Tertullian to describe women as the 'devil's gateway'; [451] and Mary the Virgin Mother who, in her purity, humility and self-sacrifice as a mother takes on the role of theotokos and reverses the downfall of Eve.[452]

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[447] For example, Lisa Guerrero describes the trope of the 'Mother in Chief' as a development of the 'Mammy' in Lisa Guerrero, "M(O)ther in Chief: Michelle Obama and the Republican ideal of Womanhood" in Gill and Scharff, *New Femininities,* 68-82. Other examples include the 'Missy' JongMi, "Is 'the Missy' a New Femininity?" in Gill and Scharff, *New Femininities,* 147-160 and Scharff's exploration of new German femininities in Christina Scharff, "The New German Femininities: Of Wetlands and Alpha Girls," in Gill and Scharff, *New Femininities,* 265-278.

[448] Felicity Cordononeau, "Identitary Character and Social Hypostases of Christian-Orthodox Femininity," *Social and Behavioural Sciences* 137 (2014): 205-210. Cordononeau offers a construction of Orthodox femininity that is grounded in the religious, social and moral traditions of the Orthodox Church and uses the two key images of Mary and Eve. I have not discussed this in depth as none of the participants in my study were of the Orthodox faith.

[449] Katie Rose Sullivan and Helen Delaney, "'A femininity that giveth and taketh away': The prosperity Gospel and post-feminism in the neoliberal economy," *Human Relations* 70, no.7 (2017): 836-859.

[450] Tina Beattie, *Woman* (London: Continuum, 2003).

[451] Tertullian, "On the Apparel of Women," Chapter 1.

[452] This image can be found in the writings of several Church Fathers, including Tertullian, Jerome, Ireneus and Justin Martyr. These writings are summarised and the image of Mary as the Second Eve

It is noteworthy, although not in the scope of this study to explore in depth, that women throughout history have looked for ways to escape this restrictive framework: from women of the early church such as Priscilla and Phoebe who took on leadership roles; medieval saints such as Catherine of Siena;[453] and women preachers of the early Methodist movement in the 18th and 19th century.[454] Alternative models of femininity to traditional images of Christian womanhood can also be found within many mainstream feminist theology texts; however, the majority tend to centre around rebuttals of traditional views rather than creating an explicit 'new Christian femininity': perhaps because the authors of such texts believe that there is not, and should not, be any one model of what it means to be a Christian woman. It is worth noting that a rejection of traditional complementarian models does not necessarily mean rejecting sex essentialism,[455] for example, Irigaray looks to uncover a true 'différence' between the sexes whilst challenging the traditional association of women with matter which has led to a lack of female subjectivities in Western culture.[456]

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expanded by John Henry Newman. John Henry Newman, *Mary: The Second Eve,* compiled by Eileen Breen (London: St. Ann's Press, 1983).

[453] Although Catherine of Siena does, as Bynum and Bell argue, break out from the expectations of her day by creating effectively an 'apostolic' ministry rather than allowing herself to be subjugated either to the role of childbearing or the restrictions of the convent, in her denial of food and retention of her virginity, in many ways she does in fact still conform to a Marian typology. Nonetheless, in breaking from the usual social and spiritual roles allotted to women in the Middle Ages, she presented an inspiring figure for two participants and thus is worth including in this list. See 2.2.2 for more detail.

[454] "The Role of Women within Methodism: The Historical Background," University of Manchester Library Special Collection, accessed October 22, 2020. https://www.library.manchester.ac.uk/search-resources/special-collections/guide-to-special-collections/methodist/using-the-collections/researching-women-in-methodism/the-role-of-women-in-methodism/.

[455] I have used the term 'sex essentialism' rather than 'gender essentialism' as such models seek to find similarities and shared experiences based on a common biological sex rather than on the basis of a socially-constructed gender.

[456] Sarah Donovan, "Luce Irigaray," Encyclopedia of Philosophy, accessed October 22, 2020. https://www.iep.utm.edu/irigaray/).

For the sake of clarity, I have divided the constructions of femininity into two categories: Protestant and Catholic, and will reflect on the mainstream images of femininity projected in each of the two traditions.[457] For each of the traditions I consider both constructions of femininity reflected in literature (including autobiographical material) and constructions of femininity reported by participants.

5.2.2. PROTESTANT MODELS OF FEMININITY

Rachel Held Evans' *Year of Biblical Womanhood* provides an informed and critical analysis of the evangelical ideal of 'Biblical Womanhood' from an insider.[458] Held Evans, brought up as an evangelical in Alabama and Tennessee, embarked on a year of following Bible passages concerning womanhood literally. In the introduction, she offers her experiences of growing up under the shadow of the 'Biblical woman' trope. From a young age her questions in Sunday school were rebutted with a reminder that girls should have a 'gentle and quiet spirit'; Proverbs 31 woman was the ideal and the contentious woman of the same book the model of 'what not to do'. She was taught that men and women were 'equal but different'; that the man was head of the household and that a woman must never preach in church. Over her year of Biblical

[457] As there were no Orthodox women in my study, I have not included a discussion of Orthodox Christian femininities. The distinction between Protestant and Catholic femininities is in many ways artificial as both traditions have the same roots and neither is homogenous. Some participants were influenced by both Protestant and Catholic traditions.

[458] Rachel Held Evans, *A Year of Biblical Womanhood* (Nashville, TN: Thomas Nelson, 2012). The 'Biblical womanhood' movement considers that there is only one 'model' of womanhood, and thus would not consider such a script to be a constructed femininity. However, I am arguing that it is a femininity as this script does not offer an essential ontological definition of womanhood but a construction based on gender expectations.

womanhood, she identifies twelve virtues of 'Biblical womanhood' that were thrust upon her in her youth which she felt she would never attain: gentleness; domesticity; obedience (to one's husband); valour (the 'woman of valour' of Proverbs 31); beauty (in order that she remain attractive to her husband); modesty; purity (sexual); fertility (motherhood); submission; justice; silence; and grace. Held Evans reflects on anecdotes of being held up to this particular Christian femininity: the wedding of a peer during which the minister openly, in the sermon, exhorted the new wife not to get fat or she would drive her husband away; the pressure to be able to throw together a covered dish for a church supper at a moment's notice; the expectation that she would have children and stay home to raise them.[459] The image of Christian femininity experienced by Held Evans in the Southern US is strikingly similar to evangelical Christian femininities proposed to Ind and Scrivener in the UK. Ind labels this image 'Super Christian', who has the virtues of modesty, purity, gentleness, prayerfulness, and, of course, can transform from modest virgin to sex goddess on her wedding night.[460] Knauss, like Ind and Held Evans, also points to the contradictions within the celibacy (chastity) narratives which demand that women should be able to 'flip a switch' on their wedding night.[461] The virtue of sexual purity is perhaps made even more difficult to navigate for teenagers in the church because of the church's silence on how to deal with sex and flesh and desire.[462] The connection between the bodily shame that such narratives promote and

[459] Held Evans, *Biblical Womanhood,* 99.
[460] Ind, *Fat is a Spiritual Issue,* 52.
[461] Held Evans, *Biblical Womanhood,* 101. Stefanie Knauss, "Let's Talk about Celibacy! How Western Christian Culture Affect the Construction of Sex, Body and Gender in Popular and Scholarly Discourses," *Inter-disciplinary Journal for Religion and Transformation* 5 (2017): 84-104.
[462] Participants in Sonya Sharma's study of 36 Protestant women responded that they felt that the church gave them little direction or teaching about sexual activities other than that sexual intercourse was only acceptable within marriage. Sonya Sharma, *Good Girls, Good Sex: Women talk about Church*

the development of eating disorders, in some cases as a way to avoid one's sexuality, often developing in teenage years should not be overlooked.[463] For Scrivener, not only does she have to follow the demands of Christian femininity, but she has an even more demanding image to live up to: the vicar's wife and children's worker who has it together and is the one to whom people go when they are in difficulty – not the one who gets into difficulties herself.[464] Finally, there is clear tension between secular and Christian models of femininity: Ind specifically notes she finds it difficult to reconcile being a feminist and an evangelical Christian.[465] It is not surprising that young women who inhabit both the secular and religious spheres have difficulty in living up to all the images of women they are faced with, especially when such images can be contradictory.

Sharma further offers an exploration of the 'good girl/bad girl' script in her qualitative study of Canadian and British Christian women and their experiences of church and sexuality. Despite her participants coming from diverse Protestant denominations, the image of the 'good girl' is chaste, in control of her body, passive, follows the rules and undertakes traditionally 'female' tasks. The 'good girl/bad girl' image is underpinned by

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and Sexuality (Winnipeg: Fernwood Publishing, 2011), 65. See also Amy Mahoney, "Is it possible for Christian women to be sexual?" *Women & Therapy* 31, no.1 (2008): 89-106.

[463] Arthur Crisp, "In Defence of the Concept of Phobically Driven Avoidance of Adult Body Weight/Shape/Function as the Final Common Pathway to Anorexia Nervosa," *European Eating Disorders Review* 14 (2006): 189-202. The avoidance of the sexual body is particularly pertinent in cases where the sufferer has experienced childhood sexual abuse. Mary Connors and Wayne Morse, "Sexual Abuse and Eating Disorders: A Review," *International Journal of Eating Disorders* 13, no.1 (1993): 1-11. It is worth noting that the Feigner et al. 1972 diagnostic criteria for anorexia nervosa included that the patient should have been younger than 25 at onset of illness. Feigner et al., "Diagnostic Criteria," 57-63.

[464] Scrivener, *A New Name,* 107-118.

[465] Ind, *Fat is a Spiritual Issue,* 87.

the 'Mary/Eve' typologies.[466] She also notes several tensions which can lead young Christian women to struggle with their developing sexual bodies: firstly, tension between what she calls 'Christian femininity' which is constructed within these Protestant traditions with its expectations of innocence and abstinence and increasingly permissive secular attitudes to sexuality; secondly tension within 'Christian femininity' that although young women are expected to be asexual, young men are not, which leads to awkward situations. This 'Christian femininity' is always heterosexual and was for the women interviewed a religious, social and personal commitment which they felt pressure to achieve.[467] Sharma's participants described not feeling comfortable with their sexual bodies as a result of these scripts, even after marriage, with one participant describing that she had self-harmed due to guilt over her sexual activities.[468] This could be indicative that anorexia is not only an attempt to remain 'asexual' as the 'good girl' script requires, but also a self-harm response as a result of guilt in not fulfilling that model.

Much literature arising from the conservative evangelical wing of the church offers understandings of what is meant by the term 'Biblical womanhood',[469] however the crux of the concept can be found within the Council for Biblical Manhood and Womanhood, founded by Piper and Grudem. The key points of this doctrine are laid out in the 1987

[466] Sharma, *Good Girls,* 7-8.
[467] Sharma, *Good Girls,* 10, 20-22.
[468] Sharma, *Good Girls,* 68.
[469] For example, Edith Schaeffer, *The Hidden Art of Homemaking* (Illinois: Tyndale House Publishers, 1971); Elisabeth Elliott, *Let me be a woman* (Illinois: Tyndale House Publishers, 1976); John Piper and Wayne Grudem, eds., *Recovering Biblical Manhood and Womanhood* (Wheaton, IL: Crossway Publishers, 1991).

Danvers Statement by the CBMW. This sets out that it is written in response to 'widespread uncertainty and confusion in our culture regarding the complementary differences between masculinity and femininity' and as a rejection of 'the increasing promotion given to feminist egalitarianism with accompanying distortions or neglect of the glad harmony portrayed in Scripture between the loving, humble leadership of redeemed husbands and the intelligent, willing support of that leadership by redeemed wives'. The statement continues asserting men and women are created 'equal but distinct' in the image of God and that Adam's headship was established at creation. Wives are called to bring 'intelligent, willing submission' to their marriages and 'forsake resistance to their husbands' authority and grow in willing, joyful submission to their husbands' leadership'. It states that 'some governing and teaching roles within the church are restricted to men'.[470] Recent research by Power and Cook adds substance to these claims, showing in a survey of 206 Christian women in the US, those who followed a more traditional or fundamentalist form of religion were more likely to adhere to traditional models of femininity, specifically including adherence to domestic roles, modesty and being 'sweet and nice'.[471]

In the UK, a small qualitative study by Penelope Stuart explores how Protestant women (in this study, all white and middle class) shape their ideas of self within contemporary culture and the church community. Her seven participants explored, individually and as

[470] "Danvers Statement," Council for Biblical Manhood and Womanhood, first published November 1988, https://cbmw.org/about/danvers-statement/.
[471] Leah Power and Stephen Cook, "An Examination of the Complex Associations between Religiousness and Femininity among US Women," *Mental Health, Religion and Culture* 20, no.7 (2017): 638-653.

a group, the discourses that 'shape' their bodies and whether they could consider the female body as 'sacred'.[472] Stuart guided the group to create two images: an 'everyday woman' and a 'worshipful woman'. The image of 'everyday woman' revealed two femininities: the 'because I'm worth it' femininity that buys into (literally) the culture which exhorts women to alter their body via make up, dieting and fashion; and the 'comfortable' femininity which participants described as 'more practical'. Both images revolved around appearance. The 'I'm worth it' woman was described by participants to be a result of their 'choice'; however, Stuart notes the impact of advertising and culture, and suggests it is impossible to tell where the lines of internalised ideal and free choice merge. The 'worshipful woman' was more muted in colour and more passive, potentially suggesting some interesting conceptions (conscious or subconscious) of women's place in worship.[473]

One participant was of particular relevance to this thesis – 'Felicity' described her struggles with 'near anorexia' in her youth, citing conjunction of secular pressures of the 'ideal feminine' with specific 'constraints' and ideals advocated by her evangelical church community. The result was that she struggled to carve out her own space and the ensuing struggle for control of self revolved around her body and her sexual and social being. She used many of the same words and phrases as my participants: guilt; low self-esteem; 'should'; 'oughtn't'; negative sense of body.[474] Stuart summarises that

[472] Penelope Stuart, "A Search for Sacred Bodies," *Practical Theology* 2, no.1 (2009): 75-91.
[473] Stuart, "Sacred Bodies," 80.
[474] Stuart, "Sacred Bodies," 83-84.

there are six key discourses at play in 'shaping' her participants' sense of selves within the church context: moral behavioural imperatives; gender roles (described as 'sexist culture'); body image; negative comments about their bodies; fashion versus 'appropriate' clothing; church beliefs on sexuality (particularly homosexuality). In short, she presents the same ideal of femininity coming from UK Protestant churches as that emerging in the US. Although all Stuart's participants were 'mature' and had struggled through these discourses to come to an enjoyment and appreciation of their bodies (all had moved to churches described as 'ethically and theologically liberal' during this process), they still could not align the female body with the sacred.[475]

An interesting comparison to Stuart's study is the work of Julia Bebbington Babb, who likewise explores ideas of women's bodies as 'sacred'.[476] She takes up Irigaray's search for an alternative female symbolic divine in her exploration of Catherine of Siena's fasting and (post)modern anorexia. Babb utilises Irigaray's 'sensible transcendental' and Jantzen's ideas on 'natality' and 'flourishing' to offer a construction of female subjectivity within a male symbolic. Reflecting on the life of Catherine of Siena, she attributes Catherine's extreme fasts as an act of creative resistance within her medieval masculinist paradigm. Through extreme fasting and subsequent social liberation from the role of motherhood, Catherine achieves the transcendent which she sought to attain, but at the expense of her mortal body – i.e. her immanence – which failed. Babb

[475] Stuart, "Sacred Bodies," 86-90.
[476] Julia Bebbington Babb, "Isn't Our Body the Only Thing We Have? Catherine of Siena, Medieval Fasting and (Post) Modern Anorexia Nervosa," *Medieval Mystical Theology* 24, no.1 (2015): 6-22.

cites Irigaray's argument that, in order to deconstruct the masculine symbolic we must reinterpret the understanding of virginity as something to be traded, and the representation of 'woman' as synonymous with 'mother'. In the same way that Irigaray asserts that in order to do this, women must become moral subjects of their own bodies, rather than objects of men, Babb suggests that sufferers of anorexia must also become moral subjects of their own bodies.[477]

In this new construction of a female subjectivity, Babb takes on Irigaray's concept that women cannot flourish so long as they lack a divine ideal made in their own image and constructs the possibility of women 'becoming divine' in taking on their own female subjectivity and putting themselves, as Catherine of Siena did, in direct relation to the divine. Unlike in Catherine's narrative, using Jantzen's emphasis on incarnation and natality, Babb comes to locate the body as the very site of transcendence and thus conceives an embodied spirituality which does not require rejection of our own immanence. Quoting Jantzen 'women cook actual meals but men preside over the Eucharist' and referring to Bynum's insight into the role food has played in women's religious symbology, Babb argues that a female symbolic must be fleshly. Salvation comes to be understood within this new female symbolic as embodied self-healing rather than disembodied self-denial.[478] For Babb, a Church of England priest and

[477] Babb, "Our Body," 18-21.

[478] There is an interesting parallel in Babb's recognition that in anorexia nervosa women are pursuing a 'disembodied spirituality' with Sonya Sharma's explanation of a 'disembodied sexuality' in which a young woman effectively takes on a dual consciousness in order to deal with the guilt she feels at her sexual activities and failure to fulfil the 'good girl' image. Babb, "Our Body," 17-18 and Sharma, *Good Girls,* 74. In Sharma's study, several of the women interviewed only became comfortable with their bodies when they left the church: perhaps Babb's 'embodied spirituality' could offer an alternative path

hospital chaplain, this offers an alternative for modern female anorexics which was not open to Catherine of Siena which embraces a spirit-centred personhood which recognises the 'spiritual' element of anorexia (and indeed, personhood) alongside the bio-psycho-social.[479]

It was clear from my study that many of the Protestant participants, particularly those who had been part of an evangelical church, had been exposed to the same kinds of models of what it means to be an 'ideal woman' – and, like Ind, Scrivener and Held Evans, struggled to live up to the image. Tracy, who had experienced several different churches but did not feel tied to any one, described her impression of how Christians think a woman should be – and her understanding of being a 'Christian woman' centred around rules, restrictions and boundaries. She mentioned rules and restrictions relating to women and religion seven times. For her, Christian femininity is about being policed in one's actions, appearances and words. She spoke nine times of the unrealistic stereotypes that women are expected to live up to, including submission to one's husband and the requirement to 'be perfect'. The link between perfectionism and anorexia is well-documented, [480] and that Christianity promotes perfectionism (specifically, perfect achievement of an unachievable ideal) should not be overlooked.[481]

for women to feel comfortable with their own bodies and sexuality without the need to abandon the church.

[479] Babb, "Our Body," 20-21.

[480] Jacobi and Fittig, "Psychosocial Risk Factors," 123-136.

[481] I have put Tracy's discussion of perfectionism alongside her thoughts on the image of Eve as the perfectionism sought within Christianity comes within an overall doctrine of Fallenness. However, this connection between perfectionism and Eve is my own, and Tracy seemed to view the two points (perfectionism and the fallenness of women) as unconnected.

Tracy pointed to Eve suggesting women were encouraged not to be 'an Eve', the woman who brought sin into the world through the act of eating. Tracy found this image particularly uncomfortable as a woman with an eating disorder, and it is perhaps in this image that we can find seeds of the ascetic saints' starvation in the teachings of the church fathers. Tertullian wrote (to Christian women): 'You are the devil's gateway… Do you not know that you are each an Eve?'[482] and elsewhere 'Emaciation displeases us not… more easily, it may be, through the strait gate of salvation will slenderer flesh enter'.[483] Held Evans upturns this image, noting Christian women throughout history have been cursed by the story of Eve – not as Tertullian writes, but in the way the story has been used to justify oppression and subordination of women. She writes: 'symbolically, the blood of Eve courses through each one of her daughter's veins. We are each associated with life; each subject to the impossible expectations and cruel projections of men; each fallen, blamed and misunderstood; and each stubbornly vital for bringing something new – perhaps something better – into this world. In a sense, Tertullian was right. We are each an Eve'.[484]

Whereas Tracy's images of womanhood came from an almost 'outsider' perspective, both Deborah and Eloise were influenced by the evangelical model of womanhood explicitly as church 'insiders'. At the time of interviewing, however, they had different understandings of how that image had shaped their identities: Deborah's reflection on

[482] Tertullian, "On the Apparel of Women". Also quoted in Held Evans, *Biblical Womanhood,* xxiv-xxvi.
[483] Tertullian, "On Fasting," trans. S. Thelwall, revised and edited by Kevin Knight. Accessed 03 August 2016. https://www.newadvent.org/fathers/0408.htm.
[484] Held Evans, *Biblical Womanhood,* xxvi.

the evangelical complementarian 'biblical womanhood' femininity was almost entirely negative from her perspective in a more liberal denomination; whereas Eloise – still an evangelical – had a more positive view of the image.

Deborah had reflected greatly on the influence that images of womanhood promoted to her by the church she was attending had made on her and her illness. Unlike other participants, she traced the portrayal of women back centuries to their pre-Reformation roots[485] in the ascetic saints of the Middle Ages, and attributed – as do both Bynum[486] and Bell[487] – their desire to starve themselves as a search for agency and identity in a culture in which women's social and sacral identity was restricted. In the same way the medieval saints rejected the roles of motherhood and took on holiness by turning to asceticism; she describes how modern women reject the passive 'supporting' and 'side-lining' roles offered to them by churches in place of genuine equality and search for their identity in something else. In her case – as, she believes, in others – this was in anorexia. Deborah posed the question: if a teaching can be told by its fruit, and its fruit is the oppression of women and denial of their gifts in the church, then can that teaching be from God? The question she poses is in direct contradiction to the complementarian approach of the CBMW, who note in the Danvers Statement that 'a heartfelt sense of call to ministry should never be used to set aside biblical criteria for particular

[485] Although I have grouped participants as 'Protestant' and 'Catholic' for the sake of clarity, in reality this is in many cases an artificial divide, not only because it is possible to be influenced by more than one tradition, but also because some participants – such as Deborah – traced their influences back to before the Protestant/Catholic division existed.
[486] Bynum, *Holy Feast and Holy Fast,* 18.
[487] Bell, *Holy Anorexia,* xii.

ministries'[488] alongside a quotation from 1 Timothy 2:11-12: 'Let a woman learn quietly with all submissiveness. I do not permit a woman to teach or to exercise authority over a man; rather, she is to remain quiet'. Like the suffragette hunger strikers, and the medieval saints who took back holiness from being solely the prerogative of men through their asceticism, modern Christian anorexics respond to the ideals and images placed upon them in the ultimately passive way: by starving themselves. They respond to the ideal of beauty by taking thinness to extremes. They respond to the command to 'be silent' with the silent response of starvation used by women throughout history. They respond to the insistence of patriarchal systems that their bodies are objects to be controlled and preserved for pleasure of men by rejecting their sexual bodies entirely and taking back control for themselves in the only way they feel possible.[489] Ind likewise explains controlling her eating as a rejection of the idea that her body is made 'for man' and should thus be womanly and pleasing.[490] The idea that eating disorders are a rejection of traditional (male-derived) ideals of femininity is discussed further by Edwards.[491]

Although Deborah had never felt pressure from her husband or parents to look good, she felt pressure from her religious community to look good and to be a good wife. On reflection, she felt that as long as women are forbidden to define themselves in roles

[488] CBMW, "Danvers Statement."
[489] Stammers, "Liberation from Anorexia Nervosa," 10.
[490] Ind, *Fat is a Spiritual Issue,* 63-66.
[491] Emily Edwards, "Are Eating Disorders Feminist? Power, Resistance and the Feminine Ideal," *Quest* 4 (2007).

other than that of wife and mother, they will look to fulfil those roles to perfection. When combined with contemporary pressures on women to look good, it is unsurprising that modern Christian women should (literally) feel the weight of these pressures and starve themselves to keep it off in pursuit of being the 'perfect' wife. Deborah was deeply concerned by the trend in Biblical diets, particularly in the US but increasing in popularity in the UK. Deborah specifically mentioned one diet: The Daniel Fast which is based on the 21 day fast of the prophet Daniel, and involves restricting specific food groups. The marketing surrounding the diet is deeply concerning, as it suggests that through following this diet for the purpose of weight loss, dieters will 'discover [their] identity in Christ' and by dieting they are 'aligning [themselves] to God's ways'. The marketing team exhort 'dropping pounds… is central to your walk with Christ'.[492] There is no subtlety, the message is clear: a Christian woman, in order to be acceptable to both her husband and God, must be thin. As I have written elsewhere,[493] this is the explicit demonstration of Caroline Banks' assertion that there is 'no fat in heaven'.[494]

Lisa Isherwood undertakes a thorough survey of Biblical diets. All those she studies emerge from the conservative wing of the church in the US, and all are based in a complementarian view of the roles of men and women. She wryly notes that the $77 billion per year the industry was worth at the turn of the millennium may be a factor in the growth of such diets. She explores narratives that claim you can *Pray Your Weight*

[492] "The Daniel Fast for Weight Loss," accessed 25 October 2020. https://www.daniel-fast.com/preorder2015/.
[493] Stammers, "Liberation from Anorexia Nervosa," 10-11.
[494] Banks, "No Fat in Heaven."

Away in which book author Charlie Shedd explains it is due to women's gluttonous behaviour that other people's diets are ruined, and suggestions that fat is the work of the devil (*Help Lord, the Devil wants me fat!* By C.S. Lovatt).[495] Further to these books on diet philosophy are the diet and exercise programmes: 'Diet, Discipline, Discipleship'; 'Praise Aerobics' 'Fit for God' and 'What Would Jesus Eat?'.[496] Such programmes are backed up by Biblical quotations concerning diet (taken thoroughly out of context). Some programmes include specific beauty elements. The message is that God is beautiful, and therefore so must women who follow him be. As Isherwood puts it 'to look good is to look godly'.[497]

Isherwood's analysis culminates in an in-depth look at Gwen Shamblin's *Weigh Down Diet* which is particularly invidious. In this, Shamblin explicitly argues fat people will not be able to enter heaven (thus – presumably unconsciously – echoing Tertullian[498]). Her programme, aimed at women, describes God as a designer husband and reduces women to nothing more than a fashion accessory for God. Women may not prophesy or preach, and their holiness can only be measured by the (lack of) pounds on the scale.[499] It is clear thinness has become an explicit and central aspect of evangelical Christian femininity.

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[495] Charlie Shedd, *Pray Your Weight Away* (Philadelphia: Lippincott, 1957) and C.S. Lovatt, *Help Lord, The Devil Wants Me Fat!* (California: Personal Christianity, 1980) referenced in Isherwood, *Fat Jesus,* 71.
[496] Isherwood, *Fat Jesus,* 72-73.
[497] Isherwood, *Fat Jesus,* 77.
[498] See footnote 483.
[499] Isherwood, *Fat Jesus,* 82-87.

Whereas Deborah, having moved to the Methodist church and taken up a leadership position as a Local Preacher was disenchanted with evangelical femininities, Eloise remained part of an evangelical church and had mixed feelings about such images of Biblical womanhood: they made her feel inadequate, but she also wanted to live up to them. Eloise did not speak about the church's position of women in leadership, but did describe herself as part of church leadership: however, as a children's worker her particular role fits well into the 'women's ministry' that is considered valuable and legitimate by more conservative churches so it may be that due to her specific vocation she had not felt this to be a problem in the same way as Deborah with her call to preach.

Eloise described herself as 'not worthy to be a Proverbs 31 woman' and explained this particular model of Biblical womanhood represented all that she wanted to be as a woman and a wife. The Proverbs 31 woman is a key image in evangelical femininity, particularly in a contemporary world when many women are moving beyond the traditional spheres of housewife and mother.[500] The Proverbs 31 woman could be described as an early form of the contemporary 'woman who has it all' femininity, and

[500] It must be acknowledged that the sphere of 'housewife and mother' has also become a site for a postfeminist reclamation of traditional female pursuits. For example, Joanne Hallows presents Nigella Lawson as a 'new femininity' which reshapes the role of the woman as the one who cooks for others, and instead presents her as one who cooks for her own pleasure and for self-care. She allows herself the indulgence of food and eating and makes time for her own leisure pursuits. Joanne Hallows, "Feeling Like a Domestic Goddess: Post-Feminism and Cooking," *European Journal of Cultural Studies* 6, no.2 (2003):179-202. However, in an analysis of 22 female food bloggers by Rodney et al, it became clear that despite this subtle navigation of the tensions of post-feminism and traditional female roles, 'food femininities' such as these can also demonstrate the pressure on women to simultaneously embody contradictory ideals. Alexandra Rodney et al., "The Online Domestic Goddess: An Analysis of Food Blog Femininities," *Food, Culture and Society* 20, no.4 (2017): 685-707.

it is perhaps of no surprise that such contemporary femininities are being repackaged within the context of the church.[501]

The Proverbs 31 woman is presented as a direct contrast to the 'contentious woman' of Proverbs. The two passages have come to be presented as a direct list of 'dos' and 'don'ts' for Christian women. Held Evans describes the Proverbs 31 model as the 'evangelical's Mary – venerated, idealised, glorified to the level of demigoddess, and yet expected to show up in every man's kitchen at dinnertime'.[502] Masenya portrays a similar cultural usage of the image in an African (Northern Sotho) context, explaining the difficulty that African women have in living up to such a model when she is presented as an historical rather than literary figure.[503] The contentious woman of Proverbs is described as quarrelsome and nagging towards her husband; the 'wife of noble character' of Proverbs 31 in contrast: gets up before dawn; is strong (but in a womanly way); praises God; cooks and cleans for her family; is fully trusted by her husband; is never idle; makes her own clothes, and those of her family; makes the family bedlinen; sells the rest of her handcrafts; works with the poor and needy; is a dutiful wife supporting her very busy and important husband who is an 'elder of the land'; with the profits from her sewing business she invests in a vineyard and thus creates a second business model; and finally she stays up working late. It is no surprise that this woman

[501] Sullivan and Delaney, "Prosperity Gospel and Post-Feminism," 837.
[502] Held Evans, *Biblical Womanhood,* 74.
[503] Madipoane Masenya, "A Literary Figure or Patriarchal Reality? Reflections on 'ēšet hayil in light of depictions of womanhood from selected Yorùbá and Sotho proverbs," *Verbum et Ecclesia* 39, no.1 (2018). https://doi.org/ 10.4102/ve.v39i1.1861.

has to get up before dawn and work long after sunset to achieve all this: perhaps in this model we can see the roots of a peculiarly Protestant femininity in its work ethic.

There have been mixed responses to Proverbs 31 by feminist scholars, as illustrated by Claassens.[504] The Proverbs 31 woman, like the 'have it all' woman today can be inspiring, inviting women to step outside their traditional roles – as the Proverbs 31 woman starts her business in sewing clothes, a traditional female pursuit, and as she grows in confidence expands to agricultural interest, a typically male pursuit. As Meyers points out, the Proverbs 31 woman breaks outside the stereotypes of women in the Hebrew Bible in acting essentially as CEO of the household.[505] The positive impact of the contemporary 'have it all' woman is that, although there is still a gender pay gap and proportionally less women in leadership than men, in the UK at least, professions are all open to women, and in June-August 2020, 72.1% of women aged 16-64 were working, close to the 79.1% of men.[506] Women have stepped outside their traditional femininities, inspired by images such as this.

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[504] L. Juliana Claassens, "The Woman of Substance and Human Flourishing," *Journal of Feminist Studies in Religion* 32, no.1 (2016): 5-19, 15-16.
[505] Carol Meyers, "Was Ancient Israel a Patriarchal Society?" *Journal of Biblical Literature* 133, no.1 (2014): 8-27.
[506] "Sex Disqualifications (Removal) Act 1919," UK Public General Acts, 23 December 1919. https://www.legislation.gov.uk/ukpga/Geo5/9-10/71/enacted. The gender pay gap (for all employees) stood at 17.3% in 2019. "Gender Pay Gap in the UK: 2019," Office for National Statistics, 29 October 2019. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/genderpaygapintheuk/2019. "Employment and Employee Types," Office for National Statistics, 13 October 2020. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes.

As with the 'have it all' woman and the 'supermum' femininity, the very images that are meant to liberate women end up as a list of demands which one person cannot possibly fulfil. Sakenfeld warns of the risks in the Proverbs 31 femininity when it is used as a prescriptive image to young women of what they should be, or as marriage advice for a young man looking for a suitable partner. Instead of presenting options or choices for women, such ideals add endless tasks to the to-do list. Instead of being the women who 'can have it all', this generation becomes the women who 'must have – and be – it all' as they struggle to be the domestic goddesses, hard-headed career women and nurturing mothers that society demands they be – all at once.[507] The problem with the Proverbs 31 woman is that, ultimately, she does not exist, and in this image of femininity we must be wary lest she ends up, as Yoder warns 'another unrealistic and dehumanising depiction of women to entice and promote the values of men'[508] rather than the inspiration she has the potential to be.

A further limitation with a Proverbs 31 femininity is that, as Claassens points out, if we transpose her as a literal role model to a 21st century context, she is no longer the epitome of a liberated woman. Although in Ancient Israel for a woman to be engaged in running a business from home that branched beyond textiles and into agriculture may have been progressive, it would no longer be viewed as such. When Claassens compares the Proverbs 31 woman to Martha Nussbaum's list of capabilities for human flourishing,

[507] Katherine Doob Sakenfeld, *Just Wives? Stories of Power and Survival in the Old Testament and Today* (Louisville, KY: John Knox, 2003) 117-124.
[508] Christine Yoder "The Woman of Substance: A Socio-Economic Reading of Proverbs 31:10-31," *Journal of Biblical Literature* 122, no.3 (2003): 427-447, 441.

it becomes clear this woman is not necessarily flourishing: although she has more of the opportunities in Nussbaum's list than other women of her time, she still has no political voice or representation, and no opportunity for rest and leisure pursuits. Connected to this lack of 'self-care' it is notable that although the passage mentions the Proverbs 31 woman providing food for others there is no acknowledgement that she also provides food for herself – to do so is clearly the feeding of last priority. Thus, the Proverbs 31 woman offers an image of a self-sacrificing and nurturing femininity that does not allow for her own self-care. The implications of such an image as a role model for a woman with anorexia are clear. Claassens also points out that the Proverbs 31 woman, although restricted by the patriarchal expectations and customs of her age, clearly has the benefits of a high socio-economic standing and can move around with no fear for her safety – opportunities many women today still do not have. Thus she can never be a literal role model, rather she is a symbolic example of the flourishing that can come when women are granted agency and freedom of choice.[509]

Scholars have suggested different ways in which we can reframe the Proverbs 31 woman to become an inspirational and liberating femininity.[510] Meyers suggests we consider her in her historical context and recognise the progressive nature of her life.[511] Claassens portrays her as symbolic of choice and autonomy.[512] Masenya argues she

[509] Claassens, "Woman of Substance," 14-15, 19.
[510] Due to the volume of feminist literature on Proverbs 31, I have selected a small sample of – I hope, varied – voices from amongst feminist Biblical scholars.
[511] Meyers, "Ancient Israel," 22-23.
[512] Claassens, "Woman of Substance," 18-19.

needs to be understood as a literary rather than historical figure.[513] Held Evans, through her discussions with an Orthodox Jewish friend, comes to see the Proverbs 31 woman not as an ideal of femininity to live up to, but the woman who is present within each and every woman when she does things 'with valour'.[514] Held Evans concludes the woman of valour is simply a celebration of women and all they do. All women are women of valour when they are women doing things with valour. The woman who is immersed in motherhood rocking a crying baby at 3am is a woman of valour. The woman who is tending the earth is a woman of valour. The woman sitting in the office is a woman of valour. All women have it within them to be women of valour – and yet not one of them is the same. The woman of valour was never an ideal to live up to, a measuring tape of how 'good' women were at all – she was each and every woman all along.[515]

5.2.3. ROMAN CATHOLIC MODELS OF FEMININITY

There were four Roman Catholic participants: Cat, Rose, Brigid and Clare. I have included Mhairi in this section rather than the previous as – although she is an Anglican, specifically defining herself as Anglo-Catholic – her images of ideal femininity both revolved around the Virgin Mary, and coincided closely with those held by Clare. This is perhaps not surprising in that Clare and Mhairi were older, both developing their eating disorders in the 1970s/80s.

[513] Masenya, "Literary Figure."
[514] Held Evans, *Biblical Womanhood,* 87-95.
[515] Held Evans, *Biblical Womanhood,* 74-95.

Cat, like Deborah, was uncomfortable with the relegation of women to subordinate roles, in this case within the Catholic church. However, she found the portrayal of women in the Bible even more uncomfortable. Cat, like many feminists before her, described the Bible as being unceasingly male-orientated saying 'all the good people are men'. Particularly interesting was her observation that lectionary readings in church were all about men. Cat was angry about the portrayal of women as sexual objects. She described her fury on reading Hosea and discovering that the ultimate insult the prophet could find was to describe Jerusalem as a whore.

Cat's narrative was woven around boundaries which were traversed. She used the analogy of 'lap-dancing' to describe a chaplaincy visit, suggesting a crossing of boundary from the public to the private with which she was uncomfortable. She spoke of her concern over women being portrayed as sinful in two ways: in terms of eating (like Tracy, she pointed to Eve being the woman who 'doomed us all' by eating); and in sexual terms. Regarding the latter, she pointed out the double standard that the woman is the sexual temptress and is to be 'blamed' and yet her body is nothing but an object and her agency is removed. In both arenas: sexual and nutritional, the boundaries of the body are traversed. Both are concerned with the flesh and in traditional dualisms have been associated with the female.[516] Both are, in the Catholic church, amongst the cardinal sins: lust and gluttony. Cat's deep-rooted sense of guilt and desire for perfectionism seemed rooted in a complex web of thinking which associated being female with sex,

[516] Bynum, *Holy Feast and Holy Fast,* 260-275.

sin, food and flesh – and in starving herself, refusing to allow germs or food to cross her bodily boundaries, she attempted to keep these sins at bay. Isherwood draws on the work of anthropologist Mary Douglas who points out that food and sex are the elements that create the boundaries of religious society, and thus are policed most heavily (as can be seen in the purity laws in the Hebrew Bible). It is not surprising that anything entering the body should be policed – it is at the boundaries that the body is vulnerable, for example, to infection or hurt. For Douglas, the human body is symbolic of the wider social body.[517] This, in conjunction with Isherwood's assertion that it is the female body that marks the boundaries of society, and the female body that represents the tribe, begins to demonstrate the political nature of the social and cultural restrictions placed on the boundaries of the female body.[518]

The influence of dualistic thinking which associates female with flesh and male with spirit on eating disorders is well-documented.[519] The history of such dualisms can be traced back to Platonic philosophy in its origins, and to the early Church Fathers in its Christian development. Isherwood describes the explicit connection made between eating and sex – the two sins of the flesh – by the early Church Fathers. Jerome taught that Eve's temptation and the subsequent sin of both Adam and Eve was the cause of

[517] Mary Douglas, cited in Isherwood, *Fat Jesus,* 40.
[518] Isherwood, *Fat Jesus,* 12.
[519] Examples of some of the numerous studies that demonstrate this link include Banks, "The Imaginative Use of Religious Symbols in Subjective Experiences of Anorexia Nervosa," *Psychoanalytic Review* 84, no.2 (1997): 227-236, 228-229; Grenfell, "Religion and Eating Disorders," 373; Morgan et al., "Spiritual Starvation," 479.

the development of their sexual bodies. Therefore, logically, if eating was the gateway to sexuality, then fasting must be the path to chastity.[520]

As discussed previously, Ind reflected that she controlled her eating in order to reject her sexual body and thus reject patriarchal eyes that regarded her as an object.[521] In a similar vein, anorexia often develops in girls around puberty as a subconscious rejection of the developing female body.[522] It is no great leap to recognise that a lifetime of church teaching on the shamefulness of the female sexual body and all appetites of the flesh could lead to such a subconscious rejection for young Christian women.[523] Parallels can be seen here in the lives of the medieval ascetics who likewise rejected the female sexual body for a life outside those parameters which allowed them to retain their own bodily autonomy without handing it over to marriage and motherhood.[524]

Brigid, like Cat, came from a liberal Catholic background and also had OCD. Unlike Cat, she did not make explicit connections between sex, sin and flesh. Although Brigid spoke of her propensity to 'Catholic guilt' it did not seem specific to the female sex. The only tension Brigid spoke of concerning bodily boundaries was the contradiction that she was

[520] Isherwood, *Fat Jesus,* 37-38.
[521] Ind, *Fat is a Spiritual Issue,* 63-66.
[522] Bruch, *Eating Disorders,* 277.
[523] For a discussion of attitudes towards women, sex and the body in the Catholic tradition, see Rosemary Radford Ruether, "Sex and the Body in the Catholic Tradition," *Conscience* 20, no.4 (2000), reprinted in *Conscience: A Commemorative Issue* (2010): 25-31.
[524] Bell, *Holy Anorexia,* xii.

taught in hospital to love her body, yet simultaneously told to cover up and wear modest clothing. She questioned: was she meant to love her body, or be ashamed of it?

Rose did not speak much about religious expectations of femininity but was clear that early models of femininity portrayed by her mother played a part in her eating disorder. She described her mother as being openly obsessed with body image and showering Rose with compliments about her appearances. Although well-meaning, this laid the groundwork for Rose finding her self-worth in her looks. This later caused the tension that Rose describes between the cultural ideals of thinness and beauty, and the religious teaching that she was worth more than her looks. The cultural expectations influencing Rose continued when she left home and she explicitly and consciously starved herself for a man. It is possible Rose was caught between religious and cultural models of what it means to be a woman, but happily, on this occasion, although the cultural models of femininity involved placing her value in her bodily appearances, the religious influences seem to have been far more balanced, offering her a healthier outlook on life, her own self-worth and identity – and this healthier outlook ultimately gave her the motivation and tools she needed for recovery.

Clare's story was centred around feeling that she needed to be 'good', and this seemed to stem predominantly from her close relationship with her mother and her desire not to disappoint her. When she was young, her mother encouraged her to 'be good' with stories of saints (particularly intriguing were her mother's annotations in the margins of

the books when the saints did not live up to the manners expected of young ladies!) The similarities between storing up her good deeds in a jar in Lent, 'winning grace' and counting calories are striking and suggest an integral link between Clare's desire to be morally good, as a Christian girl, and her desire to be thin.

Clare was the most explicit about the model of Christian womanhood which she felt she had to live up to – specifically, she felt she should be like her mother. From her description, Clare's mother was homemaker, wife and mother; and heavily involved in the local Catholic church. Clare's confusion when she did something that she thought 'good' (donated money) and her mother did not approve suggests that she saw her mother as the perfect role model of a good Christian woman, and thus her framework of what it means to be good was thrown out of kilter at this disagreement.

Although Clare felt she should be like her mother eventually, in a heterosexual marriage raising children and involved in the local community, she still felt the expectation that she should get a degree first and make something of her life before reaching this eventual goal. This is perhaps indicative of the changing opportunities and roles for women in the 1970s in the secular arena – but for Clare, the Catholic femininity of wife and mother was still seen as the ultimate goal. It seems that Clare had carved the only route by which she could co-opt the secular and Catholic femininities presented to her – by degree first, then motherhood. This attempt to compile the two models of womanhood created a very narrow path to follow.

Clare described her mother as 'disappointed' in her. It is unclear whether this is something her mother said or hinted at, or merely Clare's perception. It is interesting in terms of the development of her eating disorder as it suggests that starving herself is a direct response to a crisis of identity, and an attempt to – quite literally – shape herself into the woman she thought she should be. Clare's mother told her she was 'too chubby' and she got the impression her mother thought she should have a boyfriend. The response of dieting is a natural response to change herself into the woman her mother (and by extension, she herself) thought she should be. Although Clare did not think there was a specific connection between her sexuality as a lesbian and the development of her eating disorder, from an outsider's perspective it seems highly possible that it was an integral, albeit subconscious, element of her search for identity. Lesbianism was an unacceptable enough model of secular womanhood in the 1970s, and there was certainly no room for such a model (and indeed, perhaps still is not) within a Catholic femininity that typifies womanhood as the wife and mother.[525]

In the same way that the medieval saints attempted to escape the drudgery and danger of endless childbearing through fasting and chastity, it seems that Clare has attempted to squeeze herself into the model of 'good Catholic girl' and at the same time neutralise her sexuality through starvation. This is in keeping with the theory that puberty is the

[525] It is worth noting that there is an alternative Catholic femininity: that of virgin or nun. There are some Christian models of thought that suggest that this is the only acceptable path for homosexual Christians, however, as this model does not appear to have been on Clare's radar it will not be discussed at any length here.

most typical time for onset of anorexia due to avoidance of adulthood and sexuality[526] – however, in this case, it is specifically within the context of what would have been seen as a 'deviant' sexuality, and a peculiarly Catholic model of womanhood.

The role of the woman as wife and mother in Roman Catholicism is not only implicit, it is explicitly stated in the 1988 Papal Encyclical *Mulieres Dignitatem*.[527] The document was written as a response to changing roles of women in the secular world, and looked to justify and clarify the Roman Catholic position on 'the dignity and vocation of women': in other words, the role of women in both the ministry of the church and the social sphere. Although the document is at odds with the work of Catholic feminist theologians of the decade,[528] it is worth noting that its intention is to carve out a particular place for women which is respected and valued in equal worth to that of a man. However, it becomes clear on deeper reading that such equality is 'equal but different' (perhaps with the emphasis on different rather than equal); and that the role attributed to women (and presumably also to men, but they are not the focus of this document) offers a very narrow femininity to which Catholic women should conform.

[526] Bruch, *Eating Disorders,* 277.
[527] John Paul II, "Mulieres Dignitatem," 1988, http://www.vatican.va/content/john-paul-ii/en/apost_letters/1988/documents/hf_jp-ii_apl_19880815_mulieris-dignitatem.html
[528] Most notably, Rosemary Radford Ruether's 1983 book explicitly rejected the typology of Mary as the 'second Eve'. Rosemary Radford Ruether, *Sexism and God-talk* (Boston: Beacon Press, 1983) 151-152.

This femininity begins from a complementarian perspective:

> 'It is a question of understanding the reason for and the consequences of the Creator's decision that the human being should always and only exist as a woman or a man. It is only by beginning from these bases, which make it possible to understand the greatness of the dignity and vocation of women, that one is able to speak of their active presence in the Church and in society.'[529]

The second section of *Mulieres Dignitatem* focuses on the role of Mary as theotokos, pointing out that the 'extraordinary dignity of woman' is made manifest in the Christ-event. In her role as God-bearer, Mary represents all humanity and takes on a union with God that is only possible for a woman. Thus, the female role in salvation history as the channel between heaven and earth is representative of the worth and dignity of womanhood.

Within section three we can find the nuances that differentiate a Catholic understanding of masculinity and femininity from that proposed by conservative Protestants. This part of the document seeks to underline the equality of male and female, and to counter some misconceptions concerning submission. The equality of male and female, made in the image and likeness of God is reiterated. Turning to Genesis 2 when Eve is made as 'helper' for Adam, unlike the Biblical literalists the interpretation here is that 'helper' is mutual: Adam is likewise the 'helper' for Eve. It is the basis for a theology of human

[529] "Mulieres Dignitatem," 1:1

inter-personality, not a theology of submission. In the emphasis on the distinct masculine and feminine roles and the way this is portrayed in the church today, it is questionable whether this nuance is always truly relayed in the day-to-day workings of the Catholic church.

Section four considers the difficulty of the phrase 'he shall rule over you'. This is understood as a result of the imbalance created by the Fall to the relationships of men and women – as a result, women are disadvantaged in terms of equality. Although the document makes clear this is not the ideal state of affairs, and that the equality through diversity found in Eden is the ideal, there is little to suggest how this 'disadvantage' might be countered. Rather, there appears to be acceptance that this is the case. Furthermore, we reach an attack on feminism, suggesting that women should never take on 'masculine' characteristics in an attempt to avoid such 'disadvantage' (although it is acknowledged that women may have 'rightful opposition' to being ruled over). To do so would lose the 'essential richness' of womanhood which is 'no less' than that of a man. Apparently, the only way to conquer this domination and sin that flows through our blood as a result of Eve's sin, is to follow the path of femininity presented by Mary – the one who redeems Eve's actions. Eve is the 'mother of all living'. Mary is the 'mother of Christ' and thus the mother of all those in Christ and the new creation. Sin enters the world through a woman, but likewise the solution to sin also enters the world through a woman. Eve is there in the beginning, and Mary is there in the 'new beginning'. 'In Mary, Eve discovers the nature of the true dignity of woman, of feminine

humanity. This discovery must continually reach the heart of every woman and shape her vocation and her life'.[530] If women are, as Tertullian writes, 'each an Eve', the message of Catholic femininity is clear – we are, but must also strive to be, a Mary.

Mary is possibly the most unattainable of all the role models women could have: both a Virgin and a Mother. However, this is somewhat of a straw man as clearly there is no expectation that women will do both these things at the same time. Rather, as in the model Clare felt compelled to follow, one follows first the path of chastity, then marriage and motherhood (unless one chooses to follow the alternative path of perpetual virginity as a nun). However, that this is marginally more attainable does not detract from the fact that it is a very narrow image of what it means to be a woman which directly revolves around her sexual nature and reproductive functions. Section six of MD goes on to explore this femininity further, expressing that motherhood 'is the woman's part' within a heterosexual 'unity of the two'.[531] Women are not fitted for motherhood merely in a biological way, but also in a psychological and spiritual way. Motherhood develops the capability of paying attention to another person, and the father learns his parenthood from the mother – to whom it is, apparently, natural. The issues with this model of womanhood are glaringly obvious: without denying that there is something uniquely womanly and empowering about growing and bearing children[532] there is a problem when this is portrayed as the only legitimate model of womanhood –

[530] "Mulieres Dignitatem," 4.11.
[531] "Mulieres Dignitatem," 6.18.
[532] Mary O'Brien, *The Politics of Reproduction* (London: Routledge & Kegan Paul, 1981).

or indeed motherhood – available. The strict division of gender roles implies that men cannot be, by themselves, good fathers and that they are mildly deficient in natural compassion. The assertion that women are naturally psychologically 'ready' for child-rearing is a slight to all mothers who suffer post-natal depression or psychosis. It is also, arguably, incorrect – as argued by Ann Oakley to be what she calls 'The Myth of Motherhood'.[533] There is no alternative path offered for those women who are married (and thus not virgins) but cannot bear children, other than to 'mother' those around her in the community. Even the path of the Virgin does not really carve a femininity for lesbians, couched as it is in terms of spousal love and an offering of themselves as a 'gift' to Christ rather than their husbands. Certainly, it does not offer a femininity in which a lesbian's sexuality may be actualised and she is allowed to flourish.

The remainder of the text considers the nature of marriage and the relationship between man and woman within that. As with the Genesis text, it offers a more nuanced understanding of the household codes of the Pauline and pseudo-Pauline epistles than that offered by the CBMW, reframing the 'submission' of women as an expression of the mutual submission of the husband and wife to one another within the cultural framework of the time. However, within the context of MD as a whole that, whilst there may be no room for domination and submission, there are still distinct and set roles for man and woman within the family. MD does not consider the ways in which the set-up of these distinct roles makes women vulnerable and/or voiceless within the public

[533] Ann Oakley, *Housewife* (London: Penguin Books, 1974) 186.

sphere. This passage is followed by an explanation of the importance of the Eucharist as an expression of 'the redemptive act of Christ the bridegroom towards the Church the bride'.[534] As Christ is the male bridegroom, only the male can act 'in persona Christi' and preside. Although the church is female, there is no corresponding suggestion that only women can receive the Eucharist.

Although the Roman Catholic model of femininity offers a genuine appreciation for women and recognition of the mystery of motherhood, it is still limited. We reach at the end of MD the image of a woman who is either a Virgin or a Mother (most, of course, are expected to follow the latter – the former is the exceptional route). Her role is distinct from the man, she cannot lead in the church, she is to 'love' and offer herself in generosity, kindness and selflessness ('the dignity of women is measured by the order of love'[535]). She should be married to a male, and she is naturally inclined towards motherhood and nurturing, which she takes on with joy and shares with her husband. She is humble and submissive to God, as was the Virgin Mary. She is mutually submissive with her husband in love within the family sphere. It is a beautiful image and a glorification of motherhood – however, the delight in heterosexual marriage and motherhood is not necessarily the reality of many women, and the image offered, whilst it may be inspiring for some women, will surely be alienating for many more.

[534] "Mulieres Dignitatem," 7.26.
[535] "Mulieres Dignitatem," 8.29.

An alternative to gender complementarity within the Roman Catholic tradition is offered by Brianne Jacobs, who rejects gender essentialism entirely and critiques Pope John Paul II's *Theology of the Body* on this basis. She argues that traditional Roman Catholic gender binaries are based in Aristotelian ideas of the male as a 'blueprint' and women as less godly, no matter how one tries to package it as 'equal but different'. To retain a strict gender binary rooted in reproductive potentiality of one's body is to restrict the full personhood of both women and men. Jacobs offers an existentialist view of 'male' and 'female' based in history rather than biology: it is only through recognising this and by rehumanising those who have been historically dehumanised (women, the non-reproductive, the homosexual) and 'resacralizing' all people that we can 'perform' humanity and be in flourishing relationships with one another and with God.[536] Here are echoes of Babb and Stuart's works within the Protestant Church as they call for the body – particularly the historically marginalised and defamed female body – to be understood as sacred.[537]

Mhairi, an Anglo-Catholic who developed anorexia in her late teens in the early 1980s directly linked the development of her illness to questions concerning purpose and identity as she entered her adult life. Mhairi came from a working-class background and described how as a teenager she was presented with only one model of how to be a woman: to get married, to have children, and to live a few doors down from her mother

[536] Brianne Jacobs, "An Alternative to Gender Complementarity: The Body as Existential Category in the Catholic Tradition," *Theological Studies* 80, no.2 (2019): 328-345.
[537] Babb, "Our Body," and Stuart, "Sacred Bodies."

in the same community in which she grew up. Although she did not speak negatively about this image of 'womanhood'[538] and deeply respected her mother and grandmother who had lived it, Mhairi felt her education had offered her more opportunities and broadened her horizons, and she wanted to explore other models of how to be a woman.

Mhairi found her 'model of womanhood' within the church by reclaiming the figure of Mary as co-redemptress and theotokos as, in traditional understanding, the figure of womanhood. For Mhairi this did not mean limiting oneself to the stereotypical role of wife and mother, and it certainly did not mean restricting women from the priesthood and other roles in the public sphere. It meant, as Mary says 'yes' to God and accepts her task at the annunciation, women saying 'yes' to the challenges put before them in life. It meant saying 'yes' to embodiment, and finding an embodied spirituality and redemption in the midst of a male-dominated church which takes on dualisms of male-female; spirit-flesh and thus attempts to find a disembodied spirituality. For Mhairi, it meant ultimately saying 'yes' to priesthood. This resonates with Stuart's work on the female as a 'sacred body'; in Stuart's study she found the women she interviewed were more actively engaged in services and rituals that incorporated the use of the body (for

[538] I have used the term 'image of womanhood' rather than 'femininity' because that is how my participants felt it was presented to them by their churches and communities: as an essential model of 'womanhood'. Although I argue that 'womanhood' and 'femininity' are not synonymous, my participants' descriptions of the way such scripts were presented to them suggests that the lines between them are blurred or non-existent in many (conservative) churches. Mhairi also offers her own take on a model of 'womanhood' in which she says that 'women are more embodied' thus implying an essentialist element to her own model.

example, Eucharist; baptism; healing; candles; music).[539] This supports Mhairi's statement that women are 'more embodied' and thus a female spirituality must abandon any search for disembodiment. Mary is the symbol of embodied spirituality and embodied redemption. Mhairi takes the Catholic image of Mary as co-redemptress and transforms it into a liberating, fleshly image which all women can relate to. In some ways, her transformation of the figure of Mary into everywoman is reminiscent of the theology of Gebara and Bingemer and her representation of a liberative Mary as the single mother who steps outside the paradigm of the nuclear family and fights against the odds.[540] For Mhairi, we are each a Mary.

5.2.4. CONCLUSIONS: A MODEL OF A LIBERATED CHRISTIAN FEMININITY?

From these explorations it can be recognised that, for these women at least, questions concerning their identity and pressure to live up to particular Christian femininities were implicated in the development of their eating disorders. Two traditional femininities – the Catholic femininity and the Protestant evangelical 'biblical womanhood' – seem to fuel the underlying thought patterns and insecurities concerning self-sacrifice, 'goodness', body image and social roles. It is inevitable there will be variations on these two traditional Christian femininities across a wide range of denominations and churches.

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[539] Stuart, "Sacred Bodies," 89.
[540] Ivone Gebara & Maria Bingemer, *Mary: Mother of God, Mother of the Poor* (New York: Orbis Books, 1989).

The question is, can we find a model of liberated Christian femininity? The answer I propose to this question is both yes and no. The reason there is no explicit model of liberated Christian femininity is perhaps because once a model has been created, it becomes precisely the opposite of 'liberated' – you have a model, an ideal, and thus pressure to live up to the ideal. What is needed is the freedom for the emerging adult to create one's own model in one's own image – or to abandon the images altogether.

To abandon our images and ideals is perhaps not a realistic assessment of human nature, considering our attachment to such ideals and stereotypes. However, a starting point is to recognise that femininity can and does come in a range of guises. We can look to diverse inspirational women – and in them glimpse ourselves. Within a Christian framework, there does not need to be merely one model of femininity, for there is a rich history of diverse and inspirational women. We can look not only to Eve and Mary, but also to other inspiring women. Recent decades have seen feminist Biblical scholarship attempt to reconstruct women's history within Christianity and there is now no shortage of literature bringing their stories to the fore.[541] We can look in the Hebrew tradition not only to the sin and motherhood of Eve and the unattainable heights of Proverbs 31, but to the desperation and faithfulness of Hannah, the leadership of Deborah, the loyalty of Ruth, the courage of Esther and the defiance of Vashti. Within the early Christian tradition we can look not only to the purity and motherhood of Mary, but to the loyalty of Mary Magdalene, the determination and spirituality of Mary of Bethany,

[541] The most notable example of the use of reconstructive models is Elisabeth Schussler Fiorenza, *In Memory of Her.*

the leadership of Priscilla and the ministry of Phoebe. Within the very texts drawn upon in the restriction of women to a specific femininity, we find the 'true richness' (to use a term from MD) of femininity in its diversity. We can find stories of women who are battered and abused,[542] women who are broken by their circumstances,[543] women who follow an alternative life path to the one set out to them.[544] Perhaps we can even find a lesbian role model.[545] The story of the Bible is the story of humanity, and we do not need to 'each be an Eve' or a Mary any longer. Each woman can find her own model of femininity – or reject 'femininity' entirely – and her own path, inspired by the women – and indeed men – who have gone before.

Several participants in the study have done exactly this as part of their recovery and have come to feel empowered by images of women in the Bible and in Christian history. To do this, some have looked outside of their own traditions. Deborah and Mhairi were both inspired and found liberation within the women of the Middle Ages who provide fuel for the model of extreme fasting, noting that Catherine of Siena created a ministry outside the normal paradigm for a woman by using the tools that were available to her

[542] For example, the story of Tamar in Genesis 38 and the unnamed concubine of Judges 19. For more examples, see Phyllis Trible, *Texts of Terror: Literary Feminist Readings of Biblical Narratives* (Philadelphia: Fortress Press, 1984).
[543] For example, Naomi in Ruth 1.20 tells her daughters-in-law to call her 'Mara' because her life has made her bitter.
[544] For example, Deborah is both Prophetess and Judge of Israel in Judges 4-5. In the book of Esther, Queen Esther takes destiny into her own hands and asks for an audience with the King.
[545] Jonathan Kirsch cites suggestions that Jephthah's daughter who 'bewails her virginity with her companions' (Judges 11:39-40) may be participating in a lesbian sex cult. Jonathan Kirsch, *The Harlot by the Side of the Road* (New York: Ballantine Books, 1997) 213-215. Deryn Guest points to the erasure of female homo-erotic experience in the Bible by using a hermeneutic of hetero-suspicion and points to Adrienne Rich's comment that the descriptions of women sharing households as co-wives or concubines provides an environment in which it is perfectly possible, even likely, that lesbian relationships developed. Deryn Guest, *When Deborah Met Jael* (London: SCM Press, 2005) 124-130.

in her context: asceticism, and fasting as a symbol of holiness and a rejection of the constraints of the reproductive female body. Mhairi further found inspiration in Mary's 'yes' to embodied spirituality – her 'yes' as a woman. Deborah described Proverbs 31 as 'super encouraging'. Grace and Rose found inspiration in Biblical women, both referring to the adulterous woman and Jesus' compassion towards her as he intervenes to protect her – for Rose, from herself and her own judgement, and for Grace, from external shame. Grace sees herself in the haemorrhaging woman, a woman who suffers with a female disease that is shameful to society and results in her isolation. She sees in the haemorrhaging woman's story that Jesus heals her and removes the stigma and shame that surrounds her, making her once again a whole human being.

There were only two participants who had not found a liberative model of femininity within Christianity. Tracy was still seriously ill at the time of interview and in her exploration of different religions and spiritualities seemed to be on some nature of a quest. She spoke of different religious and cultural understandings of women, and reflected on the interplay between religion and culture and how that affected society's understanding of women. Tracy was searching for something: perhaps an identity, perhaps spiritual meaning. One of the most difficult aspects of this study has been not knowing how participants have fared, particularly Tracy who was so ill at the time of interview. I can only venture to hope that she has found whatever it is she was seeking.

The other participant was Clare who had left the church as a result of her experiences. It is unsurprising that in the 1970s she could not see a meaningful path of womanhood within the church that resonated with her own experiences and identity. I would like to think that today, perhaps, she would find such a path with improved understanding of anorexia and the increased acceptance and recognition of lesbianism even within the church. It is perhaps more realistic to recognise that even were Clare 40 years younger, she may have found the church lacking and unable to offer her the opportunity to carve out her identity within a Catholic framework. It would appear that a less narrow and restrictive approach to femininity and sexuality is needed within a church context if women are to feel accepted, welcomed and appreciated as their authentic selves.

SECTION C: IMAGES OF GOD

5.3.1. IMAGES OF GOD IN THE LITERATURE

Three studies considered in Chapter 2 discuss in some level of depth the impact of the way in which the anorexic patient views God. First, Richards, Hardman and Berrett recount what they describe as 'negative'[546] images of God they have encountered in their work with eating disordered patients and reported on widely.[547] They report many patients perceive God as angry, judgemental and punishing; and perceive themselves in relation to God as unworthy, sinful and defective.[548] The authors also noticed that patients tended to project their relationship with their parents onto God, for example, if they described their parents as critical, angry and controlling, they would likely perceive God in a similar way.[549]

Richards, Hardman and Berrett further reported that these negative images of God and their self-worth led patients to fear abandonment by God. This is a natural continuation of a belief that God is angry and judgemental and they themselves are unlovable. As above, patients who had experienced emotional or physical neglect or abuse from their

[546] I have used the terms 'negative' and 'positive' as the authors of all three studies use this terminology. However, it must be noted that 'negative/positive' refers to the effect on the patient's wellbeing and does not make any judgement on the authenticity (or lack of) of the image.
[547] A fuller description of the studies on which this work is based can be found in Chapter 2.3 and in Chapter 5.4. It is worth noting that there are several studies which have emerged from the Center for Change on this topic in addition to the book. It should be noted that all these studies emerge from a Mormon treatment centre, and thus the majority of participants are Mormon. The demographic studied attached great importance to Biblical teachings, similarly to the participants in my study. Richards et al., "Theistic Spiritual Treatment." Richards et al., "Comparative Efficacy."
[548] Scott Richards, Randy Hardman and Michael Berrett, *Spiritual Approaches in the Treatment of Women with Eating Disorders* (Washington DC: American Psychological Association, 2007) 53.
[549] Richards et al., *Spiritual Approaches,* 54.

parents during childhood projected their fear of abandonment to God. It is striking that the authors note the connection between sexual abuse (which is known to be a causal factor behind eating disorders[550]) and the belief that God abandoned them during that time.[551]

Secondly, a study by Rider et al into religious coping mechanisms in 134 anorexic patients likewise demonstrated that negative images of God (as punitive and angry) led to more severe symptomology and worse outcomes. Conversely, a secure relationship with God and consequent belief in one's own worth in God's eyes led to better recovery outcomes. Rider et al noted that patients' images of God could mature and change to improve outcomes when guided by experienced clergy alongside their treatment programme.[552]

Thirdly, Morgan et al report on case studies of patients at a London eating disorders unit. In one case study the authors report a Catholic woman who believed that her disability was a punishment from God. Her behaviours were self-punitive as a result, including ingesting rotting food and starving herself. The authors conclude that in both this and another case in which a patient was overly concerned with theological thoughts and described weight gain as 'evil', patients' images of God as punitive have become

[550] See footnote 28.
[551] Richards et al. *Spiritual Approaches,* 55.
[552] Rider et al., "Religious Coping Styles," 168 It is noteworthy that the authors use the language of attachment theory to speak of their patients' relationships with God. It is also significant that this study also points towards the benefits of experienced clergy working alongside clinical staff in a multi-disciplinary treatment model. This is further justification for the model I propose in 5.4.

intertwined with their illness and need separating and resolving in order for recovery to happen.

Although researchers in psychology tend to describe images of God as 'negative' and 'positive', using 'negative' to refer to a wrathful, punitive God and 'positive' to refer to a forgiving God such distinction is not necessarily as straightforward in theological terms. Any assertion as to which image of God is 'true' or 'authentic' is outside the scope of this discussion.[553]

However, it should be noted there is a firm Biblical basis for 'negative' images of God as wrathful and punitive, particularly in the Old Testament/Hebrew Bible. Even discounting episodes widely considered to be myths, such as the Flood narratives, within the narratives of Israel's history Yahweh can be seen to abandon and punish the Israelites for their failings: when they go astray and worship Baal, Yahweh responds in anger and 'hands them over' to their enemies (Judges 2:1-2-14); later in the fall of first the Northern kingdom of Israel to the Assyrians (722BC) and then the Southern kingdom of Judah to the Babylonians (586BC), we see scope for an argument that Yahweh does indeed abandon his people as they are exiled. Certainly, on looking to the Psalms of

[553] Although I use the terms 'negative' and 'positive' in the interests of continuity with previous studies, in doing so I am not making any judgement as to their 'truth'. A 'negative' image refers to one that exacerbates or motivates eating disordered behaviour, and a 'positive' image motivates recovery or wellbeing. Due to the issues surrounding what is meant by 'negative' and 'positive' images, in discussing my own research I have chosen to consider the development of my participants' views of God, rather than attempting to categorise them into 'negative' and 'positive' portrayals.

Lament it is clear that – whether they truly were abandoned or not – the Israelites certainly felt themselves to be so.[554]

Yahweh's relationship with individuals in the Old Testament can be argued to be similarly temperamental. Saul loses favour with Yahweh because he does not follow instructions explicitly: whereas Yahweh ordered Saul to kill all the Amalekites and all their livestock; Saul saves the best livestock to sacrifice as burnt offerings to Yahweh. For this, Yahweh 'has torn the kingdom of Israel from [him]' (1 Samuel 15:28). Another difficulty is the lack of concern that Yahweh appears to show to women. Phyllis Trible highlights the plight of Tamar, raped by her brother Amnon, who lives the rest of her life in her other brother Absalom's house 'a desolate woman' (2 Samuel 13:20).[555] Jephthah's daughter suffers the foolishness of her father's vow to Yahweh that he would sacrifice the first living creature to come out of his house.

It is, therefore, possible to construct a biblically-based view that Yahweh is capricious and capable of abandonment: however, it must also be recognised that such a view is not the norm amongst biblical scholars who counter such texts by recalling God's *hesed* (loyal love and mercy[556]) to his people, who are, after all, the 'Chosen People'. However,

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[554] The well-known Psalm 137 is an example of this feeling of abandonment, as the Psalmist writes 'By the rivers of Babylon, we wept as we remembered Zion… How can we sing a song to the Lord in a foreign land?'

[555] Phyllis Trible, *Texts of Terror* (Philadelphia: Fortress Press, 1984), 37-64.

[556] There is some difficulty in establishing an accurate translation of *hesed,* and it is worth noting that some scholars makes a distinction between *hesed* and mercy on the grounds that *hesed* (in both religious and theological usage, i.e. between humans and human-God) is reciprocal, and therefore – as long as the other party keeps their part of the covenant – obligatory. Later scholars e.g. Henry Wheeler Robinson, *Inspiration and Revelation in the Old Testament* (Oxford: Clarendon Press, 1964), however, argue that God's continuing *hesed* despite the Israelites failings demonstrates the nature of divine *hesed*

when considering the interpretations of women suffering from anorexia that may lead to 'negative' images of God, it is worth pointing to two factors. Firstly, Caroline Banks finds that a fundamentalist reading of the Bible can be a risk factor for anorexia:[557] such a reading is more likely to see the biblical images of God – be they wrathful or generous – to be 'truth'. Therefore, a woman reading the Bible in a literal way, who is therefore more likely to hold an image of an angry God, is statistically more likely to be anorexic, whether that be cause or mere correlation. Secondly, women with pre-existing anorexia, who are likely to suffer from feelings of low self-worth and are more likely to have experienced abuse from male authority figures,[558] may be pre-disposed to read such texts in a way that emphasises the messages of fear and judgement.

This leads to a difficult question with regards to images of God: can the Bible be the anorexic's friend? Or will the Bible, with a depiction of a God who punishes and abandons, always be a problematic friend at best, filled with judgement? Given the connection between abuse from a male authority figure and anorexia, it is not surprising that Christian women with anorexia who hold a view of God as angry and punishing describe a connection between such images and their eating disorder. If earthly abusive

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as a gift better defined as 'mercy' or 'grace'. Sakenfeld, who conducts an in-depth analysis of understandings of *hesed* in the Hebrew Bible, argues that it can be both a requirement and a gift. Katherine D Sakenfeld, *The Meaning of Hesed in the Hebrew Bible: A New Inquiry* (Oregon: Wipf & Stock, 1978, 2002).

[557] Banks, "No Fat in Heaven," 128-130.

[558] See footnote 28 for literature on the connection between abuse and anorexia nervosa. For a discussion on the connection between self-esteem and anorexia nervosa, see Ewa Karpowicz, Ingela Skärsäter and Lauri Nevonen, "Self-esteem in patients treated for anorexia nervosa," *International Journal of Mental Health Nursing* 18, no.5 (2009): 318-325.

fathers (and other male caregivers) can create such feelings of worthlessness, it follows that a heavenly abusive father would have the same effect.[559]

5.3.2. DEVELOPING IMAGES OF GOD

Developing images of God documented in the autobiographical works are discussed in 2.1.10, so will not be discussed further here other than to note that Garrett, Ind and Scrivener all described how their images of God changed from 'negative' at their time of illness ('distant', 'other', 'disappointed' and 'unrelatable') to 'positive' (God as loving mother, God with us, God and humanity connected and God offering unconditional grace). Ind and Scrivener both recognise they connected God in some way with their parents: for Ind, God was absent and busy like her own; and for Scrivener God was an extension of 'the grown ups' (i.e. parental authority figures).[560]

Among my participants, Tracy did not identify as a Christian, although she had been brought up as a Quaker and described herself as 'spiritual', and thus offered an almost 'outsider' perspective on Christian images of God. She described her childhood image of God in much the same way as Scrivener, depicting the typical 'male God in the sky with a beard' image and describing him as 'wise and a bit scary' and 'too powerful to trust'. The phrase 'too powerful to trust' is perhaps indicative of Tracy's own desire for

[559] Such parallels between relations with earthly and heavenly fathers and the formation of the image of God is discussed in the context of object-relations theory in: Ana-Maria Rizzuto, "Object-Relations and the Formation of the Image of God," *British Journal of Medical Psychology* 47 (1974): 83-99, 84.
[560] Scrivener, *New Name,* 77.

control and lack of trust in anything outside herself, as she was still in the grips of her eating disorder.

It might be possible to speculate further and reflect on Tracy's own experience of male authority figures, considering the emphasis she made on the submission of women in our discussions. Tracy described God as 'disappointed' in her, demonstrating the correlation between the image of God as a 'disappointed, scary and powerful' authority figure; and herself as worthless and unlove-able, deserving of punishment. Whether this is a case of mere correlation or of causation, for Tracy, an image of a 'scary, powerful and disappointed' God is directly related to low self-esteem. At this point in her understanding of God, Tracy did not really consider herself in relation to God in any positive way, and certainly not in the sense of recognising herself as 'sacred' or 'becoming divine' as discussed by Babb and Stuart (5.2.2). [561]

Whilst Tracy held such a view of God, to recognise her own sacredness was impossible. Although she was still not recovered at interview she described how through her explorations of religion and her ongoing journey to recovery she had reassessed how she saw God – and in doing so returned to the Quaker beliefs of her childhood. She described God as the light of the divine which is in each and every person. This recognition that all people, including herself, have the light of the divine within them

[561] It is worth noting that Stuart is speaking specifically of the female body as divine. I have not separated the 'body' specifically from the whole self in this analysis as the consideration of the place of mind/body dualisms in Christian tradition and anorexia is beyond the scope of this theme (although widely acknowledged as seen in the literature reviewed in Chapter 2). For a further discussion of this issue please see Stammers, "Liberation from Anorexia Nervosa," 11.

enabled her to recognise herself as sacred and precious and believe her life was worth holding onto.

Deborah's account of her developing image of God was central to her story of recovery. As with Tracy, Deborah's view of God as 'out to get her' was closely intertwined with her low self-worth. Deborah describes in great detail her paralysing fear at the height of her illness that God was angry and would punish her with hell – and her feeling that in all her sinfulness he would be right to do so. From here, her feeling of being contaminated and impure escalated, as did her plummeting self-esteem, to the point that she self-harmed as a pre-emptive penance and denied herself food. Deborah could trace this understanding of her relationship with God to specific church teachings, and indeed a specific occasion. As an articulate theology graduate, Deborah explicitly linked such images of God to a Calvinist framework which includes the doctrine of 'total depravity'.

The turning point in Deborah's recovery came when her view of God was fundamentally changed by a book she read which unpicked the Calvinist theology of total depravity and damnation and offered a more balanced view of human nature and God's grace. She came to see that the God she had believed in would have been an abusive parent, and that when we describe God as a parent it is as though our ideal parent-child relationships are a poor reflection of God's loving relationship with us – she now sees God as a perfect loving parent, and a loving parent does not vindictively punish their child. As Deborah's view of God changed, so did her view of herself: she saw herself not as unworthy and depraved but as a beloved child of God, worthy of his love and of recovery. The

overriding emphasis of Deborah's understanding of God was compassion: a God who loves much and suffers much alongside humanity. It is perhaps relevant to her rejection of Calvinist theologies that the book that changed her view of God was given to her by a Methodist chaplain. In Deborah's head, the Calvinist-Arminian debate of the 17th and 18th centuries continued to rage with the key to her recovery in her final recognition that, as Methodism teaches, 'all can be saved'.[562]

The book in question, *Good Goats: Healing our Image of God,* which resonated so much with Deborah in her Calvinist-turned-Methodist situation, actually was authored by three Roman Catholics in the Jesuit tradition.[563] The book offers a series of anecdotes and stories which illustrate commonly held images of God as an abusive or punitive parent, and then reflects on how to re-centre these images around a God who loves and heals us before we repent – not after – and offers unconditional grace to all. The authors reflect on the origins of Alcoholics Anonymous and the story of co-founder, Bill Wilson, who at his rock bottom called out to a loving God for help. The authors cite Wilson and the work of Dr Robert Stuckey to suggest that at the root of addictive behaviour – whether it be in terms of alcohol, drugs, food or anything else – is a feeling of not belonging.[564] Thus, they write 'if we have a God who can send us to hell, who can

[562] "All Can be Saved," The Methodist Church, accessed October 31, 2020. https://www.methodist.org.uk/about-us/the-methodist-church/what-is-distinctive-about-methodism/
[563] Dennis Linn, Sheila Linn and Matthew Linn, *Good Goats: Healing our Image of God* (New York: Paulist Press, 1994).
[564] Linn et al. cite Robert Stuckey, "You Gotta Have Hope," *New Catholic World* 232, no.1390 (July 1989): 160-162. The paper they reference is no longer available, however, it is an interesting claim that would seem consistent with other literature that addictive behaviours are related to a need to belong. For example, Genevieve Dingle, "Addiction and the Importance of Belonging," *The Psychologist* 31 (May 2018): 36-49. Similarly, there are well-documented connections between anorexic behaviour and issues

vengefully decide who doesn't belong, then we are more likely to become addicted people'.[565] Although the authors are not writing about eating disorders, it is a relevant connection – the 12 step programmes (which will be discussed in 5.4) which originated in the AA have been extended and adapted as treatment programmes for other issues with similar roots – including Overeaters Anonymous,[566] and are now being used as part of spirituality programmes in the treatment of anorexia. Although not definitively an 'addiction', there are distinct similarities between anorexia (particularly those subtypes which include an exercise addiction) and addictive behaviour.[567] This connection underlines not only the worth of using similar programmes, but also highlights that there may be a similar mechanism in etiology concerning negative images of God.

Linn et al preface their book with a foreword which recognises that not all Christians will concur with their understandings of God, heaven and hell. That they include a somewhat defensive foreword expressing the orthodoxy of their theology suggests they have met with controversy, as does the Q&A section at the end of the book (based on frequently asked questions at the retreats they run) which includes the question 'what about vengeful punishment in scripture?'[568] This is a pertinent question, and although the 'true' image of God is not within the scope of this study, it is necessary to recognise that this may be a barrier for some Christian women with anorexia: if they truly believe

around identity. Margaux Vershueren et al., "Identity Processes and Status in Patients with and without Eating Disorders," *European Eating Disorders Review* 25, no.1 (2017): 26-35.

[565] Linn et al. *Good Goats,* 45.

[566] "What are the twelve steps?" Overeaters Anonymous Great Britain, accessed October 31, 2020. https://www.oagb.org.uk/what-are-the-12-steps-of-oa/.

[567] Johann Kinzl and Wilfried Biebl, "Are Eating Disorders Addictions?" *Neuropsychiatry* 24, no.3 (2010): 200-208.

[568] Linn et al., *Good Goats,* 54.

that God is a vengeful God who punishes, then is there a possibility of recovery without healing their image of God? Women in my study did not explicitly set out their thought patterns on how starving themselves helped in the context of a 'negative' image of God; however, they did comment that they felt unworthy to eat, or that starvation was an appropriate punishment or penance for their sinfulness. Following on, it is possible there is also an element of seeking one's own redemption through this penance, as in the lives of the ascetic saints.[569]

Deborah is able to hold an image of God as a loving parent and to reject an image of a wrathful God despite Biblical imagery to the contrary, due to her liberal interpretation of the Bible. For her, as an academic theologian and Methodist Local Preacher, she can hold the tension between images of the Old Testament God and her belief in a 'perfect parent' God by explaining such images as the result of the scribes' human perspectives of God. In our interview, Deborah was clear had she not re-aligned her understanding of God in this way, taking on the more liberal approaches to the Bible shown in sectors of the Methodist Church, her recovery would have been more difficult or even impossible. This raises a difficult question for more conservative branches of the church: is it possible to retain a belief in biblical inerrancy and thus a God who can be wrathful and punish, and also recover from anorexia? Is an emphasis on *hesed* as God's abiding character enough to compensate for this? If not, does this mean recovery and a belief in the biblical God are incompatible?

[569] Stammers, "Liberation from Anorexia Nervosa," 13-14.

Eloise's story reflects the tension which can be found in believing in a loving God whilst also retaining a conservative approach to scriptural texts recounting God's anger. Eloise describes how her understanding of God remains relatively unchanged – but her depiction of God might well be described as 'negative' by many. She says she is 'realistic about God's wrath' who 'could be pretty angry with me'. What is notable about Eloise's image of God is that she herself does not see this as 'negative'. On the contrary, she describes a positive image of a God who, although wrathful and angry and able to punish, instead offers mercy and loves her like a daughter. Despite Eloise's belief in God's wrath, she also believed in God's grace. This could partly be due to the positive relationship Eloise had with her own father, which she describes as influencing her understanding of God. She preferred to understand God in a relational way, as a father and protector. For Eloise, it was not her image of God that changed in her recovery, but her understanding of how God viewed her. She moved from a belief based in her own low self-esteem that God was 'bored' of her and 'pitied' her to recognising that God's all-encompassing love for her enabled him to 'overlook' her failures. Thus, Eloise offers a potential answer to the question 'is belief in a wrathful God incompatible with recovery?' from within a conservative branch of the church: for Eloise, there is no difficulty with an angry God because she has an angry God who loves her. In her recovery, she does not need to change her view of God as potentially wrathful, because instead it is her view of herself that changes – as utterly loved by a God who, although sometimes angry, is righteously angry.

In Ind's autobiography she discusses her difficulty relating to God as a father expressing that she did not feel a male God could relate to her difficulties with big breasts and chocolate cake. For Ind, the turning point in recovery came as she was able to view God as a loving mother, rather than father.[570] Centuries of Hebrew and Christian tradition have viewed God almost exclusively as male with a few notable biblical exceptions such as Isaiah's depiction of God as a mother in labour (42:14) and as a nursing mother (49:15); or the Gospel writers' image of God as a mother hen (Matt 23:37 and Luke 13:34). There is not scope in this paper to discuss in depth the response of feminist theologians to such a portrayal, but the problems that such a portrayal can cause are well-documented.[571]

Linn writes of the importance he has found in shaping his own image of God in recognising both the masculine (fatherly) and feminine (motherly) aspects of God, drawing on Pope John Paul II's use of the word *rahamim* – the 'tender compassion coming from the motherly side of God'.[572] The word *rahamim* in Hebrew comes from the root *rehem* or 'womb'. Although Linn clearly recognises the importance of a balanced image of God in the same vein as Ind, and notes the issues that arise when the church maintains a male-dominated view of God, to argue for the importance of a 'balanced image' is not entirely satisfactory. Not only does it subscribe to gender stereotypes (the masculine side of God is strong, the feminine side is nurturing) but it

[570] Ind, *Fat is a Spiritual Issue,* 11, 41-42.
[571] For a few select examples: Ruether, *Sexism and God-talk*; Janet Soskice, *The Kindness of God: Metaphor, Gender and Religious Language* (Oxford: Oxford University Press, 2008); Mary Daly, *Beyond God the Father* (London: Women's Press, 1985, first published 1983).
[572] Linn et al., *Good Goats,* 41.

continues in the damaging traditions of male/female; spirit/body; heavenly/earthly dualisms that have permeated Christianity.

It has been widely recognised that the mindset of such dualisms that equate the female with flesh and sin, inherited from Platonic philosophy and endorsed by the Church Fathers, are implicated in both the tradition of Christian asceticism and eating disordered thinking.[573] Thus, to attempt to 'balance' an image of God thus implying that God does indeed have a 'male side' and a 'female side' may not be an appropriate solution to the problem of the language we use to speak of God in the context of women suffering from eating disorders. However, we must not be too hasty to dismiss such approaches, as evidenced by Mhairi's approach to understanding God.

Mhairi did not begin with a 'negative' image of God per se, rather she understood her spiritual journey to be a quest to find a God in the midst of her illness: a God she could relate to, and who made sense in the actual circumstances of her life. She explained that she found a transcendent male God difficult to relate to, but in exploring God's immanent side she felt she could relate more, as a woman, to God. Mhairi describes women as 'more embodied'. For her, the incarnation – through Mary's 'yes' to embodiment – God becoming embodied as flesh, through a woman, was where she found she could connect God to her own life and being.

[573] Studies demonstrating this link include: Banks "Imaginative Use of Religious Symbols," 228-229; Grenfell, "Religion and Eating Disorders," 373; Morgan et al., "Spiritual Starvation," 479. Bell, *Holy Anorexia,* 119, discusses dualisms in the ascetic tradition.

Clare also found God, in his transcendence, to be distant and alien, describing God as 'disinterested' although as a child she had a 'strong' (which I took to mean 'present') image of Jesus. Whereas Mhairi found meaning in God's immanence, Clare lost faith altogether. Clare's narrative raises the question of whether there is room for move in faith to something spiritual other than God. Like Tracy, Clare's enduring belief in spirituality remains, but her belief in a Christian God did not.

Catherine Garrett's exploration into recovery from anorexia as a spiritual journey follows a similar pattern: her story tells of her discovery of spirituality and the transcendent through a Benedictine monastery, meditation, Assisi relics, Hindu poetry and Bach's Brandenburg concertos.[574] Likewise, the narratives of the participants in her research offer non-Christian spiritual resolutions: Miranda spoke of finding her spirituality in music and in the community round her; Dominic told of finding meaning and 'rebirth' in the death of a loved one as he saw the space between life and death; and Naomi found spirituality through artistic rituals, both personal and communal. In these 'spiritual stories', Garrett notes the need for integration of self and body, and also to connect with something beyond oneself, be that in others or in a transcendental.[575] Garrett is not alone in the assertion that recovery from anorexia is a spiritual journey: Lelwica argues similarly that recovery from anorexia is a spiritual quest, and looks to women from diverse backgrounds and cultures, offering generic suggestions for the 'holy grail' of this quest in different religions – she is clear Christianity is not an objective

[574] Garrett, *Beyond Anorexia,* 16.
[575] Garrett, *Beyond Anorexia,* 135-143.

'answer', it is merely the tradition with which she personally is most familiar.[576] White rejects Christianity and looks to Goddess feminisms to liberate women from the 'slender performance'.[577] It is not within the scope of this thesis to explore every possible spiritual source of recovery – however, it is clear from not only Clare's story of recovery, but the narratives shared by Lelwica and Garrett, that for some sufferers, recovery will mean a move to a different kind of faith or spirituality, be that pluralist as Garrett and Tracy describe, or non-theistic altogether.

5.3.3. CONSTANT IMAGES OF GOD

'Constant' can be understood in two subtly different ways: that the image of God for the participant remains constant throughout their illness and recovery; or that they envisage God as their constant. These interpretations of 'constant' are two sides of the same coin, and prove to be both true for Grace and Rose who offer vibrant images of God. Grace described God as a healer, defender, protector, shelter, rescuer, strength and gracious, and concluded if it had not been for her image of God as her saviour, and as her constant, she would not have been able to recover. Rose likewise describes God as her 'constant' amidst the turmoil of her illness.

Discourse on the constancy and immutability of God is deeply problematic. Biblical texts (e.g. Hebrews 13.8) describe God or Christ as constant. Philosophical understandings of the nature of God likewise describe the classical theistic God as unchanging in order to

[576] Lelwica, *Starving for Salvation,* 9.
[577] White, *Spirituality of Anorexia,* 87-88.

be truly omnipotent.[578] This raises problems for a relational understanding of God. An immanent, loving God must surely be changeable – and evidence for this, too, can be found in the biblical texts (e.g. Exodus 32, Matthew 36:39-42). However, this debate is not only beyond the remit of this thesis, but is also not what Grace and Rose are discussing. When they describe God as their constant, neither is referring to a philosophical question about God's immutability: rather, they are referring to the constancy of God's love for them. It is their belief in this constancy, not any belief in a philosophical immutability that render God unable to respond to them, that forms their image of a 'constant God'.

5.3.4. GOD AS THE AUTHOR OF ANOREXIA?

A question that arose in Deborah's interview was the question of whether God is the author of anorexia. Deborah was scathing of people who had suggested to her that God has intended or planned for her to suffer from anorexia in some way: this did not fit with her understanding of a loving God. However, she noted that she had received several suggestions from fellow Christians that her illness was 'all part of God's plan' or a 'test' from God. Such a viewpoint brings into question issues concerning autonomy and free will which have implications for the nature of anorexia and recovery, as discussed in 5.1. Although this viewpoint solves potential issues with the depiction of anorexia as a sin, it creates more difficulties concerning the problem of suffering. To begin to unpick the complex web of free will, providence and the problem of suffering is beyond the scope

[578] For example, Thomas Aquinas, *Summa Theologica, Prima Pars, Q9.* Accessed October 31, 2020. https://www.newadvent.org/summa/1009.htm.

of this thesis, but it is worth noting Deborah's point that if one views God in his providence as the author of anorexia, then the problem of suffering becomes just that – a problem. If God is forcing a life-threatening mental illness on people as a 'test' we are faced with the unappealing God of the Book of Job, who forces Job and his family to suffer in order to make his point.

For this reason, Deborah rejected such a view, instead understanding anorexia as an illness, something that happens but that God can – and indeed does – bring good from. Deborah reflected on the life story of Catherine of Siena which she found inspirational. Catherine gave Deborah an example of a woman living out her calling in the only way she found available to her due to the regulations and constraints of the time: through asceticism. Both despite of and through the medium her 'illness' (of which Catherine is very self-aware as demonstrated through her letters to her Confessor[579]) she was a force for change within the church in a way in which few women of her era were, including most notably her role in the return of the Papacy from Avignon to Rome. Through her illness, although Deborah is convinced it was not 'ordained' by God, both Catherine and God brought about the fulfilment of her calling.

An interesting question is whether anorexia in each case 'has' to happen: not in the sense of being predestined by God, but in the sense that it is a psychological necessity or coping mechanism for the individual at that time. Such a view could be supported by both Garrett and Lelwica's assertions that eating disorders represent a 'spiritual quest'

[579] See footnote 113.

in which one uses rituals and myths to create meaning and find one's true 'self' in connection with an 'other'/divine/nature.[580] Certainly, examples of good coming from eating disorders and recovered anorexics' assertions of what they have learned from their illness could support this theory.[581] Feminist and psycho-analytic theories that argue for anorexia as a 'search for self' could likewise go some way to substantiating this claim.[582]

Only one participant spoke explicitly about the notion of God being 'in control': Eloise said that 'God knows what he is doing' and 'God will fight the battle for you'. With these phrases she was not suggesting God caused her to have anorexia – Eloise's tension between anorexia as sickness/sin is discussed in 5.1 – when she refers to God 'knowing what he's doing' she is referring to her journey of recovery. She says 'if I hadn't brought [God] in to just completely take over, I would never have got better'.

Eloise is not alone in feeling God is in control of recovery. However, there is a subtle but important difference between Eloise's description of a God who 'takes over' and the collaborative model of taking control *with* God cited by Rider et al, who note that patients who attempt to 'take control' of recovery in collaboration with God, as is typical of 12 step programmes, showed better outcomes.[583] The issue of control is important

[580] Garrett, *Beyond Anorexia* and Lelwica, *Starving for Salvation.*
[581] Deborah in my own study noted that as a result of her eating disorder she has an increased appreciation of food, a real understanding of what it means to be in hospital that enables her to empathise with others and self-awareness that she did not have before. She also met people through her illness who 'showed her something of Christ'.
[582] Garrett, *Beyond Anorexia,* 52 cites Susie Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age* (London: Faber and Faber, 1986).
[583] Rider et al., "Religious Coping Styles," 168.

in anorexia; Marsden, Karagianni and Morgan, in their qualitative study of ten Christian women with anorexia, describe one of five dominant themes to be the 'locus of control'. This took the form of control within the family, centring around both food and religion, which had exacerbated their eating disorder and led them to seek ultimate self-control by controlling their food intake. This theme links to a further theme, 'salvation' in which their participants saw God as the author of recovery (through medical treatment and/or through the psychological benefits and support of a faith in God).[584]

Such a finding supports Rider et al's assertion that a positive religious coping style offers a motivator for recovery. It is worth noting, however, that a participant who sought faith healing rather than seeing God's will for their recovery being enacted through healthcare professionals and the support of those around them, became disappointed when such healing did not occur and lost faith in God.[585] This once again points to the difference between a God who 'takes over' and controls, and the collaborative model in which God assists the sufferer in their recovery. The key finding from these two studies appears to be that patients who relinquish some control and move to a model in which they assert their autonomy over their lives alongside a loving God who they believe wants them to recover, have better recovery outcomes. Although Eloise found the 'controlling' God as author of recovery a helpful image, this experience is not duplicated in the literature or in the observations of other participants in the study. Rather, this

[584] Marsden, Karagianni and Morgan, "Spirituality and Clinical Care," 8.
[585] Marsden, Karagianni and Morgan, "Spirituality and Clinical Care," 10.

image appears to be more akin to the authority figures tied up with 'negative' images of God.

5.3.5. TRINITARIAN PERSPECTIVES

Participants in my study often spoke of 'God' and 'Jesus' as entirely different characters. Clare described her image of God as distinctly Trinitarian, with God the Father unreachable up in the clouds, the Holy Spirit as a dove connecting the Father to the Son (but not relational to her), and Jesus as the aspect of the Trinity with which she could engage, a 'positive figure'. Such a view seems to reflect a feeling of connection with the immanent nature of God, but disconnection with the transcendent God.

Such a disjunct between the transcendent and immanent was also described by Mhairi who expressed her search for meaning and purpose from a transcendent God 'for [her] immanent life'. Mhairi found herself on a quest for beauty, truth and goodness in the midst of bereavement, and describes her experiences of God as a spiritual 'search for God in the actual circumstances of my life'. She sought to harmonise the transcendence and immanence of God in human experience, searching for a transcendence that does not rely on disembodiment. Through the beauty of evensong and liturgy, Mhairi found the transcendence of God inspiring and beautiful. Through the human existential themes of the Psalms, she found God's relation to humans and tried to recreate an image of God that begins from a place of embodiment. This was essential to her, as a woman, for her understanding of God. She described atonement as historically being

understood as part of a 'male' search for disembodiment, grounded in the dualisms of male/female, spirit/flesh. For a transcendent/immanent God to have meaning for women, God must be embodied. This, she finds in both the figure of Jesus, and in Mary's 'yes' to embodiment as *theotokos*. Ultimately, Mhairi speaks of the integrating role of the spirit and a search for a 'spirit-centred personhood' which combines the transcendent and the immanent in each person.

For participants who were members of more typically Protestant Bible-centred churches, they – like Clare – focused on the person of Christ, turning to specific passages in the Bible from which they drew strength from their image of Christ as 'defender'. Both Rose and Grace spoke of the story in which the woman stoned in adultery is defended by Jesus. For Rose, this was a poignant reminder that Jesus defends us all in our imperfections, and defends us not only from the judgement of others, but from the judgement we place upon ourselves. Grace drew a comparison between the woman's plight as an adulteress, and her own plight as an anorexic – both are situations which she felt are 'shameful' in society. In the story, Jesus 'covers' the woman's shame by standing between her and the crowd, both literally and metaphorically. Grace felt that in the same way Jesus stood between her and the external voices that shamed her, whether that be the voice in her head that encouraged her to starve and binge, or the voices of society which belittled her illness. Although neither Grace nor Rose considered anorexia to be a 'sin', they both chose to associate themselves in the grips of their illness with a woman who is by definition a sinner (she is only ever named 'the woman caught in adultery'). However, both women noted the societal shame that they felt was

attached to eating disorders: perhaps this story, for them, is less of a story about sinfulness and more about Jesus defending those on the margins of society.

Whereas Rose and Grace focused on Jesus' actions in his life, other participants spoke of his death. A recurring theme was the issues with the ascetic Christ: a Christ who starves himself in the desert and sacrifices himself upon a cross in the most brutal and painful execution method of the Roman world, could be seen as a call to self-harm. Clare spoke of her 'fascination' with the crucifixion which normalised torture. Cat spoke of the difficulty she found with the 'glorification of starvation' with a Christ who ate nothing for 40 days and nights, and a story in which the prospect of a miraculous source of bread – the basic essential of life – is considered a 'temptation', equating eating with sin. Tracy found the image of the cross distressing, describing it as 'sin punished at all costs', 'madness' and 'self-punishment' which 'condones self-harm'. For her, this meant that following the example of Christ would mean undertaking self-penance even to the point of suicide if taken at face value. She felt that such teachings should carry 'health warnings' to say they are metaphorical. As a non-mainstream Christian, Tracy felt that a metaphorical Christ was less 'dangerous'. However, it would perhaps not be a satisfactory answer to the difficulties posed by the crucifixion for more mainstream Christians whose faith centres on the crucifixion as an actual historical event.

Deborah viewed the ascetic Christ in a different light. Whereas Tracy's difficulties seemed to arise from the implied model of penal substitution in her understanding of atonement as 'sins punished at any cost', Deborah rejected such a model. To her, the

ascetic Christ starving in the desert is a representation of a Christ who has suffered everything that she was suffering, who was with her completely in her humanity. The ascetic Christ is a Christ of com-passion – a broken-bodied Christ who literally suffers with humanity. In Christ's passion God shows his com-passion for the world. Deborah reflected on the statue in a cathedral in Brussels: a weather-beaten statue of Christ, eroded in such a way that he looked to have self-harm scars down his arms, just as she did. For her, this is an empowering Christ who is truly with us in the darkest times of our lives.

In the tradition of liberation theologies, Christ is associated as walking alongside, truly being with, marginalised groups. It is in the footsteps of this tradition that Deborah paints a picture of an ascetic Christ, a self-harm Christ who is a fully com-passionate Christ. In this model it is not problematic that Jesus starves himself or goes willingly to his death, because this is the very nature of Christ and the bridging of the gap between humanity and God. It is in God suffering with humanity that humanity can be made one with God. It is not that God suffers as an example to his followers to suffer also – it is that because God suffers, his followers do not have to. This is the point of the crucifixion in the light of the resurrection. This is a Christ who suffers with humanity – literally a com-passionate Christ.

It is this com-passionate Christ who can be seen threaded throughout all of my participants' stories and experiences of God. Grace and Rose see Christ's compassion as he defends the adulterous woman. Grace furthermore sees Christ's compassion as he

heals the haemorrhaging woman from a 'female' disease that was considered shameful. Tracy looks to a Christ who calms the storm – not just the storm on Lake Galilee for the disciples, but the storm that raged inside her during her eating disorder. As with so many theologies, this one ends at the foot of the cross. It is in the cross that images of God the Father, God the Son and God the Spirit join together. In this image of a com-passionate Christ, the Crucified God, the problematic images of God experienced by my participants are usurped: rather than fearing a sado-masochistic abusive father God, it becomes apparent that the cross is not about 'punishment at all costs' but about God himself being with humanity in suffering and in death. This is the image not of a God who sets a bad example or is disappointed, but a God who weeps with and alongside his children. Although my participants offer a disparate set of stories and understandings of God which often seem contradictory or dissonant, this is the clear image that emerges from each one of them – a com-passionate Christ.

SECTION D: PASTORAL MODELS

5.4.1. INTRODUCTION

The importance of pastoral and spiritual care for mental health patients has been aptly demonstrated in recent years through, amongst others, the pioneering work of Christopher Cook and John Swinton.[586] Swinton describes the importance of the 'forgotten dimension' of spirituality in the holistic care of patients as whole human beings rather than as a collection of body parts. Although he describes the term 'spirituality' as a rather nebulous concept, he notes that the term comes from 'spirit' or in other words, the life force. 'Spirituality' is therefore how humans respond to our life force, be that through interconnectivity and meaningful interactions with nature, with others, or with a transcendent.[587] Birmingham and Solihull Mental Health Foundation Trust define spirituality as 'what gives us meaning, hope and purpose in our lives'.[588] Spiritual care in a mental health context, then, is about listening and supporting patients to reconnect with whatever gives them meaning, hope and purpose. 'Religion' is one expression of 'spirituality', and – as researchers in the field of eating disorders have also noticed[589] – there is an important distinction to be made in mental health between extrinsic religiosity which may have negative effects on

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[586] Christopher Cook, Andrew Powell and Andrew Sims, ed., *Spirituality and Psychiatry* (London: RCPsych Publications, 2009). John Swinton, *Spirituality and Mental Healthcare* (London: Jessica Kingsley Publishers, 2001).
[587] Swinton, *Spirituality,* 12-18.
[588] "Handbook of Spiritual Care in Mental Illness," Birmingham and Solihull NHS Mental Health Foundation Trust, updated 2015, available to download from https://www.bsmhft.nhs.uk/service-user-and-carer/service-user-information/spiritual-care/.
[589] Rider et al., "Religious Coping Styles."

mental health, and intrinsic religiosity which tends to be associated with positive mental health.[590]

The work of the chaplain is, of course, far more than just what one might understand as 'religion' or even 'spirituality' more generally, whether that refers to chaplains in healthcare or in other institutions such as schools or universities. Jean Fletcher outlines the work of mental health chaplains with a CRISP model: Cultural (supporting patients' cultural practices e.g. ensuring dietary requirements are met); Religious care (for example, discussions about religious issues such as mental health and sin); Individual care (working with the individual within their framework); Spiritual care (such as ensuring they have access to their own religious practices e.g. services); and Pastoral care (support with life events, such as bereavements).[591] Although Fletcher writes specifically in the context of hospital chaplaincy, this is a model which is of great relevance to any chaplain or community clergy working with those with mental health difficulties, including – of course – eating disorders sufferers.

However, as my participants' experiences demonstrate, such standards of pastoral and spiritual care are not always met. Overall, my participants reported more negative than positive experiences of pastoral care; however, it is important to note that this is in part due to the way I am categorising 'negative' experiences as everything which has not been helpful or my participants felt did not have potential to help another sufferer. This

[590] Swinton, *Spirituality,* 29-25.
[591] Jean Fletcher, ed., *Chaplaincy and Spiritual Care in Mental Health Settings* (London: Jessica Kingsley Publishers, 2019).

naturally includes everything from well-meaning clergy with no knowledge of eating disorders being unable to help, to actively unhelpful interventions (generally borne of ignorance and misunderstandings rather than any intent to harm).

5.4.2. HOSPITAL CHAPLAINCY

5.4.2.1 EXPERIENCES AND EXISTING FRAMEWORKS

Brigid gave a positive account of her experiences of a Catholic hospital in the US. She describes the well-organised services which allowed her to 'hold onto' her faith as part of herself. Given the comfort which Brigid describes finding in routines, spirituality and sacraments, the importance of this to her recovery cannot be underestimated. Running parallel to the services, she described a spirituality group, although a decade later she was hazy about topics discussed. It was interesting that the spirituality group had closed during her time in the hospital, she thought due to another patient's actions in targeting the rest of the group for exorcisms. Although a shame that a group that Brigid described in broadly helpful terms had to finish, it is a positive sign that the hospital staff acted so quickly to risk manage the situation and to protect other patients.

The dual combination of spirituality group and regular on-site services was similarly experienced by Tracy in an NHS hospital in the UK. Although she did not recognise herself to have had the support of a 'Christian community' and did not explicitly define her experience of hospital chaplaincy as 'positive', it was clear from the way she talked about hospital chaplaincy that she did find the services helpful and comforting, and that

she enjoyed the reflective time allowed by the spirituality group. She made frequent use of the service offered by the Chaplain of 1:1 discussion, and her choice to make continuing use of this service in itself is testament that she found it a positive experience.

These positive experiences contrast sharply with Cat's experiences of hospital chaplaincy. Cat was disappointed by the lack of opportunities to continue to practice her religion in hospital. In the trust in which Cat was treated, there was a team of hospital chaplains, but they did not appear to serve the mental health hospital during this time. Cat's account of hospital chaplaincy has some redeeming features: the well-meaning nurse who found her directions to the nearest Catholic church for Sunday Mass was clearly going above and beyond her duties; and the visit from a local friar who was not a hospital chaplain suggested willingness from the local community to step into the breach, and a recognition by the hospital staff that there was indeed a breach that needed filling. However, it is concerning that during the most acute phase of her illness, when Cat was not allowed to leave the hospital ward, there was no religious provision whatsoever, despite what she had been told before agreeing to go into hospital. For both Cat and Brigid, both Roman Catholics with OCD tendencies who find comfort in routine, the ability to receive the sacraments and to attend familiar services was the most important element of chaplaincy care.

Significantly, Cat described feeling deeply uncomfortable with the male chaplain who visited her in hospital and despite speaking of him in understanding terms ('best will in

the world') she also referred to their encounter in the language of bodily boundaries ('weird spiritual lap dance'). On the contrary, Brigid had only praise for the nuns who offered her spiritual care whilst she was in hospital. It is difficult to draw conclusions from this, not only due to the anecdotal nature of the data, but because Brigid's spiritual care was undertaken by nuns who worked at and ran the hospital, whereas Cat's was a local friar with no previous connection to the eating disorders unit. In light of Cat's use of language concerning bodily boundaries and considerations surrounding preferences for healthcare practitioners of the same sex,[592] the question as to whether a male celibate priest is the best placed chaplain to understand the issues which concern a young woman with an eating disorder is perhaps an area for further research. A similar issue arises in Clare's narrative with her university chaplain, as is discussed later in this chapter. This would need consideration in cases when the sufferer is a victim of sexual abuse, which is a known risk factor for developing anorexia.[593]

The defining features of the 'positive' chaplaincy care offered to both Brigid and Tracy were as follows: the dual offer of services and spirituality group; the possibility of 1:1 talks with the chaplain or other religious figure; an organised Mental Health Chaplaincy Team, co-ordinated by either the hospital or a mainstream church; and finally – and in my opinion, most importantly – the chaplains (or nuns in Brigid's case) all specialised in

[592] Jan Kerssens, Josien Bensing and Margiet Andela, "Patient Preference for Genders of Health Professionals," *Social Science and Medicine* 44, no.10 (1997): 1531-1540. This study undertakes extensive surveys concerning preferences for healthcare staff of the same sex to the patient in different areas of healthcare, with significant numbers of women preferring female healthcare staff (14.9% preferred a female psychiatrist; 18.4% preferred a female psychologist; 24.2% preferred a female social worker and 44.9% preferred a female hospital nurse).

[593] See footnote 28.

mental health care, and had specific knowledge and understanding of eating disorders. Cat's awkward experience with the well-meaning friar with little understanding of mental health highlights the importance of having chaplains who are trained in mental health (and ideally, specifically eating disorders).

There is little in the way of formal pastoral models of eating disorders for chaplains in the literature, however, there are two manuals which have emerged from the US on the topic: one from the Mormon led 'Center for Change' in Utah; and one from the Christian run 'Remuda Ranch'. Although the latter does not specify denomination, the emphasis on Biblical sovereignty and the demographic of the location suggest a strong Protestant leaning.

The first of these models is set out comprehensively in *Spiritual Approaches in the Treatment of Women with Eating Disorders* by the Director of Research at the Center for Change alongside two other clinical psychologists.[594] Although very experienced in their work in eating disorders, they write from the perspective of 'outsiders' to the illness: as clinicians rather than people who have experienced the illness personally, and as male in contrast to their female patients. In this book, the authors set out to explain why a spiritual dimension in eating disorders treatment is important; and to produce a theistic framework for the treatment and understanding of eating disorders, giving specific examples of how this could be incorporated into clinical practice. The former

[594] P. Scott Richards, R.K. Hardman and M.R. Berrett, *Spiritual Approaches in the Treatment of Women with Eating Disorders* (Washington: American Psychological Association, 2007).

has been discussed already in Chapter 2 of this thesis, however, it is worth exploring their model for theistic spiritual treatment. At the Center for Change, patients are asked whether they wish to have a spiritual treatment approach; due to the demographic of their patients (as a Mormon treatment facility), 99% of patients choose to attend the spirituality group.[595] This is part of a multidisciplinary treatment approach, alongside group, individual, nutritional and family therapy as appropriate.[596]

Richards et al describe the spiritual issues that they frequently encounter in women with eating disorders: negative images of God as angry or violent; spiritual unworthiness and shame; fear of abandonment by God; guilt about sexuality; reduced capacity to love or serve; difficulty surrendering control to God; and dishonesty (including beliefs that others, including God, are dishonest).[597] They also describe issues to do with identity, and devotion to their eating disorder over God.[598] These can all be worked through as part of a spiritual approach to treatment.

The authors offer recommendations as to how a spiritual approach can be incorporated into treatment. They suggest that on admission, if a patient decides to include the spiritual dimension of treatment, a comprehensive spirituality assessment should be undertaken through interviews and questionnaires, similar to a medical history.

[595] Richards, Hardman and Berrett, *Spiritual Approaches,* 156.
[596] Richards, Hardman and Berrett, *Spiritual Approaches,* 85.
[597] Richards, Hardman and Berrett, *Spiritual Approaches,* 53-56. The authors do not explicitly define how they are using the word 'spiritual' but from the contexts in which they use it, it appears that they are using it to mean 'religious' in an internal sense (i.e. in terms of relationship to God and conceptual understanding as opposed to the structures of organised religion).
[598] Richards, Hardman and Berrett, *Spiritual Approaches,* 52.

Perhaps the most striking (and, in my opinion, the downfall of this treatment approach, particularly when considered for use in the NHS) is that Richards et al insist that all the spiritual treatment should be undertaken by the clinical team, predominantly the psychologist working with the patient and are clear that this is not pastoral or religious counselling, but grounded in clinical treatment. They also suggest the therapist should ideally be a theist, but at the very least should have an excellent understanding of the individual's religion.[599] They suggest the therapist should take the time to become deeply cognisant with the patient's beliefs, working with their faith community to develop this understanding where necessary.[600]

There are several difficulties with this treatment model. Firstly, the authors' claim that this is 'not pastoral or religious counselling' is by no means apparent from the treatment model they go on to outline. It appears to be a fusion of pastoral and religious counselling with clinical treatment – which is appropriate considering what they are aiming to achieve – however, it does not justify their insistence that such treatment should be carried out by psychologists rather than chaplains. Of course, an untrained chaplain inexperienced in mental health and eating disorders attempting to undertake clinical counselling could cause great harm – but arguably so could a psychologist attempting to undertake religious counselling, which this model proposes. The authors themselves note ethical issues, but to my mind do not provide adequate solutions: they warn of usurping religious authority; straying outside the boundary of expertise; role

[599] Richards, Hardman and Berrett, *Spiritual Approaches,* 11.
[600] Richards, Hardman and Berrett, *Spiritual Approaches,* 89.

conflict and workplace boundaries. As the Center is a treatment centre open to women of any faith, and the spirituality programme is open to women of any theistic faith or denomination within that, expecting psychologists to be fully au fait with each and every religion and denomination puts unfair and unrealistic expectations on psychologists, and by definition asks them to overreach the boundaries of their expertise. Such a model also arguably leaves no path for patients to reject organised religion if the religious counselling is being carried out by their primary therapist. A far more sensible approach would be to have specially trained mental health chaplains of the religion in question working alongside the clinical team: this solves the issue of psychologists overstepping boundaries, and enables the expertise of the chaplain to be brought in to add to the treatment programme – or, indeed, refused. As the chaplain would work closely with the psychologist and be trained as a mental health chaplain, concerns about the chaplain overstepping their boundaries would be far simpler to mitigate.

In addition to the risks of overstepping boundaries, there are ethical considerations concerning role conflict. Richards et al specifically suggest one possibility of a spiritual treatment approach is that 'through meditation and prayer, therapists may experience inspired insights that go beyond clinical hypothesizing'.[601] This appears to be not so much overstepping expertise, but compromising one's position as a clinician. Although of course, it is to be expected that medical practitioners of faith may pray for their patients, asking God for 'inspired insights' goes beyond this boundary and opens the clinician up to ethical difficulties: for example, should a psychologist be 'inspired' beyond

[601] Richards, Hardman and Berrett, *Spiritual Approaches,* 88.

their 'clinical' opinion, as the authors suggest, on what basis is this validated? There is no assurance that such 'inspirations' are indeed from God as opposed to wishful thinking or false belief. The expectation on psychologists that they should 'honour and respect beliefs' whilst also reframing unhelpful beliefs (for example, challenging negative images of God) appears to be an impossible ask.[602] How is a psychologist to know which beliefs to challenge and which to respect? This is surely a subjective decision. A psychologist might choose to challenge one's image of a wrathful God. A patient may feel this is disrespectful to their biblically-based belief that God can be angry (as was held by Eloise in my study). It is far more respectful and potentially more effective for a religious figure such as a chaplain to undertake such challenges, as it is less likely to be received by the patient as insulting their beliefs. It is also far more difficult to dismiss a religious authority figure suggesting you recalibrate your core beliefs, as they are, by definition, an authority on those very beliefs, whereas a psychologist is not, and should not be asked to be. The role conflict is again highlighted in the authors' recommendations: despite suggesting (amongst other things) that in individual therapy the psychologist should use sacred writings and music; encourage the patient to write a letter to God; and discuss religion and prayer, they also state that although the psychologist should pray for their patients, and for insight in their work with patients, they should not pray with the patient, as this could create role boundary confusion.[603] This seems a somewhat arbitrary line, as once the psychologist has undertaken an exegesis of the sacred texts, challenged ideas about God, prayed for insight and played some uplifting

[602] Richards, Hardman and Berrett, *Spiritual Approaches,* 89.
[603] Richards, Hardman and Berrett, *Spiritual Approaches,* 135.

psalms or worship music, this boundary has already been well and truly blurred, if not entirely eradicated. Patients may also find it helpful to pray with someone, and again, this is the role of a Chaplain.

Nonetheless, despite these questions over who should undertake which parts of this spirituality model, there is much to commend the Center of Change's spirituality programme for inpatients. It is comprised of five key elements, alongside more traditional approaches to eating disorders treatment: extensive spirituality assessment on admission to the programme; inclusion of spiritual elements into individual and (where appropriate) family therapy; attendance of a spirituality group; opportunities to worship (either on site, or transport provided to attend a place of worship); and opportunities to serve others. Richards et al recognise the contribution of religious leaders from the patient's own community and encourage them to invite them in, noting they are crucial in preventing relapse when the patient is discharged and returns to their own community.

The benefits of providing opportunities to worship are self-evident, and reflected in Brigid and Cat's stories. The importance of including patients' own religious leaders will also be highlighted later in this chapter, as many community clergy my participants came across did not know how to respond to eating disorders, and some support from specialist eating disorders services to learn how to support sufferers would have been beneficial in many cases.

Richards et al propose two possible models for a spirituality group, and also undertake research into the effectiveness of spirituality group attendance.[604] The first is their own inpatient spirituality group, which is comprised of a 60-minute session once per week, plus a manual for the patient to work through in their own time. The authors give examples of the activities, designed to reflect on themes of the self, identity, perfectionism and so on. The vast majority appear useful suggestions,[605] although they are rooted in the relatively conservative religion of Utah and the Mormon community, so adaptations would be required for use in a UK hospital.[606] Ultimately, the authors provide a helpful model for a spirituality group, but it is, naturally, tied to the theology of the Center, centred around providence and accepting God's plan. This does not mean it is an ineffective model, but professionals wanting to adapt it to UK use would need to take careful stock of the theological ideas behind the different activities to create a meaningful version. This is something that the Mental Health Chaplains at Birmingham and Solihull Mental Health Foundation Trust have already begun to create.

The second model, the 'Twelve steps', draws on the success of Alcoholics Anonymous' 'Twelve Step' approach and follows a similar pattern (see appendix 11). It offers the

[604] As discussed in 2.3.4.

[605] Examples include: building a wall and then discussing what 'walls' patients build up to protect themselves; a tree of life activity to consider the difference between 'living' and 'surviving'; and discussion around items which symbolise the things that are most important in the women's lives. More controversial – and in my opinion, potentially extremely unhelpful - is the 'body image exercise' which entails a group member standing in the centre of a circle and imagining everyone judging the parts of her body she hates the most (with the ultimate aim of accepting compassion from others). Richards, Hardman and Berrett, *Spiritual Approaches*, 133-149.

[606] For example, the authors suggest 'confronting messages of the devil', assuming a literal belief in the devil. Such exercises would need adapting for more liberal patient groups who may believe that the 'devil' is merely a personification of evil rather than a literal being.

possibility for patients to consider, in a safe group environment, issues around identity, God, control and shame and is more ecumenical, allowing for a broader patient demographic, than the Center for Change's spirituality group. It can be particularly helpful in providing a concrete path to recovery, and a support group for outpatients or those recently discharged.[607] However, such an approach strongly implies the eating disorder is a fault or shortcoming of the patient (in steps 4, 5, 6, 7, 8, and 9).[608] Although for some patients this may motivate them to make healthy choices and take responsibility for their own recovery, as my study has shown (5.1), for others the suggestion that anorexia is a 'sin' rather than a non-volitional illness can be damaging, and thus I would counsel that such an approach should be used – if at all – with great caution.

The second model for a theistic treatment model has also emerged from the US, this time from the Remuda Ranch treatment centre in Arizona. Like the Center for Change, it is an all-female treatment centre, and the book setting out its theistic treatment model is written by clinical staff of the centre, with chapters from a range of clinical practitioners including medical doctors, psychologists and specialist nurses. [609] Interestingly, two of the primary authors of this model have written a critical review of the model presented by Richards et al. In the review they support the authors' stance

[607] Richards, Hardman and Berrett, *Spiritual Approaches,* 203. C. Johnson and R. Sansone, "Integrating the Twelve-Step Approach with Traditional Psychotherapy for the Treatment of Eating Disorders," *International Journal of Eating Disorders* 14, no.2 (1993): 121-134.
[608] These steps include admitting 'wrongs' to God and allowing God to remove 'defects' of character and shortcomings.
[609] Edward Cumella, Marian Eberly and David Wall, eds., *Eating Disorders: A Handbook of Spiritual Treatment* (Nashville, TN: Remuda Ranch, 2007).

on the importance of a spiritual dimension in eating disorders treatment, but raise concerns about the details, for example, they argue that the 'false beliefs' of eating disorders set out by Richards et al is over-simplified.[610] Arguably, although this is undoubtedly true, this is potentially due to the restrictive nature of explaining them concisely rather than any deficit in understanding the issues. There are three primary criticisms of the Center for Change's model that come through in Wall and Cumella's review. The first is that they are concerned the authors do not recognise that their model is tied to their own denomination and is by no means as ecumenical or applicable to other populations as the authors have suggested. This is a pertinent criticism, but perhaps to be expected as the model was created within the context of, and for, a Mormon hospital. It is also ironically a criticism which could equally be levelled at Cumella, Wall and Eberly's own model. As I have written earlier, although this does limit the model in its effectiveness, it by no means renders it worthless, and I would recommend that eating disorders chaplains could – with caution – use it as a starting point to adapt to their own context.

The second criticism is Richards et al's repeated call for patients to 'follow their hearts'. Ward and Cumella rightly point out that requiring damaged and vulnerable mental health patients to listen to their hearts is a dangerous path, noting that Richards et al do not explain how they teach patients to differentiate between their heart and their learned beliefs and behaviours and the voice of their illness. Although Wall and Cumella

[610] David Wall and Edward Cumella, "The Spirit is Willing but the Flesh is Weak," *PsycCRITIQUES* 52, no.8 (2007), https://doi.org/10.1037/a0006940.

seem to have missed that Richards et al use 'heart' synonymously with 'soul', and thus some of their examples are misaligned, their overall point that this could be a dangerous path is valid.

Finally, Wall and Cumella raise concerns that the Center for Change's model does not always align with clinical guidelines and ethical issues are insufficiently considered. They raise safety concerns about the model. One example the authors highlighted was the group exercise that I have already cautioned against, in which the patient stands in the centre of a circle and imagines everyone staring at her body. Although I would certainly agree with Wall and Cumella that there are ethical issues with the model, their primary criticism is the authors' view of human nature, which they claim is not consistent with evidence-based knowledge of eating disorders, and too firmly rooted in the Mormon context. This is indubitably a valid criticism, however, it is likewise one which could be levelled at their own alternative model. They frequently cite lack of consistency with 'evidence-based' knowledge; however, their model falls at the same hurdle, as they shoe-horn their own belief values into the evidence base in an artificial manner.

Turning to the Remuda Ranch model, the authors begin with an explanation of their belief that the traditionally understood 'bio-psycho-social' model for the etiology and treatment of anorexia should be expanded to a 'bio-psycho-social-spiritual' model on the basis of research that has emerged over the past decades.[611] This assertion is well-

[611] Edward Cumella, "Completing the Model: Bio-Psycho-Social-Spiritual," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 15-24.

justified by the evidence (see Chapter 2). They go on to explain that even the standard 'bio-psycho-social' model should be understood in 'Christian' terms, setting out a trichotomist point of view and suggesting that the body-soul-spirit corresponds with bio-psycho-social. The obvious problem here is – despite having criticised the Center for Change for being too denominationally specific with their theology – they are assuming (and indeed stating outright) that all Christians hold a trichotomist view. Wall and Eberly set out four Biblical factors in eating disorders development, and these are again rooted in a very particular brand of theology, despite the authors claim that they are 'interdenominational'.[612] All four factors are based on the concept of a literal Fall which has caused humans to be broken and damaged: the body is vulnerable to abuse, genetics and the environment as a result of the Fall; the soul is in tune with the Fallen body and so views the world through a corrupted lens; the social aspect is that due to the Fall there is pervasive sin throughout the world manifesting in this context as abuse, unrealistic body image etc; and finally the spirit is separated from God by the Fall and needs restoration. Although there is some mileage here in a metaphorical sense, this model too is deeply rooted in the conservative theology of its provenance – the Southern United States, and would need a great deal of rethinking to serve its purpose in the UK.

The authors describe their treatment model as encompassing spirituality – and specifically, their brand of Christianity – in every aspect of treatment. Like the Center

[612] David Wall and Marian Eberly, "Four Biblical Factors in Eating Disorder Development," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 27-34.

for Change, the spiritual element of the therapy is carried out by mainstream counsellors and psychologists, all of whom must be Christian. From a UK perspective, the treatment manual is unusual, as it seems to attempt to justify medicine and science from a Biblicist perspective suggesting that the target audience for the model is devout conservative (even fundamentalist) Christians with a suspicion of medicine and psychology. This is the opposite situation to the UK, where it is Christianity and spiritual interventions which are viewed with suspicion, and thus makes this manual less applicable. It is interesting the authors feel the need to scientifically justify prayer via studies, which might suggest the book aims to bring together sceptical scientists and sceptical Christians – throughout the book the authors are trying to justify treatment by the Bible, rather than vice versa. The manual goes through each of the four elements – bio-psycho-social-spiritual – describing how their treatment regime addresses each. For the first three, bio-psycho-social, the authors justify their use of standard medical and psychological interventions with Bible quotations (for example, the use of pharmacology is justified with a quotation from Billy Graham, Matthew 26:41 'the spirit is willing but the flesh is weak' and James 1:17).[613] All these interventions are also adapted to be biblically-centred.

In some cases, the biblical angle offered suggests some excellent reflections and motivational tools for Christian women in treatment for eating disorders: for example, Carr, Zuercher and Eberly talk about nutritional support for eating disorders sufferers, and reflect on the support Christian women may gain from Psalms such as Psalm 23,

[613] Kevin Wandler, "Psychopharmacology in Patients with Eating Disorders," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 69-90.

recognising that sufferers often have a genuine fear of food.[614] Similarly, the emphasis on being 'fearfully and wonderfully made' (a quotation that also arose in my study as a motivation for Eloise) and helping women to find an identity as children of God rather than disciples of anorexia offers a powerful tool for recovery. In other cases, the authors seem to liberally sprinkle Bible quotations out of context and unnecessarily in order to appease their audience, as if everything must in some way be pinned down to a literal understanding of this text – for example, the quotation from Matthew 26:41, about temptation, is not referring to modern medicine. One particular chapter concerned me, in which the author argued for the need for 'Christian CBT' as opposed to just 'CBT' (Cognitive Behavioural Therapy).[615] The treatment facility had adapted traditional CBT, and omitted elements, in order to create a 'Christian' version. In simple terms, CBT considers irrational thoughts and rationalises them to create a new 'schema', for example, an anorexic woman might have the irrational thought that 'if I eat this jacket potato I will blow up like a balloon'. CBT would encourage her to re-form this rationally 'if I eat this jacket potato, realistically it will have no impact on my body shape, it is fuel for energy'. The author suggests offering a new schema based on 'Gospel truths' based around promoting a new identity in Christ, rather than an identity as an anorexic, and in and of itself appears a very positive framework – however, I am concerned as to why this is in place of traditional CBT and rationalising thoughts about food rather than as well as. There seems to be a need from the authors to link every single element of

[614] Janet Carr, Juliet Zuercher and Marian Eberly, "Nutrition Issues in Eating Disorders: Philosophy, Assessment and Treatment," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 91-106.
[615] David Wall, "Cognitive-Behavioural Therapy with Eating Disorders: Foundations," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 109-119.

therapy to a Bible verse, and my concern is that this means that helpful strategies may be lost. As several of my participants noted, for them the Bible was a 'double-edged sword' (Eloise) with passages which could be construed as a call to recovery, or a trigger for self-starvation and asceticism, for example, 1 Corinthians 6:19 'Your body is a temple of the Holy Spirit, therefore honour God with your body' which Cat described as a 'catch 22'. Such a literal approach to the text presumably does not recognise the potential damage that reading certain parts of the Bible with a literal view can cause for people with eating disorders (as noted by Tracy, Eloise, Deborah, Cat, Rose and Brigid).

A chapter by Eberly explains the reasoning for a Christian treatment programme: she points out there is extensive research on the links between spirituality and mental health, and also that 88% of the population of America identifies as Christian.[616] She argues that for Christians, God permeates every aspect of life so cannot be neglected in treatment. There is a great deal to justify the treatment approach, and arguably, for the demographic of their patients a biblically-based model rooted in conservative evangelical Christianity is exactly what is needed. Some of Eberly's other assertions are less justifiable: she attempts to pre-empt criticism of the model which has health care practitioners engaging in spiritual treatment approaches, rather than enlisting the assistance of religious leaders and pastoral workers. She suggests that criticism of such a model must come from people who have not considered or understood the need for spirituality in eating disorders treatment. This entirely denies the existence of (or

[616] Marian Eberly, "Bringing the Spiritual into Treatment," in *Eating Disorders,* ed. Cumella, Ebery and Wall, 211-220.

perhaps does not even recognise) people like me who feel it is an essential dimension, but should be done in partnership with mental health professionals by trained chaplains. This is perhaps less important in a more homogenous demographic where medical staff need only 'educate themselves' (as she worryingly describes it, raising the question as to who oversees the reliability and validity of this self-education) in one or two denominations, however, there are still ethical concerns around role confusion and overstepping professional boundaries. Eberly also gives an unsatisfactory answer to the question 'what of non-Christians?' Initially she asserts that Remuda Ranch is a Christian treatment facility, and that all patients are exposed to Christian beliefs and must 'assent to our holistic model'. Those who do not, may look elsewhere for treatment. However, on the next page she suggests that they respect other beliefs and boundaries set by patients who do not wish to be exposed to Christian beliefs, citing that patients of other religions have felt themselves renewed. These two statements are obviously contradictory, and leave the question 'what of non-Christians' entirely unanswered. Indeed, I would also ask 'what of Christians who do not follow a literal interpretation of the Bible?', however, the authors seem ignorant that this might even be a question.

The practicalities of the spiritual aspect of the treatment model are described by Cumella, Darden and Eberly, and include many of the same elements as the model offered by the Center for Change: a thorough spiritual assessment on admission; teaching spiritual concepts; spiritual bibliotherapy; prayer with patients; meditation;

cognitive restructuring (e.g. images of God); and encouraging forgiveness.[617] Many of these clearly are the role of a religious leader or chaplain, rather than the role of a psychologist, and there is no doubt in my mind that some boundaries are being blurred. However, the authors also call for liaison with their patients' pastors, in particular to support them after they are discharged, recognising the importance of a supportive community in recovery – the value of this, I believe, cannot be underestimated. Cumella also offers a helpful chapter exploring issues that arise from religious abuse, and how this can manifest as an eating disorder.[618]

To summarise, the manual offered by Remuda Ranch suffers from many of the same issues as that offered by the Center for Change: they are rooted firmly in their own context, so should always be considered carefully and adapted by experienced chaplains for use in their own context rather than taken at face value. It is concerning that both sets of authors do not recognise this in their own work – indeed, I would suggest that Cumella et al, despite criticising Richards et al, are even more prone to this. Both models offer some helpful suggestions, such as a spiritual assessment, the use of spirituality groups and restructuring damaging religious ideas (e.g. the need to work for one's salvation, believing God to be vengeful and punishing). However, in my opinion, the most serious issue in both models is the lack of input from a chaplaincy team. The models suggested risk not only role confusion and boundary blurring for healthcare professionals, but also imply that the necessary theological and spiritual elements are

[617] Edward Cumella, Robert Darden and Marian Eberly, "Spiritual Assessment and Treatment Strategies," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 235-244.
[618] Edward Cumella, "Religious Abuse," in *Eating Disorders,* ed. Cumella, Eberly and Wall, 245-254.

easily self-taught by any psychologist – which means that they will inevitably be less nuanced, over-simplified, and at risk of being even more damaging to the patients' wellbeing.

5.4.2.2. RECOMMENDATIONS

It is noteworthy that, despite great advances in the field of mental health chaplaincy, NHS guidelines remain vague. New guidelines published in 2015 on chaplaincy aim to 'promote excellence in pastoral, spiritual and religious care' and emphasise the importance of the work of chaplains, describing chaplains as an 'essential resource' who provide 'highly skilled and compassionate pastoral, spiritual or religious support for patients, carers and staff'. The guidelines make clear that chaplaincy has an important place in the NHS, and that it is wider than merely offering a 'religious' service. Beyond this, however, the guidelines predominantly focus on administrative details, and the one page dedicated to mental health chaplaincy merely (albeit usefully) details the number of hours for which a chaplain should be contracted based on the size of Trust.[619]

The UK Board of Healthcare Chaplaincy maintains a voluntary register of healthcare chaplains. They also provide supervision and CPD for chaplains, advice for employers on appointing a chaplain, and in 2020 published profiles of Competences and Capabilities expected of different bands of chaplain.[620] It is an expectation of chaplains that as part

[619] "NHS Chaplaincy Guidelines," NHS England, 2015, https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf.
[620] "Spiritual Care Competences for Healthcare Chaplains," UK Board of Healthcare Chaplaincy, 2020, https://www.ukbhc.org.uk/wp-content/uploads/2020/10/UKBHC-CCs-180220.pdf.

of their professional practice they will remain up to date on developments in their field in order to fulfil their duties to the highest standards. This enables the chaplain to research in greater depth the conditions and life events faced by the patients that they work with; for example, a hospice chaplain should have an excellent grounding in research and practice relating to end-of-life care, whereas a mental health chaplain would focus primarily (although not exclusively) on the challenges faced by their patients, for example issues concerning self-harm, suicide and eating disorders.

The success of this system relies on various factors. Firstly, workload. Even if we optimistically assume that all healthcare chaplains are indeed academically capable and up to date with their reading despite the demands of everyday work, the depth with which they will be able to pursue particular lines of chaplaincy will vary depending on how many different wards and specialties they cover. For example, the Birmingham and Solihull Mental Health Foundation Trust where I undertook my research, as a large mental health trust, had a number of chaplains who were not only all mental health specialists but took on key responsibility for specific wards themselves (e.g. dementia, eating disorders, post-natal etc). As a result of this, the Trust has a well-organised and efficient spiritual care team, many of whom are engaged in further research. It is also worth noting that the chaplains are considered a part of the clinical team, and contribute to patient notes as part of a multi-disciplinary treatment approach, as is advocated by Lucy Grimwade and Christopher Cook.[621] At the opposite end of the spectrum, in many

[621] Lucy Grimwade and Christopher Cook, "The Clinician's View of Spirituality in Mental Health Care," in *Chaplaincy and Spiritual Care in Mental Health Settings,* ed. Jean Fletcher (London: Jessica Kingsley Publishers, 2019), 31-44.

trusts there may be only a few chaplains who are covering not only every specialty within mental health, but also general hospital chaplaincy and palliative care. Despite the optimistic nature of the NHS guidelines, as Swinton points out, often chaplains are merely 'tolerated' as 'acceptable background noise' rather than considered an integral part of the treatment team.[622]

Secondly, the information must be available in the first place. As I have outlined, there is much written on mental health chaplaincy in general, but less written on specific disorders. The research there is either comes from a US context, or is from the perspective of psychiatrists and psychologists rather than chaplains. Fletcher's recent publication *Chaplaincy and Spiritual Care in Mental Health Settings* offers not only a general overview of mental health chaplaincy, but also further chapters concerning mental health chaplaincy in specific contexts, for example, psychosis and self-harm. This is exactly the sort of resource that is needed, however, thus far there are no specific resources of this nature for eating disorders chaplaincy in a UK context.

On the basis of the experiences of my participants and the models that have thus far been offered in publication, I would suggest that there is the necessity for similar resources and guidelines for chaplains working in the field of eating disorders (specifically anorexia) for use in NHS and private facilities in the UK – and, ideally, further training. Such a framework would need developing, testing and monitoring in practice with a larger participant pool. However, based on my research I offer the following

[622] Swinton, *Spirituality,* 41.

initial suggestions for such a framework. As this is intended to complement and add to existing models of mental health chaplaincy, I have set out my recommendations in the form of the CRISP model.

General recommendations for eating disorders chaplaincy:

- Mental health chaplains should work alongside colleagues as an integral part of a multi-disciplinary treatment team.[623]
- The spiritual element of the treatment programme should be led by a trained mental health chaplain, in partnership with HCPs (with one named HCP as the liaison point to advise and support the chaplain) and religious leaders/chaplains of other denominations or religions as necessary.
- Medical practitioners should not be put in a position in which there is the possibility to blur boundaries or cause role confusion, neither should they feel that they must discuss faith matters beyond their own expertise due to the incorporation of this treatment model. Of course, individual therapists may feel it is relevant to their own patient's treatment to discuss their faith as part of 1:1 therapy (as is the practice currently), and they may wish as part of this to discuss the patient's experiences or progress in the spiritual elements of the treatment programme.[624]

[623] As advocated by Grimwade and Cook, "The Clinician's View."
[624] This is of less relevance in an NHS context, however I have included it as a response to the US frameworks discussed in 5.4.2.1.

- A sensitive spiritual needs assessment or history should be carried out. Examples of possible tools for this can be found in the BSMHFT handbook.[625]

Cultural:

- Eating disorders patients will need additional sensitivity surrounding cultural dietary practices, particularly those that relate to fasting. The chaplain should work alongside other members of the team (e.g. dieticians) to ensure that cultural requirements are catered for in a safe and appropriate way.

Religious:

- A spirituality group should be offered, suited to the religious demographic of the ward to discuss issues such as spirituality and identity. Depending on the religious demographic of the ward, this could also include looking at images of God, questions of anorexia and sin, and intrinsic and extrinsic religious practices.

Individual:

- Chaplains should offer 1:1 sessions (which could be based around working through and restructuring damaging ideas, or spiritual bibliotherapy, or identity) suited to the specific religious needs of the patient. Liaison with other relevant chaplains or religious leaders may be necessary.
- As with other mental health patients, prayer should be offered (if possible, by a chaplain of the same religion/denomination as the patient).

[625] "Handbook of Spiritual Care," BSMHFT.

Spiritual:

- The patient should be enabled to attend worship at least once a week, and, if they wish to do so and it is appropriate, as they near recovery should be supported to attend their own church or other place of worship if it is near enough. In situations where religious abuse has taken place, this is clearly contraindicated.
- The aforementioned spirituality group may discuss more general spiritual issues such as self-worth, and could support patients to make connections with nature and find time and space for reflection.

Pastoral:

- The chaplain should support the patient and their community in preparing for discharge. If appropriate and if they desire to do so, the patient should be supported to maintain links with their own faith community during their time in hospital.
- The mental health chaplain should liaise with the patient's community leaders and offer support and advice (outside the clinical context) in preparation for the patient's discharge in order to support them in their recovery when they return home. This might be in terms of practical advice (e.g. how to approach church lunches or Holy Communion) or in terms of exploring religious images which have exacerbated the patient's disorder.

5.4.3. UNIVERSITY CHAPLAINCY

As the vast majority of my participants had suffered from their illness during late teens and early twenties, and all had attended university except Grace, it is unsurprising that the subject of pastoral care in a university context came up. Of the women, Deborah, Cat, Clare and Rose had been at an acute phase of their illness whilst at university and they spoke of their different experiences of pastoral care from university chaplains. Of the four, Cat, Clare and Rose are (or were) Roman Catholics. Clare stood out from the others as she attended university in the 1970s, whereas the others all attended university in the 2000s or early 2010s. Rose was a US participant.

It was interesting that Rose found attending a Catholic university decreased rather than increased level of pastoral care: although she found comfort in attending Mass in College each evening, there were no house-groups or pastoral structure as you would find in a typical church community, and she felt that had she been attending a 'normal' church at the time there would have been more support available. Rose did not mention a university chaplain at all during our interview.

The other three participants all spoke of their experiences with university chaplains, but Deborah is the only one who speaks positively about it: she felt able to speak with the Methodist chaplain at her university, despite at that time being unready to seek medical treatment or accept counselling via the university. This is an important insight into the role of chaplains in eating disorders in supporting sufferers during the time before they become ready to seek treatment – a very difficult and pivotal time during their illness.

There are three points that stand out about Deborah's experience of university chaplaincy: firstly, that she felt upheld by prayer and support, not just from the chaplain himself but from the wider MethSoc and church community. Secondly, that she had a good relationship with the chaplain and was able to speak with him about the difficult things that were happening in her life. Thirdly, that in the questions he asked and the book he lent her, he recognised the distorted images of God which she held after her experience at her previous church, and he gently helped her explore these images and reconstruct how she viewed God. This was not done by telling her what to believe or telling her she was wrong, but by guiding her and walking beside her as she worked through these beliefs for herself. It is a testament to his pastoral care that after recovery she could remember some of the exact questions he had asked her, and the book he lent her that helped her reconstruct her image of God (*Good Goats: Healing our Image of God'*) she credited as a turning point in her recovery.

Neither Clare nor Cat had a positive experience of university chaplaincy. Cat's experience in her college seemed almost entirely negative. It is an indication of the importance of both reputation and relationships that Cat's college chaplain was nicknamed 'Satan' and had a reputation amongst the students for sharing confidential information. It is apparent from the incident with Cat's flatmates that she overstepped boundaries, and also did not – and in Cat's view, was unwilling to try to – understand the black humour Cat employed to deal with her mental health difficulties. Although the chaplain did not deal with the situation with the required tact and sensitivity, when reading Cat's story it becomes apparent that by the time the chaplain arrived at Cat's

bedside in hospital there was very little she could do – Cat, already vulnerable, had heard of her reputation for gossiping and I felt there was very little that would have enticed Cat to confide in or trust her at this point. It is astonishing that a chaplain dedicated to a university population – vulnerable young adults recently left home – could have quite so little tact or apparent understanding of mental health (although of course we only view her through Cat's eyes) and this case study underlines the need for continuing professional development of chaplains which is specific to their working environment and the demographics of the people in their care.

Clare likewise was not entirely complimentary about her university chaplain, although her perception of him was more three-dimensional than Cat's. Clare, like Rose, sought comfort in attending daily Mass, and was very involved in the Catholic chaplaincy. She described the chaplain as a 'lonely' man, and her description of her glimpse into his cell-like bedroom whilst looking for the bathroom at his house seemed like a glimpse into his soul. Clare was aware that the chaplain did not have much understanding of anorexia – unsurprising in the 1970s – and she felt he found her 'difficult'. It would be possible to criticise the chaplain for letting his feelings about this show, but it is worth noting in his defence that firstly, this is only Clare's perception of how he felt about her and may not be true, and secondly that Clare seems to have been a remarkably perceptive young woman.

Although Clare did not find his pastoral care helpful (albeit more helpful than the college doctor), from an outside perspective he did seem to try hard: he gave her books of

Psalms to read to uplift her and invited her and others to his house for a meal every week at which she would eat properly. In the circumstances, as a celibate man in an age when anorexia and female body image were not as widely discussed as they are today, it sounds that although pastoral care was undoubtably inadequate, he did the best he could and fell short by no fault of his own. This is, perhaps, a limitation with having pastoral care to university students, male and female, supplied only by celibate males – although it is worth noting that Deborah's excellent chaplain was also male, albeit with a wife and teenage daughter of his own. Nonetheless, with a more thorough understanding of what Clare was facing, and some training or literature on mental health chaplaincy, the chaplain in this case may well have been able to find his way.

In this discussion I have not mentioned school chaplaincy thus far, primarily because none of my participants had any experience of it. Although there are of course differences in school and university chaplain (not least the age of the students and their living situation/involvement with parents), it is common sense that with a rising mental health crisis amongst teenagers, school chaplains will have similar training needs to university chaplains in this area.[626]

[626] Statistics published by the NHS in 2018 demonstrate rising rates of mental illness in children and teenagers, with a headline figure that 1 in 8 young people have at least one diagnosed mental health disorder. "Mental Health of Children and Young People in England, 2017," NHS Digital, published November 22, 2018. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017. A pre-release of 2019-20 data to the press showed that inpatient eating disorders admissions for under 18s was up by 19% in comparison to the previous year. Yohannes Lowe, "Hospital Admissions for Children with Eating Disorders rise by a Fifth in England," *The Guardian,* December 29, 2020, https://www.theguardian.com/society/2020/dec/29/hospital-admissions-for-children-with-eating-disorders-rise-by-a-third-in-england.

5.4.4. CHURCH COMMUNITIES

The role of the church community in supporting sufferers of anorexia as experienced by my participants can be broadly split into three categories: the role of worship; the role of the clergy; and the role of the wider church community.

Attending worship was important for all participants in my study in a variety of ways. At the most negative end of the spectrum is Clare's reflection that she liked going to Mass because it made her feel 'good' (i.e. moral): for Clare, there seemed little actual spiritual benefit in attending Mass, rather it was a mechanism by which she could appease the guilt and shame which surrounded (and fuelled) her eating disorder. However, Clare is in the minority in this, and all other participants described finding comfort in attending worship. For some, like Brigid and Cat, it was the familiarity and ritual which they found so comforting – as Brigid described it, holding the wafer at Mass was like 'holding on to a little piece of my background'. For both Brigid and Cat, ritual was extremely important (unsurprising as both had co-morbid diagnoses of OCD), and the predictable patterns of liturgy, music and sacrament offered a space for quiet, reflection and escape from the turmoil of their illness. Even though Cat found difficulties in Mass, with its central focus on food and her struggles with the potential for germs both in the chalice and the holy water, Mass was still a source of comfort to her. Rose, the fourth Roman Catholic in the sample, likewise attended Mass every day during her illness and found doing so a comfort.

Amongst the other denominations represented in the study, both Deborah and Mhairi found peace during their illness in the beauty of Church of England evensong. For Deborah, at this stage the anonymity of cathedral worship was what she needed rather than an overwhelming church community, and for Mhairi the worship of her Anglo-Catholic tradition offered her a glimpse of the transcendent – not as something far removed from her immanence, but as something inspiring and beautiful that pointed beyond itself. Interestingly, it was those participants attending churches with a 'high' style of worship who tended to talk more about the role of worship as a comfort, whereas those attending 'low' churches tended to gravitate more towards discussion of people in the community or Bible texts. This may be a reflection of the emphasis in some Protestant churches on the Ministry of the Word over liturgy, and it is perhaps natural that people who choose to attend 'lower' churches that focus more on the Bible may themselves focus on the Bible.

It is worth briefly considering Tracy's situation in a discussion on worship: Tracy was attending the ecumenical service in the hospital chapel, and did not identify as a Christian herself, although she did reflect that she retained a Quaker outlook on human nature and divinity. Tracy's ability to gain comfort and meaning from the services did not seem to be restricted by this. She articulately recounted the recent preaching in the chapel, and created her own moving reflection on the story of Jesus calming the storm, applying this to the torrent raging inside her and the possibility of letting go of the storm. Tracy's comfort from religion was not restricted to her encounters with the Christian

church, but was also found in the sharing of Karah Parshard at the Sikh Gurdwaras she visited, which she described as a 'blessing'.

Turning to the second element of the support (or lack of) from the church community, it was interesting how few of my participants mentioned the clergy of their churches having any involvement in their pastoral care at all. Clare mentioned the priest speaking to her mother and encouraging her mother to go home and support her, but made no reference to the priest offering any pastoral care directly to her. Although Brigid did not mention pastoral care from her priest, she was given – and greatly appreciated – the sacrament of the Anointing of the Sick before her admission to hospital, which was presumably undertaken by a priest. This lack of pastoral care may in some cases be due to a shortage of clergy and the ensuing reduction of personal pastoral visits as workloads increase, or a church structure in which pastoral care is undertaken by house groups, elders or pastoral visitors who can vary in both training and commitment from excellent to insufficient. In others it may be due to the involvement of a designated university chaplain. It may in some cases be due to an inefficient church leader, or due to the sufferer putting up barriers (as Cat did) and isolating herself from the community, including the church leaders.

The most positive experience of ministerial care was cited by Deborah, who wrote of her Minister supporting her throughout her illness, and encouraging her to engage in medical treatment. She also spoke of the early morning Communion which she went to on the day she began treatment, and the comfort she gained from that service. Her

Minister seems to have gone above and beyond her duties. It is unsurprising that Deborah's overriding emphasis was the importance of compassion and 'walking alongside' sufferers – compassion, support and walking alongside is something that both her Minister and church community did with grace and love, to the best of their ability. Eloise experienced both positive and negative pastoral care at two different churches, although she primarily spoke about other members of the congregation rather than the pastor/vicar. It was intriguing that when she spoke positively of pastoral care from the Church of England church she was working at and their continuing support via letter during her time at Mercy Ministries, it was not the vicar who maintained contact, but his wife. Whether this is because anorexia is seen as a 'women's disorder' or whether it was simply a case of a good relationship between Eloise and the vicar's wife is unknown.

Some participants spoke of teaching in their churches which in some ways contributed to their illness. Although further postdoctoral study is required to analyse the full depth of this, it is worth briefly pointing to Deborah, who traces a causal factor in her illness back to the teaching of a leader in the evangelical megachurch she attended concerning sin and the emphasis on how undeserving and worthless we all are. Similarly, Tracy's concerns as a semi-outsider to the church on the domestication and even glorification of self-harm and penance in some church teachings, notably around the crucifixion, should sound as a warning for preachers and church leaders to consider carefully the impact of their teaching and the potential for misinterpretation, particularly when they are preaching to a vulnerable group (for example, youth leaders, university and school chaplains).

Many participants had positive experiences of support from their church community: Deborah felt supported in prayer and encouragement by other members of the church as much as she did the Minister; Tracy, although she had not experienced a church community as such, spoke of the support a friend had found in her church; Brigid speaks of friends meeting her before Mass to say a rosary for her recovery. However, supporting an anorexic fellow church member is an extremely difficult path to navigate, and it is unsurprising that many fellow congregants made well-meaning mistakes. The difficulty of the situation is highlighted in my discussion with Deborah, in which she said that she felt that at times it would have helped to have someone say something about her eating habits, and at others it would not – it is impossible for an onlooker to know how to act in each situation, especially an onlooker who has no experience or in-depth knowledge of anorexia, as many of course do not.

The difficulties participants found in their church communities can be summarised thus: firstly, the stigma which surrounds eating disorders and the taboo of talking about them. Deborah was not the only participant to mention that her fellow church members saw her struggling and were 'too polite' to say anything. Grace spoke of how the topic of eating disorders was never spoken about in her church, and after she gave testimony she suddenly found many people wanting to talk with her about their own struggles, or their loved ones illnesses, which had never before been mentioned. Likewise, Rose noted that the only people to speak to her about her serious weight loss were her room-mate and her mother. It was interesting that US participants talked about the stigma of

eating disorders in society in general; whereas UK participants seemed to feel that the stigma they encountered was predominantly in church circles. Within these church environments, the stigma of eating disorders seemed to stem from the perception which people have of them as not just illnesses, but as sin, or even demon possession, as discussed in 5.1.

This stigma and suggestion of sinfulness or even demon possession was particularly pertinent in Eloise's narrative, in which the question arises: who pastors the pastor? Eloise, as a leader in the church, found it extremely difficult to maintain her role as well as her illness due to people's perceptions of it. She felt accused that she was not keeping things in perspective ('God is bigger'), or that she was ill due to not being sufficiently close to God, or as sin. She spoke twice in our discussion about people expecting her to 'step down' due to their expectation that a church leader could not be hurting or broken, and had to have life 'sorted'. Some of this may be exacerbated by her own low self-esteem, but as she received many direct comments to this effect, it is clear this was a general ethos in the evangelical church she worked in before moving to the Church of England. This perception that the leaders cannot be 'broken and hurting' creates a paradox with Deborah's experience at an evangelical mega-church that everyone had to have a problem in order to be saved – the crucial point is that everyone except the leaders had to have a problem, and established members of the church (including leaders) were meant to have been seen overcoming that problem by God's grace as a sign of spiritual maturity and worthiness. The role of pastoral care of those in ministry, whether lay or ordained, is important and provision can vary between denominations.

The second issue which participants came across in their communities was the phenomenon of – in Grace's words – 'Band Aid Bible verses'. Eloise, Grace and Deborah were all scathing about the very common tendency of those in their community to offer a 'trite Bible verse' (Grace) and imagine that that would 'fix' them. Eloise spoke of people thinking she could just say a prayer and it would 'pick her up'. Brigid likewise experienced misunderstanding from within her church and the expectation that if she just prayed harder, tried harder, she could get over this. This is an immensely reductionist understanding (or rather, misunderstanding) of anorexia, although it is easy to see how it might come about, particularly in contexts in which anorexia is still often perceived as – at least in part – a sin. All of the participants who reported bad experiences with these kinds of comments did feel that there is a role for prayer and the Bible in their recovery as a support and a motivation – and indeed, both Eloise and Deborah spoke a lot about their reflections on the Bible as part of their recovery. However, all participants were clear that offering a Bible verse as a sticking plaster was meaningless, and the idea that prayer was enough on its own was not only unhelpful, it was downright dangerous as it could lead people to reject medical care.

Deborah was particularly concerned about the possibility that faith communities could promote faith healing or prayer as an alternative to clinical treatment: she was very clear that prayer had an important place in her recovery, but that it was not and should never be an alternative to seeking and following medical advice – rather, it is a support and a motivator in enduring that treatment. It was striking that Grace, the only participant to

have experienced a miraculous faith healing, was likewise concerned that people should not rely on this, noting that although she felt 'blessed' to have been healed such instances are rare and should never be put up against or as an alternative to seeking help via traditional medical or therapeutic routes. To do so could be to deprive someone of the chance of recovery, and thus extremely dangerous.

Finally, the third difficulty frequently discussed by participants was the role of food in the church community. Many churches offered food-related fellowship, and participants spoke of student lunches, harvest meals, cake at house groups and, of course, the impact of festivals. The church year revolves around a liturgical calendar of feasting and fasting, and this was particularly apparent in the experiences of the Roman Catholic participants. Clare, Cat, Rose and Brigid all spoke of early experiences of fasting in Lenten practice, and Cat, Rose and Brigid spoke of the difficulty they had with the feast days that followed. Cat also noted the stress she experienced due to the inescapable nature of food in Catholicism: not only does the liturgical year form around feasts and fasts, but the very focal point of every celebration is the food of the Mass. The fellowship aspect, with house groups and community lunches was mentioned more by Protestant participants, with Deborah describing an occasion on which she sat at a harvest lunch eating only a plate of cucumber. Food is often used by Christian communities, particularly in churches with high numbers of students, as a form of welcome and fellowship, especially to students away from home for the first time. This is an important aspect of Christianity, and the symbolism of food and fellowship is a powerful theological pairing. The practical value of sharing food together should not be

understated: however, those working with vulnerable populations – and particularly those working with people with known eating disorders – a certain level of caution and understanding needs to be exercised to avoid isolating them further from the church due to their fear of food.

Isolation is, even without the presence of food, a problem for sufferers of anorexia: by the very nature of the illness sufferers often isolate themselves from family and friends in order to maintain their disordered eating habits. With the stigma experienced by many participants in their churches, and the overwhelming presence of food, it is not surprising that sufferers put up barriers between themselves and their community. These boundaries were particularly resonant in Cat's narrative, as she not only had clear boundaries that she would not allow certain foods or perceived germs to transgress, but she also isolated herself from the church and felt deeply hurt when the chaplain violated her privacy. Even Deborah, the participant with the most overwhelmingly positive experience of church community and pastoral care, at an earlier point in her illness attended a cathedral purely for the anonymity she found there. It is important to recognise that sometimes these barriers are protective and should not be battered down before the sufferer is ready. However, when the time has come for these boundaries to be broken down and traversed, the church community has an important role to play.

5.4.5. OTHER CHRISTIAN MODELS OF PASTORAL CARE

During my research I became aware of two further models for Christian pastoral care for eating disorders. One of these was a self-help book *The Religion of Thinness*[627] written by Michelle Lelwica, author of *Starving for Salvation* (see chapter 2). She offers an overview of how the decline of religion has created a 'spiritual vacuum' into which the 'religion of thinness' has settled. She believes eating disorders to be a social problem and a rational response to a culture which demands thinness of women, and in this book she offers a model for resetting the paradigm and changing one's mindset. This is done by two mechanisms: Mindfulness and a cultural critique.

Lelwica offers an accessible and fascinating explanation of the factors in Western history and culture (including Christianity) which have intertwined to create the social situation in which eating disorders thrive. She takes readers through the possibilities which can be found in Mindfulness in coming to be at peace in their own bodies, and using diverse perspectives from different traditions (Gandhi, Sojourner Truth, the Old Testament prophets, Muhammad and Jesus) she demonstrates how religion once offered a liberative cultural criticism and assists readers to undertake their own cultural critique of the messages concerning weight and body shape with which they are inundated.

Lelwica shows her readers both the roots of eating disordered thinking and liberative frameworks within Western Christian traditions through the web of patriarchy that

[627] Michelle Lelwica, *The Religion of Thinness: Satisfying the Spiritual Hungers Behind Women's Obsession with Food* (Carlsbad, CA: Gurze Books, 2010).

conceals them. In picking out these strands, she guides readers through an exegesis of not only the text but religious history enabling them to reposition their own understanding of religion and the part it plays – good and bad – in our 21st century understanding of women's bodies and diet culture. Although Lelwica uses examples and memoirs of anorexia and bulimia, it is obviously also aimed at women struggling with yo-yo dieting and I would be concerned about its appropriateness for women with serious eating disorders. Her analysis within the book – by the very nature of its accessible approach – is quite simplistic, seeming to suggest that a spiritual quest, media images and patriarchy are the only factors implicated in development of eating disorders. Having read Lelwica's academic texts I suspect what she means is these are the main factors, however, that is unclear in this book. My criticisms of her generalisation of what is meant by a 'spiritual quest' in *Starving for Salvation* are relevant here: Lelwica tries to be inclusive of all religious traditions and spiritualities (hence the Mindfulness approach as opposed to a form of prayer) but in doing so becomes vague as to the actual form of this 'self-help'. Here, Lelwica notes her emphasis on Christianity and acknowledges that some women do find empowerment in reinterpreting patriarchal aspects of religions, including Christianity. Having briefly acknowledged the possibility of locating liberative frameworks in Christian tradition, she then continues regardless as if such women were a minority and that, having made this caveat, she does not need to discuss them further offering instead Mindfulness as almost the 'real' solution rather than 'another' answer. Lelwica vaguely attempts to remain fully inclusive and be all things to all people. This is not possible unless she is willing to delve further into the potential for empowerment in mainstream religion, and

to my mind, her approach would be more successful if she simply narrowed her target audience. For women who are struggling with body image and compulsive dieting who have not been able to find peace in organised religion but are searching for some spiritual meaning and acceptance of who they are, Lelwica's book is a wonderful resource. For those who are still looking for meaning and hope within their own religious tradition it is less useful, although still offers insights into the role of religion in the development of a culture of thinness. What it is not is an appropriate alternative for medical care in the case of serious eating disorders, and I am concerned that there is no explicit caveat to this effect in the book. This may stem from the circumstances in which she is writing – there are many US women, particularly those of lower income and in BAME communities who do not have access to adequate healthcare and it is clear from *Starving for Salvation* that Lelwica is keen to remove the 'white middle-class' focus from eating disorders treatment.

The second alternative model I encountered was Mercy Ministries, a programme attended by Eloise. Eloise spoke very highly of the model of pastoral care offered by Mercy Ministries and credited her recovery to her time with them. Mercy UK is an evangelical Christian charity which works with women aged 18-30 who are afflicted by life-controlling issues, predominantly eating disorders, substance abuse, self-harm and victims of sexual abuse. Mercy UK offers three key services: published resources on these topics; pastoral training and support including a helpline for church communities, families and friends; and a six-month residential programme for women at the Mercy

home. A former resident, Megan, quoted on their website describes Mercy as being 'loved back to life'.[628]

The Mercy Ministries programme is a structured regime centred around Bible study, worship, discipleship and 1:1 support and mentoring. The programme is run by Christians with backgrounds in Christian counselling, pastoral care, psychology and social work, however, Mercy is clear that it is not a medical facility and cannot offer psychological therapies. For medical issues they work in partnership with a local GP. There are many things to commend the model of Mercy Ministries: although not a medical or psychiatric facility, they are clear about their limitations and do not offer detox facilities or allow patients with a BMI below 17. It is encouraging that they work closely with local NHS services, which does much to dispel concerns such as those of Deborah who was worried that pastoral programmes can often be pitted against medical treatment rather than offered as an addition. Women on the programme are supported by an 'Accountability Partner' who is nominated by their own church leader and training and support are offered to this person by Mercy Ministries: this enables the woman in her transition back to 'real life' and means she has support in place. They also have a 'Transitional Care' team to support her during this time. In addition to Christian pastoral care, worship and Bible study, the Mercy team support residents with basic life

[628] All information about Mercy Ministries is taken either from the interview with Eloise, or the Mercy Ministry website, accessed August 22, 2019. www.mercyuk.org.

skills such as CV writing, healthy eating, fitness, budgeting and implementing healthy boundaries in their relationships to equip them for life after Mercy as far as possible.[629]

On reading the Mercy Ministries publication *Mercy for Eating Disorders*[630] the explicit perception of eating disorders as sin was somewhat concerning, given the experiences and feelings of my participants in 5.1. Mercy UK clearly follows a conservative evangelical brand of Christianity, with frequent mentions of Satan and sin. Although I am not entirely comfortable with such theological leanings, and am aware that some of my participants would have similar issues, as I have written in 5.1, sufferers' subjective understandings of the nature of anorexia can and do differ, and for some, it may be helpful to view their illness in this light: certainly, Eloise was inspired and supported by her time at Mercy Ministries and I am thus wary of dismissing their work due to my own theological objections. It is worth considering that those choosing to enter a Mercy residential home are likely to be those of an evangelical background who share those beliefs, and it is noteworthy that 91% of their previous residents report that they were satisfied or very satisfied with their experience. It is perhaps difficult to square such acceptance of subjectivity and the right to understand one's illness in whichever way the sufferer finds most helpful (not least because often they are competing 'objective' beliefs about sin, illness or demon possession) with the recommendation of psychologists to challenge and re-calibrate unhelpful and damaging religious beliefs (for

[629] "The Mercy Home," Mercy Ministries, accessed February 20, 2021, https://www.mercyuk.org/residential-home.
[630] Nancy Alcorn, *Mercy for Eating Disorders* (Franklin, TN: Providence House Publishers, 2003). Published online 2007, https://www.mercyuk.org/resources//s/mercy-for-eating-disorderspdf.

example, about the nature of God[631]). Such an assertion also suggests there are objectively 'right' and 'wrong' beliefs about God – which it stands to reason if one believes in an objective God, He/She must have an objective nature. However, at such a stalemate, perhaps the truly Christian response in this situation is to recognise, in humility, that although we each hold our own beliefs firmly, ultimately what is important is walking alongside sufferers as they find their own path to recovery – spiritual and physical.

Mercy Ministries may well be a prototype for the future: as an eating disorders chaplain said to me, as NHS cuts become more stringent, increasingly more is being asked of the church and other charities in supporting those with mental health difficulties.[632] The ideal is, perhaps, a medical or psychiatric facility with a team of trained mental health chaplains; however, this is probably not a realistic goal in the current climate of austerity. At the eating disorders unit where I undertook the first phase of my research, patients told me they had not been admitted until their BMI dropped to around 11 or 12 due to a shortage of beds. Mercy Ministries is offering a possibility of help through compassion of being 'loved back to life' to those with BMIs which would not put them in the range for NHS inpatient treatment. It may be that more homes such as these – ideally with on-site medical and psychological care – may be the way forward for eating disorders chaplaincy.

[631] Marsden et al., "Spirituality and Clinical Care," 7-12. See 2.3.1.
[632] Reverend Julia Babb, in conversation, April 8, 2017.

CHAPTER 6: CONCLUSIONS

6.1. KEY FINDINGS

I began this thesis with presuppositions based on my own experience and initial reading. Many of these suppositions were supported by my fieldwork. Others were brought into question. I intended to explore further the nature of the link between anorexia nervosa and Christian faith, specifically in the case of Christian women. I anticipated that there would be aspects of Christian faith that encouraged or worsened disordered thinking, such as guilt and Christian female identity, and that there would also be aspects of Christian faith and practice that could aid recovery, such as belief in the value of human life, the promise of salvation and a compassionate and supportive community. These assumptions were demonstrated to be well-founded.

I wanted to explore in further depth the place of pastoral care in supporting Christian women with anorexia, both in an inpatient setting and in the community. As I had expected, my research illustrated that pastoral care can be extremely helpful when done well. However, it appears my initial concern that well-meaning pastoral care from church leaders who know little about mental illness can also be damaging was substantiated.

At the start of this research, I expected to see denominational differences in women's stories. I expected certain traditions would exacerbate different aspects of disordered thinking and behaviours, and to different extents. I also suspected the teachings of more

conservative traditions would put more barriers in the way of recovery than theologically liberal traditions.

This hypothesis turned out to be both true and false: there were certainly elements of teachings emphasised by the women's specific denominations evident in their stories, both in the exacerbation of their illnesses and in the support for their recoveries. I was struck that two of the Roman Catholic participants had co-morbidities of OCD, and that all the Roman Catholic participants spoke of guilt and shame more than others. Participants with evangelical influences in their backgrounds spoke of purity and sin and tended to view anorexia as a sin or something external rather than an illness. Roman Catholic participants, with the central focus of worship on the Mass, found the issue of the bread and wine more central in their concerns. The way in which participants interpreted the Bible also affected their understanding of God and impacted on their illness and recovery. For participants with a liberal interpretation of the Bible, there was no tension between the angry God of the Old Testament and a compassionate, loving God – because the Bible is a human interpretation of God, not necessarily God's direct and infallible revelation. For participants with a more conservative or even fundamentalist interpretation, the narrative of an angry and punishing God had to be reconciled with a view of God as merciful and loving towards them.

Two unexpected elements came out of the narratives. The first was the story of Grace's 'healing' which is located in the grey area between 'healing' and 'exorcism'. I was – and still am – both sceptical of any portrayal of anorexia as demon possession, and wary of

a reliance on faith healing. However, it was clear from Grace's story this was how she viewed her recovery, and that although she recognised that not everyone follows the same path, this was the turning point in her journey. The second concept I found difficult was Eloise's theology of a wrathful God who loves us and died to save us in a model of penal substitution. For me – and for Deborah, who shares my religious tradition – such a theology feels incoherent: a loving God who demands satisfaction for human sin in the form of torture and death seems contradictory. I had expected it would not be possible to reconcile these concepts, but Eloise could do so, even though I could not. Likewise, whereas I was uneasy about her 'handing the reins' over to God, implying an element of puppeteering, for Eloise this was the catalyst for her recovery and made sense within her religious framework. When we spoke, Eloise was recovered from her eating disorder (although recovery in all cases is never a permanent guarantee), content in herself and secure in her religious beliefs.

My conclusion on the connection between anorexia and Christian faith is that it is, by definition, hazy. It is certainly there, and there are clear emerging themes concerning Christian female identity, guilt, shame, images of God, sin and salvation. However, the way in which this connection manifests is different. Each woman in my study has her own story. She has her own background, her own influences and her own context. It is within these contexts that the connections between anorexia and faith are forged and so although there are similarities, the ties that connect the two – and pull them down into illness or up into recovery – crossover and tangle. Each story is as valid as the next. I – like Deborah – see coherence in liberal Christianity that focuses on community and

the compassionate Christ. Deborah and I are both Methodists. Brigid and Mhairi both found comfort in rituals – but also recognised that their affinity for rituals could be hijacked by the eating disorder. Clare came to reject organised religion entirely.

What is consistent throughout is that Christian faith played a part in the women's descent into and ascent from the depths of anorexia. Christian faith was part of these women's identities, and anorexia is a disorder closely entwined with questions of identity. As discussed in 2.3, although there is no consensus on the exact relationship, there is evidence (and anecdotal data from professionals working in the field) that there are a disproportionate number of Christian women who reach a severe stage of anorexia.[633] Alongside the precedent set within the Christian tradition for self-starvation (see 2.2) it appears there is sufficient evidence to argue for a significant connection between Christian faith and the progression of anorexia, if not a fully causal connection, then an exacerbating one.

Also consistent throughout the narratives was the importance of pastoral care: the desire for good pastoral support was unanimous, and all stories demonstrated that the support (or lack of) from the church community had a meaningful impact, whether positive or negative. Pastoral care for sufferers of anorexia is something that we need to get right – and currently seems something which we often do not.

[633] Joughin et al., "Religious Beliefs," 401. Madeleine Parkes, in conversation, July 2015.

6.2. ORIGINAL CONTRIBUTION

There is an increasing body of work on mental health and spirituality and mental health chaplaincy. Disability theologies and feminist theologies are by now well-established areas of research. My research is positioned in the gap in the literature that specifically focuses on Christianity and anorexia, with a feminist angle. This research adds to the small existing body of literature which explores the nature of the connection between anorexia and Christian faith. Several studies have considered this from a clinical perspective, which I have covered in 2.3. Much has been written on eating patterns in the history of Christianity and considered whether there is a connection to modern anorexia nervosa. A small number of works consider the wider impact of Western diet culture and Christian theology on women's eating habits, such as Lelwica's *Starving for Salvation* and Isherwood's *Fat Jesus*. Psychiatrists and psychologists in the US have attempted to produce manuals for incorporating a spiritual framework into eating disorders treatments. My research offers original data from the lived experiences of Christian women, predominantly (although not exclusively) in the UK and their reflections on how their faith intertwined with their illness. It is an exploration which has been undertaken from a theological perspective, whereas previous qualitative studies have been from a psychological perspective.

Until now, there has been no specific research published – neither theoretical nor, as this study is, using original data from fieldwork – that offers specific resources guidelines for chaplains working with patients with eating disorders in the UK. What there is so far is either non-specific to eating disorders, or emerges from psychologists rather than

chaplains, and within a US context which has different religious demographics and a different healthcare system. This thesis offers concrete possibilities and recommendations for mental health chaplains that are specific to patients with anorexia, and intended to augment and complement existing mental health chaplaincy frameworks.

6.3. LIMITATIONS

There are clear limitations in this thesis: it is based on a small qualitative study, and thus although it can shed light on emerging themes, exploring and adding depth to our existing understanding of the nature of the connection between anorexia and Christian faith in women, it cannot be generalised to apply to all Christian women with anorexia. Likewise, although alongside extant literature it can provide some initial recommendations for eating disorder specific chaplaincy care, further research would be necessary to develop this model.

The fieldwork produced rich data and, as can be seen in the data analysis in appendix 8, several themes emerged from the narratives. I have only been able to expand on the four most prominent themes in this thesis. Others included morality and rules; self-worth and guilt; depictions of women in the Bible and church; Biblical passages on the body; themes of feasting and fasting; and self-denial. It is notable that these themes connect. For example, issues of self-worth, identity and guilt have been touched upon in my discussion of Christian models of femininity. There is also ample data from the

fieldwork to produce a collection of Bible passages and reflections which the participants found either particularly difficult or motivational.

The study was limited in terms of demographic – I have focused specifically on women, and there is little ethnic diversity in my sample. This is likely in part due to the demographics of anorexia patients,[634] but also due to sampling methods. Despite undertaking phase 1 in hospital and phase 2 in the community, only one participant came from phase 1. This is a limitation of the study that it transpired the vast majority of hospital inpatients were simply not well enough to engage with this type of interview. This in itself was a useful finding, and the study was amended to take account of this with the addition of phase two. It is also of interest to note that Tracy's narrative was markedly different to other participants, although with such a small study it is not possible to say that this was entirely due to her current illness. One of my participants out of nine was a lesbian, which is in line with demographics in the general population. This is appropriate as, although the research on eating disorders and LGB people is still emerging, current data suggests that although homosexual and bisexual men are more likely to develop an eating disorder than their heterosexual counterparts, there is no statistical difference between lesbian and straight women developing eating disorders. Research does show that bisexual women may be more likely to develop an eating disorder (although the data is not specific to anorexia), but as I did not explicitly ask my

[634] The stereotype of an anorexic is a white, middle class woman. Although certainly not all anorexics are of this demographic, it is a stereotype that is based on the 'typical' anorexia sufferer. See footnote 236.

participants their sexual orientation, I cannot make any assumptions that those in the study in heterosexual relationships are straight rather than bisexual.[635]

6.4. RECOMMENDATIONS FOR FURTHER RESEARCH

My research focused on Christian women with anorexia and took a feminist angle. A further area for research would be to undertake similar fieldwork with Christian men with eating disorders, particularly considering sexual orientation as this is statistically significant among men. It would be interesting to compare data from a similar study of women with other eating disorders, such as bulimia nervosa or compulsive eating. As a Christian theologian and chaplain, my work naturally investigated the effect of Christian faith: a similar study could equally be undertaken with women of a different faith, although this may be more difficult in an eating disorders unit due to the demographics of inpatients.

The next steps for my research are: Firstly, to develop further the initial recommendations set out in 5.4.2.2 which need refining, testing and monitoring in practice, and with a larger participant pool. Secondly, to create accessible resources about anorexia and the way that it intertwines with Christian faith for community clergy. A further possible publication could be a collection of motivational Bible passages and reflections for Christian anorexia sufferers based on those identified in the fieldwork.

[635] Annie Shearer et al., "The relationship between disordered eating and sexuality amongst adolescents and young adults," *Eating Behaviours* 19 (2019): 115-119.

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APPENDICES

APPENDIX 1: INFORMATION SHEETS FOR PARTICIPANTS IN PHASE ONE

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Participant Info Sheet: Full Study, Phase 1, v1, 17.2.15

Christian women, anorexia and theological responses

An Overview about the Research Study

We would like to invite you to take part in a research study.

Before you decide you need to understand why the research is being done and what it would involve for you.

1) What is the research about?

The research is investigating the link between Christianity and anorexia nervosa in women. Some studies suggest that anorexia is far more prevalent among Christian women than in the general population and we are hoping to explore why this might be, and how faith can be used to help recovery from anorexia.

This research will be looking at how Christian beliefs, and in particular images of God and presentations of women in the Bible, inform anorexic thinking – whether negatively or positively. It will also be looking at how spiritual care could be best given in order to help Christian women suffering from anorexia.

The research is in two parts:

1) Looking at how spiritual care can be given in eating disorder treatment
2) Collecting the stories of Christian women and how, in their experience, their faith has informed their eating disorder (either in a harmful or helpful way)

2) Why have I been chosen?

You are being asked to take part because you have been identified by the chaplaincy team as fulfilling the criteria. To participate in this study you must be an adult female (over 18), Christian or from a Christian background, and diagnosed with anorexia nervosa.

3) Do I have to take part?

No, it is entirely optional. You can also choose to take part in the entire project, or in one aspect of the research but not the other, or not at all. If you choose not to take part it will not affect your care or participation in chaplaincy activities in any way.

4) What will happen to me if I take part?

If you choose to take part in (1) then a researcher will observe the spirituality group run by Madeleine Parkes and take notes. The researcher will then have an informal chat with you afterwards, which will be recorded (either by Dictaphone or written notes, whichever you are more comfortable with) asking for your views on which types of pastoral spiritual care are most useful.

If you choose to take part in (2) then you will have an interview with a researcher which will be an informal chat which will again be recorded (preferably by Dictaphone, but written notes are ok if you are more comfortable with that). The researcher will ask you questions about your faith and your eating disorder. You don't have to answer any questions you don't want to. Your observations will be written up (with any identifying features removed or changed) and shown to you for approval before inclusion in any publications.

All your personal details will be kept safe and confidential, and your name will not be used.

5) What are the possible benefits of taking part?

Primarily, the purpose of the research is that we are hoping to be able to offer better spiritual care to future patients and to understand better the link between Christianity and anorexia. We hope that it is also helpful for you to talk about your eating disorder in the context of your faith.

6) What if there is a problem?

If you are distressed by any questions in the study (which we hope you won't be!) please say so immediately to the researcher or a member of the chaplaincy team.

If you have any other problems, please contact:

Complaints (PALS): 0800 953 0045

Dr. Deryn Guest, University of Birmingham: [redacted]

Spiritual Care Practitioner – Madeleine Parkes: [redacted]

7) What will happen to the results of the research study?

A report will be written that may be published in a journal or book. You will not be identified in any report or publication. Hopefully, the research will enable chaplaincy teams in other mental health trusts to offer spiritual care to eating disorders patients.

8) Who is organising the research?

The research is being undertaken by a postgraduate researcher at the University of Birmingham, Department of Theology and Religion.

9) Who has reviewed the study?

An independent group of people called a Research Ethics Committee will have reviewed the study, to make sure your rights, safety and well-being are protected. It will also have been reviewed by the University of Birmingham Ethics Committee and the hospital.

10) What do I do now?

If you agree to take part, please complete the consent form. If you have any questions, please do speak to the chaplaincy team or researcher.

Thank you for reading this information sheet

If you have any other questions, please ask the research team

APPENDIX 2: INFORMATION SHEETS FOR PARTICIPANTS IN PHASE TWO

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Christian women, anorexia and theological responses

An Overview about the Research Study

We would like to invite you to take part in a research study.

Before you decide you need to understand why the research is being done and what it would involve for you.

1) What is the research about?

The research is investigating whether there is a link between Christianity and anorexia nervosa in women, and if so why this might be. Some studies in the US suggest that anorexia is more prevalent among Christian women than in the general population and we are hoping to explore whether this might be the case in the UK and if so, why this might be. We also plan to look at how chaplaincy care can best be used to help recovery from anorexia.

This research will be looking at how Christian beliefs, and in particular images of God and presentations of women in the Bible, inform anorexic thinking – whether negatively or positively. It will also be looking at how spiritual care could be best given in order to help Christian women suffering from anorexia.

The research will be comprised of a semi-structured interview with a researcher, either in person or via Skype

2) Why have I been sent this information?

You will either have received this information because you have responded to an advert, or because a friend or acquaintance has forwarded it to you thinking you may be interested in the study.

3) Who is eligible to participate?

To participate in this study:

a) You must be 18 or over.
b) You must have at some point been diagnosed with anorexia nervosa (any subtype of). You are eligible if you are a current sufferer, in recovery or fully recovered.
c) You are a Christian and/or had a Christian upbringing.

4) Do I have to take part?

No, it is entirely optional. If you have more questions before you decide whether to take part, please email the researcher, Hannah Stammers, at [redacted]. You can have a chat about it or ask any questions with no obligation to participate.

5) What will happen if I take part?

If you choose to take part then you will have an interview with a researcher which will be an informal chat which will be recorded (preferably by Dictaphone, but written notes are ok if you are more comfortable with that). The interview can take place at your home, at the University of Birmingham, or over Skype: whichever is more convenient for you.

The interview will last about an hour, but you can ask to stop at any point. The researcher will ask you questions about your faith and your eating disorder – some examples of the type of questions you might be asked are:

- Are there any Bible passages that you have found particularly difficult or particularly helpful for you in regards to your eating disorder?
- How do you imagine God's character?
- Do you find Communion/Mass to be difficult?

You don't have to answer any questions you don't want to. Your observations will be written up (with any identifying features, including your name, removed or changed).

About a week or two later you will have a second interview, phone call or conversation via Skype (again, whichever is most convenient for you) in which the researcher will show you the transcript. At this point you can choose to remove anything. The researcher will also discuss whether you are happy with how the identifying features have been changed. These changes will be made so that all your personal details will be kept safe and confidential. There is a possibility that the researcher will want to use

direct (anonymous) quotes in publication. This is entirely optional and you can make your choice clear on the consent form.

6) How will my data be stored?

Any data that can be traced to you will be stored on an encrypted memory stick. Within six months it will be destroyed. We will need to keep the consent forms for twelve months before they are destroyed, but they will be stored in hard copy in a locked safe, separate from the research data.

7) What are the possible benefits of taking part?

Primarily, the purpose of the research is that we are hoping to be able to offer better spiritual care to future patients and to explore whether there is a link between Christianity and anorexia. We hope that it is also helpful for you to talk about your eating disorder in the context of your faith.

8) What are the risks and what support will there be?

There is a risk that you might become distressed in this study because you will be reflecting on some sensitive topics to do with your eating disorder. If you do become distressed, please say so immediately to the researcher. The researcher will have a leaflet with a list of places you can get help if you do become distressed. If you are currently receiving treatment for your eating disorder, we strongly recommend that you let your healthcare team know that you are participating in this study.

You can stop the interview at any point you want, and you can choose to 'pass' any question you are uncomfortable with.

9) What if there is another problem?

If you have any other problems, please contact:

Dr. Deryn Guest, University of Birmingham: [redacted]

Hannah Stammers, University of Birmingham (postgraduate researcher): [redacted]

10) What if I change my mind afterwards?

You can withdraw your data for up to two weeks after the initial interview. This is because after that point it will be transcribed, anonymised and mixed up with other data so it wouldn't be practical to retrieve it.

11) What will happen to the results of the research study and how can I find out about them?

A report will be written that may be published in a journal or book. You will not be identified in any report or publication. The researcher will write up a short summary of the initial findings for those involved in the research, although this will probably be very general at first. If you would like to see the results of the full study when it is published, please let the researcher know and provide an email address so you can receive the results.

12) Who is organising the research?

The research is being undertaken by a postgraduate researcher at the University of Birmingham, Department of Theology and Religion.

13) Who has reviewed the study?

An independent group of people called a Research Ethics Committee will have reviewed the study, to make sure your rights, safety and well-being are protected. It will also have been reviewed by the University of Birmingham Ethics Committee. Phase 1 of the study took place in an NHS hospital trust, and it was also reviewed by the hospital prior to the start of the study.

Thank you for reading this information sheet

If you have any other questions, or would like to participate, please contact the researcher, Hannah Stammers, at [redacted] or on [redacted].

APPENDIX 3: INFORMATION SHEET FOR HEALTHCARE PRACTITIONERS

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Christian women, anorexia and theological responses

An Overview about the Research Study: For Health Care Team

We will be inviting your patient …… to participate in a study. They will be receiving the following information sheet and attached consent form.

The information sheet attached is a copy of the information sheet that will be received by any eligible patients on the ward, distributed by the chaplaincy team.

Please note there are two different parts to the study:

(1) Spirituality group feedback

(2) Semi-structured interviews with a researcher

Your patient has been invited to participate in……..

If having read the information sheet you have any concerns about the capacity of any your patients to consent, or if you are concerned about their wellbeing should they choose to take part please do not hesitate to speak to the researcher or a member of the chaplaincy team.

Participants will be asked to sign a consent form which allows us to share with you any disclosures which suggest a risk to the participant's health.

Thank you for reading this information sheet.

Attached: Participant Information Sheet

APPENDIX 4: CONSENT FORM FOR PHASE ONE

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Study Number: 15/WM/0090

Patient Identification Number for this trial:

CONSENT FORM

Title of Project:

Christian women, Anorexia and Theological Responses

Name of Researcher: Hannah Stammers

Academic Supervisor: Dr Deryn Guest

On-site supervisor: Madeleine Parkes

Please initial the box to the right-hand side of each bullet point to confirm you have read and understood it. If there is an option, please initial EITHER the 'yes' box OR the 'no' box.

1. I confirm that I have read and understand the information sheet dated …… for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time within two weeks of the interview date without giving any reason, without my medical care or legal rights being affected.

   *the two week time limit is solely because data will be integrated with data from other participants at this point, so it may not be practical to withdraw your information. ☐

3. I understand that data collected during the study may be looked at by individuals from Birmingham and Solihull Mental Health NHS Foundation Trust, from the University of Birmingham, or another regulatory authority who may

request access to the data. I give permission for these individuals to have access to the information I have given as part of this study. I understand that data may be published, but will be done so under a pseudonym and all identifying features will be removed.

☐

4. I agree to my healthcare team being informed of my participation in the study

☐

5. I agree that selected direct quotes, anonymised, can be used in publication (please initial either yes or no)

   Yes: ☐ No: ☐

6. I agree to take part in the following parts of the study (please initial the boxes for each part of the study)

   Part 1: Spirituality group feedback Yes: ☐ No: ☐

   Part 2: An interview with a researcher Yes: ☐ No: ☐

_____

Name of Patient Date Signature

_____

Name of Person taking consent Date Signature

APPENDIX 5: CONSENT FORM FOR PHASE TWO

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Study Number: 15/WM/0090

Patient Identification Number for this trial:

CONSENT FORM

Title of Project:

Christian women, Anorexia and Theological Responses

Phase 2: Semi-Structured interview with a researcher

Name of Researcher: Hannah Stammers

Academic Supervisor: Dr Deryn Guest

Please initial the box to the right-hand side of each bullet point to confirm you have read and understood it. If there is an option, please initial EITHER the 'yes' box OR the 'no' box.

1. I confirm that I have read and understand the information sheet dated …… for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time within two weeks of the interview date without giving any reason.

   *the two week time limit is solely because data will be integrated with data from other participants at this point, so it may not be practical to withdraw your information. ☐

3. I understand that data collected during the study may be looked at by individuals from the University of Birmingham, or another regulatory authority who may request access to the data. I give permission for these individuals to have access to the information I have given as part of this study. I understand

that data may be published, but will be done so under a pseudonym and all identifying features will be removed.

☐

4. I agree that selected direct quotes, anonymised, can be used in publication (please initial either yes or no)

   Yes: ☐ No: ☐

_____

Name of Participant Date Signature

_____

Name of researcher taking consent Date Signature

APPENDIX 6: SOURCES OF SUPPORT LEAFLET

Places of Support

We really hope you haven't been distressed by anything that came up in the study, but if you do feel the need to talk to someone about any of the issues raised, then the sources listed below are some good starting points. **If you are still in treatment for your eating disorder, you may find it helpful to speak to a member of your healthcare team or counsellor.**

If any of the spiritual issues discussed have made you uncomfortable, and you have one, it may be helpful to speak to your priest, vicar, minister or other religious or pastoral leader.

B-eat, a national charity for eating disorders in the UK, has a helpline which is confidential and open 2-4pm, Monday-Friday.

Adult helpline: 0345 634 1414 or email help@b-eat.co.uk

Youth helpline (up to 25yrs): 0345 634 7650 or email fyp@b-eat.co.uk

Anorexia, Bulimia Care (ABC) is another national eating disorders charity in the UK who can offer confidential help and support.

Supportline: 03000 11 12 13, then press option 1, or email support@anorexiabulimiacare.org.uk

Mind, the mental health charity has an infoline which is open 9am-6pm, Mondays to Fridays. They can help to put you in touch with your local Mind organisation or other sources of support in your local area.

Infoline: 0300 123 3393 or email info@mind.org.uk

The Samaritans are available to listen 24 hours a day if you feel you need to talk to someone.

Helpline: 08457 90 90 90

Eating Disorder Support runs a helpline which is available at any time of day, staffed by volunteers.

Helpline: 01494 793223 or email support@eatingdisorderssupport.co.uk

APPENDIX 7: INTERVIEW GUIDE

Preamble:

- *Check consent*
- *Check participant is happy with audio recording and brief note taking*
- *Remind the participant that she does not have to answer any questions she does not want, or share anything she does not want to*
- *Remind the participant we can stop at any point, and if she does get upset (I really hope she doesn't!) then the chaplaincy team are on hand*
- *Explain that I will type up the transcript and then at the next interview she can read it over and remove anything she does not want left in. The transcripts will be anonymised, any identifying information will be changed and the tapes will be destroyed at the end of the study. Pseudonyms will be used so there will be nothing left linking her to the data.*

Initial questions (data gathering and breaking the ice):

1) Could you please tell me a little bit about yourself? Let's start with how old are you, if you don't mind me asking?

2) And what is your usual occupation? Are you a student, stay at home mum, voluntary work…?

3) How about religion? Are you a member of a particular church/denomination?

4) (if yes) Do you go to church regularly (or would you, if you could)?

Lead into some more in-depth questions.

Anorexia and Faith – Broad Themes:

5) So were you brought up a Christian? Tell me about it…

6) So, would you mind telling me a little bit about your eating disorder before we move onto some questions about how it links with your faith?

(Aiming to cover in here – official diagnosis, length of illness, duration of stay in hospital)

7) Can you explain to me a little bit about how your faith interacts with your eating disorder?

8) What is it like, for you, being a Christian woman with anorexia?
(if she has not yet mentioned it, ask about community)

More specific themes/questions:

NB The participant may address some of these questions in the above questions

9) Are there any Biblical stories or characters, or general church teachings that make you feel uncomfortable, either about eating or body image or gender?

10) Are there any you find particularly helpful in the context of your eating disorder?

11) How do you feel about Communion?

12) How do you think of God's character?

13) How do you think God thinks of you?

'Resurfacing' questions:

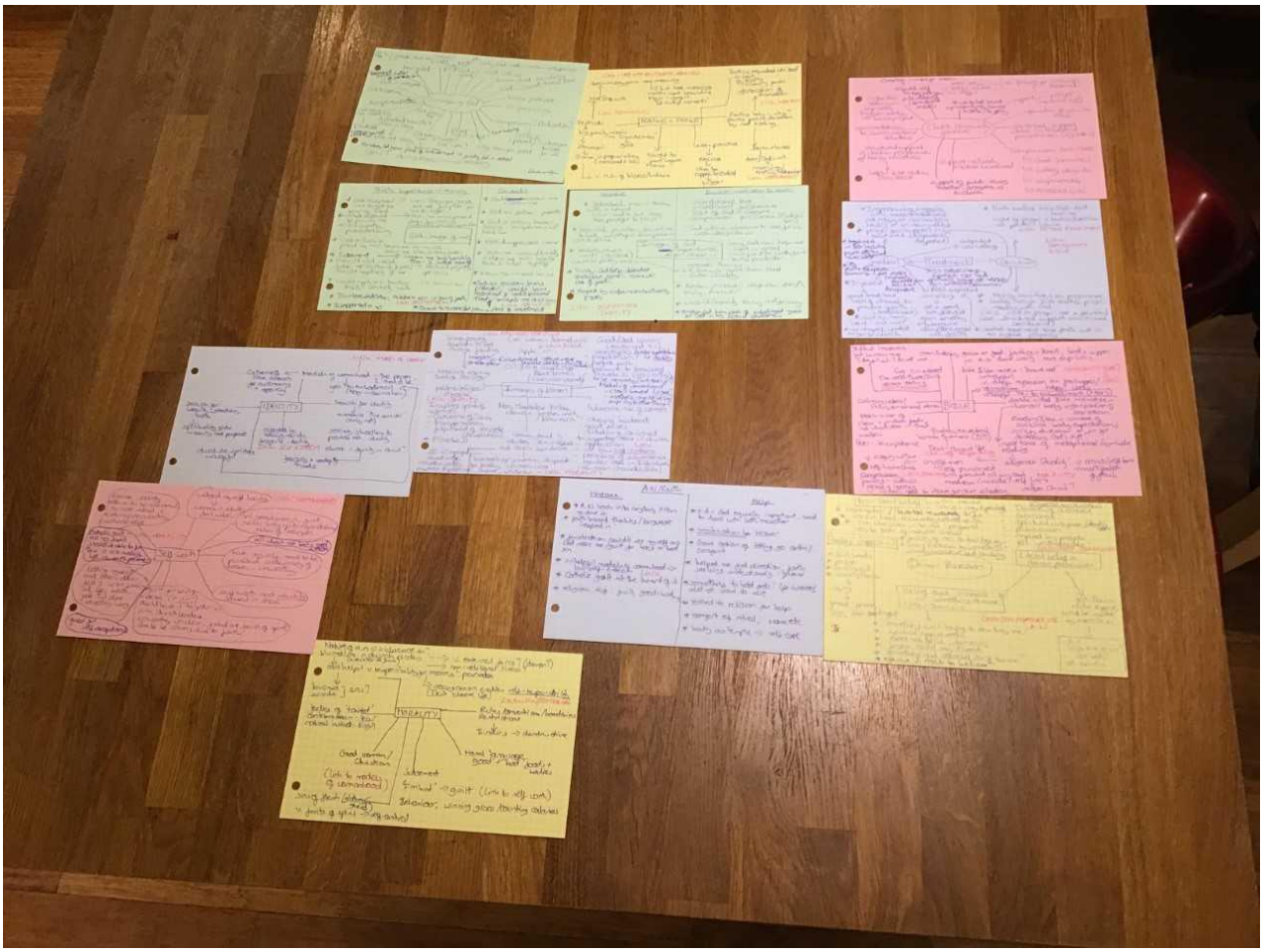
14) So, do you have any contact with your Church currently?

15) Do you think they will be able to support you in your recovery and when you get back home? (If applicable).

16) Do you have any plans for when you are discharged? What's the first thing you'd like to do when you get out? (If applicable).

Great, thank you so much for taking the time to speak with me today.

APPENDIX 8: DATA ANALYSIS



APPENDIX 9: ROSE

Rose was born in the US. At the time of interview she was in her late 20s, a stay at home mum with two young children, now living in a different part of the US. She grew up in a wealthy Roman Catholic family with parents who were extremely involved in their local church. Although she had a generally happy childhood, there were family tensions: her father drank wine every night in an attempt to ease the stress of his work; her mother was openly obsessed with her body image. They showered Rose with affirmation of how beautiful and clever she was. Although well meaning, and proud of their clever, beautiful daughter, in hindsight Rose thinks this may have contributed to her perfectionism, and her fear of trying anything that she might fail at. Rose dates her eating disorder back to high school, when as a teenager she had a full-length mirror which she would look in and wish she could 'fix' parts of herself to be smaller. However, at the time she had good friends and was happy, and she felt that this prevented her thoughts from becoming more intrusive or causing her to alter her behaviour.

During her first year at her Catholic college she met a boy and started dating. He was very body conscious and health and exercise obsessed. A while into the relationship he stopped showing physical affection, no longer holding her hand or hugging but would not tell her what had changed. In what she now sees as a subconscious attempt to regain his attention and therefore affection, she tried to be 'healthy like him' by controlling her body shape and size through diet and exercise. She reached the point where she was 'obsessed' and was so small she couldn't get any smaller – she was nothing but skin and

bones. At the end of the college year she had some counselling. The next year she described as a 'pendulum swing' in which she told herself she had to eat whatever she wanted and love her body, and ended up weighing more than she had originally – 'I was like, "this isn't normal". I was just eating cake all the time!" *Several years on, Rose now describes her relationship with food as* 'pretty normal' *but she still has difficulty with decision making around food, such as in restaurants.*

In her counselling sessions, of which she had a few in the summer break after first year, Rose's counsellor recommended a book called 'It's not about the food'. *Rose described this as telling her what she already knew – that it was nothing to do with the food. It was, for her, to do with control. She described herself as a 'perfectionist'. She noted some early family influences in this (above), but was unsure whether her faith upbringing played a subconscious part in causing her perfectionism or not.*

Throughout Rose's illness she spent time in prayer every morning asking God to 'Help me love myself in a way that's healthy and not obsessive.' *The University she was attending was a Roman Catholic college, so she attended Mass every evening. Rose described finding it frustrating: being a Christian with an eating disorder. She knew that God loved her and thought she was beautiful, but she could not see it herself. However, it was also a comfort to know that God loved her 'no matter what'. She described her understanding of God's character as 'loving and forgiving', and trying to help her – but she wouldn't give up the control. She did not see God as a vengeful judging God, and saw that: '*God

of the universe judged me less harshly than I judged myself.' *Trying to see herself as God saw her, and knowing that God valued her helped Rose in her recovery:* 'It didn't matter what I was wearing, or what my hair was like, God saw me as joyful, or creative…'

Rose also drew comfort from her daily Bible study, and mentioned a few passages that brought her particular respite. One such passage was St. Peter's vision of a sheet with unclean animals, and a voice from heaven telling him to 'kill and eat'. Rose applied this to her situation of having cut foods out – her 'unclean' foods, and being told to eat. She also mentioned Jesus' teaching that it is not what goes in to a person (food) that makes them unclean, but what comes out (words and actions). Although comforting, she also found this difficult to 'accept in her heart'.

One passage Rose described as having 'rocked my world'. *It was the story of the woman caught in adultery. Jesus dares anyone to throw the first stone, if they are perfect. What Rose saw in that story was the idea that we are all imperfect and so cannot judge anyone – and this means that neither can we judge ourselves. This was a helpful reminder for Rose when her self-esteem was at rock bottom.*

However, there were also times when her eating disorder drew justification from her faith. The passage in 1 Corinthians 6: 'Your body is a temple of the Holy Spirit, therefore honour God with your body' was a double-edged sword. On the one hand, her eating

disordered thinking could use it to justify obsessive exercising or feeling guilty about gaining weight. On the other hand, it could make her feel guilty about her eating disorder and for not taking care of her body. However, she did not go so far as to think of her illness as a sin. For her, it was an internal struggle rather than an external force, but it was not a struggle of 'good' v 'sin' – it was a struggle of illness. She noted that some people do find it helpful to think of eating disorders and addictions like alcoholism as an external force in order to detach themselves from it; however, for her, she felt that had she done that she would not have been able to take responsibility for her own recovery.

I asked Rose about her experiences of Christian diet books which seem to be prevalent in some parts of the US. She had only heard of them vaguely, but said that even if she had been aware of them at the time of her eating disorder, she probably would not have followed them as 'at that point I was so controlling I wanted to do everything my own way!'

When asked about her experiences of pastoral care in the church, Rose noted two things: firstly, that attending a university chapel she was not, at the time, attending a 'normal' church with small groups or pastoral outreach of any kind, and she seemed confident that had she been there would have been more pastoral care available to her. Secondly, she noted that anorexia was something that no one talked about, even though from her appearance it was very obvious. The only two people who said anything to her about

her difficulties were her mother and her roommate. It was as if people were 'afraid to say anything', and in turn Rose found it 'frightening' that she could get to that stage without anyone suggesting she might need some help.

She suggested that improvements in pastoral care around anorexia could include Bible studies or teachings focusing on one's worth to God; how God values each person; on loving your body as God's creation and about the importance of letting go of control and accepting your own imperfections. However, she also pointed out that this would be difficult to implement as it is such a 'personal struggle' and people 'don't reach out and talk about it'.

Rose experienced some difficulties around the rituals of the Church. She found taking the Mass made her 'very very nervous'. When she was anorexic, she had cut out bread, so even the tiny piece it was made her panic. The next year, when she was over-eating, she worried that the little piece of bread would 'put her over the top' and make her gain more weight. She described how, as a child, she learnt to fast on a Sunday morning in preparation for receiving the Eucharist, but had difficulties with this due to low blood sugar – whether this played a part in her later concerns about the Eucharist was unclear. Another difficult time for her was festivals such as Christmas and Easter which she approached with 'fear and trepidation'. *She found it was hard to focus on the '*actual Christian holiday' *because she was obsessing about the food which was the focal point of family celebrations. Similarly, she found that church events with food were difficult*

and lost the atmosphere and sense of community for her as she was so worried about the food.

*Ultimately, Rose felt that it was her faith that enabled her to recover from her eating disorder. She described having faith in God as giving her the option to give over the control of her life to Him: '*Because if you don't have faith then you're the one in control so there's nothing really to turn to, except for like, no control? Which I mean, I did do that and that's why I …. But yeah, just giving the reigns over to God was just such a better option than holding on tight or throwing them in the air.'

APPENDIX 10: BRIGID

Brigid's difficulties with food began when she was about 16. Still living at home in the US at the time, with supportive and loving parents, she was quickly encouraged into outpatient treatment and managed to stabilise her weight. However, in her early 20s, triggered by an emotionally abusive romantic relationship, she relapsed and became severely ill. At her worst, Brigid weighed less than half her original bodyweight.

Brigid described the six months she spent in hospital as a difficult time. She struggled to find a hospital that was able to provide the intense medical care she needed at such a low-weight, and counter-intuitively was told by several hospitals she approached that she was 'too ill' for them to treat her. The hospital she was finally admitted to had two stages of treatment: one 'more of a hospital setting' with IV drips; and multiple tests and observations a day to see her through the most critical phase of her illness until she was weight restored enough to engage properly in therapy. The second stage involved a transition to a different ward, with intensive therapies and group meal times combined with medical care and close supervision. Sadly, Brigid related that some of the women she was in hospital with had died in the decade between her admission and our interview.

Brigid was brought up a liberal Catholic, and the hospital was a Catholic hospital. As such, one of the therapy groups was a Spirituality Group, and a nun regularly brought

the patients the Communion on a Sunday. As part of the Spirituality Group programme they also arranged visits to local churches for Mass for patients who were further on in their recovery. Brigid described having Communion brought to her when she was too unwell to go to church as a comfort, a 'little piece of… holding on to my background' as she prayed for strength in her recovery.

*Interestingly, Brigid used the phrase 'hold onto' frequently throughout our interview. She understood her faith as something to cling to in the most difficult of times, even in the mental and physical pain of refeeding: '*It gave me something to fight for because I really did believe that, you know, that I do have a soul and that it was worth preserving and I – I did not want to die.' *Her faith reminded her that her life is sacred. She described going to Confession and having the Anointing of the Sick ceremony before she went into hospital:* 'that was a dark place… it was hard to go into treatment knowing I am not going to see the world for six months…and I think having that ceremony, that sacrament before I went, was helpful'.

Whilst she was in hospital, Brigid was diagnosed with Obsessive Compulsive Disorder, which proved a key to her recovery as she realised her problems with food stemmed from her OCD. She reflected on the role of ritual in OCD, anorexia and religion. For her, ritual and tradition is extremely comforting: both in terms of rituals in her everyday life, like triple checking the heater in her office is off, and in terms of liturgy. She described how she finds even small changes jarring, like the new translation of the liturgy adopted into

*Mass. Her anorexia involved many food rituals which she found comforting, such as cutting food into tiny pieces, and found that in her recovery she had to untangle the comforting and harmless rituals in her life from those that were unhealthy and disordered. The ritual of Mass and liturgy provided her with a safe place of comfort and refuge. Prior to her admission to hospital, a friend would meet her at her house before church and they would say the rosary together before Mass. In her reflection on the interview after, Brigid wrote: '*It's difficult to say whether an affinity for ritual and a tendency to be comforted by routines and repeated behaviour came before or after my religious background, as both have been a reality for me for as long as I can remember. As with much of my history, I can only say that I can certainly see that the two could be related.'

I asked Brigid whether she had any problems taking the Host. She responded that she had not, which she felt was 'weird for me – because I was very, very careful what I put in my mouth'. *However, it had certainly crossed her mind and she had asked her nutritionist how many calories were in the wafer and wine! Despite this, it had not stopped her taking it – it was simply too important to her, irrelevant of calories.*

Brigid noted that the element of ritual is not the only area of crossover between religion and an eating disorder. She described the moral language used by eating disorder sufferers of 'good' and 'bad' foods, and the idea of being strong and upright and resisting 'evil' (i.e. food) – all building on concepts of self-control.

Brigid's experience of anorexia and religion was not entirely typical of her fellow patients or the other participants in the study. For example, despite her OCD diagnosis, she experienced no issues surrounding thoughts of contamination of food and purity. Furthermore, she did not feel any worries about body image stemmed from her upbringing. She attributed this to her liberal Catholic upbringing: 'we were definitely not like, we're going to read this passage and it means you have to literally mortify your flesh'. *Although Brigid described her misgivings around the Roman Catholic Church's position on gender and LGBTQ issues, none of her concerns around gender seemed to cause any hang ups around sexuality and body image. She described how, in the hospital, she found herself in a controversy about wearing tank tops: it was hot, and she was proud of her re-developing cleavage which was noticeable in a tank top. However, other patients were uncomfortable with this reminder of their re-developing sexuality, and she was asked to cover up. She described the strange paradox of learning to love her body and yet being told to hide it as if it were something shameful.*

A theme that returned time and again in our interview was Brigid's feeling of guilt – as she called it 'Catholic guilt'. She expressed her certainty that her feeling that she is responsible for all things and the guilt she carries stems from her religious upbringing: 'You don't necessarily pick that apart every day, it's just, like, ingrained. So I do.. think that it is entirely that there is an element of that in me that I've had to deal with. Because I feel responsible for *everything*. You know, I sort of take on the world and I don't think that Catholicism had nothing to do with that – it's too much of a coincidence,

you know?' *Her feelings of guilt tied into how she saw God at the time of her illness – or more accurately, how she felt God saw her. She described how she felt she was a 'big disappointment' to God, not helped by the things that people would say in a desperate attempt to make her eat:* 'It was definitely pointed out to me that, "well, if you kill yourself that's a sin. And if you starve you're just killing yourself very slowly." I heard a lot of that, and it was very hard.' *Another common thing she was told was* 'well maybe if you prayed… or maybe if you just believed a little harder.' *Although people meant well, such things were very hurtful, particularly to someone in a vulnerable emotional state.*

*I asked Brigid how she felt about the suggestion that anorexia was a sin. She responded that it was certainly a belief that she took on at the time. '*Both in terms of a religious sin, and in terms of just secularly, like the idea that this is something you do to yourself rather than a disease that you have that you can't help. That stigma is very much so prevalent. People just don't understand. You hear all this 'Well why don't you stop this?', 'Why don't you eat?' 'Look what you're doing to the people around you' and yeah you feel like, or I felt like, if I was good enough I could stop this or I could fix it on my own and I wouldn't need to go through all this and I wouldn't need to put everyone through this. And I very much felt that it was my fault and it was something I was doing that was morally wrong.' *Her feeling of guilt was compounded by her desire to be a model patient and get well straight away* – 'why couldn't I get rid of these feelings?'

When we discussed different religious understandings of the nature of anorexia: as a sickness, a sin, or even demon possession, *Brigid suddenly remembered why the Spirituality Group at the hospital had 'fizzled out'. Another patient, a Baptist lady, offered to hold an exorcism and had targeted other members of the optional Spirituality Group as patients who might be open to this idea. Brigid described being utterly shocked at the suggestion* – 'It was definitely one of those "Wow this is really coming out of your mouth and I don't know what to say" moments' – *but similarly felt that as this lady was a patient and genuinely believed herself to be demon possessed that she should respect her right to believe that. Brigid felt torn: The suggestion was offensive on many levels and there were patients who may have been vulnerable to the idea; however she felt that if this lady found it a helpful belief, then she should be allowed to think that. She compromised by suggesting they pray together. Brigid did not feel the suggestion did her any harm as she was* '100% certain that I do not nor ever did have a demon inside me!' *Rather, she believes that demonic possession is* 'historically just a misunderstanding of common illnesses that we now have explanations for'. *Interestingly, Brigid also recalled that other people in her church community had suggested that the devil was telling her not to eat.*

We spoke a lot about Christian festivals and what they meant to Brigid – and the difficulties that they posed when she was ill. As a mid-30s professional with a busy work and social life, Brigid no longer attends Church quite so often – although still regularly. She described how festivals are for her the most poignant and inspiring services which

she would never miss. She described how Mass at Christmas always gave her feelings of hope and joy. For her, the Christmas story makes the Bible come alive – and an inspiring homily from the priest has more impact than any Bible reading. Brigid described the 'fraught' nature of Christmas, Easter and Thanksgiving when she was ill, with her parents, Grandma, Aunt, Uncle and cousins. There was the dichotomy of the special time and the difficulty it posed. She had very happy memories of celebrations from when she was younger, and continued to enjoy the gathering and spending time with the people she loved – but there became an added complication of this 'overwhelming meal' that she needed to plan strategies to cope with. She described how, even now she logically knows it was not her 'fault', it was an unfortunate illness, she feels guilt that 'I was the one who ruined Christmas and Easter and Thanksgiving for a long time'.

Brigid noted that she found Thanksgiving harder than Christmas and Easter, and this she attributed to the greater religious meaning and the spiritual moments of Christmas and Easter. Although it became hard to focus on the Christmas message in Mass when worrying about the dinner afterwards, she thought that had she not been at Mass listening to the religious message and enjoying the service she would have worried more. Similarly, she recalls beautiful moments at Easter sunrise services, singing hymns outside as the sun rose, even in the most fraught and difficult of times.

It was not only the festivals themselves that proved difficult for Brigid when she was ill, but also the run up to them. As a child, her family never fasted in the sense of 'not

*eating', but they did not eat meat on Ash Wednesdays or Fridays and gave up treats for Lent. The first time Brigid did 'no sweet foods' for Lent was when she first became ill. Lent became an excuse for not eating and provided a legitimate motive to not eat. The ensuing weight loss 'felt good' and although she is sure she already had an eating disorder by that point, her Lenten practice '*certainly didn't help and did, I think, hurt'. *In the decade since her recovery, Brigid has made an active effort to change her Lenten practice, and instead of giving something up instead does something each day, such as a household task she dislikes, or following a prayer routine.*

APPENDIX 11: 12 STEPS FRAMEWORK

Step 1: The patient recognises that she is powerless over her eating disorder.

Step 2: The patient recognises that a power greater than herself may restore her.

Step 3: The patient makes the decision to turn her life over to God (or whatever she understands as God).

Step 4: The patient makes a moral inventory of herself.

Step 5: The patient admits to herself, to God and to others, the exact nature of her wrongs.

Step 6: The patient becomes ready to allow God to remove the 'defects' of character.

Step 7: The patient asks God to remove her shortcomings.

Step 8: The patient makes a list of the people she has harmed, and becomes willing to make amends.

Step 9: The patient makes direct amends to these people wherever possible, unless to do so would harm them.

Step 10: The patient continues to take a personal inventory and admit when she is wrong.

Step 11: The patient seeks, through prayer and meditation, to improve conscious contact with God.

Step 12: The patient tries to carry what they have learned to others and to continue to practice these principles.