THE LOOKING GLASS SELF: INTRODUCTORY NOTES ON ANOREXIA NERVOSA

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> It follows that the body is the most indisputable materialization of class taste, which it manifests in several ways. It does this first in the seemingly most natural features of the body. . . Timidity grows with the disparity between the ideal body and the real body, the dream body and the 'looking-glass self' reflected in the reactions of others (Bourdieu 1984, p. 190, 207).[1]

Anorexia nervosa is a disorder peculiar to Western society and culture. Although the sufferer is an individual, her problems are rooted in family relationships, and the syndrome utilizes the values and symbols of a stratified society where "No woman can be too rich or too thin."[2] Seemingly, if we are to understand anorexia, we must view it in this social and cultural context; yet, since it is conceptualized as an "illness," the predominant approach to this disorder is that it be analyzed within the categorical system of Western biomedicine and treated within the corresponding institutional framework of one-on-one therapy.

Much of the relevant literature has emerged from the biomedical tradition. A few scientists work at the biological extreme, seeming to argue that the causation of anorexia is biogenetic and physiological. Most authors do acknowledge the cultural environment and family matrix of the disorder, but, since they lack any real sense of sociocultural dynamics, they can only condemn, where they need to analyze and comprehend. In this etiology of blame, the patient's family and the surrounding cultural matrix are assigned the causal responsibility for the illness; they are not perceived as providing the clues to a remediative understanding. Facilely, one may denounce a popular culture which values slenderness in the adult female--a slenderness which is painful to achieve, and which in moderation might be healthy, but in excess can surely be extremely dangerous. One may then attempt to re-educate or re-train the young women who have adopted the value system in its most exaggerated form, but this is actually of small help in dealing with the intricacies of the disorder. For the therapist is then naively counterposing the authority of biomedicine to the glamour of high fashion (as represented by women who are impeccably groomed, strikingly handsome, and as rich as they are thin), while this action reinforces the grasp of the family upon an individual who is ambivalent about maturing away from it, so that the

treatment strategy exacerbates the tensions experienced by the youthful anorexic.

A more fruitful alternative, we believe, is to regard anorexia as a disorder rooted in a particular kind of culture within a stratified society, and thus to approach its understanding with the assistance of the concepts and theories of symbolic anthropology and comparative sociology. The task of this essay is to indicate the beginnings of such an approach, and to speculate upon how empirical research could lead toward resolution or mitigation of the problem.

NATURE AND INCIDENCE

The victim of anorexia conceives of her body as unattractively *fat*, even when an unbiased eye might perceive it as slender or unattractively *thin*. To cope with this imagined obesity, the anorexic severely restricts her food intake. Once embarked upon this course, she may become thin to the point of emaciation, malnutrition, or even death. Since the sufferer cannot be influenced by either rational argument or factual perception, the disorder can be spoken of as "fat phobia" (Wilson 1983). Although she restricts her intake of food, and suffers loss of appetite, the anorexic remains much concerned with food, and, especially, with the eating habits of others. As secondary symptoms, she may also suffer from hyperactivity, constipation, and amenorrhea.

Bulimia is a disorder resembling anorexia nervosa, but differing in that the bulemic will binge on food and then attempt to control bodily weight by vomiting and purging. Thus, anorexia is a "restrictor" disorder, whereas bulimia is characterized by over-indulgence followed by attempts to undo the consequences (Fairbairn and Garner 1986). In this essay, we focus on anorexia alone.

Anorexia is seldom present among men (Jones, Fox, Babigan and Hutton 1980), and--so far as we know--unheard of among the peoples of the Third World. While precise measures of its incidence are not available, it would be fair to estimate that 95 per cent of the afflicted are women. In a detailed survey of nine private schools in London; Crisp, Palmer and Kalucy (1976) found one severe case per 100 girls over the age of 16, and one serious new case for every 250 girls over the age of 15. In contrast, the disorder was less prevalent in schools serving students of the lower social classes.

Anthropologists have noted the existence of disorders or afflictions specific to particular cultures and languages, e.g. *latah* or *taijin kyofuso*.[3] To denominate these kinds of disorders, medical anthropologists have introduced the notion of the "culture-specific (or culture-bound) syndrome." As explicated by Rittenbaugh (1982), the syndrome is a constellation of symptoms which are recognized by the members of that culture as a dysfunction or disease, and:

1. It cannot be understood apart from its specific cultural or subcultural context;

2. Its etiology summarizes and symbolizes core meanings and behavioral norms of that culture (or subculture);
3. Its diagnosis relies upon culture-specific technology, as well as ideology;
4. And its treatment can successfully be accomplished only by participants in that culture.

Judged by these criteria, "obesity" is a culture-bound syndrome specific to the modern West (Rittenbaugh 1982). Note how, at the turn of the century, women were judged beautiful who now would be considered to be overly plump, if not downright obese (Mae West was within that tradition).

Whether or not anorexia nervosa should be considered a culture-bound syndrome has been discussed by Prince (1983), Swartz (1985), and Kleinman (1987), among others. We have noted that anorexia nervosa is specific to the modern West. While Bell (1985) describes Medieval women who practiced food restriction, they were judged either to be especially holy, or religiously misled--attempting speciously to establish themselves as holy. Such women were not considered to be "ill".

In regard to the second of Rittenbaugh's characteristics, we need not devote much effort to establishing the fact that within popular culture we find a tremendous concern with the problem of being "overweight," which is regarded as a special liability for women. A longitudinal study (Garner, Garfinkel, Schwartz, and Thompson 1980, cited in Garfinkel and Garner 1982) of the dimensions of the women who won Miss America Pageants, or who appeared in the centerfolds of *Playboy*, found that, during the past twenty years, these women have become significantly thinner than the actuarial norms for their contemporaries. Meanwhile, insurance company standards for healthy or proper weight have been shifting downward, although no reliable data on mortality or morbidity exist to support the figures presented as normative and desirable. Thus, we encounter an increasing discrepancy between actual and ideal bodily weights--so much so, that, when "obesity" is defined as 120% of the ideal, then, using the standards of the insurance companies and medical authorities, the average American woman is obese (Rittenbaugh 1982)!

Responding to these cultural ideals, girls and women have been preoccupied with diet. What is not known is whether dieting adolescents differ in degree or in kind from anorexics. Are they two distinct populations, or, alternatively, can dieting behavior be arranged along a continuum: from the "normal" adolescent on a diet, to the young woman--e.g., a ballet dancer--who severely limits her intake of food (Druss and Silverman 1979; Hamilton, Brooks-Gunn, and Warren 1986), to the anorexic with a diagnosed eating disorder (Garner, Olmsted, and Garfinkel 1983; Swift and Stern 1982)?

With regard to the third characteristic of culture-specific syndromes (technology), we might mention bathroom and doctors' scales, skin calipers, blood tests, and the other technical means for establishing the presence of anorexia nervosa. While, with regard to the fourth characteristic (treatment), we must (with Shore 1988) affirm that, as of the present, no method of

treatment has been consistently reliable, although various kinds of therapists dealing with individual or familial psychopathology have reported some proportion of successes.

THE VICTIM

> The essential feature of these symbolizations is that the neophytes are neither living nor dead from one aspect, and both living and dead from another. Their condition is one of ambiguity and paradox, a confusion of all the customary categories (Turner 1967, pp. 96-97).

> The infant who fails to make contact with external reality does not usually die. By the persistence of those in care the infant becomes seduced into feeding and living, although the basis for living is feeble or absent. . . . The exploitation of this compliant false self cannot lead to a good result. The true self can only show as a refusal to feed . . . . In the extreme degree the child has no reason for living at all but in the commoner lesser degrees there is some degree of a sense of futility in regard to the false living, and a constant search for the life that feels real, even if it leads to death, as by starvation (Winnicott 1988, pp. 107-8).

While anorexia appears to be most prevalent among adolescents, the initiation is bimodal. It usually appears between the ages of 14 and 18 or during significant points of transition into womanhood (Halmi, Caspar, Eckert, Goldberg, and Davis 1979). At these moments, the young woman encounters a variety of challenges: her body is changing, her social identity is being transformed, she is separating from her family, and she is learning to establish intimate relationships outside of the family unit. She is being invited to establish her identity in a social and economic environment which claims that gender is irrelevant, when in fact it is of supreme importance, with physical appearance being judged by severe standards. To assist those encountering such complex psychodynamic tasks, many other cultures have instituted equally complex rituals--*rites-de-passage* (Van Gennep 1909; Turner 1967). Unfortunately, our culture has few rituals to mark this passage or assist the youthful actor in traversing the difficult path. Viewed within this symbolic context, anorexia nervosa can itself be regarded as a ritual process with an ambiguous set of meanings. The foregoing quotation from *The Forest of Symbols* reminds us that in the rite of passage, the neophyte-actor undergoes a symbolic death and rebirth, and that in the liminal stage between she is highly vulnerable, neither living nor dead, but in a state of ambiguity and paradox, where, without support, she cannot achieve rebirth. We are suggesting that the anorexic is in this liminal state. Like Winnicott's infant, she may be seduced into feeding and living, but this is to create a false self, rather than to encourage her (re)birth into a new and more mature status.

On the one hand, the process of anorexia maintains the girl in a prepubertal body lacking the fat deposits characteristic of the maturing woman, and therefore undifferentiated or minimally differentiated from the preadolescent male. The amenorrhea further testifies to the young woman's status as a neutered creature, incapable of reproduction. Yet, curiously, the process yields a bodily shape considered fashionably slender, and within the vogue of the tubular androgenous look (Faust 1977, 1983; Garfinkel and Garner 1982; Attie and Brooks-Gunn 1987). Thus, the anorexic is exaggeratedly within the fashionable world, while failing to mature as a reproductively capable woman. Within traditional societies where women acquire status through their fertility, her status would be totally anomalous. Within the modern West, she is a paradox, writ large.

TREATMENT

> Both the patient and her family form a tightly knit whole, and we obtain a false picture of the disease if we limit our observations to the patients alone (Lasegue 1873).

> There is little agreement on how to handle the underlying problems. Individual psychotherapy has a poor rate of success. Family therapists have reported good results, and their method may help families to cope, but there is no real proof that any kind of therapy helps patients who would not have recovered otherwise. Most anorexics recover, with or without treatment, but as many as 5% die, from suicide or physical illness (Shore 1988, p. 3).

Since anorexia nervosa is considered an illness or disorder, and may indeed lead to an early death, it requires "treatment" within the Western tradition of medicine. This has usually been practiced in a one-on-one relationship with a psychiatrist or psychoanalyst. Additionally, certain therapists (e.g. Minuchin and Selvini-Palazzoli) have worked with families. (Selvini-Palazzoli started as a classical psychoanalyst but was driven into working with the family unit in order to more expeditiously achieve therapeutic results).

Psychoanalytically, one would surmise that these girls have experienced their family situations as profoundly difficult, and that this difficulty began in the very earliest stages of development (i.e. oral incorporative). Food, its giving and its consumption, are fundamental, especially to the traditional female role (Spignesi 1983). Some psychoanalytic observers have suggested that the family of the anorexic is characterized by a dominating mother and a passive and ineffectual father. Proffered as an explanation of so many phenomena, this familiar characterization scarcely seems helpful to our understanding of anorexia. Some psychiatric observers find that often the family of an anorexic victim is unable to deal with conflict, especially between the parents, and so the conflict remains unresolved. Some acute observers

(Minuchin, Rosman and Baker 1978; Sargent, Liebman, and Silver 1985) have characterized the anorexic family as having exceptionally strong ties with weak ego boundaries between the individual members. In this type of family, personal identities are not clearly established. Within this "enmeshed" family, the girl has been an ideal child, docile, excellent in her self-discipline as a student, so that her movement into anorexia comes as a surprise, perplexing to the parents' image of the perfect and loving daughter. In Winnicott's language, the daughter has kept the family and the world at bay by displaying a false self; and now, with the transformations of her body and the requirements of new social roles, she is led to refuse food in a search for a life that feels real.

Psychiatric observers (e.g. Wilson 1983) describe the parents as being overly concerned with food and diet and fearing overweight. Rigid and perfectionist, they are characterized as being highly repressed. The absence of individual psychic boundaries (referred to above) means that the children are subject to the same intense mechanisms of control which infantilizes them. Some anorexics who have undergone deep psychotherapy report exhibitionistic sexual and toilet behaviors of their parents--but this should likely be judged in a context that is otherwise highly repressed.

RITUAL AND SYMBOL

> The Ndembu "doctor" sees his task less as curing an individual patient than as remedying the ills of a corporate group. The sickness of a patient is mainly a sign that "something is rotten" in the corporate body. The patient will not get better until all the tensions and aggressions in the group's interrelations have been brought to light and exposed to ritual treatment (Turner 1967, p. 392).

From the perspective of cultural anthropology, anorexia nervosa might best be regarded as a ritual process (or symbolic mechanism) whereby the sufferer deals with a set of conflicting interpersonal demands and disorienting physiological transformations. Not yet having found an informant with the wisdom of Victor Turner's Muchona (1967), we need ourselves to develop a hermeneutic or "meaning-centered" approach to the affliction. This might lead to a process of treatment that utilized the inner metaphors of the victim's experience to construct correspondingly therapeutic rituals. (It is striking that Selvini-Palazzoli has experimented with rituals for the anorexic family.)

In an earlier anthropological era, some theorists (e.g. Ruth Benedict 1934) posited the existence of well integrated small communities whose members suffered a minimum of conflict because the basic cultural imperatives were harmonious. These mythical communities were contrasted invidiously with modern Western societies. Since Benedict, the findings of long term fieldwork have revealed that even in the small groups of societies with simple technology, the participants suffer from norms that are contrary, responsibilities that are incompatible, and desires that are mutually

inharmonious. With this vision of the actual functioning of human societies, we need no longer find it so peculiar that in the modern U.S., teenagers are subjected to severe yet contradictory demands, and in consequence that some will embark on strategies (such as anorexia) that are terribly risky. Guided by this vision, we would suggest that, rather than simplistic denunciation of a culture that values slenderness, we seek instead to assist in devising techniques of remediation.

From the perspective of comparative sociology, we should surely be aware of the literature on popular culture, fashion, class, and status, as exemplified by Bourdieu's (1984) insightful interpretation of the symbolic meaning of *taste*--good and bad. In the culture of the modern West, thinness has become a metaphor for beauty and goodness (Attie and Brooks-Gunn 1987)--and especially good taste.

The sociological perspective might also suggest that we have recourse to the literature on *addiction*. It is characteristic of addictions that they dominate the victim's life while disrupting the network of conventional social relationships. In the minds of those who are addicted to alcohol or a drug, it is that substance which comes to dominate, at the cost of the love and trust of others, and even with the recognition that the process of addiction may lead to illness and death. The further conundrum of addiction is that it falls somewhere between voluntary and involuntary pursuits. Addicts will often claim that they could quit, while displaying conduct that shows that they cannot do so. Yet, surprisingly, some do manage to quit, but the causal sequence is unclear, as is the role of psychological and social therapies. Moreover, given the high frequency of relapse, it is difficult to compile meaningful statistics.

To speak of anorexia nervosa as an addiction is surely paradoxical. If it is an addiction, it is seemingly not to a positive consumption, but to an avoidance. Yet insofar as we deal with a substance that preoccupies the mind and with a psychic stance that grossly disrupts social relationships, especially with intimates, we find an inner kinship between an addiction to ingesting *something* and one to ingesting *nothing*.

NEEDED RESEARCH

> It is a commonplace of scientific history that the first valuable hypotheses are developed out of good observations of natural-occurring phenomena. . . . In psychiatry, on the other hand, while the research subject is the human being, he has not been studied in his natural surroundings of home, school and place of work, going about his business, but in the psychiatrist's office or, to a lesser extent, in institutions (Henry 1971, p. xvi).

If the foregoing analysis is promising, then empirical observation of the family of the anorexic and her interactions with outsiders is needed. We must understand her symbolic world, including the meanings, not only of food and

eating, but of denying herself food. We must understand the anorexic's vision of gender, gender maturation and adult female roles. Since the pioneering efforts of Jules Henry (1963), family research of this nature has seldom been undertaken, for it poses many difficulties in modern America. Yet, if we are to provide an empirical foundation toward comprehending this culturally specific syndrome, it remains nevertheless necessary that such research be ventured.

ENDNOTES

1. The "looking-glass self" was an idea insightfully explicated by Cooley (1922/1964, p. 184): "The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined reflection of this reflection upon another's mind. . . . A self-idea of this sort seems to have three principal elements: the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification."

2. The remark has been attributed to the Duchess of Windsor as well as other women who exemplify the world of great wealth and high fashion.

3. Among the Ndembu, as among other traditional African peoples, the bearing of twins is regarded as a condition requiring treatment, i.e. a ritual remediation akin to our medical therapy (Turner 1969, chap. 2). The Ndembu would doubtless be as surprised to learn that in Western society, a girl's unwillingness to eat requires that she be subjected to biomedical treatment, as we are to learn that the bearing of twins among them requires that the woman undergo a therapeutic ritual.

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RESEARCH EXAMINING IMPACTS OF ATTEMPTS TO CHANGE PATTERNS OF ALCOHOL CONSUMPTION AND RELATED BEHAVIORS

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An issue of considerable concern in American society has been that of problems resulting from alcohol consumption. Our research during the past few years has focused on attempting to understand this phenomenon and how it relates to other behavior patterns. Specifically, we have been involved in research evaluating consequences of laws and programs designed to impact drinking behaviors. In addition to these practical policy concerns, we have also focused on testing implications of neutralization and deterrence theories as sociological explanations for the domain of alcohol use and abuse. Methodologically we have focused on self-administered questionnaire formats in longitudinal designs in order to be able to examine subjects and variables over time. We have also been interested in examining response differences among student-nonstudent populations, variations in drinking patterns among racial and ethnic groups, and response differences that might occur as a result of changes in item wording on questionnaires.

During the early 1970s a trend developed in the U.S. to lower the minimum drinking age. In subsequent years, increases in accident rates among young drivers were reported, and some states then began to raise the minimum drinking age. Research seeking to understand the relationship between the drinking age and alcohol related behaviors, including accident rates, however, has produced inconsistent results (cf. Hanson, Engs, and Katter 1984; Rooney and Schwartz 1977; Williams, Rich, Zador, and Robertson 1975; Naor and Nashold, 1975). In September of 1983, the Oklahoma legislature joined those states changing the drinking age by passing a bill to raise the minimum drinking age for 3.2 beer from 18 to 21 (the minimum age for wine and distilled spirits was already 21).

A three-year grant was obtained from The National Institute of Alcohol Abuse and Alcoholism (NIAAA) to examine alcohol consumption and related behavior patterns among Oklahoma State University students, both before and after implementation of the new law. The research focused on changes in drinking patterns that occurred both over time and in relation to baseline data collected in 1981.

Questionnaires were completed by students in randomly selected Introductory Sociology classes at Oklahoma State University just prior to implementation of the legislation (September 1983); and the same methodology was repeated each semester through the spring of 1987. A total