

De-medicalizing anorexia

A new cultural brokering

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Richard A. O'Connor and Penny Van Esterik jointly wrote *From virtue into vice: Explaining anorexia as an activity* [under review]. From age 13 to 16, O'Connor's daughter was anorexic. Researching how she and other anorexics embodied ascetic values raised larger biocultural questions about nurturance and society that are being explored in *The dance of nurture: Embodying infant feeding* [in preparation]. Emails: roconnor@sewanee.edu, esterik@yorku.ca.

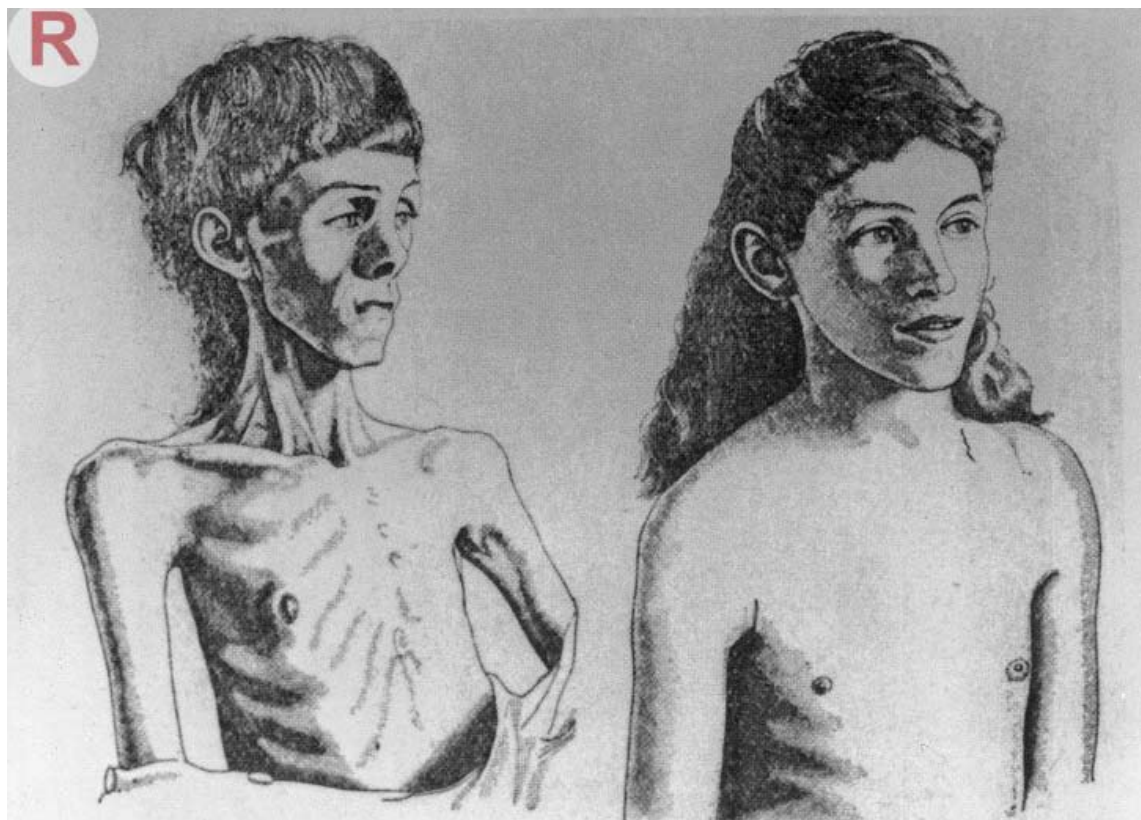


Fig. 1. Physicians isolated self-starvation in the 1870s. Named 'anorexia nervosa' by William Gull, line drawings are from his article in *The Lancet's* first volume (1888).

Anorexia mystified Becca:

To this day, I really don't know why, all of a sudden, I decided to have these weird eating patterns and not eat at all. Exercise so much. I think that I was just a perfectionist, just wanting to make my body even more perfect. But the thing is, a skeleton as a body really isn't perfect. So I don't know exactly what my train of thinking was.

The usual explanations didn't work: she had no weight to lose ('people would always tell me how skinny I was'), no festering trauma, no troubled psyche. On the contrary, an upbeat person ('I'm very energetic and very bubbly'), she got along well at home ('I have really loving and supportive parents') and school. A top athlete who made excellent grades and had good friends, life was going well when anorexia suddenly came out of nowhere. Neither Becca nor her therapists could explain how it all happened.

Becca's story isn't exceptional. Although a clinician would rightly diagnose 'atypical anorexia nervosa', her type-denying case is anything but atypical. Through in-depth interviews with 22 recovered anorexics (20 female, 2 male) in Tennessee and Toronto, we repeatedly heard type-denying cases. So did Garrett (1998) who, in interviewing 34 Australian anorexics, found vanity did not explain the disease, and Warin (2005) whose 46 anorexic subjects at three sites (Australia, Scotland, Canada) repeatedly told her 'anorexia was not solely concerned with food and weight'. Clinicians in Asia report similar findings (Khandelwal, Sharan and Saxena 1995, Lee, Ho and Hsu 1993), as do those in the US (Katzman and Lee 1997, Palmer 1993), who find many patients neither fear fat nor crave thinness as a 'typical' anorexic should. Indeed, what the public and many professionals have come to expect – women dieting madly for appearance – does not adequately explain cases on either side of the globe.

Instead of adolescent girls literally dying for looks, we found youthful ascetics – male as well as female –

obsessing over virtue, not beauty. Their restricted food intake was never just instrumental (the means to weight loss) but always also expressive or adventurous or even accidental. Most had an experience of transcendence or grace, echoing the 'distorted form of spirituality' that Garrett (1998: 110) found in Australia. That said, today's pathology is neither specifically religious, as anorexia once was (Bynum 1987), nor the performance of tradition, as monastic asceticism still is (Flood 2004). Indeed, precisely because our interviewees' self-imposed asceticism developed outside established religious institutions, it had no community or tradition to regulate it, to reign in excess. Initially exhilarating, their virtuous eating and exercising eventually became addictive. That, anyway, was what our interviewees described – the anorexic's anorexia.

Shockingly, that isn't the disease that many institutions are treating. Although most professionals know it's not as simple as a desperate striving for beauty, research has yet to capture the complexity that practitioners actually face. Take distorted body image: this is still an official diagnostic criterion, but that cliché had collapsed under contradictory evidence by the early 1990s (Hsu and Sobkiewicz 1991). Categorizing anorexia as an *eating* disorder is also problematic: many cases might more readily be called *exercise* disorders, and every case is an ascetic disorder. The pressures and challenges of adolescence have similarly been ignored, as has the unsettled issue of gender: while most sociocultural explanations treat anorexia as a women's disease (e.g. Bordo 1997), men make up from one fifth (full syndrome) to one third (full or partial syndrome) of sufferers (Woodside et al. 2001). Over the years the putative cause has changed – from hysteria or pituitary dysfunction a century ago to malignant mothering or sexual abuse today – but the one constant is the way in which these explanations look *through* rather than *at* the anorexic as a whole person. The discourse on anorexia thereby detaches

We would like to thank our informants and recognize the help and insights of Anne Becker, Leeat Granek, John O'Connor, Jim Peterman and the AT editors and reviewers.

1. In the 19th century, as modern medicine was developing its scientific authority, rationalism's theorizing often trumped empiricism's everyday evidence. Where the former was Platonic, seeing reality *behind* appearances, the latter followed Aristotle in learning from direct observation. At one point calling a physician an 'empiricist' implied he was a quack who practised by personal observation rather than scientific theory (*Oxford English Dictionary* 1989).

Fig. 2. After a death-defying fast, the Buddha discovered the Middle Way. Where traditions control religious asceticism, today's anorexics are secular ascetics whose austerities come to control them. *Ascetic Buddha from But Thap Temple, Vietnam, 17th Century.*

from that anorexic's experience and values. No wonder treatment programmes are so unsuccessful (Agras et al. 2004, Ben-Tovin et al. 2001)!

Medicalizing – and mystifying – anorexia

How has health care moved so far away from the anorexic's anorexia? The larger intellectual answer is Cartesian dualism: in dividing mind from body and individual from society, modern thought fights any realistic social and cultural understanding of disease. The more immediate institutional answer is medicalization: over two centuries, by isolating the sick and sickness from their surroundings, biomedicine has complicated diseases like anorexia and obscured their causes. An emerging literature shows how treatment programmes can exercise a Foucauldian power over anorexics (Eckermann 1997), replicate conditions that support and possibly cause the disease (Gremillion 2003, Warin 2005) and, by labelling the person an anorexic, inspire efforts to live up to that diagnosis (Warin 2005, 2006). Our interviewees supported these findings, testifying to how treatment sometimes aggravated their affliction and inspired resistance. While medicalization can save lives, in this regard its hegemony hurts patients.

Our findings stress how medicalization detracts from research, by obscuring the causes of anorexia. We set out to contextualize anorexia, only to end up demedicalizing the syndrome. When we look at the mind/body split, for example, we find that in imposing this arbitrary Cartesian distinction, medicalization makes anorexia into a mental illness – the mind's war on the body. That sounds reasonable – and if we ignore the 'mindful body' (Scheper-Hughes and Lock 1987) and neuroscience, it might be – but how and why this happens becomes a total mystery. Yet all we had to do was erase this Cartesian division to see how an intense mind-with-body activity (restrictive eating and rigorous exercise) bootstrapped anorexics into anorexia much as boot camp makes civilians into soldiers. And if we examine the individual/society distinction, we see that in isolating anorexics as abnormal, medicalization takes them out of the environment that gives them social and moral reasons to restrict. Suddenly their actions look completely senseless, inviting arbitrary psychological and biological guesswork. Yet all we had to do was put the person back in context for the obvious evidence to suggest that anorexics were misguided moralists, not cognitive cripples. Warin (2003) makes a similar point: seen in context, anorexics are following cultural rules for hygiene, not obsessing randomly or venting secret traumas. Again and again, contextualizing anorexia challenges the way medicalization constructs the condition by isolating it.

One disease, two approaches: who has it right? We don't deny that anorexics need medical attention – indeed, it's the most directly deadly mental illness – but medicalizing anorexics and pathologizing their asceticism and other cultural practices have a miserable record of repeated failure. Today, over 130 years after physicians first isolated self-starvation as a disease, biomedicine can neither adequately explain nor reliably cure, nor even rigorously define anorexia (Agras et al. 2004). As medicine's isolating has failed so spectacularly, perhaps anthropology's contextualizing can do better?

Contextualizing anorexia

What is striking about reconnecting anorexia to its context is just how much the obvious evidence can explain. Once our interviews had given us life-course and life-world details, anorexia was anything but exotic. Its extraordinary asceticism had ordinary roots: schooling, sports, work and healthy eating all taught self-denial that these over-achievers took to heart. Anorexics simply exaggerated – and eventually incarnated – the deferred gratification that



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is so widely preached to the young. Anorexia, then, did not come out of the blue. It came out of perfectly obvious surrounding values and local bodily practices.

In Becca's case, for example, although anorexia is unexpected for her, it develops out of obvious life-course patterns that she readily describes. In her words, 'I'm a real big perfectionist.' In growing up,

I kind of had this image of Becca. When people referred to me it was because of something that had been done quite well. That's what perfection came to. I wanted every little thing about me to just – I guess – be an example. That people would look at me and, like, 'Wow, there goes Becca! Oh, that's the perfect child!'

What Becca describes is a virtuous identity, not a mental pathology. What goes wrong is that she applies this to eating. Her diet thereby takes on a moral character where fat is evil and she chooses good relentlessly.

In third grade I almost had an eating disorder. For some reason I just got scared of fat. I would look at nutrition panels and I would observe the fat, what it said, and I really got scared of fat. I would only eat Kellogg's cereal. Mom was like, 'I just cooked dinner and you're eating Kellogg's cereal!' 'I like Kellogg's!' My mom got to the point where like, 'Rebecca, if you don't stop eating just Kellogg's corn flakes I'm going to take you to see a doctor.' And that scared me. I didn't want anyone to think that there was something the matter with me. So how my mom and I approached the problem was we started going to this health food grocery store called Whole Foods. They have a lot of organic products. We would go every Sunday. It was quite a distance. I would get really upset when we didn't get food from Whole Foods.

Was Becca idealizing supermodels? No – and neither was Jim. He reports the same third-grade aversion to fat ('I remember I stopped drinking whole milk and eating red meat in third grade . . . That was back when the big health trend was fat. We didn't eat anything fat. No fat at all. Never. None.'). Only much later, as a high-school runner, did this health-obsessed athlete train himself into anorexia.

Anorexia's cultural connection

Becca's restricted eating copies her mother directly ('I look up to my mom a lot and my mom eats really small portions because she gets full easily'), whereas Jim's regimen develops mutually with his mother ('we pushed

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Ben-Tovin, D. et al. 2001. Outcome in patients with eating disorders: A 5-year study. *The Lancet* 357: 1254-1257.

Bordo, S. 1997. Anorexia nervosa: Psychopathology as the crystallization of culture. In: Counihan, C. and Van Esterik, P. (eds) *Food and culture, A reader*, pp. 226-250. New York: Routledge.

Bruch, H. 1962. Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine* 24(2): 187-194.

Brumberg, J.J. 1997. *The body project: An intimate history of American girls*. New York: Random House.

Bynum, C.W. 1987. *Holy feast and holy fast: The religious significance of food to medieval women*. Berkeley: University of California Press.

Eckermann, L. 1997. Foucault, embodiment and gendered subjectivities: The case of voluntary self-starvation. In: Petersen, A. and Bunton, R. (eds) *Foucault, health and medicine*. London: Routledge.

Flood, G. 2004. *The ascetic self: Subjectivity, memory and tradition*. Cambridge: Cambridge University Press.

Foucault, M. 1990. *The use of pleasure: The history of sexuality*, v.2. New York: Vintage Books.

Frank, A.W. 1995. *The wounded storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.

Garrett, C. 1998. *Beyond anorexia: Narrative, spirituality and recovery*. Cambridge: Cambridge University Press.

Green, H. 1988. *Fit for America: Health, fitness, sport and American society*. Baltimore: Johns Hopkins University Press.

Gremillion, H. 2003. *Feeding anorexia: Gender and power at a treatment center*. Durham: Duke University Press.

Fig. 3. From childhood Simone Weil abstained from food out of sympathy for the less fortunate. An ascetic outside religious orders, she died refusing adequate food in solidarity with compatriots overseas in Nazi-Occupied France.



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Helman, C. 2006. Why medical anthropology matters. *Anthropology Today* 22(1): 3-4.

Hsu, L.K.G. and Sobkiewicz, T.A. 1991. Body image disturbance: Time to abandon the concept for eating disorders? *International Journal of Eating Disorders* 10: 15-30.

Katzman, M.A. and Lee, S. 1997. Beyond body image: The integration of feminist and transcultural theories in the understanding of self starvation. *International Journal of Eating Disorders* 22: 385-394

Khandelwal, S.K., Sharan, P. and Saxena, S. 1995. Eating disorders: An Indian perspective. *International Journal of Social Psychiatry* 41(2): 132-146.

Fig. 4. Attributing anorexia to a perceptual or cognitive 'body image' error dates from the 1960s. Now a cliché, meta-studies questioned the idea's scientific standing by the 1990s.



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each other into having these athletic, healthy lifestyles'). That familial link was typical: nearly three quarters of our interviewees (16 of 22) grew up valuing healthy eating and living. Then, as anorexics, all obsessively exaggerated the restrictions inherent in healthy eating. And now, in recovery, all of them watch what they eat, a reasonable yet distant echo of their earlier obsession.

Are these fringe attitudes, the delusions of a few health fanatics? On the contrary, our informants echo how contemporary culture moralizes eating. Witness the popular prejudice whereby fat people, seen as 'letting themselves go', are stigmatized as weak or even bad, while slim people, perceived as strict with themselves, exemplify strength and goodness. Or consider how people readily judge their own eating, speaking of 'sinning' with dessert, 'being good' with veggies, or 'confessing' a late-night binge. What is at stake here is virtue, not beauty. Over the last century or so, as the body has increasingly become a moral arena, eating and exercise have come to test our moral fibre (Brumberg 1997, Stearns 1999).

Anything but marginal, this discourse of individual responsibility is heavily promoted by health agencies and widely accepted by the public. It urges the good person to eat sparingly and nutritiously, exercise regularly, avoid all health risks, and – as a matter of self-respect – keep a slim and attractive body. True, few people live up to this demanding discipline, but fewer still contest that it is 'right', the proper way to live. So it's a bit like a Sunday sermon where the lifestyle urgings are scientific rather than religious – or are they? The discourse of healthy eating cherry-picks science. A more realistic perspective would recognize that health is broadly social, not narrowly individual, and that the 'domain of personal health over which the individual has direct control is *very* small when compared to heredity, culture, environment, and chance', in the words of Marshall Becker (1986: 20), dean of a public health school. Becker goes on to characterize today's faith in healthy living as 'a new religion, in which we worship ourselves, attribute good health to our devoutness, and view illness as just punishment for those who have not yet

seen the Way' (ibid.: 21). Well, it is religious – evangelical even – but it's not very new. Early 19th-century health and fitness movements developed this moralizing discourse (Green 1988), but it was not until the turn of the 20th century that it became mainstream (Stearns 1999).

What draws people into this discourse? Our interviewees gave us two answers: a bodily predisposition and identity politics. Here's Becca on identity:

My best friend's family – whenever I would come to their lake house or something – they would always, 'Goodness gracious, we gotta have fruit for this child! We have to have carrots. Here we have all the other little girls that are having cookies and this kid's eating carrots and fruits and healthy peanut butter snacks.'

Becca restricts her food intake and, against the background of today's cultural concerns, others notice. Their feedback makes this a point of pride, an arena for further achievement. This isn't exceptional. Most of our informants described how a slim body, strict eating, rigorous exercise, or even being anorexic became an identity that they began to value and build into their youthful sense of self. Here age matters: our informants all developed anorexia during adolescence, a transitional time that intensifies the need to find and express one's identity.

The anorexic's constitution

A further factor explaining anorexia appeared when we looked at our informants historically rather than just situationally. Here, in shifting from a life-world to a life-course context, we found a biocultural 'flywheel' carried them into anorexia. To make sense of this evidence, we had to revive the old-fashioned and decidedly non-Cartesian idea that each person has a distinctive constitution. Our update is biocultural.

Anorexics are not culturally but bioculturally constructed. To starve oneself draws on capacities and inclinations that develop only over years. From conception to adolescence, each person's initially wide possibilities progressively narrow as the organism grows and adapts to a particular environment. Day by day, the interaction of biology, culture and chance fix points that shape later interactions, and bit by bit the guiding force of this biocultural hybrid – a constitution – grows. Our informants had developed constitutions as children that later predisposed

Fig. 5. *Achieving in dance, sports and schooling hones capacities in self-denial, performance and persistence that can later facilitate anorexia.*



Kleinman, A. 1987. Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry* 151: 447-454.

Lee, S., Ho, P., and Hsu, L.K.G. 1993. Fat phobic and non-fat phobic anorexia nervosa: A comparative study of 70 Chinese patients in Hong Kong. *Psychological Medicine* 23: 999-1017.

Oxford English Dictionary 1989. 2nd edition. New York: Oxford University Press.

Palmer, R.L. 1993. Weight concern should not be a necessary criterion for eating disorders: A polemic. *International Journal of Eating Disorders* 14: 459-465.

Rich, E., Holroyd, R. and Evans, J. 2004. Hungry to be noticed: Young women, anorexia and schooling. In: Evans, J., Davies, B. and Wright, J. (eds) *Body knowledge and control: Studies in the sociology of physical education and health*, pp. 173-190. London: Routledge.

Scheper-Hughes, N. and Lock, M.M. 1987. The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly* 1: 6-41.

Stearns, P.N. 1999. *Battleground of desire: The struggle for self-control in modern America*. New York: New York University Press.

Warin, M. 2003. Becoming clean: The logic of hygiene in anorexia. *Sites: Journal of Social Anthropology and Cultural Studies*, ns 1(1): 109-132.

— 2005. Transformations of intimacy and sociality in anorexia: Bedrooms in public institutions. *Body and Society* 11(3): 97-113.

— 2006. Reconfiguring relatedness in anorexia. *Anthropology and Medicine* 13(1): 41-54.

Woodside, D.B. et al. 2001. Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community. *American Journal of Psychiatry* 158(4): 570-574.

them to anorexia as adolescents. Three dispositions stood out:

- *A performative disposition:* Although most children perform for the admiration of parents and teachers, our informants had long built their sense of who they were, and how they thought, felt and acted, around sustained superior performance. All had records of high achievement and roughly a third called themselves perfectionists. Almost all excelled academically; four-fifths grew up not just with but through dance, athletics or both, and out of that subset, over half were so good that they competed regionally or nationally.

- *An ascetic disposition:* As determined achievers, our interviewees had mastered deferred gratification long before they took up restrictive eating in adolescence. Some developed self-denial as a bodily mode through sports. Molly, for example, says: 'Athletics actually taught me self-discipline. So I knew how to push myself and I knew how to be mentally tough. I learned you can always push yourself further. What you think you can do, you can do more.' That attitude got her into anorexia as well as state tournaments.

- *A virtuous disposition:* A major figure in the study of anorexia, Hilde Bruch characterized her anorexic patients as 'outstandingly good and quiet children, obedient, clean, eager to please, helpful at home, precociously dependable, and excelling in school work' (1962: 192). That fit how our interviewees saw themselves. Although we had no way to confirm that they were as good as they said, a virtuous disposition is the single most consistent explanation for their remarkable success as children, students and athletes.

Were someone to take up dieting, healthy eating or training for any reason, these dispositions would intensify their practice. In this sense our informants were primed for anorexia. All of this was quite obvious once we looked at life-course.

Reviving empiricism

None of what we have attributed to constitution, identity and ideas about healthy living is guesswork. It's what our informants reported, each speaking independently. With remarkable consistency they describe paths into anorexia that are obvious and rather ordinary – at least until the last step. That final exceptional step – becoming anorexic – is mysterious. None of our informants could say how or even

when it happened. So perhaps here, as the change comes invisibly, clinical inference might reasonably replace everyday evidence. And yet, when we pieced together what our informants said separately, we discovered that even the final move into anorexia had left empirical tracks. We found eight recurring features that, taken together, suggested how intense restriction of food intake and exercising integrated into a self-sustaining system. That is not to say that the facts speak for themselves – in this instance Foucault's (1990) technologies of the self elucidated the dynamics. But we would argue that, taken seriously, empiricism can penetrate even the enigmatic.

Empiricism has answers that medicalization dismisses. Instead of making the most of what is obvious, specialists *assume* anorexia has an *underlying* pathology, that the cause is deeper than what the surface suggests.¹ And that might eventually prove to be the case – we certainly can't rule out what is yet to be discovered – but for now it is more helpful to reason with the obvious rather than guessing at the obscure. That is better science: by the law of Occam's razor (the principle of parsimony), simple and direct explanations should take precedence over the complex inferences that now 'explain' anorexia. It is also better medicine: addressing the obvious – by showing anorexia's everyday dimensions – would allow anorexics to participate in their own recovery, quite unlike some treatment programmes where specialists take control (cf. Gremillion 2003).

A new cultural brokering

Anorexia falls into a culturally constructed black hole. Here medicalization is less about establishing hegemony than coping with anomaly. Certainly clinicians are not silencing patients – the anorexic has no story to tell. As Becca says, what happens makes no sense. That would explain why British schoolgirl anorexics make "chaotic", "regressive" and "rebellious" statements, refusing to 'package their illness narratives' in an appropriate story (Rich, Holroyd and Evans 2004: 185-86). Their 'chaos narrative' (Frank 1995: 97) is no story at all. How do you explain what your culture hides or imagines wrongly? That puts anorexics, their families and care-givers all in the same boat, lost in culturally uncharted waters.

Applying anthropology can help. Although medical anthropologists often act as cultural brokers (Helman 2006), it is usually *between* cultures, translating Western medicine and non-Western patients for each other. But the brokering we propose, in translating a biocultural disease for today's biology-or-culture thinking, is *within* our own culture. Here the real challenge is not explaining this particular eating disorder, but establishing how sickness and health are social, and not just individual, matters. Like it or not, we fall ill and recover as social and moral beings, not solitary bodies. Anorexics, in living a truth that Cartesian dualism denies, become patients that modern medicine doesn't know how to cure.

Can cultural brokering suggest cures? Crossing cultures and healing illness take different skills. Although some exceptional individuals do both in fields like cultural psychiatry (Kleinman 1987), cultural brokering can serve medicine precisely because it comes from outside the rigorous standards, narrow focus and quick decisions that most health care rightly requires. Here, taking the role of outsider, the anthropologist can broker an appreciation of context, diversity and holism that few health care professionals have the time, training or detachment to provide for themselves. At least for anorexia, that is desperately needed. Now that medicalization has lost the anorexic's anorexia, even the brightest anorexics and best clinicians labour under a handicap that cultural brokering could relieve. ●