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# UNBEARABLE WEIGHT

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FEMINISM,  
WESTERN CULTURE,  
AND THE BODY

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## Whose Body Is This?

### *Feminism, Medicine, and the Conceptualization of Eating Disorders*

#### THE FEMINIST CHALLENGE

By the 1983 meetings of the New York Center for the Study of Anorexia and Bulimia, palpable dissatisfaction was evident—largely among female clinicians—over the absence of any theoretical focus on gender issues. In 1973, when Hilde Bruch published her landmark work *Eating Disorders*, she made little use of the concept of gender in her interpretation of anorexia. Kim Chernin, in *The Obsession*, was the first to note that the vivid descriptions Bruch provides of the anorectic's "battle" against the adult development of her body consistently lack one crucial element: recognition of the significance of the fact that this is a *female* body whose development is being resisted.<sup>1</sup> Following Bruch, the etiological models that dominated over the next decade emphasized developmental issues, family problems, and perceptual and/or cognitive "dysfunction." In each, the understanding of the role played by the construction of gender and other social factors was, at best, shallow and unsystematic.

Developmental and family approaches conceptualized interactions between mother and child as occurring outside cultural time and space; the father's role was simply ignored. Perceptual/cognitive models theorized the role of "sociocultural factors" solely in terms of "the pressure toward thinness," "indoctrination by the thin ethic"; what passed for cultural analysis were statistical studies demonstrating the dwindling proportions of *Playboy* centerfolds and Miss America winners throughout the 1980s. And, in all of this, transactions were imagined as occurring only between media images and females, or females and other females (peer pressure to

conform; criticisms from the mother); the vulnerability of men and boys to popular imagery, the contribution of their desires and anxieties, the pressures thus brought to bear on girls and women, remained—as father/daughter incest was for Freud—a hidden and somehow unspeakable secret in the prevailing narratives.

In no place was the *meaning* of the ideal of slenderness explored, either in the context of the anorectic's experience or as a cultural formation that expresses ideals, anxieties, and social changes (some related to gender, some not) much deeper than the merely aesthetic. Rather, "the media," "Madison Avenue," and "the fashion industry" typically were collectively constructed as the sole enemy—a whimsical and capricious enemy, capable of indoctrinating and tyrannizing passive and impressionable young girls by means of whatever imagery it arbitrarily decided to promote that season. *Why thinness should have become such a dominant cultural ideal in the twentieth century remained unaddressed; the interpretation of representations was viewed as outside the domain of clinical investigation.*

The one clinical model for which gender *was* a key analytical category, the psychoanalytic, theorized the anorectic's resistance to developing a female body in the terms of traditional Freudianism, as expressing anxieties and fantasies of a purely psycho-sexual nature, such as fear of pregnancy or of attracting the sexual attention of men. Traditional Freudianism has been far more attuned than other models to the symbolic nature of the anorectic's symptoms, recognizing, for example, that the fear of fat on stomachs and breasts has gender associations that demand interpretation and is not merely indicative of compulsive slavery to the latest fashion trend. But Freudian theory nonetheless (and characteristically) has failed to situate the categories of its analysis in a sociocultural setting—to appreciate, for example, that fear of pregnancy may have more to do with fear of domestic entrapment than with suppressed Electra fantasies, or that anxieties about the dangers of sexual involvement might be a realistic response to the disclosure of the abusive and violent patterns that are all too common within domestic relationships. (Research has disclosed, too, that just as many of Freud's hysterics were very likely *actually* sexually abused, as he had originally hypothesized, so incidents of sexual abuse lie in the background of the so-called flight from sexuality of many anorectics, and in the histories of bulimics as well.)<sup>2</sup>

Thus, in 1983, gender either was absent or was theorized in essentialist terms by the leading authorities on eating disorders—a situation that organizers of the conference on anorexia and bulimia sought to rectify. To do so, they had to call on feminists who had been working at the margins of the official establishment: writing for audiences other than medical professionals, practicing therapy outside the framework of then-dominant models, and developing, over the preceding ten years, a very different approach to the understanding of eating disorders. The theme chosen for the 1983 conference was "Eating Disorders and the Psychology of Women," and Carol Gilligan and Susie Orbach were invited to be keynote speakers.

Gilligan's talk introduced the audience to Catherine Steiner-Adair's provocative study of high-school women, which revealed a striking association between problems with food and body image and emulation of the beautiful, independent, cool superwoman of media imagery.<sup>3</sup> Susie Orbach's talk was a moving argument, grounded in object-relations theory and situated in the sociocultural context of the construction of femininity, that the anorectic embodies, in an extreme and painfully debilitating way, a psychological struggle characteristic of the contemporary situation of women. That situation is one in which a constellation of social, economic, and psychological factors have combined to produce a generation of women who feel deeply flawed, ashamed of their needs, and not entitled to exist unless they transform themselves into worthy new selves (read: without need, without want, without *body*).<sup>4</sup> The mother-daughter relation is an important medium of this process. But it is not mothers who are to blame, stressed Orbach, for they too are children of their culture, deeply anxious over their own appetites and appearance and aware of the fact—communicated in a multitude of ways throughout our culture—that their daughters' ability to "catch a man" will depend largely on physical appearance, and that satisfaction in the role of wife and mother will hinge on learning to feed others rather than the self—metaphorically *and* literally.

For Orbach, anorexia represents one extreme on a continuum on which all women today find themselves, insofar as they are vulnerable, to one degree or another, to the requirements of the cultural construction of femininity. This notion provoked heated criticism from the (all-male) panel of commentators, two psychiatrists and

one clinical psychologist. The political implications of Gilligan's talk had been missed by her respondents (and by Orbach's), all of whom chose to hear the paper solely as a lament for our culture's lack of esteem for the "female" values of connectedness, empathy, and other-directedness. Gilligan's talk was (mis)interpreted (as her work frequently is) as a simple celebration of traditional femininity rather than as a critique of the sexual division of labor that assigns "female" values to a separate domestic sphere while keeping the public, male space (and "masculinity") a bastion of autonomous selves.

Orbach's talk, unambiguous in its indictment of the normative construction of femininity in our culture, was much more troubling to the panelists. It elicited from them a passionate defense of "traditional women," with Orbach the feminist portrayed as unsisterly and unmotherly and the panelists cast as sympathetic protectors of those groups that Orbach had abused. So, for example, David Garner, co-author of *Anorexia Nervosa: A Multidimensional Perspective*, felt obliged to defend mothers against the "blame" Orbach had attributed to them and the "guilt" she had inflicted on them for "choosing traditional values" and being fulfilled by "nurturing." Steven Levenkron, author of *The Best Little Girl in the World*, came to the rescue of the anorectic herself—that "skinny kid in your office," as he called her, whose suffering Orbach had failed to appreciate adequately (in suggesting that her pain could be understood on a continuum with normative female suffering). Here, the feminist critique was charged with sacrificing the care of "helpless, chaotic, and floundering" children in the interests of a "rational" political agenda. The panelists thus represented themselves both as better feminists than Orbach (that is, more concerned with actual women's lives), better "women" (more empathic, more caring), and at the same time dazzlingly masculine Prince Charmings, rescuing women from the abstract and uncaring politics of feminism.

Even more provocative than Orbach's critique of the construction of femininity, however, was her questioning of the designation of eating disorders as "pathology." All the panelists, while remarking on how perfectly her interpretation tallied with and illuminated their own clinical experience, were uniform in criticizing her analysis for (as William Davis put it) its "[lack of] specific explanatory conceptions" and "indistinct and unconvincing" theorizing. How

can it be that her analysis both explained and failed to explain? This apparent contradiction in the estimation of the panel can be accounted for only by the hidden stipulation that theory, no matter how well it illuminates a given phenomenon, is inadequate unless it also sets down general criteria to enable clear and precise distinguishing between "normal" and "pathological" members of a population. This, of course, is what Orbach's theory lacked—or, rather, contested. As such, it issued a profound challenge to one of the most basic and most thoroughly entrenched premises of the medical model.

#### PATHOLOGY, CULTURE, AND THE MEDICAL MODEL

In the clinical literature on eating disorders, the task of description, classification, and elaboration of "pathology" has driven virtually all research. In the leading journals, attempts to link eating disorders to one or another specific pathogenic situation (biological, psychological, familial) proliferate, along with studies purporting to demonstrate that eating disorders are members of some established category of disorder (depressive, affective, perceptual, hypothalamic . . . ). Anorexia and bulimia are appearing in increasingly diverse populations of women, reducing the likelihood of describing a distinctive profile for each.<sup>5</sup> Yet the search for common pathologies still fuels much research.<sup>6</sup> As each proposed model is undermined by the actual diversity of the phenomena, ever more effort is put into precise classification of distinctive subtypes, and new "multidimensional" categories emerge (for instance, bulimia as a "biopsychosocial" illness)<sup>7</sup> that satisfy fantasies of precision and unification of phenomena that have become less and less amenable to scientific clarity and distinctness.

Where a unifying element *does* clearly exist—in the cultural context, and especially in the ideology and imagery that mediate the construction of gender—the etiological significance is described as merely contributory, facilitating, or a "modulating factor."<sup>8</sup> The prevailing understanding is that culture provokes, exacerbates, and gives distinctive form to an existing pathological condition. Such an understanding fails to come to grips with two striking facts about eating disorders. First, like hysteria in the nineteenth century, the incidence of eating disorders has always been disproportionately

high among females: approximately 90 percent of sufferers are girls or women. Second, and again like hysteria, eating disorders are culturally and historically situated, in advanced industrial societies within roughly the past hundred years.<sup>9</sup> Individual cases have been documented, infrequently, throughout history, but it is not until the second half of the nineteenth century that something like a minor epidemic of anorexia nervosa is first described in medical accounts,<sup>10</sup> and that incidence pales beside the dramatic escalation of anorexia and bulimia in the 1980s and 1990s.<sup>11</sup>

These elements point to culture—working not only through ideology and images but through the organization of the family, the construction of personality, the training of perception—as not simply contributory but *productive* of eating disorders. A parallel exists in the formation of female hysteria. Thanks to the benefit of historical distance and the work of feminist scholars, almost all clinicians and theorists today agree that the ultimate sources of hysteria and neurasthenia as characteristic disorders of elite Victorian women are located in Victorian culture, and especially (although not exclusively) in ideology and upheavals related to gender. Most Victorian physicians, we should remember, lacked this perspective. It is only as hysteria has shed its symbolic, emotional, and professional freight, as it has become a historical phenomenon, that it has become possible to *see* it, in some ways, for the first time. Among the important elements now revealed is the clear continuum on which the normative and the disordered were located for Victorian women; it becomes possible to see the degree to which femininity itself required the holding of breath, the loss of air, the choking down of anger and desire, the relinquishing of voice, the denial of appetite, the constriction of body.

All this is visible in part because, from the perspective of the present, Victorian ideals of masculinity and femininity and the styles of behavior that regulated them seem *themselves* as dusty and distant as the disorders of the era. They are denaturalized for us, as our own constructions of gender cannot be, no matter how intellectually committed we may be to a social constructionist view. Too, contemporary medicine, protected by its myth of progress beyond the antiquated models and methods of the past, is able comfortably to acknowledge the thrallidom of Victorian medicine to biologicistic paradigms and its implication in a dualistic gender-politics that we

pride ourselves on having transcended. Our contemporary medical models, gender identities, and other ideological beliefs are no longer enmeshed in a struggle to “conquer” hysteria and the mysterious, rebellious female world it once represented to mechanistic science and patriarchal culture. The cultural deconstruction of hysteria as a historically located intersection of Victorian gender-culture and Victorian medicine has thus become possible.

As was noted earlier, it was in the nineteenth century that self-starvation among elite women first surfaced with enough frequency to engage the general attention of the medical profession. But for the nineteenth century, “hysterical” symptoms such as paralysis and muteness expressed better than self-starvation did the contradictions faced by elite Victorian women, for whom the ideology of the compliant, refined, and thoroughly domestic lady was a coercive feminine ideal. Certainly, food refusal was an appropriate symptom in this cultural context, with its rigid prohibitions, both metaphorical and literal, against female appetite and desire, prohibitions that were locked in unstable and painful antithesis with a developing bourgeois culture of affluence and indulgence. But (for a variety of reasons discussed in essays throughout this volume) eating disorders have emerged as an overdetermined crystallization of cultural anxiety only in the second half of the twentieth century. The contemporary woman, who struggles to cope with social contradictions that first emerged in the Victorian era but who confronts those contradictions later in their historical development and as they intersect with specifically contemporary elements, is far more likely to develop an eating disorder than an hysterical paralysis.

It is one thing, apparently, to acknowledge the role played by culture in the production of a virtually extinct disorder, wrestled with by long-dead physicians who were working with now-discredited models.<sup>12</sup> It is another thing altogether for contemporary medicine similarly to interrogate the status of disorders it is still trying to subdue. Researchers do now acknowledge the preeminent role played by cultural ideology in the production of hysteria, but they still resist applying that historical lesson to the understanding of anorexia and bulimia. Although it is frequently acknowledged that cultural pressures may make women “especially vulnerable to eating disorders,”<sup>13</sup> that acknowledgment is usually quickly followed by the comment that not all individuals exposed to these

pressures develop anorexia or bulimia. Hence, it is claimed, other "non-sociocultural" factors must be required in order for the disorder to be "produced" in a particular individual. These non-sociocultural factors (among those most frequently listed: "deficits" in autonomy, tendency to obesity, perfectionist personality traits and defective cognitive patterns, perceptual disturbances, biological factors, emotionally repressed familial interactions) are then weighted alongside sociocultural factors as *equally* determinative of the disorders. In this way we slide from the understanding that culture alone is not *sufficient* to "cause" anorexia or bulimia in an individual (which is true, and was true of hysteria as well) to mystification and effacement of culture's preeminent role in providing the necessary *ground* for the historical flourishing of the disorders. Eating disorders are indeed "multidimensional," as David Garner describes them. But that does not imply that all dimensions therefore play an *equal* role in the production of anorexia and bulimia.

Often, too, it is emphasized that "factors other than culture may be at work producing the high ratio of females to males." As the editors of the *Handbook of Eating Disorders* put it:

What can explain the low prevalence of eating disorders in men? Certainly many men have the personality factors and family background of anorexic women. These men may also have role conflicts about profession and family, and they live in a culture that exerts no small pressure on males to be thin. . . . There could be complex physiological differences in the way males and females respond to chronic energy restriction. It is possible, for example, that males have a stronger counter-response to deprivation than do females, so that hunger, satiety, metabolism, or other factors exert stronger pressure for weight restoration. Males who are potentially anorexic may encounter stronger resistance to the self-imposed starvation, so fewer males progress from the early signs to the chronic condition.<sup>14</sup>

Similarly, in *New Hope for Binge Eaters* Harrison Pope and James Hudson suggest that bulimia may be biological ("Perhaps the hypothalamus, or some other part of the central nervous system concerned with eating behavior, is more easily affected in women than in men") or may be "the characteristic 'female' expression of [an] underlying disorder" which men express in different ways. These hypotheses are offered, equally valenced alongside sociocultural explanations, as part of a fascinating panoply of "possibilities," suggesting diverse "new areas of research."<sup>15</sup>

My point is not to deny that biological factors may play a contributory role in determining which individuals will prove most vulnerable to eating disorders. (It seems, however, virtually impossible to sort out cause and effect here; most proposed biological markers are just as likely to be the *result* of starvation as the cause.) But to suggest that biology may protect men from eating disorders is not to be open to possibilities; it is to close one's eyes to the obvious. Are the editors of the *Handbook* unaware of the statistics on dieting in this country? Do they not know that the overwhelming majority of those attending weight-loss clinics and purchasing diet products are women? Men *do* develop eating disorders, by the way, and, strikingly, those who do so are almost always models, wrestlers, dancers, and others whose profession demands a rigid regime of weight control. Looking to biology to explain the low prevalence of eating disorders among men is like looking to genetics to explain why nonsmokers do not get lung cancer as often as smokers. Certainly, genetic and other factors will play a role in determining an *individual's* level of vulnerability to the disease. But when tobacco companies try to deny that smoking is the preeminent source of lung cancer among smokers *as a group*, diverting attention by pointing to all the other factors that may have entered in particular cases, we are likely to see this as a willful obfuscation in the service of their professional interests.

I am *not* suggesting that, like the tobacco industry, eating-disorders researchers have a vested interest in keeping people addicted to their destructive behaviors. Nor do I mean to suggest that medical expertise has no place in the treatment of eating disorders. The conceptualization of eating disorders as pathology has produced some valuable research. But the medical model has a deep professional, economic, and philosophical stake in preserving the integrity of what it has demarcated as its domain, and the result has frequently been blindness to the obvious. This is not a conspiracy; rather, each discipline teaches aspiring professionals what to look at and what to ignore, as they choose their specialties and learn what lies outside the scope of their expertise, and as they come increasingly to converse "professionally" only with each other.

Arguments have been made, however, that are deeply threatening to the very presuppositions of the medical model and are therefore resisted more consciously and deliberately. What I will

term the feminist/cultural perspective on eating disorders is such an argument, and in a later section of this essay I will discuss the resistance to it in more detail. Before I do that, however, I will first describe the broad contours of the feminist/cultural model, examine some specific contexts in which it has clearly issued a challenge to the medical model, and attempt to correct some common misconceptions about feminist/cultural criticism.

#### "BODY IMAGE DISTURBANCE" AND "BULIMIC THINKING"

The picture sketched in the last section is not seamless. The groundbreaking work of such investigators as Kim Chernin, Susie Orbach, and Marlene Boskind-White has helped to shape a very different paradigm which has been adopted by many eating-disorders professionals.

That feminist/cultural paradigm has: (1) cast into doubt the designation of anorexia and bulimia as psychopathology, emphasizing instead the learned, addictive dimension of the disorders; (2) reconstructed the role of culture and especially of gender as primary and productive rather than triggering or contributory; and (3) forced the reassignment, to social causes, of factors viewed in the standard medical model as pertaining to individual dysfunction. In connection with (3), many of the "non-sociocultural" factors that have been dominantly conceptualized as "distortions" and "delusions" specific to the "pathology" of anorexia and bulimia have been revealed to be prevalent among women in our culture. The ultimate consequence of this, for eating disorders, has been to call into question the clinical value of the normative/pathological duality itself.

The feminist perspective on eating disorders, despite significant differences among individual writers, has in general been distinguished by a *prima facie* commitment both to taking the perceptions of women seriously and to the necessity of systemic social analysis. These regulatory assumptions have predisposed feminists to explore the so-called perceptual disturbances and cognitive distortions of eating disorders as windows opening onto problems in the social world, rather than as the patient's "idiosyncratic" and "idiosyncratic . . . distortions of data from the outside world."<sup>16</sup> From the latter perspective, when a patient complains that her breasts are too large and insists that the only way to succeed in our culture is

to be thin because, as one woman described it, "people . . . think that someone thin is automatically smarter and better,"<sup>17</sup> it is described as flawed reasoning, a misperception of reality that the therapist must work to correct. From a feminist/cultural perspective, this approach ignores the fact that for most people in our culture, slenderness is indeed equated with competence, self-control, and intelligence, and feminine curvaceousness (in particular, large breasts) with wide-eyed, giggly vapidness.<sup>18</sup>

Virtually every proposed hallmark of "underlying psychopathology" in eating disorders has been deconstructed to reveal a more widespread *cultural* disorder. A dramatic example is the case of BIDS, or Body Image Distortion Syndrome, first described by Hilde Bruch as "disturbance in size awareness,"<sup>19</sup> and for a long time seen as one of the hallmarks of anorexia nervosa, both in the popular imagination and in the diagnostic criteria. In both contexts BIDS has functioned to emphasize a discontinuity between anorexic and "normal" attitudes toward weight and body image. In the clinical literature, the initial theorizing of BIDS as a visuo-spatial problem, a perceptual defect, firmly placed anorexia within a medical, mechanistic model of illness (and a positivistic conception of perception, as well). A person who had this "defect" (sometimes conceived as the result of impaired brain-function; sometimes, as by Bruch, as part of a more general pattern of defective processing of body experiences due to inadequate infant development) was unable to see her body "realistically." In more popular renditions, the "bizarre" and mysterious nature of the symptom was emphasized; such descriptions were often accompanied by line drawings of the anorectic standing in front of a mirror that reflected back to her a grossly inflated and distorted image (Figure 3). As one not atypical 1984 article, from a magazine for nurses, described it:

In a way, "anorexia" is a misnomer. Afflicted persons don't suffer from a loss of appetite. Instead, they have a *bizarre* preoccupation with eating—coupled with an obsessive desire to attain pencil-like thinness through restricted food intake and rigorous exercise. Even more *bizarre* is their distorted self-image; it's not unusual to hear a haggard, emaciated anorectic complain that she's still "too fat."<sup>20</sup>

In 1984, however, a study conducted by *Glamour* magazine and analyzed by Susan Wooley and Wayne Wooley revealed that 75



FIGURE 3

percent of the 33,000 women surveyed considered themselves "too fat," despite the fact that only one-quarter were deemed overweight by standard weight tables, and 30 percent were actually *underweight*.<sup>21</sup> Similar studies followed, some specifically attempting to measure perception of body size, all with the same extraordinary results. A study by Kevin Thompson, for example, found that out of 100 women "free of eating-disorder symptoms" more than 95 percent overestimated their body size—on average one-fourth larger than they really were.<sup>22</sup> Such findings, of course, made the postulation of strictly perceptual defect problematic—unless it was supposed that most American women were suffering from perceptual malfunction.

The clinical response to these studies was to transfer the site of "distortion" from perceptual mechanism to affective/cognitive coloration: the contribution to perception of the mind's eye.<sup>23</sup> According to this model, it is not that women actually *see* themselves as fat; rather, they evaluate what they see by painfully self-critical standards. Lack of self-esteem now became the cause of women's body-image problems: "The better people feel about themselves," as Thompson concluded, "the less they tend to overestimate their

size." But women, as study after study has shown, do *not* feel very good about their bodies.<sup>24</sup> Most women in our culture, then, are "disordered" when it comes to issues of self-worth, self-entitlement, self-nourishment, and comfort with their own bodies; eating disorders, far from being "bizarre" and anomalous, are utterly continuous with a dominant element of the experience of being female in this culture.

Attempts to reconceptualize BIDS as affective or cognitive rather than perceptual do not, of course, resolve the problem with the medical model; rather, they make it more apparent. For once such a symptom is reclassified as affective or cognitive the role of culture can no longer be easily effaced or mystified. Ultimately, that role is perceptual as well. Culture not only has taught women to be insecure bodies, constantly monitoring themselves for signs of imperfection, constantly engaged in physical "improvement"; it also is constantly teaching women (and, let us not forget, men as well) how to *see* bodies. As slenderness has consistently been visually glamorized, and as the ideal has grown thinner and thinner, bodies that a decade ago were considered slender have now come to seem fleshy. Consider, for example, the dramatic contrast between the "Maidenform woman" circa 1990 and circa 1960 (Figures 4 and 5). What was considered an ideal body in 1960 is currently defined as "full figure" (Figure 6), requiring special fashion accommodations! Moreover, as our bodily ideals have become firmer and more contained (we worship not merely slenderness but flableness), *any* softness or bulge comes to be seen as unsightly—as disgusting, disorderly "fat," which must be "eliminated" or "busted," as popular exercise-equipment ads put it. Of course, the only bodies that do not transgress in this way are those that are tightly muscled or virtually skeletal. Short of meeting these standards, the slimmer the body, the more obtrusive will any lumps and bulges seem. Given this analysis, the anorectic does not "misperceive" her body; rather, she has learned all too well the dominant cultural standards of *how* to perceive.<sup>25</sup>

The case of BIDS is paradigmatic rather than exceptional. Consider, as another example, what have been termed the "disordered cognitions" or "distorted attitudes" proposed as distinctive to the psychopathology of anorexia and bulimia. These elements of "faulty thinking" or "flawed reasoning" standardly include: "magical thoughts" or "superstitious thinking" about the power of cer-

tain "forbidden" foods such as sweets to set off a binge, which perpetuate such "myths" as "If I have one cookie, I'll eat them all"; "selective abstraction" of thinness, as "the sole frame of reference for inferring self-worth" and "essential to her happiness and well-being" (I am special if I am thin), a belief which persists "in defiance of examples to the contrary"; "dichotomous reasoning" concerning food, eating, and weight ("If I'm not in complete control, I lose all control" or "If I gain one pound, I'll go on and gain a hundred pounds"); and "personalization" and "egocentric" interpretations of "impersonal events" ("I am embarrassed when other people see me eat").<sup>26</sup>

Each of these elements may indeed be characteristic of the sort of thinking that torments the lives of women with eating disorders. What I question here is the construction of such thinking as "faulty," "flawed," "distorted," "myths," the product of invalid logic, poor reasoning, or mythological thinking. These constructions portray the anorectic and bulimic as incorrectly processing "data"<sup>27</sup> from an external reality whose *actual* features are very different from her cognitions and perceptions. But in fact each of these "distorted attitudes" is a fairly accurate representation of

social attitudes toward slenderness or the biological realities involved in dieting.

For example, many of the "faulty beliefs" associated with eating disorders are *accurate* descriptions of psychological and physiological dynamics that we now know are endemic to dieting itself, particularly to the extremes reached by anorexics and bulimics. It is now well known, for example, that the body has a powerful system of automatic compensations that respond to food deprivation as though to starvation, by setting off cravings, binge behavior, and obsessional thoughts about food.<sup>28</sup> It has been shown, moreover, that people are better able to stay on diets if they are permitted no solid food at all rather than limited amounts of food;<sup>29</sup> the bulimic is thus not so unreasonable in thinking that total control over food is required in order for *any* control to be maintained. But of course total control is ultimately unsustainable; most people on very low-calorie diets eventually gain back all the weight they lose.<sup>30</sup> The general point here is that "the diet" is itself a precarious, unstable, self-defeating state for a body to be in—a reality that the "disordered cognitions" of bulimics and anorexics are confronting all too clearly and painfully.

FIGURES 4 AND 5 (OPPOSITE);  
FIGURE 6 (LEFT)

To turn to the bulimic's "flawed reasoning" concerning the importance of slenderness in our culture: the absurdity of categorizing the belief that "I am special if I am thin" and women's embarrassment over being seen eating as "distorted" attitudes ought to be apparent. What reality do they distort? Our culture is one in which Oprah Winfrey, a dazzling role model for female success, has said that the most "significant achievement of her life" was losing sixty-seven pounds on a liquid diet. (She gained it all back within a year.) It is a culture in which commercial after commercial depicts female eating as a furtive activity, properly engaged in behind closed doors, and even under those circumstances requiring restriction and restraint (see "Hunger as Ideology" in this volume). It is a culture in which my "non-eating disordered" female students write in their journals of being embarrassed to go to the ice cream counter for fear of being laughed at by the boys in the cafeteria; a culture in which Sylvester Stallone has said that he likes his women "anorexic" (his then girlfriend, Cornelia Guest, immediately lost twenty-four pounds);<sup>31</sup> a culture in which personal ads consistently list "slim," "lean," or "trim" as *required* of prospective dates. The anorectic thus appears, not as the victim of a unique and "bizarre" pathology, but as the bearer of very distressing tidings about our culture.

#### THE CULTURAL ARGUMENT: MYTHS AND MISCONCEPTIONS

In this section I will attempt to answer some frequently raised concerns about and criticisms of feminist/cultural approaches to eating disorders. I hope thereby to clarify what is being claimed by the cultural argument.

At the 1983 meetings of the New York Center for the Study of Anorexia and Bulimia, Steven Levenkron charged feminism with sacrificing the care of "helpless, chaotic, and floundering" children in the interests of a "rational" political agenda. Is he right? Does maintaining a continuity between eating disorders and "normal" female behavior entail a denial of the fact that anorexia and bulimia are extreme and debilitating disorders? I think not. The feminist perspective has never questioned the reality of the anorectic's disorder or the severity of her suffering. Rather, what is at stake is the

conception of the pathological as the indicator of a special "profile" (psychological or biological) that distinguishes the eating-disordered woman from the women who "escape" disorder. Feminist analysts see no firm boundary on one side of which a state of psychological comfort and stability may be said to exist. They see, rather, only varying degrees of disorder, some more "functional" than others, but all undermining women's full potential.

At one end of this continuum we find anorexia and bulimia, extremes which set into play physiological and psychological dynamics that lead the sufferer into addictive patterns and medical and emotional problems outside the "norms" of behavior and experience. But it is not only anorectics and bulimics whose lives are led into "disorder." This is a culture in which rigorous dieting and exercise are being engaged in by more and younger girls all the time—girls as young as seven or eight, according to some studies.<sup>32</sup> These little girls live in constant fear—a fear reinforced by the attitudes of the boys in their classes—of gaining a pound and thus ceasing to be "attractive." They jog daily, count their calories obsessively, and risk serious vitamin deficiencies and delayed reproductive maturation. We may be producing a generation of young, privileged women with severely impaired menstrual, nutritional, and intellectual functioning.

But how can a cultural analysis account for the fact that only *some* girls and women develop full-blown eating disorders, despite the fact that we are all subject to the same sociocultural pressures? Don't we require the postulation of a distinctive underlying pathology (familial or psychological) to explain why some individuals are more vulnerable than others? The first of these questions is frequently presented by medical professionals as though it dealt a decisive blow to the cultural argument, and it is extraordinary how often it is indeed accepted as a devastating critique. It is based, however, on an important and common misunderstanding (or misrepresentation) of the feminist position as involving the positing of an *identical* cultural situation for all *women* rather than the description of ideological and institutional parameters governing the construction of *gender* in our culture. The difference is crucial, yet even such a sophisticated thinker as Joan Brumberg misses it completely. "Current cultural models," Brumberg argues, "fail to explain why so many individuals *do not* develop the disease, even though they have

been exposed to the same cultural environment."<sup>33</sup> But of course we are *not* all exposed to "the same cultural environment." What we *are* all exposed to, rather, are homogenizing and normalizing images and ideologies concerning "femininity" and female beauty. Those images and ideology press for conformity to dominant cultural norms. But people's identities are not formed *only* through interaction with such images, powerful as they are. The unique configurations (of ethnicity, social class, sexual orientation, religion, genetics, education, family, age, and so forth) that make up each person's life will determine how each *actual* woman is affected by our culture.

The search for distinctive patterns, profiles, and abnormalities underlying anorexia nervosa and bulimia is thus not, as many researchers claim, *conceptually* demanded; a myriad of heterogeneous factors, "family resemblances" rather than essential features, unpredictable combinations of elements, may be at work in determining who turns out to be most susceptible. It may be, too, that patterns and profiles could once be assembled but are now breaking apart under the pressure of an increasingly coercive mass culture with its compelling, fabricated images of beauty and success.

For example, from its nineteenth-century emergence as a cultural phenomenon, anorexia has been a class-biased disorder, appearing predominantly among the daughters of families of relative affluence.<sup>34</sup> The reasons for this are several. Slenderness and rejection of food have, of course, very different meanings in conditions of deprivation and scarcity than in those of plenty. Demonstrating an ability to "rise above" the need to eat imparts moral or aesthetic superiority only where others are prone to overindulgence. Where people are barely managing to put nutritious food on the table, the fleshless, "dematerialized" body suggests death, not superior detachment, self-control, or resistance to parental expectations. Moreover, the possibility of success in attaining dominant ideals (for example, that of the glamorous superwoman so many anorectics emulate)<sup>35</sup> depends on certain material preconditions which economically struggling women lack; hence, they may be "protected" (so to speak) against eating disorders by their despair of ever embodying the images of feminine success that surround them. However, studies suggest that eating disorders have for some time been on the rise among *all* socioeconomic groups;<sup>36</sup> within a culture which is continually drawing us into an invented world of attainable

power, actual material restrictions on our lives may not limit the imagination as decisively as they once did.

To give another example of the tension between "difference" and homogenizing culture: it has been argued that certain ethnic and racial conceptions of female beauty, often associated with different cultural attitudes toward female power and sexuality, may provide resistance to normalizing images and ideologies. This has been offered as an explanation, for example, as to why eating disorders have been less common among blacks than whites.<sup>37</sup> Without disputing the significance of such arguments, we should be cautious about assuming too *much* "difference" here. The equation of slenderness and success in this culture continually undermines the preservation of alternative ideals of beauty. A legacy of reverence for the zaftig body has not protected Jewish women from eating disorders; the possibility of greater upward mobility is now having a similar effect on young African American women, as the numerous diet and exercise features appearing in *Essence* magazine make clear. To imagine that African American women are immune to the standards of slenderness that reign today is, moreover, to come very close to the racist notion that the art and glamour—the culture—of femininity belong to the white woman alone. The black woman, by contrast, is woman in her earthy, "natural," state, uncorseted by civilization. "Fat is a black woman's issue, too," insisted the author of a 1990 *Essence* article, bitterly criticizing the high-school guidance counselor who had told her she did not have to worry about managing her weight because "black women aren't seen as sex objects but as women. So really, you're lucky because you can go beyond the stereotypes of woman as sex object. . . . Also, fat [women] are more acceptable in the black community." Apparently, as the author notes, the guidance counselor had herself not "gone beyond" stereotypes of the maternal, desexualized Mammy as the prototype of black womanhood. Saddled with these projected racial notions, the young woman, who had struggled with compulsive eating and yo-yo dieting for years, was left alone to deal with an eating disorder that she wasn't "supposed" to have.<sup>38</sup>

#### RESPONSES TO THE FEMINIST CHALLENGE: CHANGE AND RESISTANCE

The feminist/cultural contribution to the study of eating disorders has, as was said earlier, altered the clinical terrain. Clinicians have

become much more aware of how widespread are women's problems with food, eating, and body image and of how stressful and fragmenting are the contradictory role-demands placed on contemporary women. Family interactions are no longer imagined, as they once were, as consisting solely of relations between the patient and an over-controlling, overly dependent mother. Studies are beginning to explore the role played by the teasing and criticism of fathers and boyfriends,<sup>39</sup> as well as the disturbing incidence of sexual abuse in the backgrounds of eating-disordered women.<sup>40</sup> Some clinicians previously hostile to feminism are even beginning to talk about the hyper-valuation of masculinist values in our culture.<sup>41</sup>

But the deepest implications of the feminist challenge to the concept of pathology are continually resisted. For example, rather than acknowledge how normative the obsession with body weight is in our culture, Michael Strober, editor of the *Journal of Eating Disorders*, suggests that "the intensifying preoccupation with body shape and dieting so common in nonclinical adolescent populations" may be "indicative of a symptomatically milder or partial expression of the illness."<sup>42</sup> The difference, I would suggest, is not merely semantic. Rather, Strober is so intent on retaining the notions of "illness" and "disease" that he is willing to "medicalize" the majority of adolescent women into the bargain.

Or consider the work of Joan Brumberg. Unlike dominant clinical models, Brumberg's work offers itself as a cultural analysis and is especially notable for its fine, historical account of the medicalization of anorexia nervosa in the nineteenth century, which reconstructed the bizarre behavior of "fasting girls" from miraculous occurrence to pathological condition. "Disease," Brumberg concludes, "is a cultural artifact, defined and redefined over time."<sup>43</sup>

But despite the historical detachment Brumberg brings to her discussion of the transformation of the anorectic from sainthood to patienthood, she is full of sanctimonious outrage at what she sees as the attempts of contemporary feminists to "demedicalize" anorexia. Constructing a straw-woman distortion of feminist arguments that anorexia is a voiceless, unconscious, self-destructive scream of protest, Brumberg charges feminists with "venerating" and "romanticizing" anorectics as "heroic freedom fighters" who "freely choose" a hunger strike as a form of intentional political action.<sup>44</sup> Feminists, she goes on, argue that "merely by speaking up

about sexism and subordination, women with eating disorders can cure themselves and society." Against these fabricated and inaccurate claims Brumberg positions herself, much as the panel of commentators positioned themselves at the 1983 conference on anorexia and bulimia. The anorectic, she insists, is a "helpless and desperate" individual whose voice is not that of "social protest" but expresses only "frustration and fear." Instead of "dignifying" her disorder, we should acknowledge the "infantile," self-preoccupied, deluded nature of anorectic behavior (at one point Brumberg compares the pursuit of thinness to "a paranoid schizophrenic's attempts to elude imagined enemies") and recognize that eating disorders will only be "cured" through treatment of the "biomedical component of this destructive illness."<sup>45</sup>

All of Brumberg's criticisms might be summed up by the headline of a letter that was published several years ago in *Newsday*, in angry response to a column by Karen DeCrow and Robert Seidenberg (who had articulated a version of the "social protest" thesis). The headline read: "Anorexia Nervosa Is a Disease, Not a Protest."<sup>46</sup> The opposition (either "disease" or "protest") presupposes a model within which to recognize the debilitating, self-consuming nature of a disorder is therefore to situate it outside the realm of the political. Within this model, helplessness and desperation, frustration and fear define and exhaust the reality of the disordered body; it is deemed incompatible that the subject be both "helpless and desperate" and locked in a struggle that has some meaning, trying to find honor on the ruinous terms of her culture and therefore communicating an excruciating message about the gender politics that regulate our lives. Of course, to acknowledge that a deep and embodied *understanding* of what culture demands might be the *source* of the anorectic's (or hysteric's) suffering is to suppose that the patient might have as much to teach the "experts" as the other way around.

Instead of this recognition, we find medical reassertions of expertise. New demarcations of "true" illness and disease are staked out, and as each anomaly has emerged to challenge the dominant paradigms, more rigorous criteria and stiffer definitions are demanded to distinguish between anorexia and "anorexic-like behaviors," "true anorectics" and "me, too, anorectics," "bulimic thinking" and normal female "weight-preoccupation," "true bulimics"

and those women who do not binge and purge frequently enough to threaten their lives, or "vocational bulimics" (for example, ballet dancers) who exhibit the same behaviors but lack the accompanying "pathology."<sup>47</sup>

It is not that some of these distinctions cannot be made. Distinctions can *always* be made. And because distinctions can always be made, it is crucial that we always ask not merely whether a distinction holds at some level of analysis or description but what purposes it serves and what elements it obscures. What is obscured by the medicalization of eating disorders, whether "full-blown" anorexia and bulimia or "ordinary" weight-preoccupation, is an adequate understanding of the ubiquitous and thoroughly *routine* grip that culture has had and continues to have on the female body, how *commonplace* experiences of depreciation, shame, and self-hatred are, and why this situation has gotten worse, not better, in the culture of the eighties.<sup>48</sup> In this historical era, when the parameters defining women's "place" have indeed been challenged, it is disturbing that we are spending so much of our time and energy obsessed, depressed, and engaging in attempts at anxious transformation (most frequently, reduction) of our bodies. It is hard to escape the recognition, as is suggested throughout the essays in this volume, that a political battle is being waged over the energies and resources of the female body, a battle in which at least some feminist agendas for women's empowerment are being defeated (or, at a minimum, assaulted by backlash).

#### BEYOND THE MEDICAL MODEL

Since the seventeenth century, science has "owned" the study of the body and its disorders. This proprietorship has required that the body's meanings be utterly transparent and accessible to the qualified specialist (aided by the appropriate methodology and technology) and utterly opaque to the patient herself. It has required, too, the exorcising of all pre-modern notions that the body might obey a spiritual, emotional, or associational rather than a purely mechanical logic. In the context of such requirements, hysteria and anorexia have challenged modern science, not only with their seeming insistence on the power of the body to behave irrationally and inexplicably (Weir Mitchell once called hysteria "Mysteria"; anorexia

was an "enigma" to Hilde Bruch),<sup>49</sup> but also because of the spectacle each presents of the *patient* (however unconsciously or self-destructively) creating and bestowing meaning on her own body, in a form that is opaque and baffling to the Cartesian mind of the scientist. Ultimately, Freud enabled psychoanalysis to rationalize and make clear the meanings of hysteria and to bring the hysterical body under the proprietorship of the scientist/analyst. Today the same sort of struggle is being waged over the body of the eating-disordered woman.

In the medical model, the body of the subject is the passive tablet on which disorder is inscribed. Deciphering that inscription is usually seen as a matter of determining the "cause" of the disorder; sometimes (as with psychoanalysis) *interpretation* of symptoms will be involved. But always the process requires a trained—that is to say, highly specialized—professional whose expertise alone can unlock the secrets of the disordered body. For the feminist analyst, by contrast, the disordered body, like all bodies, is engaged in a process of making meaning, of "labor on the body." From this perspective, anorexia (for example) is never *merely* regressive, never *merely* a fall into illness and chaos. Nor is it facilitated simply by bedazzlement by cultural images, "indoctrination" by what happens, arbitrarily, to be in fashion at this time. Rather, the "relentless pursuit of excessive thinness"<sup>50</sup> is an attempt to embody certain values, to create a body that will speak for the self in a meaningful and powerful way.

The tools of this labor are supplied: the vocabulary and the syntax of the body, like those of all languages, are culturally given. The anorectic cannot simply decide to make slenderness mean whatever she wishes it to. This is not to say, however, that the meaning of slenderness is univocal or fixed or clear. On the contrary, the fact that slenderness is so compelling in the contemporary context (and not only to anorexics, of course) suggests that in our culture slenderness is, rather, *overdetermined*, freighted with multiple significances. As such, it is capable of being used as a vehicle for the expression of a range of (sometimes contradictory) anxieties, aspirations, dilemmas. Within such a framework, interpreting anorexia requires, not technical or professional expertise, but awareness of the many layers of cultural signification that are crystallized in the disorder.

Among such significations, which I explore in detail in other essays in this volume, are: (1) the promise of transcendence of domestic femininity and admission to the privileged public world, a world in which admiration is granted not to softness but to will, autonomy, and rigor; (2) the symbolic and practical control of female hunger (read: desire), continually constructed as a problem in patriarchal cultures (particularly in times when gender relations have become unsettled) and internalized in women's shame over their own needs and appetites; (3) the symbolic recircumscription of woman's limited "place" in the world; and (4) the tantalizing (and mystifying) ideal of a perfectly managed and regulated self, within a consumer culture which has made the actual management of hunger and desire intensely problematic. In this last context, food refusal, weight loss, commitment to exercise, and ability to tolerate bodily pain and exhaustion have become cultural metaphors for self-determination, will, and moral fortitude.

The decoding of slenderness to reveal deep associations with autonomy, will, discipline, conquest of desire, enhanced spirituality, purity, and transcendence of the female body suggests that the continuities proposed by Rudolph Bell between contemporary anorexia and the self-starvation of medieval saints are not so farfetched as such critics as Brumberg have claimed.<sup>51</sup> Brumberg argues that attempts to find common psychological or political features in the anorexia of medieval saints and that of contemporary women founder on the fact that anorexia mirabilia was centered on a quest for spiritual perfection, "while the modern anorectic strives for perfection in terms of society's ideal of physical rather than spiritual beauty."<sup>52</sup> But Brumberg here operates on the assumption—an assumption challenged by the essays in this volume—that there is such a thing as purely "physical" beauty.

Granted, the medieval saint was utterly uninterested in attaining a slender appearance. But it does not follow that the contemporary obsession with slenderness is without deep "spiritual" dimensions, and that these cannot share important—that is, illuminating—affinities with the ascetic ambitions of medieval saints. Here, one anorectic explicitly makes the connection: "My soul seemed to grow as my body waned," she recalls. "I felt like one of those early Christian saints who starved themselves in the desert sun."<sup>53</sup> This is not to say that the meaning of self-starvation for the fasting nuns

of the Middle Ages can be simply equated with its meaning for adolescent anorectics of today. But in the context of enduring historical traditions that have dominantly coded appetite, lack of will, temptation, and, indeed, the body itself as female, surely we would expect that women's projects to transcend hunger and desire would reveal some continuous elements.

The shallow and unanalyzed conception of slenderness as merely "an external body configuration *rather than* an internal spiritual state,"<sup>54</sup> an ideal without psychological or moral depth, still predominates in the literature on anorexia and bulimia. Why? One explanation is that so long as eating disorders remain situated within a medical model, those who are entrusted with the conceptualization of anorexia and bulimia will be medical professionals who have little experience in or inclination toward cultural interpretation and criticism. But more important is the fact that to begin to incorporate such interpretation and criticism within the medical model would be to transform that model itself. Susceptibility to *images* can still be conceptualized in terms of a passive subject and a mechanical process. To acknowledge, however, that meaning is continually being produced at all levels—by the culture, by the subject, by the clinician as well—and that in a fundamental sense there is no body that exists neutrally, outside this process of making meaning, no body that passively awaits the objective deciphering of trained experts, is to question the presuppositions on which much of modern science is built and around which our highly specialized, professionalized, and compartmentalized culture revolves. Or, to put this another way: it is to suggest that the study of the disordered body is as much the proper province of cultural critics in every field and of nonspecialists, ordinary but critically questioning citizens, as it is of the "experts." This audacious challenge is the legacy of the feminist reconceptualization of eating disorders.