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The Phenomenon of Anorexia Nervosa: A Feminist Perspective

Anorexia nervosa is an eating disorder—and yet it is not. The victims of this self-starvation syndrome are obsessed with weight loss, reducing their body weight to medically dangerous emaciation while still maintaining a distorted perception that assures them they are “too fat.” Compulsive behavior, rigorous maintenance of a self-imposed regime, frenetic exercise, and a sense of isolation from others characterize the anorexic, who is almost always female, between the ages of twelve and thirty, and from a wealthy, high-achieving family background. The psychological manifestations typifying this disorder suggest that the controlling of food intake is a symbolic reaction against deeper issues in the patient’s life, so that while the physical/medical symptoms of anorexia require interception and treatment to maintain her very life system, actual therapy to correct the seat of the disorder is psychological. Hospitalization is frequently a necessary recourse to supply the patient with enough caloric intake to prevent death, and indeed the mortality rate of the disease is frighteningly high and the prognosis grim.

The great interest in anorexia nervosa as a medical/psychological phenomenon, in research circles today, is directly related to the alarming rise in cases in the United States and other Western nations. Once found only in ballet academies, an environment that seemed to justify the disorder since weight control was a prerequisite for inclusion in the company, anorexia is now prevalent on college campuses, in private schools, in sororities, and even in junior high schools. It has been estimated that nearly 20 percent of college women in the United States are affected with either anorexia or bulimia (a binge-purge syndrome).¹ Surveys and discreet questionnaires circulated by campus health centers support this estimate.² The prevalence of anorexia nervosa is illustrated in the following pathetic story. During a radio

talk show broadcast by Washington, D.C., radio station Q107-FM on 1 July 1984, a discussion on eating disorders and treatment programs was presented by Sonia Lang of the Washington Hospital Center. For the next two hours, phone lines of the station were jammed with calls from as many as thirty anorexic young women calling to seek help. Several discussed their syndrome on the air. Some insisted there was nothing wrong with them. Since the radio program aired at midnight, the haphazard audience could not have been large. The fact that such a high percentage of listeners tuning in happened to be anorexic is startling testimony to the high incidence of anorexia. How many other listeners had eating disorders but did not phone the station, did not identify themselves with the patients discussed on the air?

One of the primary problems of treating anorexia is that the behavior pattern is regarded as an *achievement* not only by the anorexic but by her peer group. "I wish I could be as skinny as you," "I wish I had your will power," are frequent remarks of admiration directed at the fanatic dieter by her friends. Why can so many women diet tiresomely, off and on, with no real commitment, when others turn the process into an obsession? How does the rise of anorexia correspond to the American ideal of beauty that says thin-equals-win? When was anorexia nervosa first diagnosed, and why are its victims overwhelmingly female?

The history of anorexia nervosa includes both medical case histories and psychological case studies from earlier periods that suggest anorexia to the modern professional. The first recorded case seems to be the fasting of the Buddha Bodhisattva Lahore in the third century A.D., a search for enlightenment that motivated the monk to prove the connection between self-denial and starvation.³ The spiritual rather than medical facet of this first case sets an important precedent: purification power and pleasure from self-denial are the guidelines of many modern anorexics. The next case recorded in history also reports the suffering of a male anorexic: a young prince treated in the eleventh century by the Persian physician and philosopher, Avicenna. According to Dr. John Sours, who has written a concise history of anorexia in his book *Starving to Death in a Sea of Objects*, "Avicenna was able to communicate with the man, break into his delusional system and create an effective therapeutic situation."⁴

Although these first cases are vague, they incorporate several factors still representative of anorexia today. The early association in Oriental and Middle Eastern medicine with spiritual and religious elements suggests that it is no accident that the phenomenon of anorexia would first be noted by non-Western healers. That the first cases focused on individuals of high

caste—ascetic and prince—also is consistent with the perpetuation of anorexia as an upper-class disease.

Dr. Katherine Halmi suggests that the first well-documented case of female anorexia is the thirteenth-century life of Princess Margaret of Hungary, whose postmortem canonization prompted extensive Vatican documentation of her brief history.⁵ She was raised in a cloister, and her dedication to religious life and subsequent rejection of possible marriage led her to initiate “bodily penance” that resulted in her death at age twenty-six (and canonization in the twentieth century). Fasting, menial labor, sleep deprivation all led to visible frailty, but did not diminish Margaret’s energy or obsession with food preparation. Her fasting was not only beyond the call of religious duty (for she was requested to cease at several points), but brought none of the serene quiescence normally associated with spiritual self-denial. Hence, rebellion rather than submission characterized her refusal to eat; her regime of deprivation was self-imposed rather than prescribed by her religious order.

The sainthood ultimately conferred upon Margaret is paralleled by the aura of “saintliness” that customarily surrounds anorexia. Victims are generally obedient, even brilliant students, praised by family and teachers as “terribly good.” The predisposition to discipline, the early acquiescence to authority set the stage for the anorexic’s complete submission to her eventual inner dictator. The *need* for control and discipline, not mere inclination, renders her a prisoner of that inner voice which commands her to stop eating.

Dr. John Sours divides the history of anorexia into four distinct phases since the first case recordings. Phase one, 1600-1910, contained initial descriptions of the disease in various case studies. While numerous cases throughout the Middle Ages went unnoticed because of widespread predisposition to religious fanaticism and phenomena incorporating all manner of odd behavior and deprivations, physicians in the seventeenth and eighteenth centuries noted many anorexics whose deaths were attributed to “anxious,” “sad,” “nervous,” or “hurtful” cares culminating in self-starvation.⁶ Clinical diagnosis focusing on the gastric nerves was the next obvious development, for the frequent syndrome of bulimia alongside anorexia suggested physical disorders. However, the psychological aspect of the disease was not discounted, and, interestingly, the central impact of family conflicts was suggested as early as 1789 by Naudeau.⁷ In 1868, Gull, another physician, also noted that “the relatives made the worst possible attendants.”⁸

The second half of the nineteenth century saw the division of anorexia into “gastric” and “hysterical” variations, as French and British physicians each discovered the syndrome in case research. Lasegue in 1873 examined

the anorexic's inability to eat, whereas Gilles de la Tourette in 1895 "knew that the anorectic suffers not from a loss of appetite; instead, a blatant refusal to eat."⁹ Finally, in the period from 1903 to 1909, the case studies of Pierre Janet produced the diagnosis of sexual self-denial, the anorexic who fears her feminine sexuality, deliberately reduces her flesh from disgust with her developing body, and denies the womanly role.¹⁰

The second phase of the history of anorexia, according to Sours, was the period from 1910 to 1938 when Hamburg pathologist Morris Simmonds's pituitary research weakened the conviction that anorexia was a psychological disturbance. Sours reports that Simmonds's "anatomical and clinical description of these panhypopituitary patients strongly suggested that they were cases of anorexia nervosa. . . . In the following twenty years innumerable anorectics were diagnosed as suffering from panhypopituitarism and were treated with various extracts from the pituitary gland."¹¹

In phase three (1938-1960) the return to psychological status of the disease was encouraged by the rise in interest in psychoanalysis and psychosomatic medicine. Oral-sadistic tendencies, fear of pregnancy, food symbolization, and sexual dread were all suggested as anorexic incentives. Finally, in the contemporary phase from 1960 to the present, the fusion of clinical, psychological, and historical research on anorexia has produced enough "experts" and concerned professionals to instigate multidisciplinary conferences, advanced research programs incorporating treatment at national clinical centers, and a plethora of timely books addressing the crisis, which available data suggests has reached epidemic proportions.

Dr. Katherine Halmi, in her article "The Diagnosis and Treatment of Anorexia Nervosa," presents a table of the current diagnostic profile for anorexia, which includes:

1. Intense fear of becoming obese, which does not diminish as weight loss progresses.
2. Disturbance of body image; for example, claiming to "feel fat" even when emaciated.
3. Weight loss of at least 25 percent of original body weight; or, if under eighteen years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25 percent.
4. Refusal to maintain body weight over a minimal normal weight for height and age.
5. No known physical illness that would account for weight loss.¹²

To these criteria may be added those utilized by the anorexia treatment

program of the Washington Hospital Center: alternative hyperactive and depressed states, extreme moodiness, and increasing social isolation, loneliness, and insecurity.¹³

The difficulty in diagnosing and treating anorexia may be exacerbated by its current medical vogue. Information about the syndrome filters through the contemporary media, and not only do young women learn how to make themselves vomit from reports on bulimarexia, but others recognize their own symptoms and begin to hide them from the family at an early stage, hindering detection until a stage of medical emergency results. Contrary to its literal translation—"nervous loss of appetite"—anorexia nervosa does not eradicate its victims' craving for, or interest in, food. Fascination with cooking and recipes, constant calculation of calories, advance planning of a week's eating regimen, and a desire to feed other family members are all part of the victim's daily thought processes. Ability to escape detection is aided by the fact that in the contemporary Western family with its hectic schedule and varied social activities, the family often eats in separate shifts, and therefore eccentric eating habits can be perpetuated in private. However, the pressure of "public" eating and the expectation to eat on at least a twice-daily basis should not be minimized when understanding the difficulty in an anorexic's recovery. Support groups and therapies for victims of drug or alcohol abuse focus on abstinence as a solution; the anorexic cannot avoid eating forever. Food neuroses must be confronted and no substitute for eating is possible.

While contemporary experts such as Hilde Bruch and Steven Levenkron recommend family therapy as part of the recovery process, it is not rare for diagnosis to begin only at the time of hospitalization or even death. Dr. Halmi reports, "It is exceedingly difficult to accomplish a behavioral change with psychotherapy in an emaciated patient. Admitting the patient to a structured environment in a hospital allows for an efficient nutritional rehabilitation and a more rapid recovery."¹⁴ The irony in the preceding statement is that despite her seemingly stubborn and unreasonable behavior, the anorexic lives a more "structured" life than anyone else. Discipline is hardly foreign to her desperate regimen of self-regulated deprivation. Transferral to a hospital environment with authoritarian personnel removes the patient from psychological interference by parents, but imposes a substitute code of behavior: being a good patient. The frequent youth of the patient and the general infantilization of patients by hospital rules and personnel trigger more rebellion on the part of the anorexic, who determines to outwit the staff and "trick" them into believing her to be either cooperative or recovered. Such "tricks," as discussed at an anorexia conference at the

Washington Hospital Center in August 1984, include hiding food in bed-springs, insertion of weights into body orifices to falsify daily weighings, and wearing several layers of clothes to stimulate weight gain.¹⁵ The anorexic, although a mastermind at covering up her extreme behavior, is nonetheless unable to accept or process information on her nutritional needs. And yet, at one point the anorexia treatment program of the Washington Hospital Center had, as patients, nine lawyers and three nurses.

The current interest in anorexia as a research topic has prompted a variety of experimental studies. While the Washington Hospital Center offers family therapy, daily exercise, nutritional lectures, and a variety of activities as part of its treatment program, clinical research currently being conducted at the National Institutes of Health in Bethesda, Maryland, offers patients a far more restricted environment.¹⁶ The NIH program is voluntary, subsidizing its patients with free care in return for their participation in a study that can last from four to ten months. Research, not preparation for return to society, is the apparent theme at NIH; the protocols of the clinical program are carefully guarded from reproduction by other clinics, and I was not allowed to retain copies although I participated in the program myself. Behavior modification is the method employed for weight gain; patients are expected to gain 0.2 kilograms per day, and failure to do so results in loss of privileges—which are few indeed. The eight or nine women live in a locked psychiatric wing, with no exercise, classes, arts, or activities to break the monotony of a nine-month stay. Restriction to the day room, with a television and magazines, and eventual permission to go on brief walks are the basics of existence other than meals and medical testing. The emphasis on research means the removal of all factors that complicate evaluation: that is, excessive stimuli, activities, and other variables. While this may result in pure clinical data, the program appears bleak and prolonged in comparison with the participatory activities—and their implication of self-responsibility—at the Washington Hospital Center a mere thirty miles away.

The reduction of patients to passive and docile research specimens suggests the complexity of a patient-doctor relationship involving a young woman and a typically male, middle-aged clinician. The deliberate actions of the anorexic patient to deny her sexuality through excessive dieting, which alters secondary sexual characteristics and causes cessation of menstrual periods, reduces her to the childlike—and androgynous—appearance she has sought.¹⁷ Behind the weak body and childlike vulnerability, however, lurk the pathological determination and cunning that are often underestimated by paternal physicians. The patient has, in most cases, been a “good

girl" all her life and is not interested in repeating that role by being a good patient.

The preceding paragraph—and indeed the entire phenomenon of anorexia—calls for the application of feminist analysis to issues such as dieting and self-image. While the known history of anorexia suggests that it is a syndrome not limited to Western or contemporary societies, the demonstration of soaring trends in the United States and Britain today—in this era of aerobics classes and Brooke Shields—indicate the seeds of misogyny in our national female-body image.

The association of a woman's status and character with her thinness sets up an underweight physique as an ideal, producing perpetual discontent in the eyes and minds of millions of young women. The weight fluctuation and body development that come with adolescence preclude a stable perfection just at the point when the young woman becomes the focus of exaggerated interest in the street and the school hallway. Dissatisfaction with the bodily self is encouraged by countless television and magazine ads, which virtually accuse women of irresponsibility to loved ones and to society (but to self?) unless they purchase such improving agents as wrinkle removers, feminine hygiene sprays, and diet aids. Products are offered to hide every stage of the normal woman's development. Almost without exception, models used for these commercials are atypically tall, thin, small-breasted professionals, many of whom are anorexic themselves. The question is not why so many women become anorexic in this society, but why more are not. Obsession with diet is considered a positive value and accorded the same importance in female peer groups as athletic prowess among males.

Among the many texts currently in print on the subject of anorexia, there is one feminist analysis: *The Obsession*, by Kim Chernin. While some contemporary studies of anorexia actually blame the rise of feminism for putting additional identity pressure on young female achievers, Chernin addresses "the tyranny of slenderness" with the following declaration: "When a girl is afraid to develop a woman's body, the conflict she feels means more than even a struggle between mind and body. Anorexia nervosa now suggests that our tempestuous warfare against our bodies involves no less than a woman's identity as a woman."¹⁸

Chernin berates the medical and psychological professions for steadfastly ignoring the obvious implications behind the fact that over 90 percent of anorexics are female.¹⁹ While the impetus to avoid sexual maturity has been well documented by anorexia specialists, it has been interpreted psychologically as fear of assuming the womanly identity without any examina-

tion of how society circumscribes that identity. While fat men are stereotyped as successful, fat women are the epitome of failure. The maturing young woman knows she has the potential to fail merely by occupying a body of unacceptable dimensions. Generous dimensions are tolerated only during pregnancy, when the woman's added curves suggest production—and production of another, not mere self-development.

That the majority of anorexic women come from well-to-do, high-achieving backgrounds suggests that excessive dieting is one way to guard against "failure." One anorexic young woman, whose father occupied a key government position, told me that whereas her parents and brother were "perfect," *she* was the oddball, the failure.²⁰

Incarceration in the patronizing hospital atmosphere is hardly a conducive environment for the development of dignity, self-esteem, or a healthy sense of body. The prognosis for anorexia, however, is poor enough to warrant extreme measures at the dangerous emaciation stage. Whether or not the patient ultimately gets a feminist therapist has a lower priority. Yet it must be reemphasized that the society which puts excessive emphasis on dieting must be prepared for dire consequences in those overzealous adherents who believe in the magical powers of dieting to resolve all social conflicts.

"Implicitly," declares Chernin, "we are asked to believe that if every woman lost twenty-five or thirty pounds she would be able to overcome the misogyny of our land; her social problems would be solved, the business world would suddenly fling wide its gates and welcome her into its privileges. . . . There is a profound untruth here and a subversion of the radical discontent women feel. In a class of this sort, women are directed to turn their dissatisfaction and depression toward their own bodies."²¹

The implication is not that anorexia is a purely political phenomenon, but that medical and psychological treatment are not sufficient therapy for returning patients to a society which sneers at healthy-sized women. Chernin advocates incorporation of positive imagery in recovery programs. That even the most well-intentioned anorexia therapists fall prey to stereotypes of women is evident in the case histories presented by Dr. Sours, who routinely describes patients in terms such as "sugary," "a bit of a cowgirl in stance," "comic-book blue eyes," "thin spinster," "wide-eyed teenager."²² While these characterizations perhaps enliven the case studies and draw the reader closer to the patient, the often disrespectful tone assumed by the clinician turns an additional scrutiny on the patient that only exacerbates her position of being under a medical microscope.

The problem in forging a comprehensive prevention *and* treatment

program for anorexia nervosa is the frequent incompatibility of nonmedical feminism and nonpolitical psychobiology. Compiling psychological data on the causes of anorexia without taking into consideration the social role dieting plays in Western female culture ignores a central motivation, as well as the pressures of cultural misogyny to which a recovered anorexic must return.

Statistics on the relapse rate of treated, "recovered" anorexics are not yet available. Therefore it is difficult to effectively evaluate the merits of disparate therapies, or to compile a superior prognosis for anorexia patients based on the application of any uniform care program. Because anorexic patients are apprehended at varying stages of physical danger, the effects of psychological therapies are constantly offset by existing medical damage ensuing from the starvation process.

The appeal of remaining a little girl, certainly a part of the syndrome that leads to cessation of menses and passive helplessness, is difficult to overcome in a paternalistic health care system. Moreover, the very "newness" and perplexing qualities of the anorexia syndrome engender a spirit of curiosity and challenge among physicians that objectifies the female patient even more. Resistance to therapy is a private triumph for the patient, who is desperate to maintain her self-imposed starvation regimen, and whose outer fragility serves as an effective blind for her ability to outwit a protective parental/medical team.

In summary, the prognosis for anorexia is obviously poor. The development of specific clinics and therapies may suffice in a percentage of cases to cope with the results of the disease, but its initiation by countless adolescents will continue to soar as long as Western society upholds the image of the underweight woman as glamorous and socially acceptable. Caution against underweight, as well as against obesity, is rarely given during youthful visits to the family physician. Medical responsibility to contradict the popular belief that a woman can never be too thin is one necessary reform. But, as Kim Chernin laments, "We feel more at home in our culture when we lose weight. Culture rewards those who comply with its standards. But we have to wonder what cost the woman is paying when she sacrifices her body in this way for the approval of her culture."²³

Notes

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1. According to Dr. Sonia Lang, director of the anorexia treatment program of the Washington Hospital Center, Washington, D.C.
2. Including a 1983 study questionnaire at the State University of New York at Binghamton, where I initially prepared this paper.
3. John Sours, *Starving to Death in a Sea of Objects* (New York: Jason Aronson, 1980), p. 205.
4. Ibid.
5. Katherine Halmi, M.D., "The Diagnosis and Treatment of Anorexia Nervosa," in *Eating, Sleeping, and Sexuality*, ed. Michael Zales (New York: Brunner/Mazel, 1982), pp. 43-44.
6. Sours, *Starving to Death*, pp. 206-7.
7. Ibid.
8. Ibid., p. 207.
9. Ibid., pp. 207-8.
10. Ibid., p. 208.
11. Ibid., p. 209.
12. Halmi, "Diagnosis and Treatment," p. 44.
13. "Food and Obsession: A Way Out," CompCare Eating Disorders Unit pamphlet (Washington, D.C.: Washington Hospital Center, 1983).
14. Halmi, "Diagnosis and Treatment," p. 50.
15. Testimony at Eating Disorders Conference, Washington Hospital Center, 30 July 1984.
16. Based upon my participation as a normal volunteer in the eating disorders research program at the National Institutes of Health, Bethesda, Maryland, in June and July 1984.
17. According to a test questionnaire administered to anorexic patients by Dr. Sandra Weiss of the National Institutes of Health, the "ideal age" cited by most anorexic women was nine years old. See her study, "Psychological and Behavioral Characteristics of Normal-Weight Bulimics and Normal-Weight Controls," *Psychosomatic Medicine* 45, no. 4 (August 1983).
18. Kim Chernin, *The Obsession: Reflections on the Tyranny of Slenderness* (New York: Harper and Row, 1983), p. 65.
19. Ibid., p. 63.
20. Conversation with a patient, aged fifteen, at the National Institutes of Health, June 1984.
21. Chernin, *The Obsession*, pp. 105-6.
22. Sours, *Starving to Death*, pp. 227, 237, 244, 262, and 264, respectively.
23. Chernin, *The Obsession*, p. 106.

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