

'CULTURE' IN CULTURE-BOUND SYNDROMES: THE CASE OF ANOREXIA NERVOSA

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Abstract—Anorexia nervosa is presently considered a Western culture-bound syndrome. A cultural focus on dieting and ideals of thinness for women are assumed to be implicated in the disorder. While research indicates that the majority of non-anorectic women in the United States are preoccupied with body weight and dieting, it is not clear what 'thinness' means to anorectics themselves or that norms about dieting are always involved in subjective experiences of anorexia. Meaning-centered studies of anorectics—especially those in non-clinical settings—are needed to clarify the cultural contexts of the disorder. Case studies of two anorectic women from Minneapolis–Saint Paul, Minnesota, show that for some anorectics self-starvation is encoded in religious idioms and symbols about the body, food, and self. A review of the literature illustrates a long-standing relation between self-starvation and religious ideals in Western culture and points to an association between contemporary anorexia nervosa and asceticism. The case studies presented here demonstrate that this asceticism may be subjectively expressed through religious concepts about the body and food and suggest that future research formally investigate the religious practices and beliefs of anorectics seen clinically. The author explores the implications of these findings for definitions of 'normality' and 'abnormality,' key issues in ethnopsychiatry. These findings also suggest that future cross-cultural research might examine asceticism about the body and food in religions other than Judeo-Christian, cultural groups with rituals of fasting and vomiting, and the presence of fundamentalist churches and missionaries in those non-Western cultures for which there are recent reports of eating disorders. Anorexia nervosa's designation as a syndrome *limited* to Western cultures or to those cultures influenced by them may reflect unexamined assumptions on the part of researchers that dieting and secular ideals of slimness are primarily involved in the disorder.

Key words—culture-bound syndrome, anorexia nervosa, religion and mental health, eating disorders, epistemology

INTRODUCTION

The role of culture in anorexia nervosa is of interest to psychiatrists, psychologists, feminists, historians, and anthropologists. Feminist scholars implicate western patriarchy in the disorder [1, 2]. Turner suggests that values of late capitalism encouraging unlimited consumption are related to eating disorders [3]. Historians Bell, Bynum and Brumberg point to religious values in the self-starvation of women in the mediaeval through the Victorian periods [4–6]. Much of the psychiatric and psychological research that recognizes a role for culture in contemporary forms of anorexia nervosa asks whether a cultural focus on 'thinness' and 'dieting' might be connected to the disorder [7–11]. Although there is wide recognition that 'culture' is involved in contemporary anorexia nervosa, there is little agreement about which cultural values and norms are implicated. This article, taking an anthropological approach, points to a role for religious conceptions about the body and food for some contemporary anorectic women in the United States and highlights the importance of taking into account the anorectic's own subjective meanings of food refusal and thinness in working toward an understanding of this perplexing disorder.

Anorexia nervosa is of interest to anthropology and ethnopsychiatry because of the role of culture in

the disorder. Ethnopsychiatry presently considers anorexia nervosa to be a culture-bound syndrome [12–15]. The term, 'culture-bound syndrome,' has been used by ethnopsychiatrists and psychological anthropologists to mean different things about mental illness. The so-called 'old transcultural psychiatry' viewed culture-bound syndromes as disorders restricted to a particular culture or group of cultures because of certain psychosocial characteristics of those cultures [16]. This meaning of the term underlies Prince's designation of anorexia nervosa as a culture-bound syndrome: he thinks anorexia is largely confined to Western cultures or those non-Western cultures undergoing the process of Westernization, such as Japan. Prince states that anorexia nervosa is a Western culture-bound syndrome "rooted in Western cultural values and conflicts" [13, p. 300]. This statement, implying that anorexia nervosa will not be found outside Western contexts, suggests the need to investigate the presence of anorexia nervosa and other eating disorders in non-Western cultures. It also begs the question: which cultural values and conflicts are involved in Western contexts?

Early works by anthropologists concerned with mental illness from a cross-cultural perspective stressed cultural and social conditions in the aetiology of mental illness. Indigenous expressions of mental illness were referred to as 'culture-bound

syndromes.' 'Latah,' 'amok,' 'pibloktog,' 'windigo,' 'susto,' 'imu,' 'koro,' and 'arctic hysteria' are some of the culture-bound syndromes noted and studied by ethnopsychiatrists and anthropologists [17]. These syndromes were viewed as 'emic' categories for indigenous forms of mental illness considered to be unique to specific cultural settings. Often the term 'atypical psychosis' was used for these syndromes; they were seen as a residual category and excluded from the major (biomedically defined) psychoses such as depression and schizophrenia [18]. This approach, in keeping with the position of extreme cultural relativism in anthropology in the first part of the twentieth century, precluded examination of organic or biophysiological factors in psychopathology and directed the attention of investigators away from noting the presence of the same or similar symptoms in different cultural contexts and settings [19, 20]. Some anthropologists, taking seriously Wallace's [19] admonition to investigate the biological components of mental disorders, have recognized that there are organic or biophysical as well as cultural features of mental illness [21-33]. Other anthropologists and ethnopsychiatrists, ignoring culture-specific meanings of symptoms, have sorted various pathologies noted in non-Western cultures into taxa on the basis of common biological and physiological characteristics and gross descriptive resemblances [32]. 'Anorexia' has been included in this effort: Simons notes, for example, that 'anorexia' appears as a feature of indigenous disorders present in a variety of cultural contexts [32].

More recent definitions of culture-bound syndromes offered by Kleinman and Ritenbaugh recognize that disorders involve core values and norms of a culture. As construed by Kleinman, illness is created by personal, social, and cultural reactions to malfunctioning biological or psychological processes and can only be understood within defined contexts of meaning and social relationships [34]. Applying this meaning-centered approach of the 'new' cross-cultural psychiatry to culture-bound syndromes specifically, Ritenbaugh states that a culture-bound syndrome cannot be understood apart from its specific cultural or subcultural context and that the aetiology "summarizes and symbolizes core meanings and behavioral norms of that culture" [35]. Ritenbaugh further proposes several 'corollaries': the same symptoms may be recognized in other cultures—but called something else. This corollary, in effect, overturns the previous definition of culture-bound syndromes as disorders 'bound to' a unique or separate culture area. Other corollaries suggest that culture-bound syndromes may be present in Western cultures and within the biomedical system itself.

Leslie Swartz explores the implications for understanding anorexia nervosa as a culture-bound syndrome in the broader, meaning-centered sense offered by Ritenbaugh [14]. Specifically, Swartz recognizes that the core meanings involved in anorexia, viewed

historically, may change over time. This point has begun to be explored by historians of anorexia [6]. Swartz further proposes that there may be *different meanings* of the symptoms of anorexia in *different subcultural contexts*. Swartz implies that these different subcultural contexts might include the biomedical community as well as populations of anorectics. Swartz suggests that we pay attention to the role of culture in the diagnostic system itself and that one avenue for future research is the presentation of case material that illustrates the role of the therapeutic process in reproducing cultural constructions, "especially around issues of femininity and control" [14, p. 729]. This suggestion is in keeping with recent studies that have pointed to culture in biomedical disease categories such as depression, protein malnutrition, and obesity [35-38]. Swartz admits that this approach to anorexia may complicate our understanding of the role of culture in the disorder and that it has implications for definitions of 'normality'/'abnormality,' key concepts for ethnopsychiatry as recognized by Devereux [39]. Swartz does not specify or investigate what different cultural values or norms might be involved in the varying definitions or expressions of anorexia nervosa, however.

The present article points to the need to recognize core values and meanings of symptoms held by anorectics themselves, as well as the necessity of investigating cultural values that may be built into the diagnostic and biomedical systems. I refer to a multiplicity of anorectic populations and contexts in recognition that the United States—like all modern, complex societies—has many subcultures. Anthropologists especially should not assume cultural uniformity or homogeneity in the genesis or subjective expression of any behavior, including psychopathology.

This article takes as fundamental that all disorders mean something to sufferers. Anorexia nervosa, like any disorder, presents certain signs and symptoms, to be detailed below. While these symptoms are related in complex ways to biological dysfunctions caused by starvation and weight loss and may be, in part, unconsciously motivated, they are also given meaning by the anorectic. The anorectic consciously understands and gives meaning to her symptoms using culturally explicit and objective symbols, beliefs and language.

In stating that anorectics give meaning to their self-starvation—and use explicit cultural symbols and belief systems to do so—I do not mean to imply that there are no unconscious elements in the disorder. Various psychoanalytic and psychological approaches to anorexia point to unresolved anxieties around separation and other deep motives in the aetiology of the disorder, motives and anxieties of which the anorectic herself may not be aware. Nonetheless, as the two case studies of anorectics presented in this article demonstrate, while an anorectic may be unaware of underlying psychological

motives and even influences of a sociocultural nature, she gives meaning to her symptoms and uses cultural constructions—language, symbols and belief systems—to do so. I use the terms 'motive' and 'meaning' respectively to distinguish between the unconscious elements and consciously expressed understandings of the disorder. The two realms are related, however, in complex ways, as Obeyesekere recognizes and develops in *The Work of Culture* [40].

Why is it important to take into account the anorectic's own subjective understandings of symptoms? Certainly it is axiomatic in ethnopsychiatry and medical anthropology that treatment will be successful the extent to which it relies on a culture-specific ideology, one in which definitions of illness and modes of treatment are negotiated and shared between healers and patients [34]. The case studies presented in this article demonstrate that some anorectics may understand symptoms of self-starvation and bodily thinness through sets of cultural symbols quite different from those held by diagnosticians, medical practitioners, students of anorexia, and even other anorectic populations. Because of the ways in which they understand their starvation, some of these women may not see themselves as 'sick' or 'anorectic' and therefore do not accept the view that they may be in need of medical intervention and treatment. By the same token, failure on the part of some medical practitioners to successfully treat cases of chronic anorexia may be due to the failure of healers to take the anorectic's own subjective meanings—and the role of culture in those meanings—into account. In short, differences between 'etic'/medical and 'emic'/subjective meanings and interpretations of symptoms may result in differing and opposing definitions of 'abnormal' and 'normal' behavior.

My own research on anorectics in the metropolitan Minneapolis–Saint Paul area of Minnesota reveals that some contemporary anorectics in the United States come from conservative religious fundamentalist backgrounds and express their desire to restrict intake of food through religious understandings about food, the body, and sexuality provided by their religious traditions. Contrary to popular opinion, their self-starvation is not motivated by a desire to meet popular ideals of thinness currently in vogue, nor is it expressed by them as 'dieting.' The case studies of Jane A. and Margaret C., focusing on the ways in which they use religious conceptions about food and the body to express and understand their food refusal, demonstrate the interplay between cultural and motivational components of the disorder and highlight the importance of taking into account the role of culture in the anorectic's own understandings of the disorder. Before presenting the case material, it is necessary to briefly review the symptoms and demographic features of anorexia nervosa and some of the major biological, psychological, and

sociocultural models that have been proposed to explain the disorder.

SYMPTOMS AND DEMOGRAPHIC FEATURES OF ANOREXIA

According to the most recent diagnostic criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn, Revised, a young woman would be considered anorectic if she presents the following signs and symptoms:

- A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g. weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g. the person claims to 'feel fat' even when emaciated, believes that one area of the body is 'too fat' even when obviously underweight.
- D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea) [41, p. 67].

Weight loss is usually the result of a reduction in total food intake, often with extensive exercising. Hyperactivity is frequently listed as a symptom of anorexia nervosa [42].

At the present time bulimia or bulimia nervosa is considered a related but separate disorder from anorexia nervosa. The essential features of bulimia are:

Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time); a feeling of lack of control over eating behavior during the eating binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain; and persistent overconcern with body shape and weight [41, p. 67].

In order to qualify for the diagnosis, the person must have had, on average, a minimum of two binge eating episodes a week for at least three months. Most bulimics are within a normal weight range, although some may be slightly underweight and others overweight. For some bulimics there may be fear of fatness, but weight does not fall below a minimal normal weight—as is the case for anorectics.

Anorexia nervosa and bulimia nervosa may be combined, however. This has led to the differentiation of anorectics into subtypes, those who control weight through restricting intake of food (Restrictors) and those who use vomiting, laxatives, or diuretics to control weight (Bulimarexics). For bulimarexics, there is severe weight loss, whereas in bulimia nervosa (without associated anorexia) the weight fluctuations are rarely so extreme to be life-threatening. It is thought that these subgroups of anorectics exhibit substantial personality and symptomatic differences.

Anorectics fall on a continuum from mild, episodic, and transitory experiences with the disorder to the chronic, where the course may be unremitting until death. Follow-up studies indicate mortality rates of between 5% and 18% [41, p. 66].

Studies of samples from different populations report a range of anorexia from 1 in 800 to as many as 1 in 100 females between the ages of 12 and 18 [41, p. 66]. According to a 1985 Gallup survey, serious eating disorders such as anorexia and bulimia may afflict as many as one teenage girl in eight (12%) in the United States. The poll found that 9% of girls, ages 13–18, believe they have had symptoms of anorexia. Another 5% think they have had symptoms of bulimia. Three percent report symptoms of both anorexia and bulimia [43].

Some experts think anorexia and bulimia are increasing. However, the apparent increase may reflect increased case-finding and diagnosis due to heightened public and medical awareness. Eckert remarks that, "Most of the reports of increased frequency have been based on series of cases assembled by investigators interested in the disorder or on psychiatric case registers and are thus subject to bias" [44, pp. 12–13]. Changing diagnostic criteria also complicate estimations of the prevalence of anorexia. Prominent differences in criteria that emphasize signs and symptoms pertain to the age of onset, degree of weight loss required, and the presence of an endocrine disturbance manifested as amenorrhea [7]. In addition, weight loss and unusual eating patterns may be present with other major illnesses such as depression, schizophrenia, and borderline personality disorder.

MODELS OF ANOREXIA NERVOSA

Attempts to explain anorexia have been variously biological, psychological and sociocultural in orientation. While my own approach to the condition favours a combination of psychological and sociocultural explanations, it will be useful to briefly review the several orientations.

Biological models

In addition to severe weight loss and amenorrhea, anorexia nervosa presents other biophysical signs and symptoms. These include bradycardia (slow heart-beat), hypotension, hypothermia, lanugo (growth of neo-natal hair), dry skin, edema, constipation, abdominal pain, lethargy, and cold intolerance [45].

Medical researchers who take a biological approach to anorexia generally seek to locate the cause of anorexia in abnormalities in mechanisms regulating hormone output that have biochemical influences on eating behavior and weight control. Much of this research implicates dysfunctions in the hypothalamus, an area of the brain that governs such functions as eating behavior, temperature regulation, and sexual activity. Stimulation of the medial hypothalamus,

sometimes referred to as the satiety center, can cause animals to stop eating—even in situations where they should be hungry. The lateral hypothalamus is referred to as the eating center of the brain. Lesioning in the lateral hypothalamus can result in starvation, decreased food intake, and weight loss. The neurochemistry of these brain areas points to the role of various neurotransmitters in the hypothalamic regulatory system. The transmitters involved are nigrostriatal dopamine, serotonin, and norepinephrine [46]. Researchers have studied a variety of these biogenic amines and neuroregulatory agents in the urine and blood of anorectics to determine if changes in the neuroregulators might be correlated with abnormal eating patterns. Johnson, Stuckey and Mitchell's review of studies on the neurochemistry of the hypothalamus concludes that the component systems involved in the neurophysiology of eating are complex and not well understood at the present time [46].

Attention to the biophysical aspects of anorexia is warranted, as there are many serious risks and medical complications. These include hematologic abnormalities, renal complications, gastrointestinal problems, metabolic and cardiopulmonary complications, dental problems, fluid and electrolyte disturbances, neurological complications and primary central nervous system dysfunction, and endocrine abnormalities, including thyroid function abnormalities [45].

The main question that biomedicine must address is not whether there are medical and biophysical aspects to anorexia. Clearly, there are. Rather, researchers have yet to establish whether the hypothalamic dysfunctions and abnormalities noted for anorectics are causes of anorexia or the consequence of starvation, serious nutritional deprivation, and weight loss. Is anorexia nervosa a medical illness that results from hypothalamic dysfunctions that cause these physical changes? Or do the biophysical abnormalities result from severe weight loss? According to Mitchell, the question of hypothalamic dysfunction remains a matter of considerable debate [47].

Research indicates that most of the endocrine abnormalities in anorectics occur in starving individuals without anorexia. Starvation, moreover, induces many of the behavioral features of anorexia, including obsessive thinking, depression, and mood lability. Mitchell remarks, "Most of the physical abnormalities demonstrated in anorectic patients resemble those described in starved and semistarved normals, and they are thus more likely secondary to the starvation process itself" [45, p. 48].

Biological and medical approaches to anorexia that locate the aetiological agents in the hypothalamus fail to address important psychosocial and cultural aspects of the disorder. Even ardent advocates of the biomedical model acknowledge that environmental stress can result in pathologic changes in organisms. The evidence pointing to the hypothalamus does not

preclude environmental influences. If the biophysical features of anorexia are the consequences of voluntary starvation, then the psychosocial processes that may motivate food refusal become central concerns.

Psychological models

Psychological models of anorexia fall into three groups: (1) psychoanalytic, (2) family systems theory, and (3) social psychology.

Psychoanalytic models view the anorectic's refusal of food as an expression of a psychobiologically regressive state in which starvation-induced changes in reproductive drive and physical appearance help to sustain an avoidance of maturational problems—such as autonomy, individuation and sexual development.

Early psychoanalytic treatments of anorexia viewed it as a form of conversion hysteria and the symbolic repudiation of sexuality. Drawing on basic assumptions of Freudian psychoanalytic understanding, various writers have proposed that anorexia is symbolic of fixated unconscious conflicts relating to oral-sadistic fears, oral impregnation, and other regressive wishes and fantasies. In general, clinical evidence confirms an interpretation that the anorectic fears adult womanhood and heterosexuality: most anorectics—especially restrictors—are not sexually active adolescents [48].

Hilde Bruch thought that anorexia was more severe than neurosis. She viewed the failure of early parent-child interactions to effectively discriminate or reinforce a child's incipient psychological identity as important. Parents' interference with growth of a separate sense of self results in a cluster of ego and personality deficits, consisting of inaccurate perception and cognitive labeling of hunger and appetite, severe body-image disturbances, and a paralyzing sense of ineffectiveness [8, 49, 50]. In Bruch's view, the anorectic's control over food and body size give her a sense of selfhood or identity. "Relentless pursuit of thinness seems to be the outstanding symptom, and in this pursuit they deliberately, seemingly willfully, restrict their food intake and overexercise" [8, p. 331]. In all probability, Bruch's view that anorexia is the "relentless pursuit of thinness" underlies the idea assumed in much of the current psychoanalytic and medical research that a cultural focus on dieting and slimness is implicated in the disorder. However, Bruch did not consider the cultural symbols and idioms through which anorectics themselves encode their desire for 'thinness.'

Other psychoanalytic theories implicate early parent-child relations and point to deficits in autonomy and incomplete individuation from the family [51]. Anorexia has been viewed as a form of self pathology reflecting a chronic disturbance or disruption in the empathic relationship between parents and child [52]. Anorexia is a defense structure to cope with

these disruptions in early parent-child relationships. In addition, suppression of the body's growth and pubertal development in anorexia has been interpreted as an attempt to avoid fusion with parental objects through a repudiation of likeness to that object [53].

Some investigators think anorexia is a distinct illness. Others regard it as a variant of other psychiatric illnesses that may present weight loss and unusual eating habits. Still others think anorexia is a symptom that can occur in many emotional disorders. Anorexia has been considered a variant of depression, schizophrenia, hysteria (conversion disorder), and obsessional disorder. Depressed mood, low self-esteem, volitional defects, and disturbances in affect are common in anorexia [54]. Many anorectics display behavior patterns associated with obsessive-compulsive disorders: perfectionism, excessive orderliness and cleanliness, and self-righteousness [55]. Anorectics are rigid and defensive about their behavior and have elaborate intellectualized theories about food and the body. Garfinkel and Kaplan believe that the obsessional symptomatology of anorexia is heightened by the starvation state itself. They caution, however, that there are important differences between anorexia and an obsessive-compulsive disorder. They remark:

Many of the anorexic patient's obsessional-like symptoms are not viewed by her as ego-alien, as are true symptoms of an obsessive-compulsive disorder. Only the anorexic patient's preoccupation with food is seen as ego-alien, while her preoccupation with weight, body shape, and drive for thinness are not [7, p. 274].

Garfinkel and Kaplan view anorexia as distinct from other causes of weight loss, with a 'drive for thinness' the central distinguishing feature; they advocate that in cases where weight loss is due to other reasons for food refusal, the primary diagnosis that leads to weight loss (for example, depression) should be described. Their view places a 'drive for thinness' as the main symptom distinguishing primary anorexia nervosa from other mental illnesses. They do not specify, however, how this 'drive for thinness' may be encoded and subjectively expressed by the anorectic.

In recent years research has focused on patterns of interactions and values within families of anorectics. Salvador Minuchin and his associates argue that certain family environments encourage passive defiance and thus make it difficult for certain members to assert their individuality [56]. They describe psychosomatic families as rigid, overprotective, and lacking in conflict resolution. Minuchin *et al.*, describe the anorectic as 'enmeshed' in her family; that is, individuation and autonomy are blocked by extreme forms of proximity and intensity in family interactions. Minuchin *et al.*, define enmeshment in the following way:

Enmeshment refers to an extreme form of proximity and intensity in family interactions. It has implications at all

levels: family, subsystem, and individual. In a highly enmeshed, overinvolved family, changes within one family member or in the relationship between two members reverberate throughout the system. . . .

Subsystem boundaries in enmeshed families are poorly differentiated, weak, and easily crossed. This situation results in the inadequate performance of subsystem functions. . . .

On an individual level, interpersonal differentiation in an enmeshed system is poor. In all families, individual members are regulated by the family system. But in enmeshed families the individual gets lost in the system. The boundaries that define individual autonomy are so weak that functioning in individually differentiated ways is radically handicapped [56, p. 30].

Rigidity and overprotectiveness make thresholds of conflict very low. Of interest for the present study of religious anorexics, they note that, "Usually a strong religious or ethical code is used as a rationale for avoiding conflict" [56, p. 31].

Investigators taking this approach find that the mother in particular figures in this enmeshment [2, 49, 53, 57]. Gordon, Beresin and Herzog [58] suggest that patterns of maternal perfectionism and self-sacrifice combined with paternal entitlement make sexual maturity threatening for females in these families—partially explaining the greater incidence of anorexia in adolescent women. Bruch [49] and Palazzoli [53] point to failures in the anorectic's early relationship with mother, resulting in lack of trust and an inability to test out hostility and aggression against a reliable and forgiving maternal presence. Chernin [2] thinks that eating disorders represent failed female development and identity and a profound separation struggle between mother and daughter. At the heart of eating problems are, in Chernin's view, problems of mother-daughter envy and a girl's guilt over desires to surpass her mother. Underlying eating disorders are 'cannibalistic' fantasies and matricidal wishes. An eating disorder is symbolic of the need, rage and violence of the mother-daughter bond introjected onto the daughter's own body: "In a stunning act of symbolic substitution, the daughter aims her mother-rage at her own body, so like the one which fed her and through which she learned to know the mother during the first moments of her existence" [2, p. 93]. Chernin's work is compatible with earlier psychoanalytic works that traced anorexia to regressive infantile fantasies and desires.

The family system investigators find evidence that anorexics come from families with traditional gender roles and relations. They also suspect that these traditional roles and relations may encourage difficulties with separation and independence. Yet, they do not consider the social, historical, and cultural background of these traditional family systems. The case studies of Jane A. and Margaret C. suggest that 'anorexogenic' families can be remarkably similar to contemporary religious fundamentalist family systems.

Sociocultural models

Most of the social science research on anorexia nervosa implicates cultural dicta, aimed primarily at women, to maintain thin bodies and the pervasive focus on diet and dieting that makes slimness one of the central standards of beauty. According to this conception, anorexia is caused by the popular emphasis on dieting and by the demands of an aesthetic ideal that stresses youth and androgyny rather than the mature female body. While many of these reports imply that the emphasis on dieting causes anorexia, clinical studies do not conclusively show a connection between subjective expressions of anorexia and this feature of North American culture.

Research on 'normal' non-anorectic subjects confirms beyond a doubt that the majority of women in North American society think they are too fat and are preoccupied with body weight and dieting. According to Feldman, girls in North American culture come to believe that thin is beautiful as early as age 7—or even younger. In a survey of 271 boys and girls, Feldman found that most girls think they are much fatter than they really are. Almost half the girls in the study thought they were too fat, even though 83% of those girls were normal in weight [59]. In a study conducted in the Minneapolis metropolitan area, 2276 suburban students aged 15 and 16 were questioned on attitudes toward physical appearance, attitudes toward food, food preparation and eating, and weight-associated behaviors [60]. The data indicate that both male and female adolescents continue to experience a high level of dissatisfaction with their weight. Females in the sample indicated:

... a level of concern or worry about the possibility of becoming overweight and an emotional involvement with this issue that could appropriately be characterized as a preoccupation. They responded behaviorally to this concern by dieting even in the absence of an objectively defined problem with weight [60, pp. 202-203].

In another study meant to show how changing standards for feminine beauty toward a preference for a thinner size are involved in anorexia, Garner *et al.*, [9] reviewed height and weight data for contestants and winners in the Miss America Pageant and the centerfolds from *Playboy* magazine over the past 20 years. Garner and his associates, finding that the measurements of most *Playboy* centerfold girls decreased significantly, conclude that the cultural pressure on women to be slim, occurring at a period of time when women are actually becoming heavier, contributes to eating disorders. How changing body measurements and weights of women featured in *Playboy* magazine are related to the anorexia of young pubescent girls is a puzzle to me. I suspect that this data reflects changing male preferences for thinner women! In any event, the crucial question remains whether and to what extent the normative concerns with 'slimness' and dieting in our culture are related to the subjective experiences of anorexics themselves.

Many women actively diet in the pursuit of thinness but never present to physicians with an eating disorder. Many clinicians would agree with the view that anorexia is distinct and different from extreme 'dieting' behavior [7, 49, 63]. Garner, Olmsted and Garfinkel [10] compared patients with anorexia nervosa with extremely weight-preoccupied women. They found a continuum of weight concerns for the weight preoccupied women that did not parallel the continua of psychopathology observed for the anorectics. Anorectics had higher feelings of ineffectiveness and interpersonal distrust than the nonclinical weight preoccupied sample. These findings support the contention that anorectics are unique from dieters in their food refusal behavior and weight loss—and in the psychopathology responsible for it. In a study of anorexia in the congenitally blind, who, presumably, have been less affected by the visual media to achieve or maintain a slender body, Bemporad, Hoffman and Herzog note that none of the blind anorectics seem to have been driven by the cultural idealization of thinness [11].

The explanatory power of the model that views anorexia as a consequence of a cultural focus on dieting and thinness is limited. It assumes that the current cultural focus on dieting and thinness is the main cultural dictum involved in anorexia, without presenting evidence from anorectic women themselves that indicates how and to what extent these pervasive values are related to their subjective feelings and thoughts about the body and eating.

Many feminists concerned with eating disorders seek to demonstrate that anorexia nervosa is a consequence of a misogynistic society that demeans women by devaluing female experience, by objectifying their bodies, and by discrediting areas of women's achievements [1, 61]. They view anorexia as protest against patriarchal values, a rigid sexual division of labor, and female subordination. Chernin remarks, "Thus her decision [to lose weight], although she may not be aware of it, enters the domain of the body politic and becomes symbolically a political act" [61, p. 101].

Bryan Turner [3] also views eating disorders—bulimia and anorexia nervosa—as forms of social protest. Rather than patriarchy *per se*, Turner implicates the consumerism of late capitalism. He views bulimia and anorexia as "two individualized forms of protest which employ the body as a medium of protest against the consumer-self" [3, pp. 180-181].

The explanatory power of the model that views anorexia as a 'protest' against patriarchal or late capitalist values is limited. It assumes that anorexia is a modern syndrome, rooted in circumstances of contemporary life. As I will show presently, historians note that anorexia appeared before the cultural imperative for a thin female body. As such, these models ignore historical evidence that eating disorders predate the late nineteenth and twentieth centuries. Moreover, the equation of anorexia nervosa with social protest against patriarchy overlooks

the role of the mother-daughter relation in anorexia. It also ignores the fact that anorectics are not known for their feminism [62]. Joan Brumberg remarks:

If the anorectic's food refusal is political in any way, it is a severely limited and infantile form of politics, directed primarily at parents (and self) and without any sense of allegiance to a larger collectivity The effort to transform them into heroic freedom fighters is a sad commentary on how desperate people are to find in the cultural model some kind of explanatory framework, or comfort, that dignifies this confusing and complex disorder [6, p. 37].

The notion that anorexia is a freely chosen means of asserting power overlooks the evidence for unconscious meanings and motives. Moreover, these works do not consider the meaning and motivation of anorexia from the point of view of the anorectic nor the possibility that contemporary eating disorders may be encoded in cultural symbols and language other than those related to Western patriarchy or economy.

CASE STUDIES

Research on the subjective experiences of anorexia by anorectics themselves is a useful step toward clarifying the cultural components and contexts of this disorder. The two case studies presented below point to religious conceptions about the body and food in the understandings of some contemporary anorectics in the United States.

Both Jane A. and Margaret C. were studied over the course of several years, 1985-1990, in non-clinical settings. That is, data on these women pertains to times when they were actively anorectic and participating in family and community contexts. The study of anorectics outside of clinical and treatment settings, while posing special concerns and challenges for the investigator, allows for the study of culture in the anorectic's own subjective understandings of the disorder. This approach recognizes that treatment often aims at providing the anorectic and her family with medical understandings of eating disorders, understandings that may differ considerably from those held and expressed by the anorectic.

At the present time, it is difficult to generalize from these cases to make statements about the prevalence of eating disorders among women in fundamentalist and other religious subcultures in the United States. In the course of my own research, I have identified several dozen women in the Twin Cities of Minnesota with anorexia nervosa who come from religiously conservative traditions. These religious anorectics were identified through various local churches, missionary groups, and church-affiliated schools, as well as in the treatment programs of a major teaching hospital in Minneapolis. The cases of Jane A. and Margaret C. demonstrate that religion is used by some contemporary women to understand their self-starvation. Future studies might investigate the prevalence of eating disorders in various religious

subcultures. Moreover, these case studies suggest that clinicians might take into account the religious background, beliefs, and practices of anorexics and bulimics seen in clinical settings and contexts [64, 65].

Jane A.

Jane A. is a recovering anorectic woman who resides in Minneapolis–Saint Paul, Minnesota. In her mid-thirties at the time of my work with her, Jane was actively anorectic between 1968 and 1972 when she was in high school. I consider her to be typical of many teenaged anorexics—their numbers and stories untold—who experience an episode of anorexia and who then leave it behind, often without treatment, as they become sexually active adults.

Jane's family belongs to the Missouri Synod Lutheran Church. She attended Lutheran parochial schools up to the seventh grade. Jane went to church regularly throughout her childhood and during her anorectic phase. While she was anorectic, Jane also participated in church-sponsored youth or family programs during the week and special services on religious holidays. Her mother or friends often accompanied Jane to church on these occasions. Jane recalls reading the Bible every day and praying frequently during these years. Reading of non-Christian philosophy or theology was not allowed in Jane's home.

I collected information about Jane, her family, religious beliefs and practices, and her anorexia from the detailed daily journals that she has kept since girlhood. In addition, Jane supplemented the diaries in focused interviews. Jane's journals are rich sources of information on the psychological, social, and cultural dimensions of anorexia nervosa. They were written for personal and private edification, as a forum for recording private thoughts, emotions, conversations, activities, and, occasionally, dreams and fantasies. As noted by some therapists of anorexics, anorexics are notoriously secretive and evasive, and it is often difficult to obtain information from them on such matters as true weight and food consumption. Jane's diaries provide information on body weight, actual daily food consumption, as well as her feelings about her body, food, family, religion and sexuality. The diaries reveal that Jane met most of the clinical symptoms of anorexia nervosa, as presently listed in DSM-III-R: body weight 15% below that expected for age and height, amenorrhea, and periods of hyperactivity [42]. In addition to the journals provide a diachronic view of anorexia. Through the journals it is possible to trace the beginnings, climax, and eventual cessation of Jane's anorexia and to relate it to other circumstances in her life. In my view, the chronological nature of the material in the diaries allows for important insights.

Jane was anorectic in the late 1960s and early 1970s, a time when anorexia nervosa was not as pervasive as it is thought to be today, and therefore was not part of the popular—or even much of the

medical—vocabulary and culture. Jane was not in therapy or counselling for anorexia during the years she was actively anorectic. She was never labeled by her parents, peers, or others as an 'anorectic' and her diaries do not indicate that Jane was ever aware of such a syndrome or label. The words 'anorexia,' 'anorectic,' or 'eating disorder' never appear in her diaries. It is only recently, as Jane has been in counselling with a psychotherapist, that she has become aware of her past as an 'anorectic.' In the absence of Jane's use of medical labels and explanations, then, her diaries provide information on how Jane's preoccupation with controlling her body was expressed and perceived by herself and others. The diaries, a window on the subjective side of anorexia, reveal the cultural symbols, idioms, and language Jane used to express her desire to control her body.

One noteworthy feature of Jane's journals is that some entries were written in a 'biblical' prose style: she used 'Thine' or 'Thou' in these passages, some of which paraphrased biblical stories and borrowed biblical language. In her journals, Jane's voice often took the form of prayer or petition. Many of these religiously-phrased journal entries ask God for control over her emotions, body and sexuality. Jane's desire to control her body weight was often phrased as religious 'fasting.' Her resolve to undertake long and restrictive 'fasts' often coincided with the church calendar. In addition to undertaking long 'fasts' during the Lenten season, Jane 'fasted' regularly for 24 hr on Saturdays in preparation for taking holy communion in church on Sundays. Numerous examples in the diaries illustrate Jane's use of the religious language of 'fasting' as the idiom through which she expressed her desire to control her body and weight.

Jane's writings at the time she was anorectic express dualistic, oppositional thinking about body and spirit. Jane saw the two realms as opposed and conflicting forces. Jane believed the soul or spirit to be heavy when the body is fat and overweight. She stated:

My soul is heavy laden.
My body hurts with excess weight.
I want to relieve myself of it.
But it won't be moved.
I must try hard once more.

Other entries suggest that Jane believed that one can eat the non-material, that blessings are a form of food:

Rejoice! Yeah!
I can creep through the evils
I can stomp over the temptation
Reap the pleasures
Harvest the joys
Feast in the blessings.

Jane's writings on the body and spirit while she was anorectic support Palazzoli's [54] and Sabom's [66] observations, to be discussed below, that anorexics treat the body and spirit as opposing and separate

realms. Jane's diaries show how her religion informed this duality.

Of importance in understanding Jane's anorexia—its onset, rise and eventual cessation—is her sexuality, initially her attitudes towards and experiences with dating, and later, her feelings about sexual intercourse. The journals express strong ambivalence about sexuality during her high school years. This theme runs through Jane's journals from the years 1969 to 1973 and, in my view, provides the backdrop for the onset of Jane's anorexia, and its eventual resolution.

Jane's anorexia started when she entered high school in 1968 at 14 years of age and was confronted with dating boys and sexuality. Her anorexia began to subside in the months following her first sexual experience at seventeen in the summer between her high school graduation and first year away at college. By her college years (1972–1976) and steady heterosexual relationships, Jane was no longer concerned with controlling her body and weight: the journals no longer record weights; lists of foods consumed and their caloric content are absent; and statements about needing to control her weight become sporadic. Jane rejected her family's Lutheranism, refusing to attend church, as she became sexually active.

The journal entries reveal Jane's ambivalence about dating and suggest that her desire to 'fast' and her appeals to Jesus and God are intimately connected with guilt and anxiety about her sexuality. Jane appealed to God to help her control her body. During the years she was anorectic, Jane was aware that her extreme thinness was perceived in negative ways by boys. While her thinness kept boys at a far and 'safe' distance and allowed her to remain virginal, it was also a means of attracting attention from her peers and family. There are narcissistic and exhibitionistic elements to Jane's anorexia. I have discussed elsewhere that Jane's ambivalences over dating and sex are, in turn, based in early childhood experiences of abandonment and abuse and are related to unresolved anxieties over separation [67].

In summary, Jane presented the signs and symptoms of anorexia nervosa—preoccupation with body weight, hyperactivity, and amenorrhea. It is also evident that her anorexia was motivated by unresolved anxieties over separation, rejection and sexuality. Yet—and this is the main point of the present discussion—Jane herself understood these 'symptoms' of food refusal, *not* as anorexia nervosa, but through religious concepts about food and the body provided by her Lutheranism.

Margaret C.

Margaret C. is a woman now in her early 50s who has been anorectic for over 30 years. Her anorexia is chronic and unremitting. She is 5'4" and weighs about 57 lbs. Although she admits that she was in treatment (involuntarily, she says) for 6 months in the late 1980s, she does not see herself as 'sick' or 'anorectic.'

Margaret stated, "For me, it's a way of life, my whole self, really. That's why I can't think of it as a disease or anything, you know." Rather, Margaret, a life-long member of the Covenant Church, a conservative form of Protestant fundamentalism, presents herself as a 'Christian miracle.' Reminiscent of the 'holy' anorectics described by Bell and Bynum for women in the mediaeval period, she tells people that she lives on faith and prayer—and on minimal amounts of food, as her emaciation and the fact that she does not eat in front of other people might suggest.

I have known Margaret since the spring of 1985. The method I used in obtaining information about Margaret, her life, and her anorexia, is more traditionally 'anthropological' than the approach I used with Jane. With Margaret I combined participant observation with focused interviews. I used all opportunities that were presented to observe and interact with Margaret in a variety of settings. I observed Margaret with her family and some of her friends and acquaintances. In addition to informal meetings, I interviewed Margaret in-depth about her anorexia, religious views and family. Projective drawings (draw-a-family and draw-a-person) yielded important information on Margaret's personality and self-perceptions.

From the start, Margaret made it clear that food was to figure in our relationship and meetings. Many of our informal meetings took place in restaurants—at Margaret's request. Even when we met in her home for structured interviews, she always asked that we go to a restaurant afterwards. It was a spoken, recognized, and absolute condition of our continuing relationship that I must eat when we were together. Margaret told me early in our relationship that she hated to be around friends who did not eat. "I like to be around healthy, normal people who like to eat." Margaret told me flatly our second meeting that if I ordered a small green salad with no dressing she would never see me again! On one occasion I ordered a beverage and no food. Margaret was displeased and commented that she was afraid I was becoming 'anorectic.' Eating, in short, was an integral part of our relationship and so provided many opportunities to observe and discuss Margaret's attitudes and beliefs about the body and food. Margaret, in the course of our many meetings, told me she had an insight into why she insists that I and others eat when she is with us. She stated, "You want to be around other people because you're fulfilling your own satisfaction. I like to be around you and look at you when you eat because I would like to eat it myself. And you're just feeding yourself through them. Isn't that interesting?"

Margaret's anorexia is, in my view, part of an obsessive-compulsive personality disorder. An essential feature of this personality disorder is a pervasive pattern of perfectionism and inflexibility [42]. Obsessive-compulsive personalities constantly strive for perfection and have strict and often unattainable

standards. Moreover, 'splitting,' a defense mechanism in which idealized aspects of the self are split off from devalued, persecutory, and 'bad' aspects, often characterizes the obsessive-compulsive personality [68, 69].

In Margaret's case, her obsessions and compulsive behavior, as well as her psychological 'splitting' of views into opposing categories, are phrased in the language and symbolic expressions of her fundamentalist Christian background. She views her repetitive behaviors and routines about eating not as compulsions, but as her private 'rituals.' Margaret rationalizes these behaviors in terms of the oppositions between true Christians and non-Christians, eternal life and death, spirit and body, heaven and earth/the world, light and dark, and purity and dirt or defilement that are a feature of Protestant fundamentalism. Briefly, Margaret eats only after midnight, usually around 1:30 a.m., and continues her eating ritual until sunrise. Margaret told me that "dark is Satan and light is good, it is Jesus, like it says in the Bible." Associated with Margaret's ideas about light and dark are ideas about purity and dirt. Margaret takes at least three baths during her eating ritual: she bathes before, during, and after she eats. Another indication that Margaret may view food and eating as polluting is that the food she chooses to eat is often 'spoiled,' 'rotten,' or 'old.' This is not a consequence of her economic situation which can be described as middle- to upper-middle class—but is a matter of choice.

Margaret's religious beliefs about heaven and eternal life shape her views about the physical body. Margaret opposes the physical body with the pure spirit. In her opinion, control over the physical body elevates the spirit: those true Christians who control their bodies especially well will get to heaven. The dichotomy between the body, flesh and fat, on the one hand, and pure spirit, on the other, is fully developed in fundamentalist eschatology and in beliefs in the 'rapture.' These beliefs hold that the bodies of believers in Christ will be 'translated' into spiritual bodies *without* experiencing physical death [70, 71]. Margaret does not believe in death. She said, "I believe that a Christian person does not really die. They just sort of pass from this life into the other." Her concept of the self poses the body and spirit in opposition. The real self, she believes, is located *not* in the body but in the spirit. She stated, "Well, the part of you that goes [to heaven] is really yourself because the body is nothing. Anybody who believes in the Bible would believe in that as a matter of fact." In Margaret's mind, control over her body and her purity assure that she will get to heaven where, she believes, she will reunite with the idealized Christian family of her early childhood, especially her mother.

In summary, Margaret understands her self-starvation to be a consequence of her attempt to be a 'true Christian,' to literally live out the precepts and ideals about the body and self of her conservative

Christian fundamentalism. She does not see herself as 'sick'; rather, she sees herself as a 'good Christian' who strives to be pure and to control her body. Viewed psychologically, Margaret's anorexia, like Jane's, seems motivated by unresolved anxieties over separation and individuation. Margaret's associations to her 'draw-a-family' drawing reveal an inability to distinguish between herself and her siblings. Moreover, her case supports arguments advanced by others, discussed above, that anorexia nervosa may not be a separate disorder but, rather, may be an aspect of depression, schizophrenia and obsessive-compulsiveness [55, 56].

RELIGION AND FOOD REFUSAL

There is a long-standing connection between Christian asceticism and food refusal. Fasting and renunciation of food were intimately associated with sexual renunciation throughout the early Christian period [72]. For some religious men and women fasting was the prime expression of their asceticism. By the middle of the fifth century, fasting and other forms of dietary restriction were common features in Christian practice. The human body and sexuality were considered secondary to the human will and spirit. These notions continued to be developed into the Middle Ages.

Recent scholarship on the mediaeval period establishes a link between food refusal and religiosity for women between the twelfth and fifteenth centuries [4, 5]. Many women chose to fast and to starve themselves in terms of religious motivations. Bell [4] and Bynum [5] document with numerous examples the widespread practices of food refusal and fasting among religious women in the mediaeval period. These cases, which include Saint Catherine of Siena and other Christian saints, are evidence that food refusal among women is not a contemporary or modern phenomenon.

While Bell and Bynum are primarily concerned with describing and interpreting food refusal and religious values in the mediaeval period, they ask whether fasting and starvation undertaken by women during the Middle Ages was anorexia nervosa. On the whole, they equivocate. Their ambivalence on whether food refusal in the mediaeval period was anorexia nervosa derives from uncertainty and unexamined assumptions about the role of culture in contemporary anorexia. It is either unclear to them which cultural values or symbols are involved in contemporary anorexia, or they assume, without investigation of specific cases of anorectics, that certain cultural dicta—such as 'thinness' as an ideal for women—are always implicated in the disorder. In short, these historians agree that culture—and especially religion—informed food refusal during the lengthy mediaeval period. Yet they assume—without investigation of contemporary anorectic women themselves—that the cultural components of modern

anorexia are qualitatively different from the cultural symbols and values that shaped earlier patterns of food refusal. They assume a break between the twentieth century, which gives rise to anorexia nervosa, and preceding historical periods. For Bell, the break is a contrast between 'holy' and 'nervous' anorexias [4]. For Bynum, the two are utterly different: in her view, mediaeval symbols and doctrines have no direct relevance to twentieth century patterns [5]. For Brumberg, an historian of anorexia, it is a transition from 'sainthood' to 'patienthood' [6]. Religion and religious values are no longer thought by these scholars to play a part in food refusal.

The break or hiatus between the mediaeval past and modern era is explained by the processes of 'medicalization' and 'secularization.' These processes are understood to have been completed by the twentieth century when anorexia nervosa was first recognized as a medical disorder. Brumberg documents that anorexia nervosa emerged as a new and distinct medical entity in the late 1800s in Great Britain and France [6, 73]. Physicians at this time transformed food refusal from an act of personal piety to a disease symptom, with causes thought to reside in the body or family—not in religion. These processes of 'medicalization' and 'secularization,' part of a larger debate between clergy and physicians over explanations of behavior, were carried out by the male medical profession, which largely ignored or overlooked questions of the subjective meaning and motivation of anorectics themselves [6, 73]. Starvation was not seen by physicians as having symbolic meaning for the anorectic girl or her family. Yet 'fasting girls' or miraculous maids in the late nineteenth century still told religious stories in the absence of saintly roles and did not concur with changing medical opinion about anorexia [73]. Brumberg views these 'fasting girls' at the turn of the twentieth century as speaking to antimodernist impulses and coming from traditions of Spiritualism, a religious movement that stressed transcendence of the spirit over the body and flesh [6].

Brumberg, like Bell and Bynum, assumes that by the twentieth century the related processes of secularization and medicalization of food refusal were complete. Brumberg is emphatic in her belief that by the early 1900s the religious delusionary had disappeared from classifications of self-starvation [6]. Acknowledging that these final processes of secularization and medicalization occurred 'in short order,' Brumberg does not consider the subjective and cultural realms of contemporary anorectics. It is an open question, in light of the cases presented here, whether the related processes of medicalization and secularization are 'complete' on a *subjective* level for all anorectics even in the late twentieth century.

Bell, Bynum and Brumberg make valuable contributions to understanding the relation between religion, ideals of asceticism and food refusal behaviors in the mediaeval and Victorian eras. However, they

are less persuasive when writing about contemporary anorexia nervosa. While modern anorexia nervosa should be viewed within its own historical-cultural context, I believe it is incorrect to assume that there has been a fundamental break between mediaeval and modern food refusal in women. Most contemporary *theories* about and *research* on anorexia nervosa are secular in orientation and focus on physiological and non-religious psychosocial factors [7, 8, 46, 48, 55, 57]. However, a different impression can be gleaned by talking with active anorectics. Some of them, such as Margaret and Jane, couch their eating behavior in religious meaning. Modern culture, moreover, is far from being fully secularized. Religion, especially in fundamentalist forms, remains important for many persons.

Religious fundamentalism may be regarded as a vital and continuing sociopolitical and intellectual tradition in American society [74]. Pertinent to the present discussion on culture and eating disorders are fundamentalist beliefs about the body, sex and food. In the first half of the twentieth century, asceticism—self-denial and rejection of 'worldly vices'—was the cornerstone of fundamentalist culture. Sermons and tract literature of the day condemned all 'appetites of the flesh,' including card playing, social and some folk dancing, using tobacco and alcohol, attending the theatre, 'worldly dress,' and 'immoral sexual practices' [74]. James West's study of Plainville, U.S.A. [75], Vidich and Bensman's study of Springdale [76], and the Lynd's study of Middletown in 1929 [77] and again in 1935 [78] found these preoccupations in certain groups. West estimates between two-thirds to three-fourths of the residents of Plainville believed in the tenets of fundamentalist Protestant theology, including a literal interpretation of the Bible [75]. Hunter posits that the behavioral norms of conservative Protestantism remained relatively intact through the first half of the twentieth century [79].

Contemporary fundamentalist tradition extends an asceticism about sexuality to control of the appetite and consumption of food. Many Christian diet books, aimed primarily at women, are published by fundamentalist church-affiliated presses. They are readily available through church libraries and bookstores. These books advise women to get control of their bodies and flesh and to substitute the consumption of symbolic biblical images for real food. One of these diet books states that the Christian attitude toward food is one that "eats in the Spirit" not in the flesh and that "feeds on the Word" [80, p. 70]. This book divides foods into "Kingdom Foods" (low-fat foods) and "World" or defiled foods (fattening foods), directly equating the spiritual realm and God's Kingdom with bodily thinness and lack of fat. Another Christian diet book equates dieting with a trip to the Promised Land (a land of freedom and 'lightness'), and provides women readers with meditations to help them find strength and self-discipline "by feasting on the fruit of the Spirit" [81]. The

imagery in these diet books opposes body, fat and food, on the one hand, to spirit and lightness, on the other. Moreover, the former is considered sinful and defiling; the latter beautiful, pure and good.

Refusal of food and sexual purity have been ideals in Christian theology since the early Christian era. They have persisted through the mediaeval and early modern periods into the twentieth century. Today in the United States they are most pronounced in conservative fundamentalist groups. And, as we shall examine briefly, asceticism about the self, sex, body, and, of course, food, is a major characteristic of anorexia nervosa in contemporary forms.

ASCETICISM IN CONTEMPORARY ANOREXIA NERVOSA

Psychologists and psychoanalysts who have worked with contemporary anorexics have commented on their asceticism. While acknowledging an association between asceticism and anorexia nervosa, these scholars do not consider the social and historical factors that may heighten and intensify asceticism and make it an explicit cultural value for particular groups or individuals at a specific time. Moreover, these works, generally more psychological than sociological or anthropological in orientation, do not address the cultural symbols, idioms, and language through which the extreme asceticism, self-denial, and moral superiority of anorexics is subjectively expressed or encoded. That the asceticism of contemporary anorexia nervosa in the West may be expressed religiously is, in most cases, ignored. It is not surprising, then, that formal research on the religious dimensions of contemporary anorexia nervosa has been minimal or nonexistent in clinical and therapeutic circles. Nevertheless, some published reports, as well as autobiographies by anorexics and the cases presented here, suggest that religion does play a role in the lives of some contemporary anorexics.

Asceticism and anorexia nervosa

Asceticism reaches extreme forms in anorexia nervosa [3, 54, 66, 82, 83]. What exactly is meant by 'asceticism' or the 'ascetic' element in anorexia nervosa? As it is used by various researchers, 'asceticism' refers to self-denial, a dualistic split between the body and mind or spirit, asexuality, rejection of bodily death, and heightened morality and idealism.

Palazzoli comments on the ascetic element of anorexia nervosa that reflects a rigid belief in a split between the body and mind. This dualistic logic leads the anorectic to believe that "one has only to crush the one (the strong body) to enhance the other (the weak spirit), thus magically reversing their respective roles" [54, p. 74]. Sabom notes the anorectic's tendency to bifurcate the mind, body and spirit and to reject the body [66]. Bemporad and Ratey also refer to the self-denial and asceticism that are major characteristics of anorexia nervosa [84]. They de-

scribe the anorectic's sense of moral superiority derived from endurance of painful abnegation and relinquishment of gratification of desires; self-control is praised, while any form of indulgence is disapproved. Feelings of moral superiority entail feelings "that other women are weaker and thus inferior because they cannot endure hardships like oneself. The corollary of this belief is that men are generally lacking in self-control, are dangerous and markedly morally inferior individuals" [84, p. 461].

Preoccupation with sexual purity is an important aspect of asceticism generally [85]. Sexual purity and abstinence are distinctive characteristics of anorexia nervosa [51, 83]. Anorexics typically suppress the libidinal side of life [51, 58, 86]. Adolescent girls and young women with anorexia nervosa show little interest in heterosexual relationships; they also resist learning about sexuality [51]. While cautioning against sweeping generalizations and recognizing that anorectic patients show a spectrum of sexual experience, knowledge and attitudes, authors of another study suggest that anorectic patients may be divided into two groups on the basis of the behavior they use to induce weight loss. Patients whose weight loss occurs as a result of dieting and abstinence-types of behavior (as opposed to those who use vomiting as a means of weight control) tend to be sexually inexperienced [49, p. 139]. Data gathered by Rost, Neuhaus and Florin on the behavior of bulimarexics indicate that bulimarexic women tend to follow a gender role concept of passivity, dependency and unassertiveness [63, p. 406]. Their behavior conforms more closely to the traditional female role than the behavior of most non-anorectic women.

Mogul, a psychoanalyst, proposes that anorexia nervosa may be an exaggerated or extreme form of asceticism. Anorexia nervosa can be viewed, according to Mogul, as asceticism that has become an end in itself [82]. Extreme asceticism—with its focus on moral transcendence and goodness—leads anorexics to a sense of moral purity.

Most of these investigators, however, have little to say about the religious dimensions of anorectic asceticism. Mogul, drawing an analogy between the asceticism of anorexia nervosa and the asceticism of Indian theology and mythology, considers the asceticism of Hindu myths, Jainism, and Buddhist legends [82]. He mentions the "lofty spirituality of the day in which the materialism of everyday life had no part" in one of his patients [82, p. 171], but otherwise does not consider the religious expression of contemporary anorexia in the West. Masson also compares Indian asceticism, with its traditions of fasting, and anorexia nervosa [85]. He does not explore the religious expression of anorexia nervosa in the West, however.

Palazzoli, dismissing the parallels inferred between religious ideals of asceticism and anorexia nervosa, states with regard to the asceticism of anorexics:

This type of asceticism should not be confused with the religious: the saint becomes an ascetic not as an end in itself but as a means to attain mystical communion with God and all His creatures. The *religious sentiments of anorexics, in so far as we have looked into them at all*, do not, by contrast, involve this mystical element: what religious beliefs they profess are schematic, rigid and quite without love. . . . Anorexics do not become ascetics after a slow and arduous process of inner development—they are in a hurry to reach a pathological goal, they 'jump to conclusions.' Hence they achieve no more than an ascetic 'appearance,' a hastily constructed somatic shadow of the true ascetic [emphasis added] [54, pp. 74–75].

While Palazzoli is quite correct in asserting that contemporary anorexics are not saints, it may be premature to conclude that anorectic asceticism is not religious. Moreover, Palazzoli's statement, while contrasting the saint or mystic with the anorectic, prompts the question: what are the religious sentiments, beliefs and practices of contemporary anorexics? The rigidity, authoritarianism and lack of genuine love that she mentions are typical of the anorectic's religious beliefs, while perhaps lacking an authentic mystical element, are, nonetheless, aspects of religious systems and are remarkably close to the beliefs and practices of contemporary religious fundamentalists.

Rampling, recognizing that ascetic ideals in anorexia nervosa imply spiritual or religious meanings, remarks, "The religious connotations of asceticism have remained relatively unexplored in terms of the understanding they might shed on the pathogenesis or psychodynamics of the anorexic state" [83, p. 89]. He proceeds to explore the life of Saint Catherine of Siena, whom he, like Rudolph Bell, considers to have been anorectic. He states, "If there were to be some clues as to a spiritual dimension in anorexia nervosa one might reasonably expect to find them here" [83, p. 90].

Palazzoli, Rampling, Mogul and others, in pointing to ascetic strains in anorexia nervosa, do not ask through what cultural beliefs and practices those ascetic characteristics are encoded and expressed by anorexics themselves. They hint at or point to religion and religious systems—without consideration or examination of contemporary cases of anorexia. Instead, they focus on examples of religious 'anorexics' from the mediaeval period in the West, or point to similarities between anorexia nervosa and the asceticism of Hindu and Buddhist religions in the non-West. The cases of Jane and Margaret suggest that future research might directly explore the manner in which the anorectic's asceticism about the body is subjectively expressed through religious concepts and understandings.

Religion and contemporary anorexia nervosa: the clinical evidence

Although there has been little actual research on religiosity in contemporary anorexia, some published reports suggest that religion does play a role in the

lives of some contemporary anorexics. Wilbur and Colligan note the greater religiosity of anorexics seen clinically [87]. They compared 34 female patients in a clinical setting diagnosed as having anorexia nervosa with two control groups of non-organically ill, non-psychotic female psychiatric patients. Profiles on the MMPI (Minnesota Multiphasic Personality Inventory) indicated, among other things, that the anorectic patients had significantly higher scores on religious fundamentalism. Of the twenty MMPI items that were found to discriminate significantly between the anorectic group and both control groups, several pertain to religiosity—praying several times a day and reading the Bible several times each week [87, p. 91].

Sykes, Gross and Subishin recently found a significant relationship between eating disorders and religion for 160 cases seen clinically [88]. Their study was conducted to elucidate demographic information on anorexia nervosa and bulimia. Religion was among several variables the researchers thought might be related to eating disorders. Specifically, they report that of the 160 patients, 71 were Protestant, 70 were Catholic, 11 were Jewish, 2 had other religious affiliations, 4 stated no religious preference, and 2 did not respond. When the anorectic patients were considered separately from the bulimic patients, the proportion of anorectic Catholics (46.5%) was significantly higher than the proportion of Catholics in the general population (24.9%). The proportion of anorectic Jews (4.0%) did not differ significantly from the proportion of Jews in the general population (2.7%). When the bulimic patients were considered separately, the proportion of bulimic Catholics (44.2%) was significantly higher than the proportion of Catholics in the general population (24.9%). The proportion of bulimic Jews (11.6%) was also significantly higher than the proportion of Jews in the general population (2.7%) [48]. Sykes, Gross and Subishin believe that the higher prevalence of both bulimia and anorexia nervosa among patients of Jewish and Catholic religious backgrounds than the general population could be related, in part, "to the importance of food within these religious groups" [88, p. 28].

Case studies presented in the clinical literature on anorexia nervosa sometimes imply that for some anorexics religion shapes attitudes towards the body and food. Minuchin *et al.*, although not directly addressing the religiosity of anorexics, reveal an association between religiosity and eating disorders in their data. Minuchin's widely cited *Psychosomatic Families* is a compilation and analysis of four 'anorexogenic' families [57]. In one case—an Italian Catholic family—the girl's anorexia started during the Lenten season. Minuchin describes 'anorexogenic' families as typically enmeshed: boundaries between family members are blurred and differentiation diffused. In one family overprotection and enmeshment of family members were exacerbated by

their religious fundamentalism. The father of several anorectic daughters remarked:

We stress in our children the virtue of living a God-fearing life and obeying and loving each other We did not want them to play with kids in the neighborhood because they would be subject to bad influences and learn bad things. Everyone was kind to the others and got along fine with others. We did not allow any quarreling between the children [57, p. 62].

The mother, herself diet conscious during the course of her marriage, stated, "I have encouraged the girls not to eat between meals and I have told them that the renunciation of food has some virtues . . ." [57, p. 63].

The religious symbolism and language used by one anorectic girl cited in Hilde Bruch's *The Golden Cage* is striking and evokes the 'holy' anorectics discussed by Bell and Bynum. This anorectic girl, age 15, stated, "My body became the visual symbol of pure ascetic and aesthetics, of being sort of untouchable in terms of criticism. Everything became very intense and very intellectual, but absolutely untouchable" [51, p. 18]. According to Bruch this girl had read about the visionary experiences of people during The Middle Ages and thought that through her starvation she was molding herself into "that wonderful ascetic pure image" [51, p. 17]. In another work Bruch mentions in passing the heightened morality of anorectic girls [89].

Autobiographies and biographies of contemporary anorectic women also point to religion and religious idioms in the symbolic expression of their anorexia. Simone Weil, an extremely religious French woman who lived and wrote in the first half of the twentieth century, died of self-starvation in 1943 [90]. Weil chose 'hunger' and 'nourishment' as central metaphors for her spiritual quest and connected eating and food to religious imagery in her works [91]. Psychiatrist Robert Coles, in consultation with Anna Freud over many years about Weil's life and views, while hesitating to call Weil an 'anorectic,' does concede that Weil suffered from eating disorders [92].

In the past decade, several recovering anorectics have published their autobiographies [93-95]. Some touch on the ethical, moral and religious themes of their patterns of food refusal. For example, Liu refers to her food habits as 'fasting' and states, "The spiritual significance of losing weight, of discipline, of sacrifice . . . It strengthened the soul, so to speak" [93, p. 115]. And, "It's like, since there's so little of you physically, there has to be more spiritually and intellectually" [93, p. 138]. Likewise, MacLeod discusses her early education in a Roman Catholic convent, her deep guilt and fear when her atheistic parents denied her request to be baptized, and her feelings of 'moral superiority' while anorectic [94]. MacLeod notes the parallels between her anorexia and the fasting undertaken by religious mystics.

Various studies and writings, then, hint at an association between religion and contemporary anorexia nervosa. Through the lives of Jane and Margaret, two women from religious fundamentalist backgrounds who express their food refusal through religious idioms and symbols, we have explored the nature of the association in more detail. These cases show that some contemporary anorectics give meaning to their symptoms through religion and suggest that researchers might systematically and directly investigate the religious beliefs and practices of anorectics seen clinically.

SUMMARY AND CONCLUSION

As noted above, clinicians have documented that asceticism about the body, food and sex is an integral aspect of anorexia. This asceticism often includes an antisexual morality and dualistic thinking about the body and spirit. These researchers, however, have overlooked the wider cultural contexts and expressions of this asceticism. Jane's and Margaret's stories illustrate that, for some contemporary anorectics, this asceticism about the body and food may be understood by them through religious language, symbols and idioms. Durkheim [96], William James [97] and Menninger [98] noted that asceticism, including denial of food and sex, is a part of religion, partly explaining why contemporary anorectics who come from religious traditions might encode their food refusal through religious symbols and language. It is precisely concepts about food and the body that are universally a part of religion that these religious anorectics use to understand their self-starvation, thinness and self-control.

What are the implications of these findings for the question of 'culture' in anorexia nervosa posed at the beginning of this article and for the present designation of anorexia as a Western 'culture-bound syndrome'?

In keeping with the tenets of the 'new' transcultural psychiatry, which considers the meanings and contexts of illness, this article points to the necessity of taking into account the anorectic's own understandings of her starvation and thinness. The data on Margaret and Jane presented here question the views expressed by Bell, Bynum and Brumberg that religion no longer plays a role in modern food refusal. There is no doubt that most contemporary theories about, and research on, anorexia nervosa are secular, and eschew religion. But if one looks at how anorectics themselves express and understand their food refusal, some still draw on religion and religious values about the body and food to encode their personal concerns. These concerns may be, in turn, motivated by anxieties of which the anorectic may be unaware. Nonetheless, she gives meaning to the various symptoms and uses explicit cultural beliefs and symbols about the body and food, such as those that are a part of religion, to do so.

The answer to the question about which aspects of culture are involved in anorexia depends, therefore, on whether one takes the point of view of the biomedical system or the varying points of view of anorectics themselves, some of which, at least, may be religious. The fact that symptoms may be given different meanings and interpretations in varying subcultural contexts has important implications for whether an individual will accept the designation of 'sick role' label and for the success or failure of treatment. Margaret and Jane do not see themselves as 'sick' or as 'anorectic.' Rather, they understand their starvation as a literal attempt to meet the normative ideals about controlling the body provided by their religious traditions. Treatment can only be successful the extent to which medical practitioners begin to recognize alternative cultural explanations for symptoms as well as the role of culture in their own diagnostic and biomedical systems. It is possible, for example, that core values about the body in Western culture may be expressed religiously as 'fasting' by those persons who adhere to religious traditions and may be 'secularized' as 'dieting' for other segments of the population. The latter values may be built into the diagnostic system and into treatment modes. This possibility warrants further investigation.

The designation of anorexia nervosa as a syndrome largely confined to Western cultures awaits validation through further cross-cultural research. The belief held by many researchers that anorexia nervosa is largely a (or even *the*) Western culture-bound syndrome reflects, in my view, unexamined assumptions built into some biomedical research and into the diagnostic system itself that cultural preoccupations with thinness and dieting are the main cultural values implicated in the disorder. The designation of anorexia nervosa as a syndrome unique to the West tacitly assumes that preoccupations with dieting, weight control, and slimness will exist only in those cultures and groups where food is plentiful and overeating a potential problem—and thus are not likely to be found in those (non-Western) cultures that are presumed to experience chronic or periodic food shortages. Thus it is assumed that eating disorders, especially anorexia, are *bound* to affluent Western cultures and to affluent strata within those cultures. Anorexia nervosa and bulimia were at one time thought by researchers to be disorders of the [white] middle or upper social classes [99]. I believe, in agreement with Kleinman [12], that the view that anorexia nervosa is a syndrome 'bound' to the West is too simplistic and may have to be revised as our understanding of the complex role of culture in the disorder in Western contexts becomes clarified. This is not to say, however, that anorexia nervosa is not a culture-bound syndrome as Ritenbaugh defines and understands the term. Clearly, the disorder involves core cultural values and cannot be understood apart from these values and contexts.

The data on Margaret and Jane demonstrate that self-starvation can be expressed by contemporary anorectics in the West through religious symbols and idioms about food and the body. These findings can be understood in light of the values of asceticism about the body and food refusal that have long been a feature of Western Judeo-Christian tradition. These findings suggest several possible avenues for future cross-cultural studies investigating the presence and extent of eating disorders in non-Western contexts. Specifically, in the search for 'eating disorders' in non-Western cultures, anthropologists and other researchers might study the food asceticism of religions other than Judeo-Christian (Buddhism, Hinduism, Islam, etc.) as well as cultures with traditions of ritualized fasting and vomiting [100–104]. Rituals of fasting and vomiting are often undertaken in many traditional cultures during rites of passage associated with the assumption of adult gender roles and relations. Moreover, the ethnographic record on shamanism and spirit possession includes references to self-starvation and 'anorexia' [39, 105–107]. Future anthropological research might explore the relation between spirit possession and starvation in light of the association noted here between religiously motivated asceticism and eating disorders in the West.

For those non-Western cultures presently undergoing 'Westernization' and for which there are reports of increasing cases of anorexia nervosa and other eating disorders (i.e. Japan), anthropologists might look to missionizing activities of fundamentalist churches in those areas and to involvement of anorectics in those religious institutions. S. G. Lee's account of 'anorexia' among Zulu Christian sects is a case in point [26].

Only when various studies like those suggested above have been completed will we be able to say whether anorexia nervosa is a singularly Western phenomenon. My own view, based on reviews of the ethnographic literature on spirit possession and rituals of fasting and vomiting, is that the symptoms of 'anorexia nervosa' will be found in a wide range of contexts outside the West. The material presented here suggests that future cross-cultural research might investigate the extent to which these cases of self-starvation are also religiously motivated and expressed.

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