SPACES OF S(H)ELF-CARE: THERAPEUTIC NARRATIVE READINGS IN ANOREXIA

ESPACIOS DE AUTO(FICCIÓN)-CUIDADO: LECTURAS NARRATIVAS TERAPÉUTICAS EN LA ANOREXIA

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ROCÍO RIESTRA-CAMACHO
Universidad de Oviedo
riestrarocio@uniovi.es
<https://orcid.org/0000-0002-1791-9297>

Abstract

This paper delves into the realm of art therapy, offering tentative evidence of the effectiveness of reading in anorexia nervosa (AN) recovery based on an analysis rooted in three theoretical frameworks: cognitive literary criticism, space studies and the perspective of care. In the first part, AN is discussed as a spatial disorder and one which compromises practices of care. The second part of the paper explores narrative transportation theory, a cognitive literary studies paradigm that explores the various psychological effects of reading, and on mental imagery, a concept that focuses on the mental effects of descriptions and imagery in books. By drawing on research from these spheres, this theoretical framework serves as a valuable lens to frame the third part of the paper, which addresses the pivotal role played by reading in Laura Freeman's journey toward overcoming anorexia, as depicted in her autobiographical work *The Reading Cure: How Books Restored my Appetite* (2018). In particular, the study offers a close reading of some of the narratives Freeman addresses in her work, meaning the fiction and non-fiction texts she found inspiring, which exclude poetry and drama, and which stimulated her appetite through vivid descriptions of food.

Keywords: British autobiography, anorexia, space, bibliotherapy, care.

Resumen

Este artículo se adentra en el ámbito de las terapias artísticas ofreciendo evidencia de la potencialidad de la lectura en la recuperación de la anorexia, abriendo paso a un enfoque novedoso enraizado en tres marcos teóricos principales: los estudios literarios cognitivos, los estudios del espacio y la perspectiva del cuidado. En la primera parte del artículo, se discute la anorexia como un trastorno del espacio y como una condición que compromete las prácticas de cuidado. La segunda parte del artículo se adentra en la teoría narrativa del transporte, un paradigma de los estudios literarios cognitivos que explora los efectos psicológicos de la lectura, así como en la imaginación mental, un concepto que se centra en los efectos mentales de las descripciones e imágenes en los libros. A partir de investigación proveniente de estos campos, este marco teórico da paso a la tercera parte del artículo, que aborda el papel crucial que desempeña la lectura en el viaje de Laura Freeman hacia la superación de la anorexia, tal como se describe en su obra autobiográfica *The Reading Cure: How Books Restored My Appetite* (2018). En concreto, este estudio hace una lectura atenta de algunas de las narrativas que Freeman aborda en su obra; es decir, los textos de ficción y no ficción que la inspiraron, y que excluyen poesía y teatro, a estimular su apetito a través de imaginativas descripciones de alimentos.

Palabras clave: Autobiografía británica, anorexia, espacio, biblioterapia, cuidado.

1. Introduction

Individuals with anorexia nervosa (AN) think obsessively and negatively about food. Time is spent ruminating about food or meal times (Vitousek and Brown 2015: 224), and relationships are constituted by people with whom to go out and avoid eating (Warin 2010: 54-59). Similarly, the experience of space is mediated by a constant threat of food encounters. Centering the attention on space, when a person with AN perceives places in relation to eating, she experiences the process as incredibly threatening and anxiety-causing, which mediates her motivations to eat or not (Augustynowicz 2015).

Motivations to eat in AN are related to the question of care (Lavis 2015). To eat and to be fed have to do with basic self-care and other care practices. But in AN, people display extreme reluctance to eat and, as a result, to recover from their illness. Resistance to treatment is sustained by ego-syntonic symptoms, that is, by a frequent wish to maintain their eating disorder (ED) (Fassino and Abbate-Daga 2013). As a result of ego-syntonic features, motivation to change the behaviors associated with the condition diminish. This is one reason why AN is a uniquely

treatment-resistant condition, and one in which people are highly prone to relapse. Nevertheless, the question of what constitutes full recovery from AN is elusive, as systematic criteria are not universally agreed upon.

Modifying the negative perception of space in relation to eating can contribute to the decision to engage in practices of (self-)care, and therefore, to recover from AN. Reading could promote this change in perception thanks to the inclusion of descriptions of spaces that evoke positive connotations of food and the act of eating. In the first part of this article, I will examine AN as a spatial condition, then I will analyse the idea of "s(h)elf-care", a concept that will relate narrative reading to therapeutic effects. In the subsequent sections of this study, I will examine evidence and discuss certain limitations derived from the experience of Laura Freeman, a writer formerly diagnosed with AN who insists that it was through reading "wonderful descriptions of food in books" that she had her "appetite stirred" and thus began to "eat again" (2018a).

2. AN as a Spatial Condition

1.1. Physical Spaces of AN

The space that our bodies occupy influences our sense of body perception (Espeset et al. 2012). A balanced bodily perception is one in which the person is, overall, satisfied with the way her body looks and how she imagines others perceive it. But several conditions can alter a person's perception of their body. A person with a restrictive ED may believe they are too fat, either temporarily or sustainedly in time. In AN specifically, public displays of the body (at a swimming pool or a changing room, for example) create a context-dependent sense of being fat, while looking at themselves in a mirror can make the individual see their emaciated state (Espeset et al. 2012).

From a phenomenological perspective, AN may be understood as a spatial disorder. This ED was in fact defined by Orbach as "an expression of a woman's confusion about how much space she may take up in the world" (1986: 14). Refraining from eating is the most evident behavior in AN. It is a direct attempt to lose weight, but it is also related to subtler components of the condition, such as the sense of disgust prompted by the act of eating or the fear of contaminating the purity of the body via food intake (Warin 2010).

In AN, motivations to avoid eating and lose weight can also be seen as an attempt to minimize "the consumption of space in an attempt to appear physically smaller and disappear" (Warin 2005: 104). Thus, refraining from eating is self-reinforcing as a consequence of its correlation with weight loss and dis-occupation of space.

Interviews with people with AN support this view of the condition as one sustained by a desire to have a body that increasingly takes up less and less space in the world. The medical anthropologist Lavis found that for the group that she interviewed, AN was seen as "a space to zone into" (2015: 11). For example, she highlights that, for one participant, AN was described as "my space" and for another as "my little bubble" or even as "a safety net" (2015: 11-12). In her spatial analysis of AN, anthropologist Warin showed how the participants she interviewed repeatedly spoke of a need to "fade away", "dissolve into thin air" or "fit into a matchbox" (2005: 103).

1.2. Social Spaces and Careful Eating in AN

Central to the relationship between eating and space is the understanding that places need not only be understood as geographical spaces, but as "spaces of relatedness" (Warin 2006). Although eating is an act that can be performed alone or in groups, eating in the company of others is certainly a popular social activity. When there is no pathology involved, group eating normally involves a higher consumption of food in comparison to when the person eats on her own. Furthermore, we also tend to eat more when we go out, merely because there are more choices to select from than normal. This phenomenon is known as "sensory-specific satiety".

In AN, eating in the company of others poses two difficulties. For one, eating is problematic in itself, because AN is characterized by an aversion to food and weight gain, and therefore to the act of eating. On the other hand, AN is usually isolating, since social occasions and contact with people are often avoided. Lavis remarks how one of her participants described AN as "a world that you live in, that's separate from everybody else" (2015: 11). People with AN can find it difficult to engage in intimate romantic or intimate friendship relationships despite having a desire to have such connections (Warin 2010: 82-83). Moreover, individuals with AN may also keep away from family members. One major reason to avoid social contact in AN is precisely that meetings with people are frequently centered around food. As Warin notes, "social gatherings around food such as meal times, drinks with friends or any social event present a level of anxiety that can only be circumnavigated by withdrawal" (2005: 9).

Someone with AN will therefore commonly try to eat alone. This allows them to control the act of eating, letting them choose what and how much to eat. In order to eat alone, people with this ED adopt various strategies. For example, they might lie about having already eaten when it is not the case. Furtive eating is a classic feature of binge ED, bulimia or obesity, but people with AN also eat secretively (Warin 2010: 87), for instance, at night.

Warin discusses interesting findings about how her participants negotiated space in order to maintain eating-withdrawal behaviors. For example, she points to the fact that participants decided to only share food time with a few "privileged" acquaintances and that "negotiating the commensality around food was a constant dilemma for participants" (2010: 59). As such, she could only share a "coffee or a diet Coke" (2010: 59) with them, but never a full meal. When talking about the family home, participants in Warin's observation referred to how they "retreated to bedrooms, toilets (water closets) and bathrooms" (2005: 19) to eat on their own. Warin's research sheds light on the ways in which individuals who engage in eating-withdrawal behaviors negotiate and maintain their habits. Overall, Warin's findings highlight the deliberate actions taken by individuals to uphold their withdrawal behaviors and the impact it has on their social interactions within and outside of the home.

The above only applies to individuals in outpatient care, which is the preferred treatment modality in AN (NICE 2004). However, there is still a substantial minority who receive inpatient care, where eating behaviors are monitored. Health regulations determine that "patients may require inpatient care if they are suicidal or have life-threatening medical complications […] or weight below 85 percent of their healthy body weight" (Williams et al. 2008: 187). Given the clinical risks of severe emaciation, inpatient treatments focus on refeeding the patient. For Lavis, this makes food "a central vector of care" (2015: 5).

Feeding in the context of in-hospital AN treatment is, however, a highly controversial issue as well as a problematic imposition for patients. Feeding patients is considered the main practice of care in AN treatment, but ego-syntonic symptoms may mean that patients need to be compelled to eat (or even force-fed via tube-feeding). Despite being "only one outcome of interest" (NICE 2004), AN treatment is focused on weight gain but not on learning to eat more autonomously. Thus, a hospital experience does not prepare someone with AN to care for herself and continue eating after being discharged.

Another problem about inpatient care in AN is that hospital rooms "conflate all spaces" (Warin 2005: 111), since they function simultaneously as bedroom, bathroom and the place where patients eat, alone. The result of being confined to a hospital bed is the reinforcement of maladaptive "closeted" behaviors in AN. The hospital room becomes the space where patients avoid social networks and the relatedness of eating, which is precisely one of the factors sustaining the ED. Even more, the re-configuration of private spaces in hospital treatment might allow patients to outwit personnel and avoid food consumption, since patients spend most of their time alone.

1.3. The Mental Space of AN

For someone with AN, food does not only take up physical space in the literal sense of the word; rather, food, eating and weight dominate patients' train of thought. This creates attentional and memory biases: people with AN pay more attention to and evoke more memories about food-related stimuli than cohorts without the ED (Vitousek and Brown 2015).

To constantly think about food may seem contradictory for someone who arranges her life around food avoidance. The short explanation is that people with AN experience a rebound effect, and the more they try not to eat and think about food, the more they will experience invasive thoughts and the urge to eat. These ruminations are, however, perceived as consistent with the individual's aims, since such level of preoccupation with food is necessary to achieve precisely the "right" amount of intake.

From a discourse perspective, the disorder is described by patients as an illness which literally occupies mental space. As Maddy, a recovered AN patient who took part in Warin's study, stated, "[t]he place where anorexia is, it's a very narrow space, and there is little room for anything else" (2010: 7). Laura Freeman, the author whose work is the focus of this article, complains that AN made her feel "trapped" and that she "needed to find something that would take me *out of my thoughts*" (2018b: 145, emphasis added).

To fully understand the disorder, it is then essential to examine it from a cognitive perspective, which offers evidence not only with regard to what a person with AN thinks about but also how they think. In short, a framework of AN needs to explain how people with AN think and feel about food. On a general level, AN reduces cognitive flexibility, which means that it is difficult for them to change their thoughts (Vitousek and Brown 2015). Some of the emotions that food and eating conjure in AN are fear, disgust, shame or guilt, whereas food avoidance generates pleasure, a sense of control or feelings associated with purity and cleanliness. However, people with AN often find it difficult to assess and express their emotions (Esplen 2013), which in psychology is known as "alexythimia".

A comprehensive model for understanding AN could be based on Fairburn and Beglin's famous Eating Disorder Examination Questionnaire (EDE-Q), a structured clinical interview that assesses the main features and associated psychopathology of EDs. The EDE-Q has shown high reliability, internal consistency and validity across multiple studies (Lev-Ari et al. 2021). The questionnaire comprises questions related to restraint, eating concerns, weight concerns and shape concerns. Below I illustrate the questionnaire items that are relevant for AN from a cognitive-affective perspective, specifically.

In AN, restraint concerns appear in the form of thoughts related to a wish to limit or avoid intake of specific foods to influence shape or weight, as well as strict eating rules and a desire to have an empty stomach. Purgative behaviors are also adopted, such as spitting out or throwing away food, vomiting or evacuating meals through the abuse of laxatives. Eating concerns cause thoughts to be focused on foods, eating or calories as well as fearful thoughts of losing control over one's eating or being seen eating by others. Weight concerns include feeling fat and the desire to lose weight, and thoughts of dissatisfaction with current weight. Finally, shape concerns have to do with equivalent trains of thought and emotions, but focused more specifically on shape, for example experiencing fear about the stomach's outline after eating.

It can be said that AN literally constricts the mind of the those with the illness, limiting their psychological horizons and life possibilities: preoccupations with food, eating, and weight permeate thoughts and mental processes, creating attentional and memory biases toward food-related stimuli. Conceptualizing this model through the concept of the "mental space of AN" enhances comprehension of its phenomenology, since the idea aids in linking the cognitive overload induced by AN to the corresponding rigidity of behavior and emotions related to food and eating that characterize the disorder.

2. Spatial Reading and Caring

Fiction organizes a sequence of events according to different dimensions which essentially include time, space and causality. Descriptions serve to capture the spatial dimension, and when we read a description of a place in a story, this information activates representations of mental spaces in our imagination (Speer et al. 2009). One way to approach the representation of spaces in literature is to examine narrative transportation theory, where the term "transportation" is defined as the "feeling of being lost in a story", that is to say, the moment when readers get "immersed" in a narrative world (Green 2021: 87). This process can arouse pleasant or unpleasant feelings, exactly because spaces can be positively or negatively perceived and pictured. The theory of therapeutic landscapes explores the beneficial properties of being and imagining oneself in certain spaces. Both narrative transportation theory and the theory of therapeutic landscapes are useful to understand how narratives can lead to therapeutic appraisals of space, and, uniquely, to therapeutic readings of eating spaces in AN.

2.1. Therapeutic Spaces

People with AN may benefit from modifying their perceptions of eating contexts, causing these to evolve from sources of dread to safe spaces. In AN cognitive behavioral therapy, patients are helped to change their behaviors and negative concept of food and eating so that they can start feeding again (Vitousek and Brown 2015: 225-226). However, no AN therapy program has ever specifically focused on the therapeutic possibilities that spaces, landscapes or geography have to offer despite their potential to alter eating behavior and food perceptions.

Since the 1990s, the idea of therapeutic spaces has been gaining momentum. Particularly, the publication of Gesler's article on therapeutic landscapes in 1992 established medical geography as a discipline of inquiry. Gesler argued that it was crucial to "explore why certain places or situations are perceived to be therapeutic" (1992: 735). In his theory, Gesler employed the notion of therapeutic landscapes as a geographical metaphor to facilitate the exploration of the beneficial properties of space.

Early publications in this area focused on the idea of health geographies as referring to physical spaces, despite Gesler's figurative theorization of the notion of landscape. At the beginning, scholars mostly researched people's spatial perceptions of sites considered sacred, such as Lourdes, or health facilities like hospitals and clinics. Health geographers later expanded their conceptualization of healing spaces to incorporate therapeutic "networks"; that is, informal social systems through which people gain support and establish practices of care. For Smyth, therapeutic networks include "kinship groups and networks of care provided by family, friends, therapists and other agents of support" (2005: 490). In therapeutic networks, practices of care are enacted in settings that are more casual than clinical care, including care delivered in the home, the community as well as "bookstores" (Smyth 2005: 493).

Andrews adds another layer of complexity to the notion of therapeutic space, insisting that the concept should account for the idea that "therapeutic associations and effects may be experienced somewhere other than in physical locations and, specifically, in spaces and places created by the mind" (2004: 304). "Mental imagery of place" is the area of psychological research that explores this phenomenon. Psychoanalytic therapists (Philo and Parr 2003; Callard 2003) are early proponents of the therapeutic potential of a mental imagery of place. In a nutshell, they suggest that instructing patients to evoke pleasant spaces in their imagination can be beneficial in the processing and treatment of phobias and trauma.

A problem Andrews identifies in psychoanalytic analyses of therapeutic landscapes is that "imagination can be an elusive and slippery human capacity to access and

manipulate, even for experienced therapists" (2004: 308). Moreover, in the context of current research into mental imagery, it remains difficult to measure the overall contribution that mental imagery therapy has with regard to health. Methodological difficulties of this kind are in fact the main reason why psychoanalytic theories have become largely discredited. Despite these drawbacks, evoking unpleasant simulations of space constitutes a distressing experience, but the opposite remains true as well. Andrews concludes that "the current lesson learned from psychoanalytic geographies is straightforward; a recognition that therapeutic places may not necessarily exist in 'real' (linear) time and in physical space. Rather, they could exist as spaces and places created by, and located in, the mind" (2004: 309).

I suggest that medical geography could open up the research field to include not only physical or even self-imagined spaces, but also therapeutic spaces created by reading fiction. After all, when we engage with a story, we have to create an imagined space in which the narrative events take place. In other words, fiction causes readers to evoke mental imagery, including powerful spatial imagery (Speer et al. 2009). This effect of reading works of fiction is more natural than the artificial manipulation of imagination by psychotherapists, and it also opens up the possibility of controllably measuring mental imagery, as it becomes elicited by an input stimulus. In particular, mental imagery effects and, more specifically, spatial imagery, have been assessed in narrative transportation theory, the field which examines the psychological feeling of losing oneself in a story.

2.2. Narrative Transportation Theory

Using a metaphor of traveling, transportation theory postulates "that experiences of narrative […] create a mental state in which the experiencing subjects […] 'lose themselves' in the story they encounter" (Schleifer and Vannatta 2019: 5). The process of narrative transportation can occur across different types of media, including books, cinema, drama or videogames. Both factual and fictive stories create transportation effects. In the case of fiction, events need not be real, but consistent in the storyworld created. Researchers have identified four major effects constituting the phenomenon of narrative transportation that result from reading fiction: identification, reduced counterarguing, emotional engagement and mental imagery.

Identification and transportation are related but separate concepts. Identification has to do with character, whereas transportation has more to do with the dimensions of time and space. Identification takes place when readers see their values aligned with those of a character in the story, usually the protagonist. Succinctly, it refers to the process by which readers project themselves into the

experiences and emotions of characters, often those with whom they share similarities, to create a sense of connection. This phenomenon is crucial in shaping reader response and engagement with a text (Tukachinsky 2021). Transportation, on the other hand, refers to "the feeling of being immersed in a narrative, a state of cognitive, affective, and mental imagery engagement" (Fitzgerald and Green 2017: 49). It involves a combination of attention, imagery, and the feeling of becoming immersed in the narrative world. The potential of narratives to effectively make audiences feel "absorbed" is proposed as the main mechanism through which readers identify with characters, making them more likely to adopt the beliefs, attitudes and, ultimately, the behaviors expressed in the story (Murphy et al. 2013).

Reduced counterarguing is explained by the fact that fiction is not intentionally persuasive. As a result, readers spend less time and effort establishing counterfactuals to the narrative. If they identify with a character, it is likely that they will be persuaded by her values, as the effect is not perceived as being externally imposed. This effect, which is particular to fictional narratives, has been found to increase over time, because the ideas become integrated into real-life knowledge, a circumstance known as "absolute sleeper effect" (Appel and Richter 2007: 113). Therefore, reduced counterarguing is useful to self-generate motivation to change behaviors in the long-term (Murphy et al. 2013). Lastly, emotional engagement is the evocation of feelings and affect that takes place when readers are immersed in a story. The stronger the emotions the story conjures, the easier it is for a reader to feel moved by it (Green and Brock 2002).

2.2.1. *Mental Imagery and Mental Health*

As argued above, narratives inspire the formation of mental images. These can be presented to subjects in the form of drawings or moving images if we think about comics or cinema, respectively. But mental images can also be created by descriptions in the text that readers need to visualize on their own. In *Healing Images: The Role of Imagination in Health* (2013), Sheikh, a Professor of psychology, reviews the state of knowledge concerning the health consequences of using imagery in a range of fields, including pain management, trauma or emergency department care, among others. One of the most compelling forms of evidence is derived from the physiological impacts of using imagery within clinical environments. Mental images, in particular, have been shown to regulate physiological arousal in patients dealing with various health conditions, increasing their capacity for affective regulation.

From the point of view of narrative persuasion studies, Green and Brock's transportation-imagery model (2002) highlights the role of visual imagery in

transportation-based belief change. The authors demonstrate how narratives that evoke rich mental imagery are highly persuasive. Using a short story rich in descriptive imagery, they showed that this narrative produced high transportability and that this effect mediated belief change, positive evaluation of protagonists and persuasiveness of story content, concluding that transportation imagery is a key mechanism in narrative-based belief change (2002: 319). Mental imagery of space can be assessed through the notion of "spatial presence", defined as the feeling of having moved to "an alternative space" in the context of narrative engagement (Lyons, Tate and Ward 2013: 2). This concept of spatial presence is useful to explore how reading elicits spatial mental imagery with relevant therapeutic effects for readers.

From a psychosocial intervention perspective, Glavin and Montgomery emphasize the role that spatial presence effects plays in mental health, when they argue that stories allow patients to distance themselves from psychological disorder or trauma (2017: 98). They propose that this kind of transportation into fictive worlds mediates some of the beneficial effects that reading has for war veterans with post-traumatic stress disorder.

In AN, this distancing effect of narrative reading can be overshadowed by ego-syntonic symptoms. Individuals with AN are commonly motivated to aggravate their disorder, and it has been shown that they purposefully seek to immerse themselves in the fictive worlds of characters with EDs. For instance, AN memoirs have been shown to be abused by patients "to exacerbate their anorexic thoughts and behaviours" (Seaber 2016: 488). Troscianko provides additional evidence of this phenomenon from the perspective of cognitive literary studies. In her survey, Troscianko showed how literature on EDs is often used to "deliberately exacerbate an eating disorder" (2018: 1).

Obtaining a distancing effect such as that provoked by narrative mental imagery could be therapeutic in AN. People with the condition could benefit from transporting themselves to story worlds that are unrelated to the ED framework. In fact, a few controlled studies show modest to significant improvements in AN using guided mental imagery. For instance, imagery has been used to improve body image distortions or to identify stimuli precipitating disordered behaviors (Esplen 2013: 281-282). It would be useful if readers with EDs became absorbed in narratives rich in descriptions of characters eating and set in positive scenarios. Transportation to this kind of scenes seems even more relevant in the case of AN given that readers with the disorder might think that characters do not eat unless mealtimes are specified in books (Troscianko 2018). By exposing themselves to such explicit descriptions, people with AN may begin to challenge their belief that not eating is conventional or a practice to align with.

2.3. Practices of Care and Reading Therapy

Care can be provided to people or it can be practiced in the form of self-care. In effect, care has been ideally defined as a "voluntary" practice. If we focus on self-care, understood as "the provision of daily, socio-psychological, emotional, and physical attention" (Kremer 2007: 17) we deliver to ourselves, it is not difficult to imagine why illness compromises practices of self-care. In depression, patients can be very lethargic, disabling them from getting out of bed, cleaning and dressing themselves. In AN, social withdrawal, depressive symptoms and food avoidance make it impossible to comply with basic forms of self-care.

Focusing on the question of eating in AN, there are different conceptualizations of the relationships between feeding and caring. "Caring through food", "caring-as-feeding" or "food as care" (Lavis 2015) are some of the ways in which food can be approached as a central vector of care. In AN, "refusal to eat […] comes to be seen as a refusal of their care" (Lavis 2015: 6). Given that most people with AN struggle with ego-syntonic symptoms but are treated on an outpatient basis, recovery can thus be articulated as the capacity to engage in acts of self-care.

Periods of AN care (and therefore AN recovery) can be reduced when patients receive complementary therapies, including reading therapy, which can be prescribed in the form of self-help books. In self-therapy, which is one of the main branches of bibliotherapy, patients are given self-help books normally to complement psychological assistance. Self-help works normally used in bibliotherapy interventions are non-fiction books written by psychologists and trained psychotherapists that focus on motivating patients to change their maladaptive behaviors and substitute them with more adaptive ones.

In AN, self-help books have been the norm in bibliotherapeutic interventions (Troscianko 2017). Freeman, however, is skeptical of their usefulness when she complains that "[t]here are too many self-help guides that say: get fit, lose weight, make friends, find a hobby, revamp your wardrobe. […] Eat right —and right is always avocado, chia and other whatnot" (2018b: 188-189). There is also some evidence of the potential of memoirs about EDs in AN self-help therapy. In particular, there is qualitative evidence of a recovery continuum whereby the influence an ED memoir has on an individual depends on their recovery stage and will to recover (Shaw and Homewood 2015). Given the results of this study, ED memoirs might be therapeutic only when people with AN are already willing to attempt recovery. This notion is consistent with the fact that AN is an ego-syntonic condition.

Fictional works remain an untapped resource in bibliotherapy, while they are convenient and quite accessible candidates. According to Ellmann's study, reading is a common favorite pastime in AN (1995: 58). It has already been mentioned

that people with AN deliberately read literature about EDs to exacerbate their condition. But just as they read to worsen their state, reading could also be a form of therapy. I have coined the expression "shelf-care" to refer to this idea of reading books as a part of a self-care routine.

According to Cook-Cottone, self-care "is a set of active, daily behaviors that operationalize what it means to take care of and appreciate the self" (2015: 102), covering both the internal and external dimensions of the self. Practices that focus on the internal experience include self-awareness, self-compassion as well as four basic physical practices: eating, hydrating, moderate exercise and rest. In turn, self-care practices that focus on the internal dimension of the self include the cultivation of supportive relationships, the creation of "a body positive environment" and "setting personal boundaries" (2015: 4).

Although the use of complementary therapies has been the subject of debate, self-help books, dramatherapy or poetry therapy, among others, have also been shown to play a role in AN care and recovery (for a review, see Riestra-Camacho et al. 2023). On the other hand, narrative reading has been scarcely used in AN therapy, although this genre has untapped potential as a valuable resource in bibliotherapy and as part of a self-care routine.

3. A Spatial Reading of Freeman's AN Recovery Memoir

We shall now turn our attention to Freeman's memoir and the notion of "spaces of shelf-care". The concept can be defined as the process by which reading may broaden the spaces in which one can imagine oneself, resulting in therapeutic outcomes. With this concept, I will focus on the role that fictional spatiality played in Laura Freeman's attempts to recover from her ED, which should not be regarded as a straightforwardly successful or complete experience. Thus defined and with this caveat in mind, the following section will examine selected extracts from Freeman's AN recovery memoir *The Reading Cure: How Books Restored my Appetite* (2018). This book was chosen because it illustrates the role of narrative transportation to potentially therapeutic eating spaces. I have divided the analysis into three sections, each dedicated to a figurative type of space, rather than structuring the sections according to literary genre, as Laura Freeman simultaneously engaged with fiction books alongside other works.

3.1. Rural Spaces

A recurring motif in *The Reading Cure* is the idealized portrayal of natural eating spaces. Andrews argues that in mental imagery therapy, "connecting with nature

plays a significant part" (2004: 313). As Esplen has noted, nature imagery is used in AN guided imagery therapy to attain relaxation and soothing (2013: 282). This feature can be seen at the beginning of Freeman's attempt at recovery, which was sparked by reading descriptions of breakfast in the memoirs of the English war poet Siegfried Sassoon. As the author notes, "[i]t began with Sassoon's eggs. His ham sandwiches eaten perched on a country gate. His slice of cherry tart at a very good cricket area. My curiosity was piqued. Dare I say my stomach rumbled?" (2018b: 14). This quote focuses on the description of food eaten in the countryside. The foods are presented as tempting precisely because they are part of a picnic context, with the "country gate" and "cricket area" evoking expansive fields of grass in a romanticized English countryside.

As Freeman relates in the book, the solitude of her house was making it difficult for the author to feel encouraged enough by Sassoon's descriptions to move herself to eat. This block gradually improved when Freeman started reading about more fictional characters eating al fresco, like Mark Twain's Huckleberry Finn's berries "over a campfire" and Kenneth Grahame's "riverbank picnic" of cold tongue and sandwiches in *The Wind in the Willows* (2018b: 171). As a result of reading passages focusing on food and food baskets, Freeman herself tried eating outdoors during visits to different villages. One of the most blissful moments in the memoir is when she describes eating "on a boulder high on the cliffs" at St. Ives and how, together with her partner, they "shared out the crumbling, saffron dyed buns" (81).

Freeman describes how she overcame her fear of dairy products in the bucolic descriptions of milk in Thomas Hardy's *Tess*: "He painted milk in the sweetest, palest, colours, made it something quite lovely, a cool, marble-white balm for a dairymaid's soul", and, as a result, "I could see the dairy cows in my mind's eye" (2018b: 59). Thanks to this idealized spatial imagery, "the dairy papers in Tess finally weaned me off soya", assures Freeman, making her feel "not that I ought to drink true, court-beauty milk, but that I wanted to" (60).

Adopting a medical humanities perspective, Bates states that "therapeutic landscapes always operate in relation to another imagined place and —even more powerfully— an imagined self who exists outside of the hospital" (2019: 15). For Freeman, it was not the hospital but her own family house that was blocking her willingness to eat. In this regard, Paddy's meals "in the hollow of a willow trunk" or "on top of a hayrick" and "a pebble beach near Varna" in Patrick Leigh Fermor's *The Broken Road* led Freeman to believe that it was possible to conceptualize eating beyond "the awful sense of confinement at a table" and its "captive ways: supervised at dinner, following a meal plan, compelled to stay at the table until I had at least tried what was on the plate" (2018b: 84).

Freeman insists that learning that meals could be enjoyable was made possible by reading fictionalized acts of eating outside of walled spaces, a reading experience not entirely valued because of the "contents" described, but because food descriptions "taste[d] of new liberty" (2018b: 172). Freeman's "sense of confinement" should not be understood in a metaphorical sense. In her narrative, the author draws a connection between starting to eat and becoming able to walk. Specifically, she refers to the following experience: "I remembered what it had been like, at fifteen, to be too thin to walk" (35). This recollection emphasizes the significance of finding the necessary energy to regain mobility, which served as a driving force for her ongoing efforts to recover, along with her growing interest in rural aspects of life. This desire to escape those feelings of confinement played a significant role in her motivation to persist in her journey toward recovery, which she further strengthens as she struggled to find a new sense of "home".

3.2. Home, Sweet Home

The preceding section analyses Freeman's perspective on her family household as a hostile environment. The feelings of confinement within this space can be largely attributed to the negative social dynamics she associated with it. Specifically, it was her family members who strictly controlled her meals ("supervised", "compelled to stay at the table"), which resulted in her dreading this physical space. This rationale is consistent with the explanation of withdrawal behaviors in AN, which influence behaviors of eating away from friends or even relatives as a way to obtain calorie and intake control (see section 1.2).

However, therapeutic environments often develop in the imagination of readers in connection with a "feeling of homeliness". Homeliness, specifically, "symbolises leaving illness behind, and an imagined healthy self" (Bates 2019: 19). The function of an imagined "home" is to provide a distancing effect similar to that implied by spatial presence (Glavin and Montgomery 2017), so that it becomes easier "to forget the illness" (Bates 2019: 19). Returning to the memoirs and letters of the war poet, Laura Freeman was inspired to feed herself more based on the "friendliness of food […] for men at the front", because eating signified "comfort, warmth, a taste of home, a reminder that you were still alive when the batman returned from Givenchy with beer and chocolate" (2018b: 44). This new sense of homeliness differs from Freeman's negative perception of her family house, as from here on she is able to envision new connotations for the word "home" as a place of relief and solace.

Reading English children's books further strengthened Freeman's associations between food and homeliness. The author stops carefully to review more effects that Kenneth Grahame's *The Wind in the Willows* had on her. She in particular describes

the sardines that Toad takes after a long trip home, noting "that is why the sardines were worth remembering. Not because they are sardines, but because of what they signify: home, comfort, the beginnings of a brightening, beaming winter supper" (2018b: 173). Further on, the author elaborates on the idea of home as a place of companionship when she re-read Dickens' *Pickwick Club* series (1837), describing her increased motivation to start eating meals next to others, even envisioning the possibility of feeling festive about it: "I liked the club […] I was so much better in my mind, so much more tolerant of food and festivity" (Freeman 2018b: 228).

By transporting herself to the houses of fictional characters who eat in the company of loved ones, Laura Freeman was able to envisage herself eating those dishes in her own place. Halfway through her book, she describes visualizing herself "in imagination at least, putting the fish in the pan to warm, turning the pepper mill, lifting the capers from the jar and tipping the fillets onto rye crackers to be eaten at my own table in my own home-sweet kitchen" (2018b: 173). In narrative transportation theory, this is known as "simulation", defined as a reading-induced mechanism by which readers mentally rehearse the actions in the narrative. Simulation has been identified as a major factor in improving health-related behavior in different interventions (Lyons, Tate and Ward 2013). Simulating characters eating homemade food influenced Freeman to herself try those foods: "thanks to Mole I am now never without a tin [of sardines] in the cupboard" (2018b: 174), although the hedging ("in imagination at least") calls for caution in interpreting this too optimistically.

In J.K. Rowling's *Harry Potter* series, the author learned that food could mean "company, home, and warmth" (2018b: 44), and further on she reflects on the idea of eating food as a practice of care and relatedness, in particular: food, in "children's books", she declares, "is given not just to build bones or put hair on chests", because "it is care and kindness […] a loving, motherly, fatherly, sisterly thing to do" (174). Imagining food in connection to the idea of home probably strengthened the author's associations of the relatedness of homemade food prepared by family members and close friends as a practice of care.

3.3. Gendered Spaces

Gender is inherent to an understanding of AN. While this is not the place to offer a detailed account of AN from this perspective (for an overview, see for example Orbach 1986), it would be unwise to approach Laura Freeman's experience without taking this dimension into consideration. Gender-related factors in fact intersect with Freeman's experience of the ED, particularly in connection with questions of self-identity and societal expectations, as well as with the way she portrays space and femininity.

Medical anthropology studies have noted how the individual with AN might experiment pleasure as a result of preparing food for others (Jacobson 2007). This resonates with the stereotyped notion of women as providers, and specifically as those who shoulder the burden of cooking and housework. As Jacobson points out, women are expected to prepare meals for relatives and friends, but "when it comes to herself, she manipulates, parses, and rejects" the food "as if it were harmful or exotic material" (2007: 163). This could be explained by the fact that acute hunger and eating copious amounts in public has not been classically welcomed in women (Orbach 1986).

Laura Freeman was aware of these contradictions and addresses them explicitly when she notes that she "had been reading almost entirely about men. Men with uncomplicated, unashamed appetites" (2018b: 91). This realization led her to understand that she needed to model the appetites of women. Thanks to her zealous interest in many forms of narrative reading, she began to find solace in female authors, and writers of cookbooks in particular, who challenged conventional notions of femininity by displaying a hearty appetite and making a profession of it. In particular, Freeman understood that she had to learn to appreciate food preparation as part of the recovery process: "If I could enjoy all the parts that came before —the shopping and scrubbing and soup bowls— I stood a better chance with the meal itself" (2018b: 105). This can be interpreted as an embodied self-realization, to adapt Cook-Cottone's terminology, and as another example of food reappraisal.

Freeman acquired this awareness in the recipe books of two women, Elizabeth David, a writer from Sussex, and the Californian Mary Frances. However, anticipation around cooking and eating was facilitated by the ease of narrative transportation effects —although other potential mechanisms could also be at play. In this way, the author marks a distinction between the effects of reading the cookbooks by David and Frances. For her, the simplicity with which she could imagine David's dishes seems to have caused the book to have a stronger persuasive effect on her eating, in comparison with Mary Frances's book: "I knew Elizabeth David's England in a way I couldn't know Mary Frances's Californian beaches, ranches, vineyards, West Coast boarding schools and Hershey's bars" (2018b: 112).

The distinct provenance of Frances and David's dishes caused their recipes to be perceived with varying accessibility. Familiarity with David's place of origin made Freeman more easily convinced by her descriptions. She further reflects on this idea when she explains that "the England of Elizabeth David, though separated by seventy years from the one I grew up in, was recognisably my England: […] Scotch eggs for picnics; fish at school on Fridays with custard and tinned fruit cocktail" (2018b: 115). As a consequence of the narrative proximity to the recipes of Elizabeth David's, Freeman was able to start eating, in particular, the omelets

described in her books. She admits that her curiosity was piqued by the English author's descriptions of "a golden bolster of an omelet", admitting to having made "many […] since" (119). This stands as an example of a dish becoming a "safe food", a term commonly seen in experiences of AN that refers to a foodstuff that is not anxiogenic, which makes one wonder whether Freeman remained too fearful of incorporating other recipes so systematically.

One of the reasons why Freeman specifically started reading books written by women was because she sometimes found it hard to feel inspired by men's descriptions of food, men with "unashamed, uncomplicated appetites" (2018b: 91). Gender was especially relevant when Freeman faced relapse as she developed obsessions about healthy and "clean" eating, an ED known as "orthorexia". Orthorexia is a common form of AN relapse, though sometimes its predecessor. This moment in Freeman's narrative shows that AN recovery is not straightforwardly represented, nor that it should be, since recovery is a challenging process subject to many vicissitudes. In this regard, Merav Shohet has identified "sideshadowing" as a common feature of AN memoirs, where steps toward recovery are integrated into an erratic narrative of gains and losses, to present healing "as ambiguous, conflictual, unstable, subject to constant revision" (2018: 495).

During this phase of relapse, Freeman identified with Virginia Woolf's philosophy of eating. As Freeman is quick to spot, Woolf was an author who may have suffered from AN as well. Leonard Woolf, her husband, kept a journal of her eating habits, where he elaborated on the idea that Virginia regarded eating as a taboo act. In her diaries, she conceded that Leonard was "clearsighted" about this, as she admitted feeling "really frightened" of "a loss of control, a chink in the armour, a breaking of some unspoken rule" when it came to eating (in Freeman 2018b: 131).

This experience contributed to Freeman's identification with the author. As a result of identifying with her, Freeman notes that she found in Woolf's diaries and letters "a corrective to clean eating" (2018b: 136). Contrary to male authors, who described eating as an unproblematic habit, Freeman saw Virginia Woolf as someone who "struck a balance between not wanting to eat and knowing she must eat" (135). Thus, Woolf, a woman who struggled with fragile mental health and poor eating habits but who still made the effort to eat, convinced Freeman that she had to return to a recovery mindset.

4. Conclusion

In this article, I have examined AN from a spatial perspective in order to delve into the experience of what constitutes being anorexic from a physical, social and

cognitive-affective point of view. Articulating AN in this way has enabled a productive positioning of the condition along with the questions of recovery and care. It has allowed me to discuss AN in relation with practices of care, opening up the possibility of considering reading as a form of self-care.

Specifically, I have proposed that narrative reading could contribute to AN recovery, since descriptions about food in books have potential to reconfigure how somebody with AN thinks and feels about spaces associated with eating. The concept of shelf-care has been coined to focus on the role that fictional spatiality could play in narrative transportation and mental imagery, as well as in reconceptualizing recovery within the paradigm of self-care and art therapies that include self-help and bibliotherapy. A selection of passages from Laura Freeman's memoir *The Reading Cure: How Books Restored my Appetite* (2018) has been used to exemplify the therapeutic potential that narrative reading could have in AN. Some limitations of Freeman's experience have also been alluded to, in order to be faithful to the view presented of AN recovery as a non-linear phenomenon.

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