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The “Network-Boundness” of Anorexia Nervosa:
A Study of Scientific Knowledge Production and the Negotiating Implications of
an Actor-Network Approach

by

Hege Bakken

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of the requirements for the degree of

Masters of Arts

Department of Sociology and Anthropology

Carleton University
Ottawa, Ontario

July 16, 1998
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The "Network-Boundness" of Anorexia Nervosa: A Study of
Scientific knowledge Production and the Negotiating
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submitted by Hege M. Bakken, Candidata Magisterii
in partial fulfilment of the requirements for
the degree of Master of Arts

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Chair, Department of Sociology and Anthropology

Carleton University
September 3, 1998

Abstract

This thesis explores the recent genealogical developments in the production of scientific knowledge of anorexia nervosa. Applying an actor-network approach to the understanding of how certain knowledge claims about the syndrome have become strong and encompassing “black-boxes”, with particular emphasis on the diagnostic concepts of “fat phobia” and “body image disturbance,” the thesis argues that the debate about anorexia nervosa can be used to illustrate how recent contributions to the Sociology of Scientific Knowledge (SSK), and actor-network theory in particular, can contribute as a negotiating device between scientific realism, postmodern nominalism, and reflexivistic social constructivism. It is suggested that the anorexic debate has formed a large and pervasive actor-network where “truths” about the syndrome, or what I call “standardization packages”, are constructed through a series of “translation” and “negotiation” practices, enrolling a range of different social worlds. As such, it is argued, anorexia nervosa can be seen as a “network-bound” syndrome, a conceptualization which may open up ways of understanding the syndrome that direct attention to the heterogeneous, dynamic and inclusive possibilities of the network rather than to fixed external truths or a set of *a priori* macroscopic social forces.

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Introduction

Through the beaded curtain enters the eagle, eager to do his bidding. Slowly eroding at self, beak and talons siphon. Nail it shut. So where is justice? (“young anorexic” quoted in Lester, 1997:488).

(. . .) Thus, the two constitutional guarantees of the moderns - the universal laws of things, and the inalienable rights of subjects - can no longer be recognized either on the side of Nature or on the side of the Social. The destiny of the starving multitudes and the fate of our poor planet are connected by the same Gordian knot that no Alexander will ever again manage to sever (Latour, 1993:50).

We need to ask questions (. . .) that focus, for example, on what scientists produce, who they produce it for, how they produce it, and with what social, political, economic, and environmental consequences (Croissant & Restivo, 1995:86).

Some of the most important questions raised in the sociology of scientific knowledge (SSK) in recent years are concerned with the dominance of scientific knowledge construction, how certain claims to truth become more powerful and influential than others, how such truth claims develop into institutionalized building blocks and make it possible to “act at a distance” (Callon et al., 1986) - to “raise the world” (Latour, 1987), how these scientific knowledges and practices have impact on and are related to the social world, and what an alternative epistemological position should consist of. According to Latour (1993), it is the failure of the “Modern Constitution” to realize the simultaneousness and inseparable ontological relationship between the natural and cultural (or what he calls “hybrids,” or “quasi-objects” and “quasi-subjects”), on the one hand, and what he calls “purification work” and “translation work” on the other, which has led to the present “crisis” of traditional

modernist epistemology. While the modernists¹ have tried to overemphasize their work as processes of purification between nature and culture, humans and nonhumans, their *actual* and *simultaneous* involvement in processes of translation between these dualities - processes which have been subjected to continuous attempts of denial and silencing - has contributed to a vast proliferation of hybrids, which, Latour argues, points to the urgent need to rethink the whole Constitution - to retie the Gordian Knot, and to realize that, in fact, we have never been truly modern (Latour, 1993).

I argue that a genealogical examination of the recent scientific debate about anorexia nervosa² can be seen as capturing this epistemological debate, and that recent contributions to the SSK literature, with particular emphasis on actor-network theory, can be used as a way of negotiating a path between scientific realism, postmodern nominalism, and reflexivistic social constructivism (Latour, 1993; Ward, 1996). This change of perspective on scientific practice will in turn make it possible to raise claims about the relation between epistemology and social order - the responsibility of science in its production of “monsters” (Leigh Star, 1992). Questions of particular concern in this study are how the core diagnostic criteria of anorexia nervosa, “body image disturbance” and “fat phobia”, have become such undisputable “facts”; how these “facts” have become determinant and stabilizing aspects for

¹ Due to a common tendency to purify the world as either naturally, socially or textually determined, he includes both scientific realists, social constructivists, and postmodernists into the project of modernism.

² I will use the term anorexia nervosa, or anorexia according to the various (psycho-medical) meanings and interpretations that the practices and effects of self-starvation have been subjected to since the concept was first formed in the late nineteenth century. In contexts where I intend to signal the looser and multiple layers of meanings associated with the syndrome I will use the “self-starvation”. Sometimes, however, the two concepts may be used interchangeably.

the classification of anorexia nervosa as a psychopathological disorder; and how these criteria have implications for the distinction between “normal” and “pathological”.

As the first quote above may indicate, the many attempts by the double-headed “eagle” of medico-psychiatric science and cultural feminism³ to purify the anorexic syndrome - either as an overdetermined natural or social entity - may often be experienced as “eroding” or marginalizing the anorexic *self* enrolled into the processes of diagnostic standardization and experimentation, practices of forced feeding, psychotherapy, self-help, etc. For example, since anorexia nervosa was redefined, from being understood as a religious fasting capacity throughout the Middle Ages, into a psychiatric and medical property in the course of the eighteenth and the nineteenth century, the syndrome has been portrayed and made comprehensible through what is claimed to be the “objective representation” of scientific realism, more specifically by practitioners within the medico-psychiatric establishment. In the following, I will question the common understanding of these processes as having taken the form of a linear evolution of knowledge by which hidden realities of the disorder and its “mysterious” etiology are “(re)discovered” and further embedded in a succession of ever-revealing scientific sensations and celebrations. These moments of sensational “certainty” - “the mirroring of reality” - are said to occur if, and only if, proper methodological procedures are followed, and is thought to be an outcome of the researcher(s) being *driven* toward the truth, rather than seeing him or her as active participants in the

³ The term “cultural feminism” is used to describe, in a broad sense, the collection of feminist theories of anorexia nervosa which see the syndrome as predominantly constructed through various processes of macrostructural social forces inscribed on the individual female body.

various stages of the research process (Fuchs, 1992). According to scientific realism, it is reality itself, not scientists, that forces our reasoning into accurate representations and correct conclusions. Thus, certainty cannot be established before every stage in the research process has been replicated in detail - thus defining the objectivity and representability of the process and its "producers." Experimental and statistical testing and laborious examinations of different treatment strategies have therefore been acclaimed for bringing to light the unique interaction between cognitive, chemical, biological, familial, and also social, abnormalities and psychopathological characteristics of "true" anorexia nervosa. According to the recent criticism brought to the fore by cultural feminism, these psycho-medical strategies for understanding anorexia nervosa have contributed to the creation of "disembodied anorexic selves," whose basis is a brutal Cartesian dualism:

The anorexic body is nothing more than a machine in need of repair, and any subjective perceptions of the self housed in the faulty body are invariably "distortions," products of the incorrect processing of data from an external reality and not to be trusted. Not surprisingly, this leads quickly to the construction of the anorexic woman as manipulative, secretive and deceitful (Lester, 1997:480).

Rejecting such a stand, cultural feminists and social constructivists, who entered the anorexic debate in the beginning of the 1980s, have argued for a strictly cultural or political understanding of the syndrome, reading off the anorexic "text" its cruel *parody* and *rebellion* of our culture's image of the "ideal woman" (Turner, 1984, 1990; Orbach, 1986; Chernin, 1983, 1986b; Bordo, 1990; MacSween, 1993; Malson, 1998):

Her struggle for survival, her hunger strike, the cause she has taken on become increasingly apparent as we allow ourselves to engage with her actions. The universe she inhabits is that same universe given to all women. Her response is an inchoate political protest, her *gestalt* the indictment of a world which squanders that richest of all resources - the capacities, passions and nobilities of both sexes

(Orbach, 1986:115).

However, as Lester (1997) argues, cultural feminists, by producing a parallel split between body and mind, culture and nature, have themselves come to replace the medical model's "*individual body*" with feminism's essentialist "*cultural body*," and the medical model's "*disembodied self*" with feminism's "*de-selfed body*" (Lester, 1997:481). In this sense, parts of the feminist discourse about anorexia nervosa have demonstrated a paradigm of resistance, but at the same time engineered powerful mechanisms of stabilization and classification of the Other as in the same tradition of those toward whom they have pointed their criticism (the medico-psychiatric establishment).

As such, viewing reality and scientific "facts" as merely products of macro-social forces (e.g., economy, politics, gender, class, interests, etc.) social constructivism seems to "socialize" all phenomena in the same fashion as advocates of scientific realism have "naturalized" them (Latour, 1993). Hence, social constructivism seems to be caught up in what Ward (1996) calls a "reflexivistic spiral," where statements about reality's constructed character have been turned against their own account, making their knowledge claims both paradoxical and ineffective. The problem rests upon the difficulty in seeing the difference between a realist and a constructivist account except from their distinct terminologies. Furthermore, social constructivism has been criticized for its lack of a specific and detailed attention to the multiple and heterogeneous *linkages* that make up a construct or network. It is merely relying on an *a priori* "naturality" of social factors that are seen as guiding forces for human behavior (Law, 1992; Knorr-Certina, 1981; Lynch, 1993), and perhaps even more important, for a reliance on essentialist arguments about political intervention and criticism

(Woolgar & Grint, 1996).

Along the same lines, Latour (1993) argues, postmodernism's struggle to overcome modernism's naturalization of phenomena, contributes to the same type of "purification" work, or Great Divide, as its proclaimed "opponent," since all there is are "hybrids" of nature, culture, and discourse. That is, there is no pure nature to be deconstructed. Furthermore, Ward (1996) holds, seeing all statements about truth and falsehood, due to their discursive grounding, as equal and symmetrical, postmodernism fails to notice that some statements are in fact made stronger and more real than others, and that some scientific domains are more authoritative and irrefutable than others.

An important task of actor-network theory has been to examine how certain black boxes have been created as more closed and thereby more costly to reject than others (Fuchs, 1992). A "black box" is here understood as the outcome of a process where an "assembly of disorderly and unreliable allies is slowly turned into something that closely resembles an organized whole" (Latour, 1987:131). Viewing the contemporary meaning and explanation of anorexia nervosa as such a black boxed entity, the present study intends to examine the ways in which the syndrome has been translated into a seeming stabilized psychiatric disorder, with particular emphasis on how this has been made possible through the introduction and massive support of the concepts of "body image disturbance" and "fat phobia" since the 1960s. Hence, and this is my main argument throughout this study, rather than seeing these processes of fact stabilization as a result of the purification work of psychiatric science, that is, discoveries of external realities or, as certain feminists have claimed, caused by overarching social structures, the present genealogy of anorexia nervosa

will show that the success and strength of scientific fact stabilization, exemplified by anorexia nervosa, is in fact *produced* through the dissemination, heterogeneity and the careful plaiting of weak ties between many different actors and social worlds (Latour, 1997) - processes of translation where the outcome is the proliferation of hybrids of anorexia nervosa. Starting from the point of separation or conjunction (Latour, 1993), that is, from the symmetrical point where nature and culture, purification and translation work intersect, and proceeding toward the extremes, will simultaneously allow us to see the numerous attempts to purify anorexia nervosa, either as a psychopathological disorder or as an extreme version of “the ills of our culture” (Bordo, 1990), as particular cases of mediation, or translation work (Latour, 1993:78). Latour argues:

We do not need to attach our explanations to the two pure forms known as the Object or Subject/Society, because these are, on the contrary, partial and purified results of the central practice that is our sole concern. The explanations we seek will indeed obtain Nature and Society, but only as a final outcome, not as a beginning. Nature does revolve, but not around the Subject/Society. It revolves around the collective that produces things and people. The Subject does revolve, but not around Nature. It revolves around the collective out of which people and things are generated. At last the Middle Kingdom is represented. Natures and societies are its satellites (Latour, 1993:79).

Moreover, I argue that the continuous stretching and expansion of what I will call the “anorexic network” in recent years has made it difficult to continue to justify the proclaimed purification work of the scientific actors involved in the network. For instance, the strong influence of feminism in the anorexic network and its claim for the inclusion of the social in the understanding of the syndrome, can be seen as contributing to important notifications of the simultaneousness of nature and culture in the construction of the syndrome (despite feminism’s emphasis on social determinism), and the responsibility of science and

epistemology in the production of a particular social order (Ward, 1996).

Directing the focus to the work of translation, the actor-network approach can contribute to a rethinking of “anorexic selves” where polarizing processes of “disembodiment” and “de-subjectification” can be inverted, where dualities like nature and culture, body and mind, are traversed (Latour, 1993), and where marginalization and heterogeneity can be turned into powerful experiences (Leigh Star, 1992). I argue that an actor-network perspective, by focusing on how scientific work is in fact produced through a series of inclusive and manipulative practices, and where multiple memberships are made visible and possible, has the ability to envision ways in which marginalized voices can turn into empowering ones. That being said, the question of the Other has become a central criticism against actor-network studies. While, for example, Latour (1987) studied Pasteur’s standardization work on the anthrax vaccine, and Callon and Law (1989) the scallop community in St. Brieuc Bay, they did so from the very perspective of the leading actors of the network - the scientists. The result is that the “prime movers become the spokespersons, talking in unison for the entities which are brought together - and these entities become ‘docile’ points in the network” (Timmerman & Berg, 1997:274). The result may be that we will only see those who are strong enough and shaped in the right way to have impact on the world (Leigh Star & Bowker, 1996).

Hence, exploring the ways in which it comes to be seen that different scientific networks make claims to objective “truths”, and how some others, by resisting the former, defend their own construction of political subjectivities, will still beg the question about the lives (and deaths) of those fragile, marginalized and invisible Others - in Leigh Star’s (1992)

words: “the monster”, or “the outcast.” This is not to say that we should stop “following the actors” in their construction of hybrids. This will in fact be a significant point of departure of my own analysis. The point of departure here will be to argue for hybrids to be manufactured, be it by psychiatry, medicine, and/or feminism, and to describe the construction, expansion and durability of the anorexic network. Only then, I will argue, can we start to explore the “terrain of the politics of science in action” (Leigh Star & Bowker, 1996:11), to specify the types of trajectories that are obtained through highly different mediations (Latour, 1997), and the power relations that may be ensured and expanded through processes of delegation, discipline, and the control of standards (Latour, 1987). It is further argued that it is this particular reflexive component of actor-network theory which may make the perspective attractive to feminist scholars and activists in their search for alternative, local, and effective epistemologies.

Chapter summary

Chapter one is divided into two main sections: first, an outline is given of the theoretical concepts (e.g., “actor-network”, work of “purification” and “translation”, “black box”, “standardization package”, “robustness”, “immutable mobiles”, etc.) and framework employed in the study. These are based on recent contributions to the sociology of science and knowledge (SSK). This will be considered in relation to the methodological (genealogical) ramifications of the analysis. The second will discuss the ways in which anorexia nervosa has been widely perceived as a “culture-bound syndrome”. This understanding is based upon the recent stabilization of “body image disturbance” and “fat phobia” as the most central diagnostic components of the syndrome, which in turn has

stimulated a broad discussion among (psychiatric) historians about the universality, “emergence” and “discovery” of modern anorexia nervosa. Most authors draw upon Prince’s conception of a “culture-bound syndrome,” defined as a “group of signs and symptoms of a disease that is restricted to certain cultures primarily by reason of distinctive psycho-social features of those cultures” (Prince, 1985:198). Based on the actor-network perspective, the notions of “culture-boundness,” “emergence,” and “discovery” will be discussed in light of the epistemological shortcomings of scientific realism and social constructivism which have dominated the historical research on the syndrome. The chapter will therefore conclude with an argument for a replacement of the term “culture-boundness” with the concept of “network-boundness” in the understanding of anorexia nervosa. This argument is based on the proposition that the term “culture-boundness” does not take into account the active role of scientific and therapeutic actors in the production of knowledge about the syndrome, and that it views “culture” as a fixed and purified macro-structural realm, detached from the physical and mental strains of the individual self-starvers and scientific work itself. The network-boundness of the anorexic debate also defines the geographical boundaries of my study. The main actors, diagnostic systems (such as the Diagnostic and Statistical Manual of Mental Disorders (DSM)) and ideas which are followed in this study come from North-America. However, links to countries in Europe (e.g., Italy, Britain, Germany and Norway) and Asia (see chapter one) will be made to illustrate the expansion of the anorexic network. Chapter two will be concerned with the questions of how and why anorexia nervosa received such increasing attention in psychiatry in the 1960s, and explore the ways in which certain actors managed to enrol support sufficient for a particular theoretical and diagnostic

framework which could be further translated into a standardization package of the syndrome, defining it as a distinct psychiatric pathology. It is argued that this was made possible due to a certain actor's (Hilde Bruch) ability to link very heterogeneous interests and multiple identities into a stable black box.

Chapter three provides a further genealogical examination of how the three interwoven strands of classification practices, laboratory research (to reveal the true nature of certain key diagnostic criteria), popularization and therapeutic regimes have created a pervasive and powerful actor-network in which anorexia nervosa and its diagnostic implications have become common-sense and robust "realities". It is argued that these processes were facilitated through the diagnostic-theoretical and therapeutic standardization package which had been constructed to enable interaction between different social worlds and increase the opportunity to transfer knowledge and experiences into, and enrolling members of, other worlds (Fujimura, 1992).

Chapter four will address the various implications of the expanding and encompassing anorexic network. I argue that the present expansion of the anorexic network and the tendency by the medico-psychiatric and feminist communities to purify the syndrome into stereotyped categories points to a crisis in the debate about anorexia, where the anorexic selves are marginalized and refuse enrolment. Hence, I will discuss how the actor-network approach can be useful for a rethinking and critical point of departure for marginalized selves to realize the multiple ways in which to participate and use their voices.

Chapter 1

The question of culture-boundness in anorexia nervosa

When you have at last arrived at certainty, your joy is one of the greatest that can be felt by human soul (Louis Pasteur in Vallery-Radot, 1948, quoted in Beveridge, 1950:144).

A lifetime of happiness! No man alive could bear it: it would be hell on earth (George Bernhard Shaw, in *Man and Superman*).

The linkage is impossible as long as we remain truly modern, since Nature, Discourse, Society and Being surpass us infinitely, and because these four sets are defined only by their separation, which maintains our constitutional guarantees. But continuity becomes possible if we add to the guarantees the practice of mediation that the Constitution allows because it denies it (Latour, 1993:89).

The purpose of this chapter is twofold: first, to examine the ways in which recent applications of the concept of “culture-boundness” to anorexia nervosa direct attention to the epistemological debate between *scientific realism* and *social constructivism*, or what Latour (1993) calls the “Modern Constitution,” and second, to point out a framework for a Sociology of Science and Knowledge (SSK) which can negotiate a path between these two epistemological poles in the discussion of processes of fact stabilization (Ward, 1996; Latour, 1993). Drawing on recent contributions by actor-network theorists to the SSK literature⁴, I will argue for a rethinking of the term “culture-boundness” that is not merely deduced from a set of ready-made diagnostic ‘truths’ and/or some *a priori* macro-social assumptions about self-starvation, but which incorporates the local and collective practices

⁴ E.g., Bruno Latour, Michael Callon, John Law, Steven Ward, Joan Fujimura, Steve Woolgar, Michael Lynch, Susan Leigh Star, and Ian Hacking.

of a whole range of different participants into its conceptual framework. Such a framework would therefore involve the bodies and minds of the many self-starving individuals themselves, the inseparable set of nature *and* culture, as well as the medical and psychiatric professionals, feeding techniques, other therapeutic, measurement and medical instruments and standards, organizational routines, etc.

In accordance with such a view I will argue for a replacement of the term “culture-boundness” with the concept “network-boundness” in the understanding of self-starvation. The philosophical point here is to see scientific facts and knowledge as only existing and making sense within certain networks of practices and circumstances that define their validity (Latour, 1988). The actors within the network are therefore only given meaning inside the network and are nothing outside it. How then are such networks formed and made durable, how are they influential in the understanding of scientific knowledge and fact stabilization, and how can such an approach be used to bridge the epistemological divide between scientific realism and social constructivism? The following section will try to answer these questions while simultaneously outlining the framework of actor-network theory that forms the basic interpretative approach of the present study.

The following chapter will therefore focus on the various ways in which self-starvation has been practised, observed, interpreted and treated throughout history, and how it became such an unquestioned medico-psychiatric property. This will in turn offer some indications of how we are to examine the “hardening” and “robustness” (Wimsatt, 1980) of the concepts of “fat phobia” and “body image disturbance” into diagnostic “facts”, and the proclaimed “discovery” of the “true” psychopathology of anorexia nervosa in the 1960s. As

mentioned, such processes must be seen as outcomes of collective, complex, and constructivist enterprises taking place between several heterogeneous humans and nonhumans, rather than as a sudden event of “pulling back the curtains on the (always-existing) facts” (Woolgar, 1988:55).

1.1. The idea of science and actor-network theory

While the question of culture-boundness in anorexia nervosa has raised questions about the situatedness of the syndrome of self-starvation in time and space (Nasser, 1997), a question which will be discussed below, it simultaneously induces us to ask questions about the “very idea of science,” (Woolgar, 1988), and the penetrating and authoritative ways in which science occupies different areas of our lives. What is it, then, about science and scientific knowledge that make them more “reliable” and trustworthy than other knowledge producing systems? How is it that scientific “truths” constitute such demarcations to everyday life experiences and lay knowledge? As Fuchs (1992) writes:

Science has replaced religion as the most authoritative worldview, but shares with religion a charismatic remoteness from the profanities of everyday life and mundane reasoning. The label “scientific” lends special credibility and authority to knowledge claims and discursive practices, and so social groups try to mobilize science in support of their interests (Fuchs, 1992:2).

While questioning the epistemic justification of science and scientific knowledge, and arguing for a more collective, manipulative and constructive *explication* of its power and “robustness,” I argue that the very genealogy of anorexia nervosa offers a good example to demonstrate and examine the production and proliferation of scientific knowledge, and to give some insight into the constitution of truth formation and distribution. The approach

taken toward these questions is not intended to reveal falsity or to engage in an essentialist or universal *explanation* of anorexia nervosa, given that there is no one “pure cause,” nor external unified Reality, or foundation for the practices of power (Foucault, 1991; Latour, 1993; Lather, 1991). Rather, the present study will follow the lines of Foucault’s methodological approach toward the *explication* of knowledge and power, and the “history of the present” (Foucault, in Dean, 1991). Foucault’s “history of the present” or “genealogy of problems” (Foucault, in Lotringer & Hochroth, 1997) has directed its focus to methodologies adequate to reflect upon the contingency, singularity, interconnections, and potentialities of the diverse trajectories of those elements which compose present social arrangements and experiences. Such a history also renews the quest for methodologies which seek to manage

the problem of dispersion, and difference within history, and seeks to prevent anachronistic understandings of the past that make the present a necessary outcome of a necessarily continuous past. Such a history is geared toward the critical use of history to make intelligible the possibilities in the present and so can yield to neither universalist concepts of rationality and subjectivity nor metanarratives of progress, reason, or emancipation (Dean, 1991:21).

At the core of this approach lies the emphasis on the analysis of *practices*, and the questioning of how particular ways of doing things have been accepted at a certain moment as a principal component of a given system or community (Foucault, 1991). According to Foucault such “regimes of practices” are “places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect” (Foucault, 1991:75). Such a genealogical approach, that is, how certain behaviors have become problematic, and how certain regimes of regulatory practices have become powerful

and self-evident, will form the basic methodological focus of the present study. It does not ask *why* but *how*? This, according to Foucault is a method which wouldn't yield "the maximum of possible illuminations, but at least a fairly fruitful kind of intelligibility" (Foucault, 1991:74).

Therefore, this chapter will explore the following question: How was it that medical "explanations" of self-starvation became so much more credible in the last part of the nineteenth century than religious "convictions," a transformation which in fact has been demarcated as the historical point of "discovery" of anorexia nervosa as a psychopathological disorder (Hof, 1994), and seen as the root of the syndrome's "culture-boundness"? This discussion will relate to the following chapters in that it offers a point of departure for examining the ways in which anorexia nervosa has been stabilized as a psychopathological disorder; a way of understanding how natural, as well as social, scientific knowledge is constructed and made into "robust" entities; how certain claims to truth become stronger and more resilient than others; and how these processes of knowledge creation are outcomes of series of collective and manipulative practices between many heterogeneous actors, or what Latour (1993) calls "actants," to avoid a separation between nature and culture, humans and nonhumans.

The use of the term "robustness" points to a central aspect of actor-network theory. The concept was introduced by Wimsatt (1980) to the SSK approach as an attempt to replace the restrictive concepts of "reliability" and "validity" with a more useful concept to the explication of scientific knowledge (Leigh Star, 1995). It is defined for sociological use as "the durability of collective action despite the fragility of any one instance" (Leigh Star,

1995:11)⁵.

Such emphasis on replacement of terms and language for the analysis of science and knowledge has been undertaken by actor-network theorists to offer more symmetrical concepts that avoid the strong divide between social and natural, the constructed and the real in both realist and social constructivist analyses of scientific knowledge (Callon & Latour, 1992; Leigh Star, 1995). As Callon and Latour (1992) argue:

All the shifts in vocabulary like “actant” instead of “actor,” “actor-network” instead of “social relations,” “translation” instead of “interaction,” “negotiation” instead of “discovery,” “immutable mobiles” and “inscriptions” instead of “proof” and “data,” “delegation” instead of “social roles,” are derided because they are hybrid terms that blur the distinction between the really social and human-centered terms and the really natural and object-centered repertoires (. . .) We have never been interested in giving a social explanation of anything, but we want to explain society, of which the things, facts and artifacts, are major components (Callon & Latour, 1992:347/348).

The issue of symmetry, therefore, points to a central aspect of the actor-network approach in its attempt to level out the distinction between humans and nonhumans, and to oppose the tendency of scientific realism to “naturalize” all phenomena in the same fashion as social constructivism tries to “socialize” them. Such “purification” work, Latour (1993) argues, has been a central conviction of modernist philosophers such as Kant, Hegel, Husserl, Heidegger and Habermas. It is found in the writings of contemporary analysts of science and language, and is even present in the work of postmodernists. As Latour argues:

Postmodernism is a symptom, not a fresh solution. It lives under the modern Constitution, but it no longer believes in the guarantees the Constitution offers. It

⁵ Wimsatt (1980) borrowed the concept of “robustness” from biologist Richard Levins, who defined it as “the intersection of independent lies” (Star, 1995:11).

senses that something has gone awry in the modern critique, but it is not able to do anything but prolong that critique, though without believing in its foundations (Lyotard, 1979). Instead of moving on to empirical studies of the networks that give meaning to the work of purification it denounces, postmodernism rejects all empirical work as illusory and deceptively scientific (Baudrillard, 1992) (Latour, 1993:46).

This creation of a distinction between the purity of scientific practice and the chaotic network of hybrids constituting its subject matter, has resulted in the creation of “two entirely distinct ontological zones”: that of human beings on the one hand; and nonhumans on the other” (Latour, 1993:10/11). This ignores the fact that science itself plays a crucial role in the production of hybrids, or “quasi-objects” and “quasi-subjects,” that are simultaneously natural and human, local and global, transcendent and immanent. Scientific actors are both involved in processes of what Latour calls translation (mediation), and purification. Translation is understood as the methods by which an actor enrolls others through a series of “interessements” (see below) to construct a fact (Latour, 1987), and “creates mixtures between entirely new types of beings, hybrids of nature and culture” (Latour, 1993:10). This is done through: a) the definition of roles, their distribution, and the delineation of a scenario by an actor-world, or what is called “enrolment”; b) the strategies in which an actor-world renders itself indispensable to others by creating a geography of obligatory passage points; and c) the displacement imposed upon others as they are forced to follow the itinerary that has been imposed (Callon et al., 1986:xvii).

But as long as science refuses to conceptualize hybrids as “quasi-objects” that are simultaneously natural, collective, discursive, political etc., it will consider them as pure objects, pure subjects, pure texts, etc., and will attempt to sort out and purify hybrids through

strategies of naturalization, socialization, or discursivization (Latour, 1993). In this sense, Latour argues, we remain truly modern. However, scientific fact building, or “fact stabilization,” is a process of translation that blurs distinctions between the natural, social and discursive, since it is simultaneously all of these. The idea that there is a special scientific method, a realm where truth prospers in the absence of power, is therefore seen as a “myth” (Callon et al., 1986). For Latour (1987), science is politics by other means, which in turn renders the division between society and science opaque. Thus, if we realize that the practices of science have always consisted of the two sets of practices: the work of hybridization and purification - a “historical period that is ending,” according to Latour - we will simultaneously realize that “we have never been wholly modern” (Latour, 1993:11).

Facts must therefore be seen as *produced* and *negotiated*, not discovered (Callon & Latour, 1992), and just how this is *done* is the core question in the sociology of science and knowledge (Fuchs, 1992). The object of social science studies is to trace the local, collective and expansive processes and techniques which turn statements into “black boxes”⁶ (Latour, 1987). Hence, such processes of black-boxing are simultaneously involved in the forming of an “actor-network.” An actor-network can be seen as the outcome of the linking and forming of alliances between many heterogeneous humans *and* nonhumans through a series of negotiations, manipulations, and what Thevenot (1984) designates as “investments of form.” This is understood as “the work undertaken by a translator to convert objects that are

⁶ As defined in the introduction, a “black box” is understood as the outcome of a process where an “assembly of disorderly and unreliable allies is slowly turned into something that closely resembles and organized whole” (Latour, 1987:131).

numerous, heterogeneous, and manipulable only with difficulty into smaller number of more easily controllable and more homogeneous entities” (Callon & Law, 1989:64).

The actor-network approach therefore not only includes interaction between social actors, but also such elements as technology, the material means of scientific production, levels of resource concentration, etc. - hence the word “actants” (Callon et al., 1986). The success and strength of such actor-networks are therefore not contingent upon the scientists’ ability to concentrate and purify an external chaotic reality, but rather their ability to mobilize alliances with, and distribute arguments and “standardization packages” to, a whole range of different social worlds and actants. As Latour (1997) argues, the strength of certain scientific works does not come from concentration, purity and unity, but from dissemination, heterogeneity and the careful plaiting of weak ties, which in turn makes action at a distance possible (Latour, 1987). For example, in Latour’s case study of Louis Pasteur’s work on the anthrax vaccine, he discusses how the vaccine would only work universally if the farmers respected some crucial laboratory standards such as disinfection, cleanliness, conservation, inoculation gesture, timing, and recording. The universality and durability that followed Pasteur’s work were, according to Latour, due to his capability to change the work practices of farmers to adhere to those laboratory standards. In this process, the extension and strengthening of networks is the trick that allows universality to take place - that is, “to raise the world” (Latour, 1987).

In the present study Fujimura’s (1992) concept of “standardization package” will be useful for the understanding of how the psychiatric theories, therapeutic and methodological tools succeeded in enrolling members of multiple social worlds in the construction of a large

and encompassing diagnostic definition of anorexia nervosa. The concept of “standardization package” is used to capture two interweaving processes in the crafting of science: 1) collective work across worlds with different viewpoints and agendas (what Star & Griesemer (1989) call “boundary objects”), and 2) the “hardening” of claims or theories into “facts.” Thus, standardization packages enable claims to be transferred from one laboratory to another, or from one discipline to another. As such, Fujimura (1992) argues, they also serve as a dynamic “interface” among different social worlds. An interface is “the means by which interaction or communication is effected at the places “where people meet” or different social worlds intersect. It is the mechanism by which multiple intersections occur” (Fujimura, 1992:178). Importantly, Fujimura contends, while such a package acts as a constraint on scientists’ work practices, defines and describes the use, and contains representations of nature and reality - the way we come to know about the world, the same packages can simultaneously act as a flexible dynamic construction with different faces in other research and clinical and applied worlds (Fujimura, 1992:105).

As such, the making of scientific statements about either natural or social phenomena must be negotiated, manipulated and established by a variety of differentially powerful actors. This is done through collective practices, and must receive support from and be utilized by other (groups of) researchers and people in order to be transformed into a “certainty,” and even then some of these “certainties” become or are perceived as more authoritative and persistent than others. For example, if a statement originates from certain prestigious scientific communities (e.g., endocrine medicine or cognitive psychiatry), and has enrolled strong support networks, it seems to be easier to black box and therefore more

costly to reject than others, despite the fact that *as* constructions such certainties only exist as long as no one manages to produce a new and stronger network to give voice to powerful and persistent opposition (Fuchs, 1992; Ward, 1996). The ways in which certain facts become more black-boxed than others are related to various techniques employed by the scientific actors involved, which Latour and Woolgar (1986) designate as the “deletion of modalities” that surrounds particular statements. To establish such a “fact,” attempts are made to reduce the subject pole of a statement to a minimum through a variety of different *textual* and *nontextual* devices. That is, subjective speech and active involvements in the research process are continuously manipulated in such a way as to create an objective and “pure” account of “reality” as possible (Latour & Woolgar, 1986).

In my own work of tracing the multiple links which have made up the wide-ranging actor-network, formed through the distribution of a standardized anorexic package since the 1960s, I will investigate the various textual and nontextual techniques employed to translate multiple other actants in order to exercise power at a distance. I will therefore draw on deconstructivist or semiotic practices to analyse the *moves* of the scientific statements, actants, and networks involved in the anorexic debate. The deconstruction is here referred to as the more “moderate” and “mundane” deconstructive movement. In contrast to “radical deconstruction,” the moderate form is the common and widespread practice of weakening the claims of one’s opponents and competitors by disturbing the social and cognitive networks that surround and are meant to strengthen those claims (Ward & Fuchs, 1994).

1.1.1. Textuality

In contrast to the mundane oral reasoning in a laboratory or a clinical setting, where the subjects are themselves present in their own speaking and argumentation, the written account of an experiment or other scientific practice is usually regarded as presenting scientific activity as if it had followed the rational and objective canons of scientific methodology all along (Law, 1986). The written statement is not designed to express an opinion but rather the “way things are” - as the “out-there-ness” of the reality it tries to describe (Fuchs, 1992). Hence, a written statement is assumed to be trusted more than a spoken statement since readers are more easily convinced than listeners, and the texts lack the uncertainties, inconsistencies, and imperfections of the spoken word (Fuchs, 1992). Furthermore, unlike spoken arguments, the written account is not an event. It does not vanish once it is read, but remains in its place for subsequent readings and justifies itself by its own self-referential logics, thus establishing its stable historical existence.

Hence, research reports or articles are often written in such a style as to push statements as far as possible toward the object-pole of the subject-object continuum (Latour & Woolgar, 1986). Statements which lack authors, contextual specifications, and reference to time therefore give the impression of having been freed from the modalities (i.e., uncertainties, imperfections, and inconsistencies) that make them fragile and open to refutation, and can therefore be “trusted” as facts (Fuchs, 1992). An example of such a statement is the following: “Besides fear of fatness, anorexics and bulimics exhibit distorted body image” (McLorg & Taub, 1986). McLorg and Taub do not make any attempt to define or explain the two concepts in question. Neither do they refer to any author(s) to show where

the concepts originated. It is simply taken for granted that there exists a common agreement about the general meaning of the two concepts - as if the conditions were timeless and universal categories.

Such textual strategies have been termed the “empiricist repertoire” of scientific written accounts (Fuchs, 1992), which implies the objective, neutral and purely representational style of statements found in research articles. In scientific texts results are “found,” not produced, and data are “collected,” not manufactured. Furthermore, the standard form of the conventional research article signals that the research represents Reality in a trustworthy way and deserves recognition as a professional and technically competent contribution to knowledge (Fuchs & Ward, 1994). This in turn, makes it possible and even represents a security for other scientists to utilize these statements in their own work, thereby contributing to the gradual transformation of a claim into a certainty (Fuchs, 1992). For instance, the editorial board of the *International Journal of Eating Disorders* has developed a rigid standard form to be followed in order for an article to be published. *All* articles must, for example, be structured around the following headings and order: Objective, Methods, Results, and Discussion, categories which give the impression of the texts’ objective representation of reality and the universal and detached character of scientific practices.

Such textual devices are one of many important resources scientists utilize to enrol support for a statement, or to enforce “interessement” among the audience. Interessement is defined as “the action of interesting, enrolling or translating. (. . .) Interessement involves attracting one entity by coming between that entity and a third” (Law, 1986:71). The initial aim of a paper is therefore to try to “suck in as wide an audience as possible” (Law,

1986:77), thereby further translating and enrolling the reader from the generally respected and conventional through a “network of problematizations” to particular and concentrated series of points, which in turn circuits back to the general. This is what is understood as the “funnel of interests” (Callon & Law, 1982). In this sense, the research article itself creates an actor-world in which laboratory events are presented as having an extraordinary capacity to resolve general problems. As Law (1986) argues, the text itself constitutes and indexes a mixture of a whole variety of scientific, social, economic, and organizational forces.

1.1.2. Nontextual devices

The “pragmatic realism” of actor-network theory does not adopt a stand that merely relies on the textual or social dimensions of processes of scientific fact building, since such processes also require the involvement of a variety of nonhumans, instruments, representations and inscriptions (Knorr-Certina, 1981; Woolgar & Latour, 1986; Hacking, 1992). In fact, certain texts or statements become more authoritative and encompassing than others. By the time an article has reached the stage of being published, the author is able to draw upon an impressive nontextual support network and various external resources (Fuchs, 1992), making it more difficult to develop critical opposition against the claims. In addition to technical support drawn from work employed in the laboratory (see below), such nontextual support networks also consist of both the *reputation* a particular scholar has achieved, and the use of *references*. The latter, it should be noted, is again dependent upon the history and strength of such texts and references. Fuchs (1992) argues:

References to the classics - plus to some six or seven decades of exegesis - bestow

the charismatic epistemic dignity radiated by the Founding Fathers upon a text, and thus are particularly difficult to question. (. . .) The reader is now literally, *physically* surrounded by literatures that are invoked to join in a harmonious chorus of mutually reinforcing anonymous voices. To be sure, readers could work their way through the jungle of the literature, but the simple yet crucial point is: *they usually don't* (Fuchs, 1992:63).

The importance of this is that the textuality and materiality themselves contribute to the transformation of a statement into a fact. Depending on the strength of a statement's textual and nontextual agents, or the network of agents supporting the claim, people will put their relative trust into the statement and gradually contribute to the closing or weakening of the black box.

In the same fashion, *reputation* plays an important part in the process of inducing "interessement", and influencing how certain claims to truth are perceived as more authoritative and persistent than others. Awareness of a particular scholar's reputation, or the prestige of his/her co-workers, helps other researchers in their every-day work to make decisions about whom to listen to, whom to ignore, and whom to trust and enrol in their own work. As Fuchs and Ward (1994) argue, in the production of scientific facts, a scholar's reputation, as a generalized form of cultural capital⁷ is essential as it provides clues for others' selective attention (Fuchs & Ward, 1994) and reduces complexity, thereby enhancing a statement's visibility (Fuchs, 1992). Furthermore, informal encounters and conversations among scientists, which result in collegial recognition, install the premises and are seen as necessary factors for whose work gains respect and recognition as serious work in the field.

⁷ Here they draw on Bourdieu's conception of use and exchange value in the intellectual or cultural market.

This will usually comprise a “Matthew-effect,” where those who once gain credence will continue to be mentioned, cited, published, and funded. By further boosting the scientist’s ability to expand and make resistant (both in time and space) her/his claims to truth and knowledge, this provides the author with a “moral authority that commands respect and impresses other people who start seeing the world in the terms of the statement” (Fuchs & Ward, 1994:494). It becomes the truth against which other arguments are measured.

In contrast to the resources mentioned above, reputation as a sort of intellectual property is not equally distributed among scientists. This indicates the importance of professionalization, standardized intellectual and organizational practices (e.g., taking required university courses, passing examinations, obtaining credentials, being enrolled in laboratory work, etc.), membership in a local laboratory community, and different control or “gatekeeping” mechanisms. In other words, statements and their authors must be part of relevant professional communities or networks in order to be taken seriously, and they need the support of these professional communities to be considered as reasonable candidates for fact stabilization (Ward & Fuchs, 1994). Furthermore, Fuchs (1992) argues that the process of accumulating advantages ensures that symbolic profits are converted into material payoff, so that scholars with high prestige and reputation are likely to control organizational property such as experimental equipment, jobs, journal space, etc., and the every-day practice of research tasks.

Hence, far from being that “pure” representation of reality with relevance far beyond time and place, as is commonly pursued in scientific textualities, these formats can be seen as a collection of heterogeneous forces, which in turn represent the structure of the actor-

network built into the various texts. Concepts, references, people, funding policies, official agencies and journal space all make their appearance in addition to “discoveries” and theories. The strength of an argument is therefore resting upon the number and power of the elements that may be borrowed to give it force, rather than its purity and unity (Latour, 1997).

As we will see in the present study, most research work on anorexia nervosa in the 1970s was performed as laboratory work, or what Knorr-Certina (1981) termed a creation of an “artificial reality.” Borrowing from ethnomethodology, several authors within the SSK have argued that laboratory studies offer a fruitful area for examining the internal workings of science, and how the content of knowledge claims is actually manufactured and negotiated through the interaction between scientists and a variety of technical and electronic apparatuses (Latour, 1987). As scientific statements are secured in working pieces of technical and electronic equipment, this makes them more resistant to deconstruction and criticism (Hacking, 1992). However, without professional education, technical and theoretical skills and experiences, the manufactured data would remain a chaotic and fragile entity. These formalities make it possible for the scientists to render something meaningful and coherent out of the chaos of signals that are produced through these machines. Hence, because reality cannot be observed directly in the laboratory, scientists use a series of “inscription devices” to render nature and reality “visible.” An inscription device is understood as any item of apparatus or particular configuration of such items which can transform a material substance into a figure or a diagram which is directly usable by the members of the office space (Latour & Woolgar, 1986:51). Such interpretations are done

through the transformation of what is read off from the variety of technical sources and into graphs, tables, and figures which are further presented in the research report (Knorr-Certina, 1981; Latour, 1987). On the one hand, one can say that technical and electronic instruments *reify* the constructive operations involved in the fact production, but at the same time they constitute the *shaping* of the results, thus indicating the fabricated and heterogeneous images of these results. For instance, the shape of the instrument, such as the wording of questions and the response formats, also constitute the very response obtained, suggesting that a different instrument would yield a different response (Latour, 1987).

Nevertheless, the way in which these technical processes and inscription devices are used to stabilize facts may contribute to increasing the costs for objecting to such statements - especially for those who do not have the requisite material resources and allies to contest such fabrications. Hence, despite the indecisive results of the many experiments employed to render the “body image disturbance ” of anorexics visible since the 1970s, the heterogeneous actor-network that had been mobilized and expanded through a series of translations and intersements had made the anorexic network robust and solid, and costly to reject. The reader was now confronted with a whole body of literature and a network of expertise, professional organizations, distinct local “cultures” of laboratories, articles and journals, numbers and scales, and pieces of technical apparatus.

Even as such “standardization packages” may flourish and expand within and between scientific communities, the success of (scientific) truth claims is to a great extent dependent upon the manipulation and forging of alliances with non-scientists - the outside world. That is, the extension and application of scientific practices and standardization

packages in the world external to the laboratory, or the clinic, or what Bowker (1994) calls, “infrastructural work,” is therefore a significant step for universality to take place - in order to “raise the world” (Latour, 1987). Furthermore, in order to “*work*” or “*exist*” scientific facts must be consistently constructed and applied. For example, to be anorexic or to have a body image disturbance is only possible within a particular constituted or “associated network” (Ward, 1996). That would mean that in order to contest such an encompassing actor-network as that of the anorexic network it would require that large numbers of actants be forced or persuaded to construct and enrol a new and more powerful one (Ward, 1996). While the enrolment of a whole range of different internal and external actants may generate problems in terms of the potential for their changing the nature of the fact, this is often solved through the development of standards of control mechanisms or delegation of standardized and materialized tasks to the enrolled (Latour, 1987). For example, the empirical and technical language in the various editions of the *Diagnostic and Statistical Manual of Mental Disorders*⁸ can be seen as a way of making standardized local practices stable, and of securing the preservation of the diagnostic standardization package of various mental disorders.

Although such networks may seem too powerful and too encompassing to overthrow, the actor-network approach also demonstrates that such networks are in fact the result of collective and heterogeneous enrolment and participation of humans and nonhumans. As

⁸ These manuals are published by the American Psychiatric Association. I will come back to a discussion of these classification systems in chapter three.

such, individuals enrolled are positioned and have the possibility to act upon their particular situatedness within the network. This is where I think actor-network theory can be useful for groups who are preoccupied with the politics of scientific knowledge, or what Leigh Star and Bowker (1996) call “the politics of science in action”, that is, the concern with the “excluded voices” of network formation. Since differences are so visible, Callon and Latour (1992) argue, what must be understood are their constructions, transformations, their remarkable variety and mobility, in order to substitute a multiplicity of little local divides for one great divide. This points to how the “study of science in action” opens up its doors for outsiders, with no scientific credentials, to observe the “chaos of science” (Callon & Law, 1992).

What difference then does the actor-network approach offer to the epistemological debate between scientific realism and social constructivism? Furthermore, what alternative does this approach offer to groups that are concerned with the political and moral implications of network formations?

1.1.3. Actor-network theory as a bridging device between scientific realism, postmodernism and social constructivism

As outlined above, it is the simultaneousness and inseparable link between processes of purification and the mundane, local heterogeneous practices of translation which constitute the key contribution of actor-network theory to the understanding of scientific knowledge production. It is the assumption of the divide between these two practices as *real*, while at the same time constructing a Great Divide between humans and nonhumans which constitute the shortcomings of the modernist projects of scientific realism, social

constructivism, and also postmodernism, in the explication of the power and the encompassing character of scientific knowledge (Latour, 1993).

First of all, actor-network theory opposes scientific realism and argues that knowledge is always *produced*, and can never be separated from the context in which it is constructed and manipulated. Because there is no external reality or nature to be “discovered” or “purified” from human interruptions and imperfections, the realist project fails to see that the strength of scientific knowledge is rooted in the multiple practices and extensions of ties between actants. As Latour (1993) argues, in the modernist struggle toward a universal understanding of the world the paradox that occurs is that it has constructed sets of hybrids - binaries between nature and technology, culture and politics - gaps that the modernists never were able to narrow down, and were thus never really signs of scientific progress. The outcome consists rather of processes of negotiations and struggles of “quasi-objects” and “quasi-subjects” that are not yet divided up neatly between these poles. This is what Latour (1993) envisions as the crisis of Western social philosophy and epistemology, which has stimulated the popularity of postmodernist thought (Seidman, 1994).

Secondly, actor-network theorists share their criticism of scientific realism with the many advocates of postmodern approaches toward the understanding of knowledge and science. They claim that there is no external “Reality” to be captured or approximated and that knowledge is produced imagery and never can be separated from the signs used to represent it (Ward, 1996). By discarding objectivity and value-neutrality in science and research (Lather, 1991), actor-network theory draws to a large degree on postmodern epistemology. However, while postmodernists argue that no discourse (or will to truth) is

innocent of the Nietzschean “will to power,” actor-network theorists have charged postmodernism for not offering ways of questioning who or what (kind of) discourse(s) has the power to nominate claims to truth and how some claims to truth in fact become more authoritative, more real and pervasive than others (Ward, 1996). In fact, a central point in actor-network theory is to account for how certain knowledge claims become so strong that they can act as structural constraints on human (and nonhuman) agency. For instance, the concept of anorexia nervosa is not only created by people, it is engaged in a process of creating people: “Concepts create new categories of scholars, bureaucrats, physicians, psychiatrists, lay people, and other analysts to place people in and a means through which to understand, manipulate, and/or control them” (Ward, 1996:7). Furthermore, as Hacking (1988) contends, while concepts and classification of people affect people and their actions, there is also a “feedback effect” between these people and their actions and the produced knowledge about them. Nevertheless, the strength of a claim is not contingent upon the inner nature of such a claim, but rather the way it can draw upon a long and strong network of various actants.

Hence, in contrast to social constructivism, which sees all phenomena as the “pure” results or creations of macro-social forces, network theorists have emphasized that we should not begin our analyses with such *a priori* essentialist classifications of the observable world and organize the world according to such discrete sets of categories. Rather, we begin with a set of relations, from which we derive maps and typologies of structures (Wellman & Berkowitz, 1988). For example, the proliferation of feminist analyses of anorexia nervosa in the 1980s and 1990s saw the determination and treatment of anorexia nervosa as a mental

pathology as a result of the prevailing patriarchal ideological convictions about the “irrational” properties of females (Hepworth & Griffin, 1990; Bordo, 1990; MacSween, 1993). However, these theories have failed to provide detailed descriptions of the various linkages that make up such a “social construct,” and have not accounted for why these analyses should have higher epistemic status than, for instance, the biomedical model. Furthermore, such accounts are usually caught up in what Ward (1996:3) calls the “problem of reflexivity.” That is, constructivist arguments are often presented as if the notion of reflexivity does not apply to their own arguments. They do not recognize that their own particular research practices and perspectives are themselves temporary social phenomena - similar to those perspectives and practices that they examine or criticize (Woolgar, 1992). This does not mean that criticism should not be encouraged. Rather, as Woolgar (1992) argues:

In social studies of science, for example, criticism of preceding perspectives is commonly used as the basis for moving to a new stance. The social study of science thus contains within itself the capacity for redefining the major issues and methodological questions in virtue of attention to the nature of its practice. There is, in other words, a critical dynamic - we call this the “dynamic of iterative reconceptualization” - (Woolgar, 1991) whereby practitioners from time to time recognize the defects of their position as an occasion for revisiting its basic assumptions. Once we understand the value of reflexivity in terms of the dynamic of iterative reconceptualization - in short, as an attitude for enhancing our ability to pose fresh questions about epistemic matters - we recognize that the social study of science has the capacity to revisit taken-for-granted assumptions which underpin particular phases or research perspectives (Woolgar, 1992:333/334).

While the present project is mainly concerned with the making and expansion of what I will call the “anorexic network,” several recent feminist contributions to the SSK have pointed to the political and moral implications of processes of truth making (e.g., Leigh Star,

1992; Singleton, 1996; Sinding, 1996), which will therefore be an additional concern in this study. The actor-network approach to questions of power, marginalization, and silencing of voices is thus useful in the following ways: i) its focus on deconstructing and debunking established and powerful claims to truth and dualist perspectives, whether they originate from natural or social sciences; ii) its critique of the individualist, detached and rationalist view of science; iii) the emphasis on the constructedness and historical situatedness of modernist dualities like nature and culture (Latour, 1993); and iv) the possibilities to demonstrate the multiple points of views within scientific communities (Singleton, 1996).

As Singleton argues,

The aim of the analyst is not to contribute to the continued stabilization of such constructions (male/female, nature/culture, etc.), but to describe how they are made. Consequently the analyst is talking about how things could have been otherwise rather than assuming the ahistorical existence of such categories. (. . .) For actor-network theory, power is a consequence rather than a cause of action. Power relations are the consequence of defining and associating entities (Singleton, 1996:457).

Actor-network theory is certainly not an idealistic or political project. However, it does represent a very useful method of rendering visible and comprehensible the multiple ways in which power is formed through strategic and enrolling practices. Before engaging in the discussions about the political and moral implications of truth and network building, however, we need to describe the network (Leigh Star & Bowker, 1996).

In the next part of this chapter I will examine how various authors have interpreted the ways in which self-starvation became a psycho-medical entity and was termed “anorexia

nervosa” in the late nineteenth century⁹, and how this has also been seen as the origin of the syndrome’s proclaimed culture-boundness as a modern mental disorder (Hof, 1994). I will argue, however, that the concept of culture-boundness in anorexia nervosa is based on a reductionistic modernist way of interpreting phenomena and knowledge, which ignores the ways in which self-starvation and knowledge claims about it can be seen as outcomes of collective, local, and translation work between several heterogeneous actants enrolled in a particular network. Basing my own interpretation of anorexia nervosa on such a perspective, the concept of “network-boundness” will be introduced, which in turn will form the basis of further examinations of the syndrome’s genealogical paths.

The question of culture-boundness will simultaneously direct attention to the very history and responsibility of medical science as an undisputed mediator of factualities and as a control agent of this and other similar phenomena. It will thereby question the problem of power discrepancies between the expert therapist/scientist and the individual anorexic patient and the right to diagnosis, illness interpretation and treatment strategies. Since anorexia nervosa has primarily been a medico-psychiatric property throughout this century - defined, classified and treated in light of psychiatric and medical theories about the human body and mind - it is important to examine the ways in which this came about. Attention is therefore drawn to the realist/constructivist divide - or the “Great Divide” between nature and culture - which actor-network theorists seek to overcome by arguing for an approach that

⁹ The term “anorexia nervosa” was first used by the two renowned physicians Sir William Gull in England and Charles Lasègue in France in 1873 and 1874, and this is the point where the modern type of self-starvation is said to have both “emerged” and “discovered.”

takes as its point of departure a reconciliation of the work of “purification” and the work of “hybridization.” According to Latour (1993), when these Great Divides are bridged and we stop being and having been modern, this can also be seen as traversing the divide between past and present in the anorexic debate, thus opening up possibilities for future discursive participation (Singleton, 1996) and patient empowerment (Katzman & Lee, 1997). Before entering this debate, however, we need to outline the concept of “culture-boundness,” and its various relations to the understanding of anorexia nervosa.

1.2. Culture-boundness and anorexia nervosa

Due to the conviction that a dramatic rise of anorexic incidences took place after WWII in most European and North-American countries, in association with historical changes and sociocultural conditions which altered the experience of adolescent women in these countries, anorexia nervosa has been termed a “culture-bound syndrome” (Swartz, 1985; Prince, 1985; Nasser, 1997). Central to this predominant understanding of the syndrome is that fear of fatness and body image disturbance form the ‘core’ psychopathology of the syndrome, and that these features are bound to particular psychosocial characteristics and “Western cultural values and conflicts” (Prince, 1985:200). This view is based upon the understanding of culture-boundness presented by the “old transcultural psychiatry” (Banks, 1992), which defined culture-bound syndromes as disorders restricted to a particular culture or group of cultures because of certain psychosocial characteristics of those cultures.

Swartz (1985) has applied a somewhat broader view to the understanding of culture-boundness and has argued for the inclusion of the biomedical community itself as well as the

populations of anorexics into the approach of culture-boundness. However, Swartz's argument parallels Prince's in that it lacks specifications as to what degree and how such assumed macro-cultural values and features may create and shape deviant behaviors, and a lack of identification of what norms and values are thought to be involved in the expressions and definitions of anorexia nervosa. Another concern related to these approaches is the way in which both Swartz (1985) and Prince (1985) have based their arguments about the culture-boundness of anorexia nervosa on already established psychiatric diagnostic "truths" about the syndrome, and thus on its particular "naturalized" pathological properties. As such, the link between nature and culture assumed in these studies is not a symmetrical one, but rather based upon an assumed divide between these two poles. Epidemiological studies of anorexia nervosa conducted in countries outside the Western world, which have usually employed diagnostic measurement scales (e.g., Eating Attitude Test (Garner & Garfinkel, 1979), Eating Disorders Inventory (Garner, Olmsted & Polivy, 1983), or Structured Clinical Interview for DSM-III-R (Spitzer et al., 1990)) elaborated for the evaluation of fat phobia and body image disturbance, have therefore tended to conclude that anorexia nervosa "just does not appear in many other countries" (Prince, 1985:197). The recent proliferation of cultural feminist studies on anorexia nervosa has also taken as a point of departure the premise that Western cultural ideals associating slimness with beauty lead to anorexia nervosa. As Bordo says: "anorexia calls our attention to the central ills of our culture" (Bordo, 1990:37). The determination and treatment of anorexia nervosa as a mental pathology are equally seen as social constructions based upon the prevailing patriarchal ideological convictions about the "irrational" properties of the female psyche (MacSween, 1993). As already mentioned,

however, these constructivist analyses have usually ignored the various local linkages that make up a network, and struggle to account for its problem of reflexivity (Ward, 1996).

In this sense, the notion of culture-boundness in anorexia nervosa has stimulated a wide-ranging epistemological debate about the universality, the realness versus constructedness of the syndrome, the question of form and content and the psycho-pathology of anorexia nervosa, and the “culture-boundness” of science itself (Banks, 1992; Lee, 1995). Historians, anthropologists, and non-Western psychiatrists have therefore become increasingly involved in questioning the degree to which anorexia nervosa can be understood as a universal or strictly culture-bound syndrome. For instance, Chinese psychiatrist Sing Lee (1995) has sharply criticized the “monothetic,” detached, and “theory-driven” ways in which Western psychiatric and biomedical actors have produced what they conceive to be the universally true diagnostic criteria of the syndrome. She emphasizes that several recent studies¹⁰ on self-starvation in Hong Kong, Taiwan, China, Malaysia, India, Singapore, Japan, and the former Czechoslovakia have noted the total absence of “fat phobia” as a central criterion for otherwise “obvious” anorexics. In the same way, the American anthropologist Caroline Banks (1992), has argued that even within American culture there exist self-starvers whose fasting practices do not make sense within the common framework of biomedical diagnostic emphasis on fat phobia and body image disturbance. As she points out:

Margaret and Jane do not see themselves as ‘sick’ or as ‘anorexic.’ Rather, they

¹⁰ Lee (1995) lists the following studies: Lee, 1991; Tseng et al., 1989; Song & Fang, 1990; Goh et al., 1993; Chadda et al., 1987; Khandelwal & Saxena, 1990; Ong & Tsoi, 1982; Suematsu et al., 1985; Faltus, 1986.

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 to 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 (Banks, 1992:881).

These accounts may give important indications of the ways in which well-established standards always imply that what is taken for granted and made visible in a network always also means that someone or something will be invisible or excluded (Leigh Star & Bowker, 1996). The following discussion, however, will focus on the historical dimensions of the question of culture-boundness in anorexia nervosa. We will then be able to examine the processes of the proclaimed “emergence” and “discovery” of anorexia nervosa as a Western psychopathological phenomenon, a question which lies at the centre of the contemporary debate about its culture-boundness.

Self-starvation or abstinence from food was certainly not a new phenomenon when a growing number of references to and publications about the “enigmatic” syndrome started to appear in the 1960s. Neither was it a new phenomenon when it was termed and medicalized as “anorexia nervosa” in the late 1870s, the period associated with the “discovery” of its modern and psychiatric form. As Bruch¹¹ notes: “To call it a new disease is not correct in the literal sense. (. . .) Yet I call it a new disease because for the last fifteen or twenty years anorexia nervosa is occurring at a rapidly increasing rate” (Bruch, 1978:vii). These acknowledgements have stimulated a proliferation of research on anorexia nervosa in

¹¹ As I will come back to in chapter two, the American psychiatrist Hilde Bruch became one of the main actors in the expanding psychiatric debate about anorexia nervosa in the 1960s, and it was the basic concepts of her theoretical framework that became the most influential in the further expansion of the network.

an attempt to trace the existence of the syndrome prior to the formal medical descriptions of it in the late nineteenth century. Some historians and psychiatrists (Bynum, 1987; Bell, 1985; Bemporad, 1996) have therefore sought to rediagnose cases of what were seen as “holy starvers” in the fourteenth century, and “miraculous maids” in the sixteenth and the seventeenth century using modern medical definitions of “anorexia nervosa.” They aim in this way to reveal the underlying and universal psychological (Bell, 1985) or sociocultural (Bemporad, 1996) forces of the syndrome. Bell (1985) for instance, argues that anorexia arises from an “adolescent crisis” in which the young girl tries to seek that autonomy of action which her culture demands: “The real struggle is for autonomy, self-sufficiency and a sense of self, and in this sense the anorexic response is timeless” (Bell, 1985:56). Thus, Bell seems to forget that “adolescence” itself is not a “timeless” category, but arises as a specifically twentieth century problem dependent on a specific social construction of individuality (Aries, 1973, in MacSween, 1993). Bell is therefore on the one hand making a distinction between the universal psychological needs of the individual self-starver, and on the other, the changing “cultural imperatives” that inform the differing forms or styles that anorexia has taken. He thus interprets the holy fasters of the fourteenth century in light of twentieth century psychiatric categories, and leaves aside questions of the involvement and situatedness of medical discourses in the first place. Others have again focused on the aspect of “weight concerns” and wondered whether this may have constituted an overlooked or unrecognized concern in earlier medical reports - either by the therapist at the particular time or by the historians interpreting them (Habermas, 1989; Vandereycken & Van Deth, 1990).

However, most authors (Brumberg, 1988; MacSween, 1993; Vandereycken & Van

Deth, 1994) who have been influential in the debate about the “emergence” and “discovery” of anorexia nervosa have argued that what the British physician Sir William Gull (1874) and the French physician Ernest Lasague (1874) observed and diagnosed in the Victorian era was the origin of a distinctively new and modern disease: resulting from the development of macro-structural processes such as secularization, medicalization and industrialization in the nineteenth century, which the fragile and subordinate female psyche could not bear (Brumberg, 1988). What is unclear, however, is the degree to which these authors relate the “modern” nineteenth century form of anorexia nervosa to the contemporary “fat phobic” form. For instance, does this imply that fat phobic or what Bruch termed “primary anorexia” are seen as having always existed but having only recently been “discovered”? Or is primary anorexia nervosa a new and independent *form* of self-starvation altogether - one that both emerged and was successfully discovered in the 1960s?

Asking such questions implies that we are left with various *realist* options with which to comprehend self-starvation as a culture-bound syndrome. One option is to see the syndrome as universal in pathology, but different in its manifestation in different cultures and times. The second option is to see it as a universal disorder which occurs more frequently in Western or western-like countries (Hof, 1994). Hence, most authors have tended to divide the syndrome into a content/form¹² debate which can be seen as an extension of the nature/society dichotomy where the many actors themselves have become invisible as active

¹² *Content* being that which characterizes the external, physical manifestations of the syndrome, or the practices of starvation in itself: food refusal, emaciation of body, etc.; and *form* that which varies; the “purpose” or “theory” (Lester, 1997), or the possibility of different meanings attributed to those externalities and practices.

participants and negotiators of the debate. I am not arguing that the distinction between form and content is irrelevant for the understanding of self-starvation. Rather, it must be seen as a creation of the ongoing negotiation and translation practices that take place among the many different actants enrolled in the network.

1.3. The “emergence” and “discovery” of anorexia nervosa and its culture-boundness

The contemporary understanding of anorexia nervosa is commonly based upon what is seen as the “emergence” and “discovery” of anorexia nervosa as a psychopathological disorder in the late nineteenth century. The term “anorexia nervosa” itself was first established as a clinical diagnosis of the self-starving syndrome in 1874 when the renowned English and French physicians Sir William Gull and Ernest Lasague independently, introduced the “new” disease to the medical establishment in their respective countries. Although both physicians were preoccupied with the classification of the disorder in terms of physical and biological symptoms in order to distinguish the syndrome from other diseases which included emaciation, their most prevailing understanding of the disorder was the emphasis on mental aspects (Gremillion, 1992). While most historical accounts of the history of self-starvation have been characterized by their reliance on what Woolgar (1988:31) calls a “fundamental dualism” between “representation” and “object”¹³ in scientific knowledge production, implying a detached and event-like discovery of the external realities of the self-starving syndrome, these historical accounts will also give some insight into the

¹³ This dualism can for example be expressed as distinctions between knowledge and fact, language and meaning, signifier and signified, image and reality, etc. (Woolgar, 1988:31).

very role and practices of science and its active involvement in the production of scientific truths about a particular phenomenon. Furthermore, they offer an insight into the present scientific situatedness of anorexia nervosa as an established mental and what I will call a “network-bound” syndrome.

In the following section I will discuss three different contributions to the discussion of the “emergence” and “discovery” debate about anorexia nervosa as a modern psychopathological disorder. The first contribution is Joan Brumberg’s (1988) acclaimed historical study, an impressive account of the socio-economical conditions in which what had been called “holy anorexia” or “anorexia mirabilis” was replaced by the psychopathological form and property “anorexia nervosa” in the late nineteenth century. Brumberg’s historical analysis focuses primarily upon the “*emergence*” of anorexia nervosa as a new form of self-starvation, and therefore a “new disease” in the late nineteenth century. She sees the scientific “discovery” of the syndrome, although not yet a fully correct one, as merely a necessary and objective scientific representation of the occurrence of a particular reality or naturality: anorexia nervosa. Her arguments seem to rest upon the notion that science and its truth seeking methods always consist of a set of fixed and neutral practices whose goals are only to try to represent as precisely and reliably as possible the realities that exist or occur in the chaotic social world.

The second account discussed in this section is a critical discussion by Julie Hepworth and Christine Griffin (1990) of the ideological discursive strands which they see as having *constructed* and thereby established anorexia nervosa as a psychopathological disease in the late nineteenth century. Hepworth and Griffin (1990) are therefore implying

a great divide between what they see as the “real” social meanings of self-starvation and what they present as five authoritative and blinding discursive forces involved in the creation of the syndrome as a biomedical disease category.

Finally, I will discuss the work of Sonia van’t Hof (1994), who includes both the “emergence” and the “discovery” processes of anorexia nervosa in a realist-constructivist account, and argues for a less *a priori* and detached analysis of the “detection route” of anorexia nervosa. Instead, her analysis tries to trace the multiple and interweaving practices between the social and natural, the individual self-starvers and the scientific actors, which came to produce a different and expanding account of self-starvation from the previously religious understanding of the phenomenon. On the basis of Hof’s analysis the final section of this chapter will propose the introduction of the concept of “network-boundness” in the understanding of anorexia nervosa.

1.3.1. Great divide I: The “emergence” of anorexia nervosa

Clearly, Brumberg (1988) views the *emergence* of anorexia nervosa as a qualitative transformation of previously existing (female) fasting practices, where the *form* of self-starvation radically changed from being a distinctive form of female religious piety and empowerment after the fourteenth century, into a discrete *psychological* form of individual self-starvation “occurring” in the late nineteenth century because of certain socio-cultural forces developing in this particular period.

The most famous “holy starver,” who has been referred to as an archetype, and also a role model for the numerous religious self-starvers reported to have flourished in late

Medieval and early Renaissance Europe (Bynum, 1987; Bell, 1985; Brumberg, 1988; Bemporad, 1996), was the Italian St. Catherine of Siena, who after her death was elevated to sainthood by the authoritarian Medieval church. As Bemporad (1996) writes

After her sister's tragical death in childbirth in 1362, Catherine, who was now 15 years of age, underwent a profound psychological change, turning inward and shunning the everyday world. She started to eat little, and to spend much of her time in prayer. At this same time, Catherine's parents began to search for a suitable husband for her, to which Catherine responded with an intensification of asceticism and religiosity. The loss of a second sister further pressed Catherine to a life of devotion to God. She cut off her hair, began lengthy meditations, and secretly flagellated herself in imitation of Christ's passion. (. . .) She became a nun, and from this point until her death from malnutrition at age 32, Catherine lived an austere, ascetic existence. She ate almost nothing, often forcing herself to vomit the little she had ingested. She seemed to have had no limits to her energy, however, devoting most of her waking hours to helping others (Bemporad, 1996:221/222).

Religious self-starvation remained a public fascination up to the late nineteenth century, and often provoked pivotal battles between religious lay communities and the growing scientific and medical establishment who saw the "holy starvers" or "miraculous maids" as merely cases of fraudulence, deceit and female irrationality. Brumberg (1988:99), however, views the gradual disappearance of such religious forms of self-starvation and their replacement by the modern psychological form of self-starvation, or "anorexia nervosa," as capturing the parallel processes of secularization and medicalization in the course of the nineteenth century.

According to Brumberg, a new form of self-starvation emerged in the late nineteenth century. She argues that the particular form that self-starvation took in this period can be seen as a psychopathological representation of the changing socio-cultural, economic and thus familial conditions developing in eighteenth and nineteenth century Europe and North

America: industrialization, secularization and the rise and intensification of the bourgeois families. These changing material and social conditions, Brumberg argues, involved particular implications for the middle-class girls. These girls were no longer required to contribute to the economic survival of the family as before, and this contributed to the repression of their freedom of action or expression of private mental space, leaving them with the sole task of preparation for marriage and child-production. As a result, Brumberg contends that they had to resort to the nonverbal expression of their psychic distress through food which was one of the strongest symbolic means in the Victorian middle class family. Brumberg argues that middle-class girls in the Victorian era turned to food as a symbolic language because of this particular culture's emphasis on the connection between food and female appetite as a symbol of sexuality and thus an indication of lack of self-restraint. Girls' options for self-expression outside the family were limited by parental concerns and social conventions. In addition, doctors and parents expected adolescent girls to be careful and restrictive about their food due to its connections to "gluttony and physical ugliness" (Brumberg, 1988:179). Young women searching for an idiom in which to say things about themselves therefore focused on the concentration of fruitful language of food and the body. As a result, certain girls became preoccupied with expressing an ideal of female perfection and moral superiority through denial of appetite: "The popularity of food restriction or dieting, even among normal girls, suggests that in bourgeois society appetite was (and is) an important voice in the identity of a woman. In this context modern anorexia nervosa was born" (Brumberg, 1988:188).

Brumberg (1988) certainly offers an interesting description of how medical doctors

and endocrine scientists were actively engaged in the interpretation and therapy of self-starving girls in this period, accompanied by changing diagnostic categories and concomitant status aspirations. She discusses how the diagnostic success of certain British and French physicians (e.g., Sir William Gull and Charles Lasegue) can be seen as contingent upon their prestigious positions within their respective national scientific communities, their ability to distribute and create support for their arguments¹⁴, and their ability to enlist the bourgeois families of the self-starvers by providing a disease definition acceptable for the girls' families from a medical as well as social-class point of view¹⁵.

Brumberg's description of the beginning transformation from a religious interpretation of self-starvation to an encompassing medical-scientific explanation of the syndrome in the course of the nineteenth century, offers a good example of how such "successful" processes in fact involved a series of translation and manipulation work, and intense battles between the various people enrolled in the "truth-game." The case of Molly Francher, or "Brooklyn Enigma," in Victorian New York, illustrates the medical actors' strong engagement in the religious communities in which these girls became widely famous for their religious spirituality, where physicians tried to convince the "superstitious" population of the fraudulence of the self-starving girls and their families. It also illustrates the heated debates developing between the often strong religious public and the proclaimed

¹⁴ Sir William Gull was both an intimate of Queen Victoria and her family and a consultant in the professional elite that dominated English medicine after 1860.

¹⁵ Lasegue's emphasis on the "nervous" connotations of the syndrome, and not defining the girls as "lunatics," avoided hospitalization of the self-starving family member in an asylum, and the "family problem" remained a secret.

rational medical interpretations. The famous American neurologist, William Hammond took to the popular press, proposing in the *New York Sun* that he would place a certified check of 1,000 dollars on Francher's table, and said that he would rethink the nature of modern science if he were proved wrong in his claim that she had to eat something during a thirty-days watch (Brumberg, 1988)¹⁶. Against these armies of neurologists arriving in remote agrarian communities from their scientific headquarters in the major cities and demanding objective scientific investigations of the "frauds," trustworthy people such as teachers or priests were mobilized by the community to give testimony in favour of the girls¹⁷. Brumberg also notes how neurologists and physicians started an aggressive use of the popular press and wrote books and reports at a great rate hoping that this would convince a religious/superstitious population that science was the best and only legitimate interpreter of human behaviour.

Brumberg shows how the success of *earlier* scientific work was dependent to a large degree upon the manipulation and forging of alliances between the many social worlds involved in the debate about self-starvation. However, in her examination of scientific

¹⁶ Hof (1994) has sought to explain why these physicians saw the fasting girls as deceivers: "Around 1750 (. . .) People did not attach symbolic meaning to speech and appearance. Social intercourse was based on the rules that applied between theatre actors and spectators: people had to be credible to others without giving insight into their private life. This credibility was based on a person's *behavior*, not on his character. (. . .) The fasting behavior and the claim of miraculous starvation were taken at face value, as signs (not symbols). The investigators saw it as their only task to establish whether the girl's claims of not eating was true or false" (Hof, 1994:86).

¹⁷ A former teacher and professor of one of the famous starving girls in the late nineteenth century United States, wrote: "as a common sense man, a physicist and chemist (. . .) dealing with facts I can't imagine how I could be deceived (. . .) She is a member of the Church. She is honest, if anyone is honest (. . .) I can place my hand on her abdomen and feel her backbone. Is there any deception there? (. . .) she is simply a miracle. She says she is a miracle, and I know she is one. The entire scientific world should know about her" (West, New York Times 1878, in Brumberg, 1988:86).

practices in the contemporary debate about the syndrome biomedical or psychiatric translation work is either overlooked or denied. Her “realist-constructivist” analysis is heavily based upon a traditional modernistic divide between an emerging new and modern reality of self-starving girls in the Victorian era (i.e., anorexia nervosa), whose primary *form* is determined by socio-cultural circumstances, on the one hand, and the progressive purifying medico-psychiatric work, which sole aim is to detect and on the other stabilize the “real” natural components, or *contents*, of the syndrome. In Brumberg’s view, Lasegue’s medical examinations came close to a “real” diagnostic description of the phenomenon, taking account of “the pressurized family environment in anorexia nervosa,” and Gull managed to separate the syndrome from related forms of aberrant eating, attributing the anorexic’s alleged lack of appetite to a morbid (diseased) mental state and not to gastric disorder of any kind¹⁸ (Brumberg, 1988:121). However, according to Brumberg, it was not until the American psychiatrist Hilde Bruch introduced her diagnostic and therapeutic framework of “true” anorexia nervosa in the 1960s that a real and complete diagnostic “discovery” could be done due to Bruch’s uncovering of the anorexics’ “own inner meaning” of their starvation (Brumberg, 1988).

¹⁸ “The lack of appetite is, I believe, due to a morbid mental state. I have not observed in these cases any gastric disorder to which the lack of appetite could be referred. (. . .) That mental state may destroy appetite is notorious, and it will be admitted that young women at the ages named are specially obnoxious to mental perversity. We might call the state hysterical without committing ourselves to the etymological value of the word, or maintaining that the subjects of it have the common symptoms of hysteria. I prefer, however, the more general term, “nervosa,” since the disease occurs in males as well as females, and is probably rather central than peripheral. The importance of discriminating such cases in practice is obvious; otherwise prognosis will be erroneous, and treatment misdirected. (. . .) The treatment required is obviously that which is fitted for persons of unsound mind. The patients should be fed at regular intervals and surrounded by persons who would have moral control over them, relations and friends being generally the worst attendants” (Gull, 1874:136).

Hence, Brumberg seems to argue that if science is done correctly and objectively, then reality will render itself visible, and the “helpless and desperate” anorexic individuals will be cured through the treatment of the “biomedical components” of the illness (Brumberg, 1988:40). In this sense, Brumberg also seems to assume a distinct divide between the mere cultural and the more serious natural “components” of anorexia nervosa, which also addresses her prospects of a division of labour between a cultural-historical science, on the one hand, and medical science, on the other, presented through her two-staged “dependency-addiction model.” The first stage in this model involves the sociocultural context or “recruitment” to fasting behavior, while the second stage incorporates the subsequent “career” as an anorexic and includes physiological and psychological changes that condition the individual to exist in a starvation stage. As such, Brumberg (1988) leaves contemporary biomedical science untouched by the constructivist approach which became at least modestly apparent in her discussion about scientific practices in the nineteenth and early twentieth century. For Brumberg then, the fixed “truths” about anorexia nervosa which emerged in the late nineteenth century have been successfully purified and discovered through the right means of psychiatric models; while culture may have played an important part in the *construction* of anorexics, science; and biomedical science in particular, is only validated through its detached and objective revealing and representation of the inner truths about this and other similar phenomena.

1.3.2. Great Divide II: The “discovery” of anorexia nervosa

While Brumberg (1988) has validated what she views as a process of progressive and purified medical and psychiatric work on anorexia nervosa throughout the twentieth century, Hepworth and Griffin (1990) have argued for a more critical and constructivist stand toward the proclaimed “discovery” of anorexia nervosa as a psychopathological property in the late nineteenth century. In contrast to Brumberg who sees anorexia nervosa as a distinct psychopathology, Hepworth and Griffin oppose the continued biomedical and psychiatric pathologization of female self-starvation. Instead they view it as a social construct or as the outcome of the close interplay between five different and powerful discursive strands, what they call a “hidden ideological agenda” in late nineteenth century Europe.

Hepworth and Griffin discuss these discourses as the following: i) The discourse of *femininity*, which is the most central discursive strand of their “discovery” model, and which is seen as representing the common conviction in this era of the typical irrationality and weakness of female behaviours, placing “women and the feminine outside the realm of masculinity and the masculine world”, and in need of moral regulation (Hepworth & Griffin, 1990:322); ii) the Western *medical scientific* discourse, representing the traditional detached, empirical and rationalistic view of science and its assumed purification practices; iii) the *clinical* discourse, which assumes a relationship between the discovery of anorexia as a psychopathological entity and the need for scientific justifications of the strong advocacy of social and *moral* control in the dealing with problematic self-starving populations; iv) the discourse of *discovery*, which draws attention to the prestigious battle between the two physicians Gull and Lasague in their attempts to separate anorexia nervosa as a distinct

illness category; and v) the discourse of *hysteria*, which assisted the central medical actors in their attempts to legitimate the "cause" of anorexia nervosa as its mental or psychological components, when the search for an organic cause failed.

According to Hepworth and Griffin, women were always seen in negative contrast to everything masculine: women represented the creative, emotional, deviant and mad, as opposed to the rational, scientific, and logical man. Hepworth and Griffin argue that self-starvation was defined within the common conviction of the "mental perversion" (Gull, 1874) of (affluent) young women. Although Gull had initially stated that anorexia nervosa could not be defined as a typical female disorder, this seems to be only a formal articulation due to the fact that Gull preferred to classify the syndrome as a predominantly medical disorder, which would honour him as the first to "discover" and diagnose anorexia nervosa as a separate illness. Gull could therefore not exclude men from the definition due to the "metabolic universality" of the human body. However, in his clinical practice he was primarily preoccupied with young affluent girls and their seeming lack of "mental equilibrium." According to Hepworth and Griffin, there was therefore an inherent link between the discourse of (middle class) femininity and the way in which anorexia nervosa was defined as a distinct psychopathological disease within the scientific-medical discourse in this period:

By grounding anorexia in the discourse of femininity, Gull and Lasegue were able to present such 'mental perversion' as a state which was only to be expected of young women, who are after all, inherently irrational and emotionally unstable. This explanation formed the basis of a developing aetiology of anorexia which was influential due to the scientific and medical context within which it was grounded, and to the status of the observers as respected physicians. (. . .) Thus we can see the emergence of the notion of an inherently female madness which

could develop into specific nervous diseases (Hepworth & Griffin, 1990:326).

This leads us to the next two ideological strands: “the medical scientific,” and “the clinical discourse.” Gull had concluded that anorexia nervosa was caused by a “perversion of the ego,” which also demonstrates his strong advocacy of “moral treatment.” This was, however, still articulated within a context where the search for the *real* origin and “cause” of the disorder, and his attempt to develop a set of distinct diagnostic criteria, took place along the lines of a medical/endocrine science. The etiological and diagnostic research on anorexia nervosa was by now also closely connected with the clinical treatment practices of the anorexic girls. When the application of medical remedies such as cinchona, the bichloride of mercury, syrup of the phosphate of iron, citrates of quinine and iron, etc. (Gull, 1874, in Hepworth & Griffin, 1990) failed to show any signs of effective recovery in the patients, and Gull directed his diagnostic and etiological attention toward the *psyche* of his anorexic patients, the modes of treatment changed in the same directions. Warmth, food and stimulants (tonics) became common treatment measures, but the most essential treatment recommendation became *moral* treatment or *control*. Hepworth and Griffin see this in relation to the overall aim of physicians to control patients, which they see as an integral part of the doctor/patient relationship, that allows “the medical process to function with relative ease” (Hepworth & Griffin, 1990:329).

Furthermore, by the late nineteenth century the difference between physical medicaments and moral treatments was not yet so obvious to the medical establishment, and moral control started to receive much attention from the medical profession as an instrument which could be employed by physicians in the emerging arena of “mental illness” (Hepworth

& Griffin, 1990:330). Moral control was also chosen, they argue, due to its strong religious connections and therefore already established acceptance of moral control techniques and further, a preference from the enrolled upper-class families, which saw this sort of treatment as an opportunity to keep their “mentally perverted” daughters away from the public hospital or insane asylums which had unpleasant class associations with the workhouse.

Based on the discourse of scientific knowledge, the discourse of “discovery” is also seen as central to the construction of anorexia nervosa as a mental and thus independent, condition. Claiming that he had “discovered” anorexia nervosa, Gull, for instance, could emphasize the independence and exclusiveness of his own work, thereby boosting his career and recognition within the medical scientific community in Britain. Furthermore, Hepworth and Griffin argue, “a strong link with medical science was established because Gull was a physician, despite the fact that the contribution of medical science to the explanation of anorexia nervosa was minimal” (Hepworth & Griffin, 1990:331), due to the shift toward psychological explanations of the syndrome. They further explain the claim to discovery of anorexia nervosa as part of a competition between Gull and Lasegue for a secure position among the nineteenth century’s “Great Men of Science.”

Lastly, Hepworth and Griffin argue that the discourse of hysteria helped to establish anorexia nervosa as a distinct pathology. Firstly, the link between women, femininity and hysteria “had an established history” and secondly, the connection between hysteria and anorexia was “functional in maintaining a psycho-medical framework.” For example, they argue that the shift from the organic to the psychological in the search for a ‘cause’ of anorexia nervosa was partly managed via the hysteria discourse:

Hysteria became a linguistic ‘catch-all’ to explain women’s behavior outside their domestic lives. It is possible that anorexia nervosa offered a way of explaining the mind and its relationship to psychosomatic illness. This enabled physicians to articulate the condition as having a psychological (central) origin and as such they wrote about the effects of ‘mental perversions’ (Hepworth & Griffin, 1990:333).

Hepworth and Griffin’s constructivist approach is one of few which has emphasized that the nineteenth-century concept of anorexia nervosa was bound to the social and medical knowledge and practices of the time and cannot be uncritically applied to self-starving or dieting young women. That being said, their main argument that medical ideas about women and womanhood gave rise to the disease label of the syndrome relies on an *a priori* macro-social concept of “patriarchy,” or what they argue to be the principal “discourse of femininity,” as a purified explanatory force of both self-starvation and its medico-psychiatric diagnosis. This in turn ignores the many local heterogeneous links involved in the construction of such factualities and does not account for their proclaimed higher epistemic status than the medical-scientific discourse they contest. It therefore seems that their approach implies a distinct divide between the purely socially constructed “nature” of the scientific medical discourse, on the one hand, and what they see as the “real” political anorexic voices, on the other. Hence, it is unclear in their analysis whether the medical ideas had any relation to “reality” at all, and furthermore to what degree their own representation of the social “truths” about anorexia nervosa can be justified given that they employ such a disengaged and *nonreflexive* (Woolgar, 1992) stand toward the world and phenomenon they describe. Writing that

these nineteenth century texts allowed little space for the notion of anorexia as a form of resistance or rebellion,” and “the overwhelming force of the medical/scientific and clinical discourses served to depoliticize this view of

anorexia as form of resistance (. . .), and should be seen as a reflection of women's subordinated status in patriarchal capitalism (Hepworth and Griffin, 1990:335),

Hepworth and Griffin rather uncritically assume that self-starvation is "caused" by, and must be seen as a political rebellion against "patriarchy," which has persisted as an unbreakable constant social fact since the late nineteenth century. It is also unclear how they see the emergence of self-starvation as a rebellion against patriarchy. Are we to see "patriarchy" itself as having always been a fixed political "cause" of female self-starvation, or is this also simply a recent constructed concept which carries its own hidden feminist ideological agenda?

Therefore, the next section will present an approach to the question of "emergence" and "discovery" of anorexia nervosa which has tried to overcome the divides that have often been created between various kinds of realist and constructivist accounts in the discussion of the history of anorexia nervosa (Hof, 1994). This will also imply a rethinking of the question of culture-boundness which takes into account the many heterogeneous links between various actants and practices which make up a particular black box, or network. We need to see the black box as secured and stabilized through multiple and local processes of enrolment, translation and mobilization of various actants rather than as a representation of a pure social, ideologically biased, or a pure natural, thus universal, reality.

1.3.3. A realist-constructivist approach to the “emergence”/“discovery” question of anorexia nervosa

In her re-construction of the “emergence”/“discovery” debate Hof (1994) has argued for an analysis which takes into account the interweaving, active, and process-like character of both the “emergence” and “discovery” of anorexia nervosa. In contrast to Brumberg, Hof (1994) sees the transformation of self-starvation into what she calls “psychological” self-starvation¹⁹ as developing out of more local social processes taking place in the course of the seventeenth and the eighteenth century: i) “an increasing sense of selfhood,” which gave rise to the notion of ‘personality’ and ‘subjectification’; ii) a “transformation of emotional life”, which stimulated an interest about people's inner life, in particular, their emotions; and iii) a “transformation of body awareness,” which implied that the body became the most significant “mosaic work” (Perrot, 1987, in Hof, 1994:84) by which to express and uncover a person's emotions and personality features. This is seen in relation to the fact that dress codes became less important for the determination of social status and self-expression due to the uniformity and neutrality of dress codes in the beginning of the nineteenth century²⁰.

As Hof concludes:

By 1840, fasting behaviour and thinness, like other behaviour and body characteristics, had come to represent a hidden ‘inner’ reality. Fasting had become meaningful for psychological and emotional reasons and no longer needed public affirmation. While miraculous fasting girls did not immediately disappear, it is

¹⁹ By psychological self-starvation Hof (1994) means modern, weight concern anorexia nervosa.

²⁰ Drawing on the works of Sennett (1974) and Elias (1969) Hof argues that these processes took place due to a) transitional modes of conduct, speech and dress among the bourgeois classes in Paris and London in 1750, 1840, and 1890, b) changes in the economic and social structure in Western Europe in this period, and c) a transformation from ‘public’ persons into ‘private’ persons.

plausible that between 1750 and 1840, fasting girls came to the fore for whom fasting and private meaning. Thus, there indeed emerged a new kind of fasting behaviour, with a different motivation, meaning and function (Hof, 1994:86).

Hence, rather than reducing the emergence of modern anorexia nervosa to an *event* necessarily following macro-structural forces like industrialization and secularization in the late nineteenth century, as does Brumberg, Hof's discussion shows that this form of self-starvation may just as well have emerged much earlier - in the seventeenth and eighteenth centuries due to multiple processes of transforming local and symbolic meanings related to the many practices and connections in people's everyday life.

From this follows that the discussion of "discovery" may be rethought. As long as Brumberg (1988) sees the emergence of anorexia nervosa as an event occurring in the late nineteenth century, she restricts her main analysis of the successful "discovery" to those diagnostic practices that followed this particular incident. According to Hof (1994), Brumberg tends to ignore the fact that several physicians in both France and United States had reported cases of what Hof views as examples of psychological or weight concerned fasting girls. According to Hof, the diagnostic success of Gull and Lasègue, in contrast to those earlier physicians, can only be explained if one considers a series of epistemological and practical transitions that took place within medical science throughout this period. These transitions were i) a central, as opposed to peripheral, determination of behavior (i.e., the *brain* was now seen as the locus of behaviour, which implied that psychological explanations were enrolled in medical scientific models); ii) emotions as causes of mental and somatic disorders; iii) the rise of medical clinicism; and iv) a shift in medical emphasis from *classification* to the *identification* of disorders.

Thus, while Hof sees all these scientific enterprises as constructions, she claims to avoid the problem of a social constructivist approach which disputes the possibility of claiming anything about reality. Rather, she argues

research is geared toward achieving knowledge that is accurate enough to be instrumental. Viewing science as a construction process emphasises that researchers actively pursue a description of a phenomenon in reality. (. . .) Thus, acknowledging the constructivist nature of scientific research does not devalue scientific results in themselves and does not preclude that the results give an accurate description of reality (Hof, 1994:45).

The main objective for Hof is therefore to answer *why* it is plausible to assume that weight concerns were overlooked in the earlier patients, and to examine and account for the choices and interpretations made at a particular time and place.

While her realist approach is not based upon a view which sees nature as existing apart from our observation of it or “disclosing” itself to us unproblematically, she sees the discovery of anorexia nervosa as a process which involves the “research interests of the national medico-psychiatric tradition and the probabilities that anorexic patients would be detected

(. . .) The discovery required the time and active input of various people” (Hof, 1994:45).

Turning to Hof's analysis of “discovery,” she argues that together with the new idea that the human body could be seen as a system of nerves²¹, which in turn stimulated the scientific focus on the brain as the *centre* of behavioral control (i.e., the central versus peripheral determination of behavior), and the introduction of emotional factors in the

²¹ Exemplified by Franz J. Gall's (1758-1828) introduction of his popular theory of phrenology, which assigned the emotions a place in the brain, and not in the heart where they were earlier thought to be located. This was a major change from the earlier models of “humoral economy”, which Hof argues worked to prevent detection of the “psychological starvers”.

explanation of disease and dysfunctions, these processes gave rise to psychosomatic medicine and to modern, dynamic psychiatry in which the current understanding of anorexia nervosa is embedded:

The psychologization process gave rise to a new form of starvation, psychological starvation. Yet, psychological starvation could not be observed and medically interpreted as psychological until medico-psychiatric traditions had been shaped accordingly. The relative autonomy of medico-psychiatric traditions from socio-historical conditions is witnessed by the fact that the national traditions did not all develop in the same way, and had decidedly different research interests and approaches to psychiatric behaviour (Hof, 1994:100).

Two additional factors contributed to the conditions for the shift in observation, interpretation, description and labelling of anorexia nervosa in the last part of the nineteenth century. These were the shift in medical focus on disease from the preoccupation of recording and classifying symptoms²² to the importance of looking for *causes*, and the increased emphasis on the localization and clinical diagnosis of disease in the latter part of the nineteenth century (Hof, 1994). Hof argues that this may explain why, prior to the middle of the nineteenth century, there seems to have been no idea that new clinical descriptions pertained to new diseases because descriptions of sickness were only seen as “variations, subtypes or subclasses of other diseases” (Hof, 1994:98). A last factor Hof ascribes to these processes was the various changes in clinical practice during this period. For instance, while French medicine emphasized the importance of detailed clinical examination and descriptions of patients, the German and Italian medical scientists preferred

²² What Foucault (1986) calls the great era of nosology in the last half of the eighteenth century. Drawing on the Aristotelian tradition, a skilled diagnostician was “he” (sic) who was able to correctly classify symptoms within a disease, a disease within a group, and a group within a class. This gave little room for inventions of “new” diseases because classifications were already existing - in nature.

experimentation²³. Furthermore, changes in clinical practice and examination such as counting the pulse and measuring the body temperature with a thermometer became general practice for the determination of the organic location of the disease from the last decades of the eighteenth century. This was followed by the development of the *clinic* as the prime source of medical knowledge in the early nineteenth century, which now implied limited autonomy for the patient in her/his individual contact with the expert physicians, and which decreased the importance of his/her own account of complaints. Focus was now concentrated on what the body of the patient revealed about his/her physical or mental condition, which in turn facilitated the idea that diseases were restricted to certain parts or organs of the body, rather than being pathological processes affecting the whole body (Nicolson, 1988, in Hof, 1994). These practices and relations were further manifested through the systematic clinical training which became an important component of the formal education of physicians in the middle of the nineteenth century and which came to dominate French and British medicine in this period (Ackerknecht, 1967; Foucault, 1986, both in Hof, 1994). Procurement of the *place* and possible *origin* of the illness was now the central focus of medical clinicism, and this facilitated the location of the anorexic cause in the mental state of the patients.

These processes may be seen in light of what Giddens (1990) defines as the *reflexive* nature of knowledge and its contribution to social order, system reproduction and alteration

²³ This, Hof argues, explains why French psychiatry observed and described psychological starvation earlier than elsewhere in Europe - although they (Imbert, Briquet, Chipley and Marce) have not been acclaimed for having "discovered" anorexia nervosa. This, Hof (1994) argues, is due to Brumberg's and other historians' tendency to think of everything prior to 1873 as qualitatively different - including the form of self-starvation, and not necessarily due to Gull and Lasague's prestigious positions. Marce and Chipley were equally recognized (Hof, 1994).

in modern societies. In this sense, both scientific and lay practices or conventions are “constantly examined and reformed in the light of incoming information about those very practices, thus constitutively altering their character” (Giddens, 1990:38). Hence, knowledge and meaning are not reflections of an external and universal reality, but constructed and transformed through conversations and practices among humans and nonhumans, lay people and scientists. As Hacking (1988) notes, there is also a level of social interaction between knowledge and what is known, or what he calls “feed-back effect” or “making up people.” That is, while classifications of people and their actions affect people and their actions, these people will in turn affect our knowledge about and classification of them.

Thus, following ethnomethodological notions of reflexivity and social order (Lynch, 1993), the strength of Hof’s analysis lies in her problematization of the common assumption that the emergence of a particular disorder is directly followed by its “correct” observations and discovery. Rather, her argument is that discoveries, as well as emergences, must be analyzed as a set of multiple interconnected *processes* that do not “by nature” reflect reality. Scientific observations and descriptions, she argues, always reflect the beliefs, interests and selective and ordering strategies of the researchers - no matter how accurate these descriptions may be. “The descriptions, as is always the case, were mitigated reflections of reality” (Hof, 1994:67). Further, Hof pays attention to the long and complex process through which complaints are acknowledged and seen to be matters of medical concern, a process that culminates in the presentation and acceptance of a diagnosis. This process involves a long chain of people: patients, families, family doctors, specialists, and consultants, and cannot only be explained by a coincidental juxtaposition of the occurrence of self-starvation

with some *a priori* macro-social concepts. Hof concludes: “The first stages in the discovery process of anorexia nervosa and the early actors in it have disappeared from sight, leaving us with the distorted picture of the discovery as the act of two brilliant physicians” (Hof, 1994:66). The fact that the self-starving girls came from middle-class backgrounds may also indicate that there was a general reluctance to send them away to public asylums or clinics²⁴ which accounts for a time-lag between the general medical interest and notification of the phenomenon. Gull’s own account of 1874 was itself based upon cases he had treated several decades before his publication (Gull, 1874). Furthermore, I will argue that there may not have been a strong public interest in controlling the anorexic girls in the same manner as was the case for the “insane” and “lunatics.” Starving girls were (and to a certain degree still are) regarded as a private middle or upper-class family problem, and can therefore be seen as having constituted a potential commercial interest for private practitioners in the nineteenth century. Doctors could exchange security from public visibility and expert control over the starving daughter for the family in a lucrative business.

Based on her realist-constructivist analysis, Hof (1994) tries to redefine the concept of culture-boundness which sees in anorexia nervosa the *symptoms* similar to those of older forms of fasting, but different in *motivation, meaning, and function*. This, she argues, will imply that the symptomatology is not restricted to modern, Western countries or to a specific time, and therefore she does *not* consider the notion of culture-boundness as useful for the study of the historical-cultural specificity of anorexia nervosa (Hof, 1994:43). What Hof

²⁴ Which was only done when the situation became extremely critical (Brumberg, 1988).

means by “similar symptoms” however, is unclear. If she means the very act of abstaining from food and the various physical effects this may cause, it seems that she has inserted a renewed division between nature and culture, content and form which sees the *symptomatology* (nature) of the syndrome as the most important for its determination. While she emphasizes the cultural variations in “motivation, meaning, and function” that self-starvation may take, she seems to imply that these elements are of less importance for a more “*real*” and universal understanding of anorexia nervosa to take place - which is based on “symptomatology” in contrast to its cultural meaning and interpretation. This, in turn, raises questions about the ways in which to understand and legitimate the standardization of diagnosis and pathologization of self-starvation and its relations to gender.

However, Hof’s strong emphasis on how *meaning* and *interpretation* in fact *are* involved and interconnected with biological processes and bodily practices in the transformation of self-starvation through the ages, her rejection of viewing anorexia nervosa as implicitly emerging and discovered as an event shaped by the parallel process of the rise of modern society, and her reservations against the concept of “culture-boundness” may pave the way for the introduction of a new concept in the debate about the syndrome. I will therefore conclude this chapter with the introduction of what I see as a more suitable concept for the understanding of anorexia nervosa, that is, a “network-bound” syndrome.

1.4. The “network-boundness” of anorexia nervosa

The present chapter has demonstrated how the conception and use of the term “culture-boundness” in anorexia nervosa is based upon the modern Constitution’s

asymmetrical separations between nature and culture, body and mind, translation and purification, local and global, reality, textuality and construction (Latour, 1993). At the same time, however, the recent problematization of the concept of culture-boundness has drawn attention to the need for a more symmetrical way to conceptualize the syndrome which includes the expansion of the network, the multiple actants and therefore multiple layers of meanings enrolled in and constructing the anorexic network. Following the argument within SSK literature which proposes the formulation and use of more “hybrid terms” (Callon & Latour, 1992) to capture how scientific knowledge is actually produced, I argue that the term “network-boundness” can contribute to blur the distinction between the “really social” interpretations of social constructivism and the “object-centred” explanations of medico-psychiatric science in the debate about anorexia nervosa.

As Hof (1994) has shown, the “modern,” or psychological, understanding of anorexia nervosa must be seen as the outcome of a long chain of multiple interconnected and expanding processes involving many different, more or less powerful, actants, which are translated and manipulated to form a strong and powerful conception of the syndrome in question. In this sense, the processes Hof has described come close to resembling what actor-network theorists have defined as an actor-network. The various simplified entities constituting both the syndrome’s *forms* and *contents*, have as such been successfully translated or enrolled by various other actors who have been able to borrow or manipulate their force, and as a result spoken and acted on their behalf or with their support (Callon et al., 1986).

As such, there are no strong divides between content and form, nature and culture,

emergence and discovery, meaning and interpretation, because all these entities are linked together in complex chains of hybridization work. Hence, anorexia nervosa cannot be seen as a purely universal syndrome caused by certain persisting physical or psychopathological symptoms, because these symptoms cannot be separated from the signs used to represent and interpret them. Neither can anorexia nervosa be seen as purely fixed to one particular culture due to its assumed links to certain macroscopic social forces, because the successful production of such knowledge claims also involves the active and local involvement of both humans and nonhumans. Production of knowledge is collective in character, not because of the constraint of some macro-social or ideological forces, but because of the many heterogeneous links between many actants that constitute an actor-network.

Furthermore, the strength of such networks, or the fact that anorexia nervosa and the anorexic network have become such durable, encompassing and pervasive entities throughout the twentieth century, cannot be explained purely by the progressive ever-revealing character of scientific work or the saturation of ideological forces rooted in the concept of “patriarchy,” with the sole interest of controlling self-starving young women in their “political protest”. Rather, the endurance of the anorexic network, where self-starvation has been established as a psychopathological disorder, must be seen in relation to what Latour (1997) sees as the heterogeneous multiplication of weak ties between the many actants enrolled, translated and thereby made controllable within the network.

This is not to say that arguments about social control, politics and the “ecology of knowledge” (Leigh Star, 1995) are irrelevant for actor-network analyses - on the contrary. As I will come back to in chapter four, the actor-network approach may in fact offer a

particular productive framework for debates about the implications of knowledge production and fact stabilization; for the understanding of the relationship between self, body and culture; for acknowledging the heterogeneity of identities and multiple memberships in the networks; and for the opening up for a “dialectical sense of situatedness”²⁵ (Harvey, 1993, in Singleton, 1996).

However, it is only after we have described these networks that we can begin to explore the political and moral implications of science in action (Leigh Star & Bowker, 1996). The next chapter will therefore explore the initial and successful strategies of translation which started to proliferate in the 1960s in order to stabilize and mobilize the anorexic syndrome as a distinct psychopathological disorder.

²⁵ Harvey (1993) defines this as a dialectical power relation between the oppressed and the oppressor, or in Latour’s (1991) words: the “definer” and the “defined.”

Chapter 2

Crafting the initial facts of “primary anorexia nervosa”

What we call knowledge is the transformation, the transport, the translation, to the laboratory - in the most extended meaning - of practices and notions already in place somewhere in some segment of the society (Latour, 1988:67).

This self-regulation appears to be grossly disturbed in adolescents who grow fat or become cachectic (anorexic), not on basis of some organic defect, as has often been assumed, but on account of a deficit in their awareness of and control over bodily needs. (. . .) They have failed to achieve what I should like to call a *sense of ownership of their own body*, are lacking in awareness of being a self-directed separate organism, and suffer from a basic misconception of not being an independent self and a conviction of being the misshapen and wrong product of somebody else’s action (Bruch, 1970:184/185).

Having presented the concept of “network-boundness” as a replacement of “culture-boundness” in the understanding of anorexia nervosa, this chapter will explore the ways in which certain actors managed to link heterogeneous interests, provide and enrol wide-ranging support for what has become a stabilized and mobile “standardization package” (Fujimura, 1992) of the syndrome.

I will therefore examine how and why anorexia nervosa became such a significant preoccupation among psychiatrists in the 1960s, and explore the various processes that worked toward the initial theoretical and therapeutic standardization of the syndrome as a separate psychopathology and a particular social problem. The clinical and theoretical work of the American psychiatrist Hilde Bruch will be the focus of this discussion due to her central role in the production and black boxing of the “true” form of anorexia nervosa since the 1960s. This was to a large extent made possible through the translation of support for the concepts “excessive pursuit of thinness” and “disturbance of body image” in the

psychopathological description of the syndrome. As we will see in the next chapter, by the end of the 1970s the two psychological concepts “fat phobia” and “body image disturbance” were mobilized into a determinant diagnostic “standardization package” of (female) self-starvation, which was now seen as a distinct mental and “culture-bound” disorder, one having “reached epidemic proportions” (Bruch, 1978).

The success of Bruch’s work, that is, the strength and durability of her diagnostic model and concepts, has usually been attributed to her therapeutic methodology which enabled her to “uncover” and represent the “real” components of anorexia nervosa. The clinical work of Bruch would have been of great interest for an actor-network approach, analysing the various processes of enrolment, manipulations, and forging of alliances taking place between the many patients and herself as a psychotherapist during the 1950s and 1960s. However, the lack of substantial material from these practices leaves us with the option of analysing the many textual and nontextual devices used in the initial processes of transforming and hardening the theoretical categories into robust and mobile “facts”. Having said that, based on what is known about clinical work with anorexic patients from recent studies and through clinical descriptions by Bruch herself, it may be possible to make certain assumptions about the struggles, persuasions, and manipulations that might have taken place within the clinical setting of Bruch and her patients.

While the various endocrine, psychodynamic and psychosomatic theories and therapeutic practices of self-starvation that had existed between the beginning of the twentieth century and up to the 1960s had not managed to define or treat the syndrome as a distinct disorder, the triumph of Bruch’s model can be explicated by her careful enrolment,

forging of alliances, and translation work of a large and heterogeneous world of self-starving individuals, lay and academic actors, methodological tools, theoretical perspectives and concepts, and the later distribution of the model and its mobilization in a multiplicity of new and different social and academic enterprises. It is through these processes that Bruch's initial model of anorexia nervosa can be seen as having become a powerful and durable standardization tool with wide-ranging implications.

Before examining the network which started to expand in the 1960s, however, we need to take a brief look at the "unsuccessful" processes preceding this decade in the numerous attempts to reveal the "true" etiology and cure of anorexia nervosa. Rather than ascribing these failures to methodological flaws, theory-ladenness, or lack of scientific objectivity, it will be argued that their lack of success in making expandable models, compared to Bruch's project, can be attributed to their overemphasis on purification and unification work, and their consequent inability to make heterogeneous, workable and durable alliances with the different actants involved.

2.1. Interlude: From endocrine testing ground to psychodynamic confession practices

As mentioned, self-starving patients were not an entirely new experience for psychiatrists or medical doctors when the academic world, and psychiatry in particular, started to intensify its interest in these patients in the 1960s. Furthermore, statements like "fear of becoming fat" (Bliss & Branch, 1960), or "Magersucht"²⁶ started to appear as

²⁶ "Magersucht" is the German expression for "addiction to thinness".

clinical descriptions of self-starving women from the 1930s (DiNicola, 1990). These statements, however, were usually interpreted as typical symptoms or variants of other, more “real” mental disorders (e.g., hysteria, schizophrenia, obsessive compulsive disorders, affective disorders, or depression), or endocrine diseases (e.g., “Simmonds’ disease”), dependent on what clinical paradigm was the ruling one at different times between the turn of the century and the 1960s. Brumberg (1988) has pointed out two distinct and largely isolated treatment models of self-starvation in this period: the biomedical and Freudian psychoanalytic. In the 1930s, however, Brumberg argues that the first signs of a bridging of the divide between body and mind in treatment and etiology of the syndrome were evident in the growing interest in a psychosomatic approach within American and Continental psychiatry, which became the dominant paradigm in which to enrol the problem of anorexia nervosa due to its assumed dualistic components: a visible emaciated body, caused by the irrational and mentally dysfunctional act of self-starvation.

In the years following Gull’s and Lasague’s clinical descriptions of anorexia nervosa, the common interpretation of the syndrome was to see it as of a psychogenic origin. This understanding was based upon the notion that recovery was assumed possible if the patient could be dissuaded from her refusal to eat and because autopsy findings revealed no organic pathology. However, due to a new and growing interest in glands made possible through recent advances in microscopy (Brumberg, 1988), the German pathologist, Morris Simmonds’ clinical descriptions in 1914 of a form of emaciation or “pituitary cachexia” found in anorexia nervosa, and which he claimed carried striking similarities to what he had observed in women with atrophy of the pituitary gland, endocrine research and treatment of

self-starvation reached a high point in this period (Bemporad, 1996). Cases of self-starvation, now termed “Simmonds’ disease”, were seen as caused by a severe destruction of the anterior lobe of the pituitary, and thus treated with pituitary extracts, natural and synthetic hormones (Brumberg, 1988). However, with growing scepticism among some prominent physicians in Britain and the United States from the mid-1930s²⁷, the experience among physicians that self-starving individuals did not demonstrate any particular glandular insufficiency (Brumberg, 1988), speculations that anorexia nervosa had an organic basis were put to rest (Bemporad, 1996). The publication of a summary of the world literature on Simmonds’ disease, conducted by Sheehan and Summers in 1948, which concluded that there were significant endocrine and psychological differences between anorexics and those with pituitary insufficiency²⁸, can be seen as the final denunciation of the organic model. Anorexia nervosa was “again reconstructed as a psychological disorder by mid-twentieth century psychiatry” (Brumberg, 1988).

In the late nineteenth century, psychodynamic practitioners²⁹, had already drawn an etiological link between loss of appetite (“anorexia”) and dysfunctional sexuality and

²⁷ E.g., the prominent British medical practitioner and professor of medicine at Cambridge University, John Ryle, observed that physicians subject to the lure of endocrinology had failed to find the cause of anorexia nervosa in either deficiency or disharmony of the internal secretions. For Ryle, Brumberg (1988) states, anorexia nervosa was preeminently a disturbance of the mind accompanied by prolonged starvation and nothing more.

²⁸ The significant differences noted in this publication were that anorexics usually lost weight gradually, whereas those with pituitary insufficiency only did so late in the course of the illness, and that the former were hyperactive and denied any personal discomfort, whereas the latter routinely complained of exhaustion and conserved their limited energy. In addition, anorexics did not lose their pubic hair but rather showed a growth of fine hair on arms, back and legs and in the face (Bemporad, 1996).

²⁹ The most prominent, Sigmund Freud and Pierre Janet.

deficient developmental experiences in early childhood³⁰. However, the consistent popularity of endocrinological explanations and the dominance of empirical science impeded the idea of anorexia nervosa as a psychosexual disturbance until the 1930s, when it was integrated into clinical practice through the influence of American psychiatry (Brumberg, 1988). During the 1930s, nonetheless, anorexia nervosa was established as a female psychological or “neurotic” disorder. This significant shift can be related to the failure of the endocrinologic model to establish either a predictable cure or a definitive cause (Brumberg, 1988), and the growing reputation and influence of the Freudian psychoanalytic movement and its emphasis on the unconscious in psychiatric and medical thinking (Kaufman & Heiman, 1964).

Moreover, physicians had started to pay increasing attention to the role of emotions and the meaning of personality in disease (Stainbrook, 1952; Reiser, 1974), which initiated the development of psychosomatic medicine in the 1930s. Writing the lead article in the first edition of *Psychosomatic Medicine* in January 1939, the American medical doctor, and one of the pathfinders in the field, Franz Alexander, stated that “the solution of the mystery of the diseased mind,” a persistent problem within psychiatry in late nineteenth century due to its reliance on medical methodology and its lack of an independent theoretical framework, came from the psychoanalysis of Sigmund Freud:

Psychiatry with its psychological problems became the stepchild of medicine and was not considered as equal to the other fields (e.g., biomedicine, endocrinology, physiology, etc.) but rather a foreign body threatening the purity of scientific medicine which has fully adopted the methods of physics and chemistry.

³⁰ For instance, in a letter to a colleague in 1895, Freud wrote: “the well known anorexia nervosa of girls seems to me on careful observation to be a melancholia occurring where sexuality is underdeveloped” (Freud, 1959:103, in Bemporad, 1996:229).

Psychiatrists, in self-defence, made strenuous efforts to make the rest of their colleagues accept them as equals and overemphasized their nonpsychological attitudes. . . . Psychological symptoms were only considered insofar as they served for the classification of certain diseases as in the system of Kraepelin, but no attempt was made to study their meaning (Alexander, 1939:65).

The mental sufferer was seen as a nuisance, someone seen by most psychiatrists as a living accusation of the inadequacy of prevailing methods and dogmas, and who therefore refused to deal with these symptoms on a “psychological level”. In this situation, Freud’s psychoanalytic approach, as a theory of personality and therapy of nervous disorders, was seen as contributing to the significant breakthrough for the development of psychosomatic medicine (Kaufman & Heiman, 1964). Psychiatry was seen as the gateway for the introduction of the synthetic point of view into medicine. A “disease” could now be regarded as resulting from a continuous functional stress arising during the every-day life of the individual in its struggle for existence and in its social contact with the environment and other people. Thus, a different conception of etiology emerged, making a distinction between “functional” and “organic.” The cause of disease was now more and more sought as a *function* of a disturbance in the psychosomatic equilibrium. This, in turn, contributed to a different understanding of “normality” versus “abnormality.” It was believed that every emotional situation had a corresponding syndrome of physical change, or psychosomatic response (e.g. laughter, weeping, blushing, changes in heart rate, respiration, etc.). While these were considered to be “normal” conditions and “functional” reactions of the psychosomatic social individual, a permanent emotional disturbance might disturb this “equilibrium” and chronic disturbances of the body might develop.

Alexander’s hope was that the psychoanalytic approach could be for psychosomatic

medicine what the optical microscope had become for medicine. He argued for the need to make manifest the “realness” of emotional conflicts in the same way as micro-organisms had revealed their existence through the optical microscope.

Advocates within the new field of psychosomatic medicine, who now tried to come to terms with the problem of the Cartesian dualism, might have seen the complex character of anorexia nervosa as a paradigm that could both elevate the status of the psychosomatic approach, and raise their own status as scientific practitioners and therapists. In their book *Evolution of psychosomatic concepts: Anorexia nervosa: a paradigm*, Kaufman and Heiman (1964) present a collection of research on the anorexic syndrome since the late nineteenth century in order to proclaim the obvious psychosomatic character of the syndrome. They argue that both Gull and Lasegue emphasized the mental aspects of the syndrome, but that it was not until the “Freudian turn” that a new and better etiological (psychogenicity) account of anorexia nervosa could be drawn. They conclude:

The syndrome of anorexia nervosa seems to us to be a happy choice as a paradigm of the interaction and interrelationship of all the facets of psyche and soma. The growing trend toward cellular biology makes it even more evident that psychological factors assume increasing significance on all levels of organismic function, and that the “mind” functions as the great integrator (Kaufman & Heiman, 1964:354).

From this point psychotherapy, which now had replaced the rather unspecific device of “moral control,” and (forced) re-feeding was now seen as necessary for a healthy and permanent recovery of the anorexic patient, and constituted one of the two most utilized therapeutic tools. The moral aspects of illness were thereby more formally integrated into

and justified in the medical-scientific discourse. As figure 1. indicates³¹ photographs of nude anorexic bodies were often presented as evidence of the successful effects of psychotherapeutic treatment.

—A case of anorexia nervosa. A, Shortly after admission to hospital; B, Following psychotherapy in hospital (patient of Dr. Ian Stevenson at University of Virginia Hospital). Behaviour therapy, with operant conditioning techniques, was also employed in the psychotherapy. (See Bacharach, Erwin, and Mohr (1963) in *Case Studies in Behavior Modification* (ed. Ullman and Krasner). New York: Holt, Rhinehart and Winston, Inc.)

This general acknowledgement of psychotherapy in the overall treatment picture of anorexic patients involved the establishment of a new and influential category of psychodynamic practitioners. The patients' statements were interpreted within an orthodox Freudian psychosexual framework, and the focus was directed particularly to the girl's

³¹ The photograph on figure 1. is presented in Abse's book *Hysteria and Related Mental Disorders: An Approach to Psychological Medicine*.

emotional life and family relations, in particular with her mother. Throughout the 1940s, 1950s, and well into the 1960s, psychotherapists reported that anorexic girls and women feared eating as a source of impregnation and regarded obesity as a sign of pregnancy (Bruch, 1973). In 1940, for instance, the American psychoanalyst, Masserman, reported in front of the Chicago Psychoanalytic Society that his anorexic patient had finally admitted her “fantasy of eating the analyst’s penis” (Masserman, 1941).

The new psychodynamic orientation among physicians also contributed to endocrinologists’ increasing interest in the patients’ sexual organs and functions (Brumberg, 1988). A range of new diagnostic and therapeutic techniques that made it possible to direct particular attention to the anorexic’s sexual functioning also led to the development of the new field of sexual endocrinology. The new methods included vaginal smears that measured follicular activity, biopsies of the endometrium, and the administration of synthetic oestrogens that could stimulate ovulation and the development of secondary sex characteristics (Bemporad, 1996). Rather than being seen as the effects of malnutrition itself, internal and external sexual maladjustments were taken as a confirmation that the patients suffered from real psychosexual dysfunctions (Brumberg, 1988). Accompanying this distinct focus on the sexuality of the self-starving individuals was the strong conviction that the anorexic adolescents (girls in particular) suffered from an intense confusion about their own sexual identity, and were at risk of adjusting poorly to the healthy heterosexual norm. This concern can be related to the extensive popularity and legacy of the work of Stanley Hall, an American psychologist working in the first decades of the 20th century, and an associate of Freud (Ross, 1972, in Brumberg, 1988). His book *Youth: Its Education, Regimen, and*

Hygiene (1906) was widely used in normal schools for training teachers (Ross, 1972 in Brumberg, 1988). His most important argument was that, due to the biologically based processes of sexual maturation, the emotional turmoil associated with adolescence was inevitable. Adolescent girls were thought to be particularly susceptible to environmental factors that might redirect or subvert a “natural” sexual course of heterosexual interest and maturation (Brumberg, 1988).

What is striking about these accounts is the fundamental lack of attention to the integrity of the voices of self-starving girls themselves. It is true that they were frequently quoted, at length about their physical and mental condition. But this initial interest was translated into the framework of the therapists’ own theoretical and therapeutic convictions. The bodies and brains of the self-starvers constituted extraordinary challenges to the psychiatric and medical establishment, and were seen to be in need of immediate therapeutic and medical intervention. The understanding of the “anorexic self” as a highly disturbed psychosomatic entity, and the syndrome itself as a “natural” disease category, served to justify tube feeding and other forms of forced treatment practices. It is this understanding of anorexia nervosa that Lester (1997) argues still constitutes the construction of a “disembodied” anorexic self within the traditional and rationalistic biomedical model. These anorexic patients were usually drawn (mostly against their will) into a scientific battle where psychiatry and psychology on the one hand were trying to free themselves from the empirical grip and dominance of medicine on the other, while at the same time struggling for scientific recognition and influence. Such recognition was most likely obtained by claiming successful, that is, *visible*, treatment results - measured by rapid weight gain. In this context,

psychoanalysis alone was regarded and most often experienced, as incapable of reaching these requirements. A lack of fully articulated accounts of oral pregnancy fantasies and the seeming lack of scientific credibility and generalizable material (Bruch, 1974), combined with the developing positivistic and “neo-Kraepelinian”³² trends in leading (American) psychiatric thinking after WWII, can be seen as having contributed to the decline of classical psychoanalytic perspectives in general and on anorexia nervosa in particular (Bruch, 1974; Brumberg, 1988).

The psychoanalytical neglect of patients’ own accounts of their feelings toward starvation, the meaning attributed to their starvation, and the pure emphasis on the patients’ sexual dysfunctions, were now recognized as the main weaknesses of the Freudian psychosexual approach by the 1960s. The most energetic antagonists referred to it as either brutally theory-laden, or even as non-scientific dogmatism (Blashfield, 1984). For instance, Bliss and Branch (1960), in their influential first review of anorexic research and therapy after WWII, *Anorexia nervosa: Its history, psychology, and biology*, state the following:

Patients are people with feelings - they live, suffer, laugh, and love. But their humanity too often is lost in the medical report. Somewhere between the examining room and the manuscript they are transformed into facts, organs, complexes, and statistics. Patients can speak for themselves - and often with a clarity that adds dimensions to a scientific description (Bliss & Branch, 1960:116).

In addition to their scepticism of “fantasies about oral impregnation” as prime movers

³² Neo-Kraepelinianism refers to a movement in American psychiatry since the end of WWII whose advocates felt “alienated” by the dominance of the psychoanalytic perspective in psychiatry and were united through their mutual adherence to a biological orientation to classification and diagnosis that emphasized the relationship between psychiatry and traditional medical principles (Blashfield, 1984). I will come back to this movement in chapter three.

in the (psycho)genesis of anorexia nervosa, Bliss and Branch (1960) refused to see it as a unique entity distinct from the broad classification of mental illnesses. According to them, “these patients have character disorders, neuroses, or psychoses in which malnutrition of emotional origin is the dramatic symptom” (Bliss & Branch, 1960:50), emphasizing the *multidimensional* manifestations and etiological factors of the syndrome. A similar position was held by the author of another report on anorexia nervosa published in 1960: Lesser et al. (1960) argued that anorexia nervosa was not a disease but a constellation of symptoms (Lesser et al., 1960, in Sours, 1969).

What Bliss and Branch argued was that there was an internal *logic* (however individual) to the “choice” of starvation, vomiting, etc. as expressions of internal dysfunctions, and that this logic could be revealed through the examination and evaluation of the developmental and familial history of the disordered self-starving girl. A fundamental deviation from what was considered a “healthy” upbringing was therefore the new focus of attention, bringing in the responsibility of the family, and the mother in particular, as crucial agents in the production of deviance and social problem categories. However, because Bliss and Branch could not stabilize any particular aspects as prime movers of the disorder, they could not classify anorexia nervosa as a distinct disease category.

Interestingly, Bliss and Branch emphasize their patients’ “value systems” or “symbolic meaning” concerning *food* and *obesity* as an important dimension in the general understanding of the syndrome. For instance, they hold that fear of being or becoming fat could sometimes be a lifetime preoccupation for “these individuals.” One of their patients wrote:

The fear of being fat has to this day constituted my most real, constant and terrifying problem. Without doubt my inferiority complex has arisen from this one deep-seated fear. I need to stay thin - if I stay thin everything will be different. I won't be the same as when I was growing up. I'll lose my identity and not be that fat, insecure adolescent. It is like someone with a different name (Bliss & Branch, 1960:58).

A decade after the publication of Bliss and Branch's study, the aspect of "fat phobia" had been translated as the key diagnostic criteria of the syndrome, and had made it possible to separate the syndrome from other already established mental disorders. Bliss and Branch (1960), however, who argued for a sharp distinction between statements about "trivial and easily discarded" fixations of the individual³³, on the one hand, and what they viewed as "absolute true" and "pure" values, such as the "incest taboo," on the other, did not see statements about "fear of becoming fat" as significant enough to be translated into a distinct definition of anorexia nervosa because they were merely related to the varying rules of fashion. Hence, anorexia nervosa was seen as a symptom (with a variety of different manifestations) of more universal or pure mental disorders.

As argued in the previous chapter, processes of "emergence", "discovery", observation and interpretation are interconnected but do not follow a purely progressive or logical line of objective revelations of "truths." Hence, while "fat phobia" may have been an expressed concern of self-starving individuals prior to its official "detection" in the late 1960s, it was only when the symptom was evaluated and enrolled as a determinant "factor" for the diagnostic stabilization of anorexia that it became such a wide-ranging academic and

³³ Bliss and Branch (1960) compared statements about "fat phobia" with styles of fashion, by which women are easy targets. They state: "One year, long dresses are stylish and valued; the next year, by edict from Paris, short dresses are the ultimate, and the female population makes the transition rapidly, although at some financial sacrifice" (Bliss & Branch, 1960:55/56).

public concern. It was seen as an increasing, new and culture-bound mental disorder that formed an expanding, durable and associated network in which anorexia nervosa and its diagnostic concepts have become robust factualities. In the following section I will therefore try to answer the questions of how and why the concepts of “fat phobia” and “body image disturbance” were enrolled as such integrated factors in the manufacturing of a strong diagnostic work of anorexia nervosa as a gender and culture specific mental disorder, and why it was seen as important to distinguish the syndrome from other mental disorders in the first place. What will be examined is how a series of scientific theories and concepts, treatment practices, the many anorexic patients, academics and therapists were successfully enrolled and translated into a new, expanding and durable standardization package of anorexia nervosa. First I will examine some aspects of the clinical setting which in most cases formed the background for the growing scientific interest in the syndrome and the particular directions it took in the course of the 1960s. I will then focus on the textual and nontextual devices through which the most central scientific actors (in particular the American psychiatrist Hilde Bruch) in the 1960s managed to mobilize a variety of allies to produce a stable anorexic network.

2.2. Scientific and clinical definitions of an increasing social problem

The renewed and increasing scientific interest in “anorexia nervosa” in the 1960s has usually been ascribed to the common conviction within most medico-psychiatric communities and among lay people in the Western world that a dramatic increase of the syndrome had taken place since the 1950s, and that this could be seen as an outcome of what

was viewed as the disruptive and anomic forces associated with and evolving out of the economic boom, consumer culture and individual/female liberalism (exemplified by the women's liberation movement) of the post-war era (Bruch, 1973; Selvini-Palazzoli, 1974; Brumberg, 1988). What is not clear, however, is the basis on which this increase was measured, given the lack of consistent diagnostic nosologies and the absence of any workable treatment protocols related to the syndrome. Furthermore, Hof (1994) notes, the impression of an increase in anorexic patients was established within conventional medical wisdom before any relevant epidemiological research was conducted. As Hof (1994) argues, what she calls the "putative increase of anorexia nervosa after WWII" must rather be seen as a result of the increasing chances of being noticed and labelled as anorexic due to the expansion of the health care system, the increased involvement of psychiatry³⁴ in medical treatment in most Western countries after WWII, and a general interest in psychiatry to link eating and other mental problems of women to the changes in the female role in the 1960s and 1970s. Hof concludes:

The concern over the changing role of women, implicitly and explicitly related to women's improving education, was a general theme in the literature (psychiatric and medical). The initial concern was never empirically studied, and the actual role of education and emancipation in the psychogenesis of anorexia nervosa has never been established. Its central role in the aetiological models of anorexia nervosa is therefore debatable. In my opinion, there is more evidence that the education and emancipation of women contributed to the growing public and medical *interest* in anorexia nervosa than to any actual increase in the number of anorexic patients (Hof, 1994:160).

The main conclusions drawn at a multidisciplinary international conference on

³⁴ For instance, girls who were assumed to have an eating disorder were increasingly given referrals for psychiatric rather than pediatric or gynaecological treatment (Hof, 1994).

anorexia nervosa, held at Göttingen University in Germany in 1965, may stand as an indication both of the significant scientific attention directed toward the syndrome, and the basic premises established in this decade. The epidemiological contribution by the German sociologist Pflanz confirmed the impression among most psychiatrists and medical doctors that there had been an increase of anorexia nervosa since the 1950s. Furthermore, it was recognized that the rise of the syndrome could be associated with or explained by the emancipatory tendencies among Western women after WWII. For instance, the German psychiatrist Von Baeyer, stated:

Man kann in diesem Zusammenhang auf die besondere Problematik des Heranreifens des jungen *weiblichen* Menschen zur Frau hinweisen, und zwar in einer Epoche in der die Rolle der Frau seit Jahrzehnten einen tiefgehenden Wandel durchmacht; ich meine den als Emanzipation bezeichneten Wandel der Frauenrolle aus der traditionellen, familiären und ehelichen Geborgenheiten zur modernen sog (Von Baeyer, 1965:151, in Hof, 1994:133)³⁵.

Moreover, concerns about the emancipation of women in this period were paralleled by an expanding interest in “the problem of adolescence”. It was to a large extent through the inclusion of the problem of anorexia nervosa in various psychiatric handbooks and journals³⁶ directed to the debate about adolescence that the syndrome was defined as a distinct area of research, and where expert authors (e.g., Bruch) writing on the subject became recognized as such. The central argument running through these works was how

³⁵ Translation: “In this context we can relate this particular problem to the issue of maturation and upbringing of young female individuals into womanhood, particularly in a period when the female role has been subjected to deep-rooted changes throughout the last few decades; I mean the particular emancipation of the female role from the traditional, familial and marital protection toward a more modern upbringing” (Von Baeyer, 1965:151, in Hof, 1994:133).

³⁶ See Lebovici & Caplan (eds.), *Adolescence: Psychosocial Perspectives* (1969); Zubin & Freeman (eds.), *The Psychopathology of Adolescence* (1970).

psychiatry both had the theoretical and therapeutic capacities and therefore a particular responsibility to cure the ills of adolescent individuals, caused by the “sociopolitical and ethical consequences of our technological revolution” (Lebovici & Caplan, 1969:xi). Drug (marijuana) abuse, sexual disturbances, learning disabilities, hormonal and genetic extremes, eating disorders, and depression were put on the agenda, and seen as urgent problems of adolescents in the new post-war economy. These problems, it was argued, could only be solved on an individual level with the help of progressive psychiatric research (Rosen, 1970). Bruch’s early accounts of anorexia nervosa conformed perfectly with these perspectives. For example, her articles centred around the question of how the disturbed adolescent could be treated and helped through psychotherapy to return to a healthy, rational and normal way of life - to win over his/her inner “childish” and “bizarre” delusions (Bruch, 1970).

These aspects indicate how scientific, that is, psychiatric practices became increasingly involved in a series of socioeconomical and political issues, and how this engagement in fact may have contributed to a further expansionary enrolment of psychiatric actors in the definition of and production of techniques to control risk populations. Rose (1986) sees such examples of “behavioral techniques” as an essential constituent of the new “therapies of normality” that started to proliferate in the 1960s, and which were aimed at the reshaping of subjectivity in desired directions, with the claim that they could produce certain functional capacities or psychological attributes (Rose, 1986:81). This again had consequences for the further production of risk groups and standardized diagnostic tools to make *predictions* about these groups. As Castel contends:

The modern ideologies of prevention are overarched by a grandiose technocratic

rationalizing dream of absolute control of the accidental, understood as the irruption of the unpredicable. In the name of this myth of absolute eradication of risk, they construct a mass of new risks which constitute so many new targets for preventive intervention. Not just those dangers that lie hidden away inside the subject, consequences of his or her weakness of will, irrational desires or unpredictable liberty, but also the exogenous dangers, the exterior hazards and temptations from which the subject has not learnt to defend himself or herself, alcohol, tobacco, bad eating habits, road accidents, various kinds of negligence and pollution, meteorological hazards, etc. (Castel, 1991:289).

Hence, these processes may illustrate the importance of including the active translation work of scientific actors if we are to understand the distribution and standardization of meaning of a particular phenomenon. Rather than merely seeking a purified explanation of the syndrome by studying and proclaiming its “real” independent nature, be it culturally or naturally determined, we need to examine its production, existence and expansion on the basis of the multiplicity of practices of *interesements*, manipulations, negotiations and struggles that have taken place between the many quasi-objects and quasi-subjects enrolled in a particular network. As such, “anorexia nervosa” was nothing outside the constitutive network which started to expand in this period.

As the discussion above indicates, the mobilization of awareness among professional health practitioners and scientists about the rising tendencies of anorexia nervosa furnished a further interest in and tendency to detect and label self-starving or emaciated young women as anorexic. According to Hof (1994), it therefore seems plausible to suggest that “cases” of anorexia nervosa were defined as such before any clear and distinct diagnostic nosology or treatment protocols were developed for the syndrome. As we have seen, there existed a whole variety of different clinical reports and treatment protocols on the syndrome by the beginning of the 1960s. These varied from Gull’s (1874) and Lasague’s (1874) advocacy of

moral treatment and control, Simmonds's (1914) endocrine experimentations, Nicolle's (1938) schizophrenic understanding of self-starvation, to the various psychoanalysts's investigations of oral pregnancy fantasies (e.g., Alexander (1939), Masserman (1941), Binswanger (1944), and Thomä (1961)). However, when an increasing number of self-starving or emaciated individuals (young women) in fact *were* enrolled and defined as anorexics during the 1950s and 1960s this seems to have generated a particular quest for the development of a theoretical, diagnostic and therapeutic standardization package of the syndrome. These undertakings must also be seen in relation to the simultaneous need among health professionals to justify the combination of forced feeding and surveillance practices and the transference of treatment responsibility to psychiatric/psychological professionals (Hof, 1994). On the basis of this complex situation we can start to explore the settings and processes in which anorexia nervosa has become black boxed as a psychiatric entity.

As mentioned, I will start by exploring the characteristic conflicts and struggles which usually took place and still are taking place between the hospitalized (usually against their will) anorexic patients and the medical staff. While this served as the background on which later psychiatric experts (e.g., Hilde Bruch (USA), Arthur Crisp (Britain), Mara Selvini-Palazzoli (Italy)) based their seemingly unified diagnostic arguments, it is important to notice the rather complex and laborious struggles and manipulations that in fact constitute an important part of the polished written accounts that have become distributed and known to the world.

The very confrontations between an emaciated young woman and members of the medical or psychiatric staff were and still are usually characterized as a process of sharp

social conflict and struggle (Orbach, 1986; Turner, 1990). For the patient, the hospitalization itself, the diagnosis of being sick, the surveillance and coercive treatment practices (e.g., tube feeding, routine weight examinations and eating surveillance, and prohibition from exercising), and the people administering these tasks come to constitute an all too powerful regime in which her/his denial, struggle, and attempts to escape these treatment routines will only be interpreted as another sign of her/his sick and delusional condition. For the doctors, nurses, and psychiatrists, their confrontations with and therapeutic practices on the self-starvers constitute an impossible dual role where the caregiver is simultaneously in the role of the enforcer of feeding, and the supposed provider of a therapeutic situation. As Orbach (1986) has described, the stress on eating is frequently accompanied by coercive measures such as guarding the patient while or until she ingests her food, and the taking away of 'privileges' until eating is regularized and a certain weight achieved. Food preferences of the anorexic are not respected: indeed in some treatment programmes the patient's fear of food is dealt with by 'feeding' her up with calorie-rich drinks, bypassing solid food altogether. The anorexic patient will in such circumstances feel humiliated, desperately angry, depressed and out of control. There is no way out:

(...) perhaps the patient throws the food on the floor. Perhaps she is made to eat another plate or the same plate. She searches frantically to find a place to deposit the ingested food. The window is locked, her side-table has no drawers and she is not allowed to leave the cubicle to go to the toilet. She jumps out of her bed and exercises frantically... (Orbach, 1986:187).

In such contexts, recovery is measured by weight gain and acceptable electrolyte balances, but the road to such results requires long periods of hospitalization, and is experienced as extremely challenging, both practically and emotionally. Hence, this created

a problem which required that new theoretical and therapeutic expertise be pursued. Also, the increasing availability of psychiatric expertise in most hospitals after WWII (Blashfield, 1984; Hof, 1994), may have contributed to the handing over of “delusional” anorexic patients to professionals who could deal with the mental side of the “matter”. As Bruch writes: “The question is how to persuade, trick, bribe, cajole, or force a negativistic patient into doing something he or she is determined not to do” (Bruch, 1974:804). Psychiatry had the theoretical means required to create a diagnostic framework which could legitimate the labelling of their “sick” behavior and outlook, and which could simultaneously ease the stress on the physician and nurses in the employment of coercive and physical treatment techniques. The important thing was to be able to construct a diagnostic framework which made it possible to convince the patient of the “childishness” and “irresponsibility” of her behaviours, to legitimate treatment and therapeutic judgements, and to make the patients cooperate in the recovery process. What became a key issue from the late 1960s, underscored by the new psychiatric experts after the fall of classical psychoanalysis, was how to give the patients “help in becoming alerted to any self-initiated feelings, thoughts, and behavior, and thus gradually to develop awareness of their own participation in the treatment process and in the way they live their lives” (Bruch, 1970:192). The responsibility for recovery was now the patient’s and not the therapist’s, indicating a particular form of the regulative ideal of the self proclaimed through the reigning authority of and the proliferation of sites of practices of the “psy” professions since the 1960s (Rose, 1986). The “anorexic” was enrolled in a treatment situation and expected to participate in its own transformation toward a rational, normal and self-regulative human being. As Rose argues:

These therapies of normality transpose the difficulties inherent in living on to a psychological register; they become not intractable features of desire and frustration but malfunctions of the psychological apparatus that are remediable through the operation of particular techniques. The self is thus opened up, a new continent for exploitation by the entrepreneurs of the psyche, who both offer us an image of a life of maximized intellectual, commercial, sexual or personal fulfillment and assure us that we can achieve it with the assistance of the technicians of subjectivity (Rose, 1986:82).

Bruch had initially managed to create alliances with the many anorexic patients who were either handed over to her by medical doctors and nursing staff, or who later came to her private practice guided by their frustrated but hopeful middle-class mothers, by emphasizing and listening to what the patients had to say about their everyday relationship to food and their bodies. This setting may in turn have invoked trust and a kind of openness between the patient and the therapist, but also created room for processes of negotiations and translations of the bodily stress of the patients' condition, their various subjective feelings and meanings, their frustrations, their denial and ritualistic practices directed to food and their bodies. It is through her extensive written work, however, that Bruch received her academic and later public recognition. Bruch's use of textual and nontextual resources to create strong and wide-ranging academic and public support for her diagnostic, theoretical and therapeutic claims, and the further "hardening" of these claims into diagnostic facts - the anorexic *form* - will therefore be discussed below.

2.3. Constructing “primary” anorexia nervosa with “fat phobia” and “body image disturbance”

Actor-network theory sees the authoritative status of science as resting upon the powerful networks it mobilizes to support its statements and constructs (Latour, 1987; Callon et al., 1986; Ward, 1996). To induce other scientists to transform statements into facts, scientists may draw upon heterogeneous alliances and a variety of material and symbolic resources. While Bruch had collected and could draw upon a large network of more or less cooperative anorexic patients, including the many individual, bodily and social meanings related to their conditions, the rather “messy” relations produced in these clinical settings had to be translated into more homogeneous and “purified” written accounts, and given authority through a broad reference to and enrolment of external textual resources and agents, in order to mobilize support for her diagnostic and therapeutic claims. The scientific community needed to be enrolled through series of imputed interests - interests directed toward the support of defining anorexia nervosa as a separate mental disorder through the key diagnostic criteria of “fat phobia” and “body image disturbance”.

First of all, Hilde Bruch was already acclaimed as an expert on childhood obesity³⁷, and was working at one of the hospitals in New York which started to “receive” and diagnose an increasing number of anorexic patients during the 1950s and early 1960s. It was assumed by the medical staff that her experiences with the psychotherapy of obese

³⁷ Bruch had been recognized in the field of eating disorders in 1939 when she published an article on the so-called “Frölich Syndrome,” rejecting the idea of pituitary disturbances and arguing that the causes were simply overeating and underactivity, and that the patients could be treated with psychotherapy (Bruch, 1973).

adolescents had prepared her for treating this new and expanding problem population (Bruch, 1985). This may explain how her diagnostic view on anorexia nervosa came to be based on the inversion of the same theoretical framework as the one she had developed for adolescent obesity³⁸. Anorexia nervosa and obesity were viewed as two opposite extremes on a continuum, both seen as surface reactions associated with or growing out of what she called “weak ego boundaries,” “disturbed body image,” or “identity confusion”. Because her model drew upon such a general theoretical and material basis, she did not define anorexia nervosa as a typical female disorder, as had been emphasized by other authors (e.g., Selvini-Palazzoli, Crisp, and later feminists). Anorexia nervosa could be seen as a gender neutral and thus a “real” mental disorder, which might have worked to increase the scientific credibility of her model.

While Bruch had published extensively on childhood and adolescent obesity, in the beginning of the 1960s she started to publish on the subject of anorexia nervosa. Her reputation allowed her to publish in reputable medical and psychiatric journals such as *Psychosomatic Medicine*, the *American Handbook of Psychiatry*, and the *Journal of Nervous Mental Disorders*, which implied that she received a large audience and significant attention. Her article *Perceptual and Conceptual Disturbances in Anorexia Nervosa* (1962)³⁹ became a much read and cited account on the syndrome⁴⁰, and included the main theoretical and

³⁸ Among Bruch’s patients obesity was equally distributed between.

³⁹ Published in *Psychosomatic Medicine* 1962, 24:187-194.

⁴⁰ Even in 1993 this article was cited in 9 different works: 5 medical and psychiatric and 4 social science works.

diagnostic arguments - arguments which have since been standing as the foundation of and which were further enrolled and translated into the large and encompassing anorexic network we know today. The main argument presented in this and her following articles and books was the importance of distinguishing between what she saw as "*primary*" and "*secondary*" anorexia nervosa.

Primary anorexia nervosa was defined by a "relentless pursuit of excessive thinness" in conjunction with three interrelated "perceptual and conceptual" disturbances, or what has been later called Bruch's "tripartite perceptual/conceptual model" (Garfinkel & Garner, 1982). As we will see in chapter 3, this model became subjected to extensive empirical experimentation in the 1970s and the 1990s in order to render the nature of these rather theoretical concepts visible. The three criteria were: i) a disturbance of body image; ii) interoceptive disturbances, such as an inability to identify internal sensations such hunger, satiety, or affective states; and iii) an overwhelming sense of personal ineffectiveness.

The "true" or primary type of anorexia nervosa was distinguished from what Bruch saw as "secondary" anorexia nervosa, the latter defined as an unspecific symptom associated with a variety of psychiatric disorders, such as depression, conversion hysteria, and schizophrenia. The primary form of anorexia nervosa was strongly suggested to be treated as a separate mental disorder due to its "amazingly" homogeneous and increasing characters - defined through the patients fundamental "pursuit of thinness" coupled with a serious cognitive dysfunction of "body image disturbance".

In an attempt to enrol support for this statement Bruch emphasized her unique therapeutic methodology, which was given scientific authority and justification through

reference to her famous teachers in moderate psychoanalytic method and theory: Freida Fromm Reichmann, Harri Stack Sullivan and Lawrence Kubie. Bruch argued that a focus on and attention to the patients' external articulations of the disease (e.g., the patients' statements of feeling too fat) and their day-to-day thinking about food and body, contributed to a "democratization" of the therapeutic setting where the anorexic patient could speak out, be listened to, and taken seriously (Brumberg, 1988). The "true" or "hidden" realities of the anorexic "enigma", or what she remarks as "the amazingly homogeneous" entity of the syndrome, was therefore said to have unfolded itself to the open-minded therapist. On the basis of this approach, Bruch (1973) found that there was little difference between primary and secondary anorexia. What was more important, according to her, was what actually defined the true type of the syndrome: the underlying, mental distress of the patients. She had thereby translated the hybridization work and struggles within the clinical context where the content of the syndrome consisted of an ongoing and inseparable interaction between body and mind, nature and culture, into an emphasized and presumable purified mental form of anorexia nervosa - practices which themselves consisted of series of translations, imputed interests, and forging of alliances.

Although earlier accounts had made note of the anorexic patients' desire to be thin (e.g., Bliss and Branch, 1960), Bruch's and other recognized psychiatrists' (Selvini-Palazzoli, 1963; Crisp, 1965; Dally, 1969) strong argumentation of a dramatic increase in *primary* anorexia since WWII may have contributed to a wide acceptance of her diagnostic theory and the view of treating it as a separate mental disorder. Also, since Bruch had been given the responsibility, because of her trusted experience as an expert on childhood obesity,

for treating a large number of self-starving individuals hospitalized in this period, she drew on a “significant enough sample” to gain scientific credence for her viewpoints (Bruch, 1985). Due to the empirical trends within American psychiatry since WWII, in order to gain scientific recognition (Blashfield, 1984), it had become increasingly difficult for orthodox psychoanalysts to get acceptance for their arguments of a psychological explanation of anorexia nervosa. Hence, in an article in 1974, Bruch emphasizes the problematic aspects of the classical psychoanalytic setting, and how this is actually felt as an additional and reinforced burden on the “distorted” anorexic identity. She writes: “Many had previously been in psychoanalytic treatment and had given up in despair because they had felt once more caught in a situation where the other person gave meaning, knew the answer, while they became even more convinced of their “nothingness”” (Bruch, 1974:192).

Bruch, on the other hand, managed to argue for a strong empirical grounding of her theory (the relatively large number of anorexics and their homogeneous statements about weight or fat phobia), thus meeting the scientific demands required by the “new” psychiatric movements in the post-war era. At the same time she was able to enrol strictly psychological support for her observations, combining a moderate, asexual psychodynamic approach with Piagetian developmental psychology (the Piagetian sequence of pre-symbolic conceptualization), developmental learning theory, and Harlow’s primate research.

While “fear of abdominal fat” was now seen as such, and not as a symbol of its sexual connotations, this “fear”, or “perceptual disturbance,” was still interpreted as an external expression of underlying or internal meanings which could be traced to deficient developmental factors in the patient’s early childhood. Bruch (1962) saw this as largely due

to a failure of the mother to take notice of the child's own inner needs, and thus solved through psychotherapy. Bruch could, without difficulty, translate what the patients told her about their relationship to food and body into what was seen a fundamental lack of self identity, self-control, and self-esteem. She writes:

They [the anorexics, and the obese] have failed to achieve what I should like to call a sense of ownership of their own body, are lacking in awareness of being a self-directed separate organism, and suffer from a basic misconception of not being an independent self and a conviction of being the misshapen and wrong product of somebody else's action (Bruch, 1970:184).

The aim of therapy was therefore to convince the patient of her own deep-rooted mental disturbance - a remnant of her/his "childish thinking and resistance" and thus in need of guidance and cautious psychological and physical repair. Bruch argued that a permanent physical recovery was only possible if the patient had made considerable psychological improvements - that is, a realistic body image (Bruch, 1973). Claiming that the anorexic patients seem to have formed an "amazingly" and unhealthy homogeneous entity, she concluded that the correct psychotherapeutic perspective would gradually contribute to the reemergence of "individual personal features" (Bruch, 1978):

Instead of interpreting intrapsychic conflicts and the disturbed eating function, therapy will attempt to help him [sic] deal with the underlying sense of incompetence, encourage correction of the conceptual deficits and distortions, and thus enable a patient to emerge from his [sic] isolation and dissatisfaction. The patients need help with their lacking sense of autonomy, their disturbed self-concept and self-awareness (Bruch, 1974:807).

Thus, what Bruch could conclude and communicate to her scientific and clinical community was that she, for a substantial period of time (from the early 1950s to the early 1960s), had observed and treated a large and significant sample of anorexic patients (12

cases) which, due to its obvious psychological basis and “amazingly universal” character, had to be explained through a distinct psychological framework. Earlier references and juxtaposition of self-starvation with other “real” mental disorders were now replaced by the enrollment of a variety of different already accepted psychological theories, and a selection of empirical case material, to explain and gain support for the syndrome as a separate mental illness.

Furthermore, Bruch also drew on a large number of external theoretical resources to make her claims costly to reject. I have already mentioned her combination of moderate psychoanalysis and developmental psychology, and her strong rejection of earlier classical psychoanalytical and endocrine approaches. In addition, it is interesting to see how much emphasis she, notably in her earlier works, put on the schizophrenic aspects of the syndrome/patients. Whereas former authors and some of her contemporaries saw anorexia nervosa as merely a symptom of schizophrenia, it seems that Bruch made use of these aspects to argue for a distinction between anorexia nervosa and schizophrenia. In her article *Perceptual and Conceptual Disturbance in Anorexia Nervosa* (1962) she links “perceptual and conceptual disturbances,” the concepts on which “body image disturbance” itself is built, to the schizophrenic state of the anorexic patient - an ego disorganization along the lines of schizophrenic despair. Interestingly, the concept of “body image disturbance” is itself derived from earlier psychoanalytic literature on schizophrenia, psychoses, and “bizarre delusions”. Bruch was the first, however, to translate and establish its meaning and connotations into her own etiological framework on eating disorders (first obesity, then anorexia nervosa). For instance, she drew on the work *The image and appearance of the*

human body by the Austrian-American psychiatrist, Paul Schilder (1935), and the notion of body image disturbance in psychotherapy advocated by Fisher and Cleveland (1958), to define the importance of body image in the explanation and recovery of anorexic patients⁴¹. While Schilder and Fisher and Cleveland's works were heavily framed within the Freudian psychodynamic tradition, their ideas could, by the mid-1960s, be made durable when included in the more acceptable theoretical and therapeutical approach of Bruch. Bruch's statements and use of the concept of "body image disturbance" were in return made stronger through the reference to these authors.

Furthermore, in her early works Bruch also emphasized the important, but too often ignored, work of the American psychiatrist, Grace Nicolle (1938), who had seen anorexia nervosa as a subcategory of schizophrenia. Bruch, however, argued that anorexia nervosa constituted a *semblance*, not a subcategory of schizophrenia. According to Bruch, it had to be seen as a separate condition, but one as serious and dangerous as schizophrenia.

The wide acceptance and expansion of Bruch's arguments, primarily within psycho-medical circles, must also be seen in relation to her reputation as a therapist and scholar - initially as an expert on childhood obesity, then as an expert on anorexia nervosa. I have already mentioned her close academic and personal contact with psychiatric authorities like Stack Sullivan, Kubie and Fromm Reichman. As Joanne H. Bruch (1996) notes in her bibliography of Hilde Bruch: "Reputation preceded her. What sort of person, colleagues wondered, tells humorous anecdotes about Harri Stack Sullivan and consults with Lawrence

⁴¹ Schilder, Fisher and Cleveland themselves did never apply the notion of body image to anorexia nervosa or obesity.

Kubie and Freida Fromm Reichman simultaneously” (Bruch, 1996:142).

Although primarily acclaimed as an expert on obesity up to the late 1960s⁴², from the beginning of the 1970s Bruch began to be invited as guest author on the very subject of anorexia nervosa in a variety of journals and handbooks. For instance, in 1970 The American Psychopathological Association invited her to write an article about the twin pair of obesity and anorexia nervosa in the edited volume *The Psychopathology of Adolescence* (Zubin & Freeman, 1970). And in 1974 she wrote an article which summed up her perspectives and experiences with the syndrome in the *American Handbook of Psychiatry: Organic Disorders and Psychosomatic Medicine* (Reiser (ed.), 1974). She also became a popular guest speaker at a whole variety of medical, psychiatric, psychological and feminist conferences on eating disorders in the decades that followed the publication of her most cited book *Eating Disorders: Obesity, Anorexia nervosa and the Person Within* (1973). From 1928 to 1984 she wrote more than 250 articles and published over seven books - varying from general psychiatry, schizophrenia, obesity and anorexia nervosa. She received six academic awards from 1978 to 1981, and has an annual award named after her: Hilde Bruch Award for Excellence in Psychiatry (Bruch, 1996).

In retrospect, Bruch’s initial work on anorexia nervosa, characterized by her profound linking of ties among various actants, textual and nontextual agents, can be seen as having succeeded in designing a theoretical, diagnostic and therapeutic standardization package, well suited for further mobilization and practices of *interesement*. As we will see in the next

⁴² In 1969 Bruch wrote as an expert on childhood obesity in the handbook *Adolescence: Psychosocial perspectives* (1969).

chapter, Bruch's "anorexic package" was taken up and translated into a whole range of different academic and public contexts in the course of the 1970s and 1980s, signalling the significant expansion of the anorexic network, the "immutable mobility" of the diagnostic statements, and their subsequent transformation into robust "realities". That is, the diagnostic statements of fat phobia and body image disturbance could travel across the network without being diminished (mobility), and were not fundamentally altered along the way (immutable) (Latour, 1986).

Nevertheless, the 1960s concluded with no clear agreed upon nosological framework of the syndrome. For instance, in his review of the literature on anorexia nervosa since the early 1960s in the book *Adolescence: Psychosocial perspectives* (1969), the American psychiatrist, Sourse, concluded that anorexia nervosa "for Bruch, becomes a distinct variety of schizophrenia", and

(. . .) that although anorexia nervosa is a syndrome with a distinctive phenomenology, there is little clinically to justify its classification as a specific nosological entity. The anorexia nervosa syndrome is found in a wide range of psychopathology. In pubescent and pubertal girls, anorexia nervosa is usually a neurotic disorder; in older females and in male patients, it is often part of a borderline to blatant psychosis (Sourse, 1969:206).

However, several practices stimulated an increasing conviction from the beginning of the 1970s that anorexia nervosa was to be seen as a separate psychopathology instead of a subcategory of other disorders: The already existing establishment of trajectories of communication and exchange of knowledge; the tendency to include the subject as a separate theme in various journals and books; the establishment of a group of experts on the subject; the increasing focus on aspects of prevention alongside the growing interest in classification

among psychiatrists in the 1970s; and the increasing conviction of a rise of anorexic incidences since the 1950s - a conviction of the existences of a social problem which started to be communicated to the general public during the 1970s and 1980s. Hence, anorexia nervosa and its diagnostic criteria became hardened into independent and robust “realities” through series of translation work among different actors and social worlds.

That being said, what becomes striking about the scientific accounts which started to proliferate on the subject of anorexia nervosa in this period is a seeming divide created between the many invisible heterogeneous practices, struggles and imputed meanings taking place within the various clinical contexts on which these accounts are based, and the visible textual narratives which main objective is to “delete modalities” in order to construct an impression of the purity of psychiatric work (Fuchs, 1992). If, for instance, struggles and conflicts, or what Jordan and Lynch (1992) calls “mess”, occurring in the clinical setting were ever referred to in the scientific reports they were usually carefully explained or standardized into signs of the typical complications of the illness, which could only be solved through correct (psycho)therapeutic techniques. However, in this work toward purity, the authors are in fact involved in complex processes of translation work - in the proliferating production of hybrids of nature and culture. This does not mean that we are prevented from asking questions about the invisible or marginalized voices in the network. Indeed, the actor-network approach is effective in explicating how certain black boxes or standardization package are produced and have become pervasive in the world, and how certain actors are strong and influential enough to have impact on the world. However, it becomes equally imperative to direct attention to the many actors enrolled in the network who are usually

presented as a marginalized or invisible homogeneous entities. Nevertheless, within actor-network theory, power is seen as a *consequence* rather than a cause of action (Singleton, 1996). Therefore, “difference” (e.g., gender, race, and class) is not denied as part of the analysis, but is not considered as an *a priori* explanatory scheme (Callon & Latour, 1992). We need to explore the “ecology” of the network before engaging in debates about the politics of difference, exclusion and marginalization of knowledge production. My first step in this direction has therefore been to trace the initial series of translation work employed by Bruch in the 1960s.

While Bruch has been rewarded for her “democratic” treatment strategies, which in fact may demonstrate the proliferation of translation work, and participation of the self-starvers themselves in the processes of conversations, resistance, persuasion and treatment, her written accounts often give the impression that she has been working with a purified realm of knowledge, hiding the diversity and struggles in the clinic within a polished theoretical and homogeneous framework. The reflexive task of actor-network theory, however, has been to demonstrate that what made Bruch’s work strong, acceptable and expandable, was the constant translation work and building of alliances between theory and practice, past and present, object and subject. In this sense, actor-network theory offers a way of analysing how powerful networks are formed and made durable, and as such, it offers a way of looking at power relations as constructed dynamic linkages between many heterogeneous actants, and where marginalized membership often can be seen as a powerful experience (Leigh Star, 1992). The next chapter will therefore constitute the following steps in this direction by tracing the further travelling, translation and expansion of the anorexic

standardization package.

Chapter 3

Making the diagnostic package of anorexia nervosa “user-friendly”: Processes of standardization and popularization

Our Appendix amply demonstrates how taxonomy and nosology have occupied the attention of psychiatrists, who resemble the little girl grouping and regrouping her pebbles. I myself, the senior author, must confess participation in this attempt to better define, label, and classify psychiatric syndromes. Someone has suggested that this is almost an avocation - a veritable addiction - of psychiatrists, this defining new syndromes and reordering them. A month never passes but what a few new psychiatric syndromes are announced in the literature, and yet they are not really new (Menninger, 1963:11).

It is an important book because little is known about this complicated psychological phenomenon that strikes thousands, and Levenkron succeeds in unfolding the mystery (quote of review of *The Best Little Girl in the World* by *Syracuse Post Standard*).

While the previous chapter focused on the multifaceted processes by which certain influential actors managed to build alliances, enrol support for and stabilize a theoretical-diagnostic package of anorexia nervosa, this chapter will examine the multiplication of trajectories that the anorexic debate took in the 1970s and 1980s by focusing on three interwoven strands of standardization practices. First this chapter will discuss the development and influence of the main classification system(s) in (American) psychiatry throughout the twentieth century (e.g., the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD)). Second, I will look at the processes and "situations" (Clarke & Fujimura, 1992) in which the concepts of body image disturbance and pursuit of thinness became subjected to intensive experimentation work and therefore co-constructed as mobile and robust diagnostic "certainties". Third, the chapter will conclude with an examination of the ways in which the anorexic network began

to expand to include the general population, and the ways in which this dispersion of knowledge and popularization of a phenomenon had implications for questions about therapeutic regimes and diagnostic practices.

I will use Fujimura's concept "standardization package" to illustrate the ways in which anorexia nervosa and its key diagnostic criteria turned into a stabilized, robust and dynamic diagnostic black box through a series of linkages and collective work between many different social worlds and actants. This concept may simultaneously create support for the application of the concept of network-boundness of anorexia nervosa. The point here is to analyse scientific practice and knowledge as situational fabrications. That is, to analyse the multiple *situations* in which scientific work is done, including all the elements and their interrelations (Clarke & Fujimura, 1992:6). Clarke and Fujimura (1992) define these situations as consisting of a whole variety of different *elements* (e.g., workplaces, scientists, theories, models, other representational entities, research materials, instruments, technologies, skills and techniques, work organization, sponsorship and its organization, research material and subjects, regulatory groups, audiences and consumers of the work), and the complex, transformative and even conflicting *relations* among them.

The aim here is therefore to capture and examine the complexities and relations of the anorexic network which began to expand in the 1970s, and to make them *visible*. As I will come back to in the next chapter, it is through this visibility and the recognition of the situatedness of knowledge and knowledge production that the various actors involved in the network can begin to explore and see the possibilities for constructing and participating in discussions about the political and moral implications of scientific action - making visible

the dialectics of science (Singleton, 1996).

3.1. *The disease of the decade*

While the slogan “anorexia nervosa - the disease of the decade” is not commonly associated with the scientific practices developing on anorexia nervosa in the 1970s, but rather linked to the spread of the conviction that a dramatic increase of the syndrome had taken place in this period (Brumberg, 1988; Hof, 1994), it should be emphasized that the academic activity mobilized within the psychiatric discipline and related disciplines throughout this period may as well be used to justify the use of the phrase. For instance, the widespread conviction in academic circles of the increasing prevalence of anorexia nervosa stimulated a rapidly growing scientific interest in the syndrome, which led to a remarkable expansion in research and publications. Figure 2. gives an indication of this tendency.

Figure 2: Source Cumulated Index Medicus in Hof (1994).

Moreover, the cd-ROM search tool, PsycLIT, indicates that a total of 1, 814 psychiatric and medical articles were published on “anorexia nervosa” from 1974 to 1990

(it found 2, 232 articles on “anorexia”), and 1, 382 from 1990 to 1997 (1, 642 on “anorexia”). The “Sociofile” has listed a total of 178 articles on “anorexia nervosa” from 1974 to 1997 (210 on “anorexia”).

As Hof (1994) argues, the very issue of increase in anorexic incidences can be seen as an example of how citation practices have turned methodologically doubtful and inconclusive epidemiological studies into authoritative “facts” about the dramatically increasing tendencies of the syndrome. As an example, the British feminist and therapist, Susie Orbach writes: “anorexia nervosa (. . .) has shown a dramatic rise during the past twenty years, and more especially in the last decade” (Orbach, 1986:32). Hof (1994), however, has shown that the study by Crisp et al. (1976), on which Orbach based her claim, was both limited in time (conducted between 1972 and 1974), and established no actual incidence rates.

Due to the conviction of a rise of anorexia nervosa combined with the many unanswered questions of etiology, diagnosis, and epidemiology, the syndrome became a popular and more or less independent field of study, and as a result, mobilized research and treatment interests from a variety of different academic disciplines and subfields: psychiatry, psychopathology, epidemiology, biomedicine, endocrinology, cognitive psychology, family psychology, psychotherapy, social psychology, etc. This proliferation of academic and therapeutic actors and reports stimulated a growing concern with the lack of a distinct diagnostic framework of the syndrome. Furthermore, the expansion of the anorexic network, treatments and research investments in the syndrome caused the syndrome to be increasingly viewed and treated as a separate psychopathological entity. This, in turn, created a demand

for a distinct definition of the syndrome. In 1969 the British psychiatrist Dally argued that in order for anorexia nervosa to be recognized as a specific syndrome, a precise definition was needed. Thus, the importance of defining a set of strict diagnostic criteria came about (see Appendix I for Dally's criteria). Dally's diagnostic scheme, however, was rarely used or accepted in either clinical or research practice (Beumont et al., 1994).

Although Bruch's *theoretical* definition and diagnostic criteria of anorexia nervosa had enrolled significant and wide-ranging support, the enlargement of the anorexic network stimulated a significant demand for a more objective and "user-friendly" nosology which any researcher or therapist could use to measure and diagnose the syndrome (Garfinkel & Garner, 1982), and to create a dynamic "interface" to translate interests between social worlds (Fujimura, 1992)⁴³. Such an interface is therefore an important component of a standardization package due to its ability to allow people in different fields of work to adopt and incorporate a standardization package into their academic and therapeutic enterprises more easily and quickly (Fujimura, 1992), and to make standards work at a distance (Latour, 1987).

Theoretical criteria, like those used by Bruch, might have been effective and generated little stress in the (private) psychotherapeutic settings of Bruch and Selvini-Palazzoli and other psychotherapists working with anorexic patients in the 1960s, for both the individual patient (who could be treated as an outpatient, on a more or less voluntarily

⁴³ As defined in chapter one, "interface" is understood as "the means by which interaction or communication is effected at the places "where people meet" or different social worlds intersect" (Fujimura, 1992:178).

basis), and for the therapist (who did not have to use physical force of any kind). However, in the hospital, where a range of medical and nursing staff are involved with the anorexic patients, more objective and efficient criteria are needed. Hospitals were usually the anorexic patient's first encounter with the health system. Furthermore, self-starvers who finally seek help have usually reached severe emaciation (Garfinkel & Garner, 1982). Therefore, hospital treatment was, and still is, seen as the most essential establishment required to save the patient's life, and eventually to prepare the individual for more substantial psychotherapeutic counselling (Garfinkel & Garner, 1982).

Moreover, the accumulation of scientific work on the syndrome began to generate new questions and a particular demand for a distinct diagnostic system of anorexia nervosa. For example, a series of epidemiological studies was conducted during the 1970s to establish the rising tendencies of the syndrome. However, due to diverging diagnostic criteria, these studies showed very inconclusive results, which stimulated a quest for a more universal nosology (Garfinkel & Garner, 1982; Hof, 1994). Furthermore, the variety of diagnostic tools employed in research and therapy during the early 1970s came to a large degree to depend upon the subjective researcher's or therapist's particular interests and understanding of the syndrome. This generated a problematic situation when the various disciplines and their respective tasks enrolled in the anorexic network started to become more integrated and co-operative. Hence, a user-friendly standardized interface was required to make communication and exchange of knowledge and therapeutic tools across the network easier and more effective. A clear and standardized diagnosis makes it possible to act at a distance, which has implications for the question of control and management of populations. As I will return to

in the last part of this chapter, processes of "demedicalization" or "depsychiatrization," or what Castel (1991) sees as the replacement of means of control implied by regimes of medical or psychiatric *treatment* with what he calls practices of "administrative assignation", and which intervenes on the basis of a medico-psychological *diagnosis*, have had implications for the intense focus on diagnosis in the academic work on anorexia nervosa. The distribution of knowledge about anorexia nervosa and its diagnostic structure to the general public becomes in this way a crucial mechanism for the promotion of self-diagnosis induced by the therapeutic industry in consumer culture (Ewick, 1993).

To return to the relative confusion about diagnostic tools, this can be exemplified by how two different research interests made use of two quite different diagnostic schemes: i) the criteria presented by the American psychiatrist Feighner and his co-workers (1972) for clinical research; ii) and the epidemiological study by the Swedish psychiatrist Theander (1970). The diagnostic criteria presented in the renowned paper by Feighner and co-workers (1972) (see Appendix I), which were intended to be based on strict categories (e.g., 25% weight loss and onset prior to age 25 years) so that investigators from various centres could be reasonably certain of the comparability of patients in different studies, have been criticized for being too rigid to be employed, for example, in a therapeutic or clinical context (Rollins & Piazza, 1978). As Garfinkel and Garner (1982) argue, the "Feighner criteria" may have been useful for clinical *research*, but excluded "many individuals who have the essential features of the disorder but miss some ancillary symptoms, and several of their criteria are misleading" (Garfinkel & Garner, 1982:28). Thus the criteria became problematic for therapeutic practices. Rollins and Piazza (1978) noted that, of their "anorexic patients"

who were diagnosed clinically, only 23 per cent would meet the rigid interpretations of the Feighner criteria. What these accounts seem to imply is that there is such a thing as a true anorexic state which can be defined objectively through a quantitatively and qualitatively correct set of diagnostic criteria. Perhaps a more fruitful way of looking at these debates, however, is to view them as highly constructed phenomena. The impression of the constructedness of anorexic criteria is further reinforced if we turn to another study employed in the same period - the well-known and most frequently cited epidemiological study conducted by Theander (1970). For him, the diagnosis of anorexia nervosa hinges only on the totally preoccupying pursuit of thinness. No strictly defined degree of weight loss, age of onset, or biological changes were seen as necessary, except from the individual's change of attitudes towards food, eating, and body weight, and that this should have caused some weight loss. As I will show, such emphasis on "fat phobia" and "body image disturbance" has in recent years stimulated a broad academic debate about the degree to which a distinction should be drawn between anorexia nervosa and "normal" weight, food and body preoccupation, thereby raising questions about the notion of pathology in anorexia nervosa (Garfinkel & Garner, 1982; Bordo, 1990; MacSween, 1993; Beumont et al., 1994).

A link that became increasingly established during this period was the one between clinical practice and scientific research, and which might have stimulated a demand for a more unified nosology. The experience of receiving more anorexic patients (regardless of whether this represented a "real" increase of anorexia in the general population or not), together with the organizational, and emotional, difficulties this may have created for the actors involved (e.g., diagnosis and thus determination and justification of treatment

practices, length of hospitalization, expert counselling, etc.), may have initiated the provision of more clear and objective diagnostic schemes. The initiative to employ such research was eased by the fact that for some of these actors (e.g., Crisp, Russell, Dally) there was a direct connection between their roles as clinical practitioners and psychiatric researchers on anorexia nervosa.

Hence, throughout the 1970s several authors and working groups (e.g., Dally (1969), Russell (1970), Feighner et al. (1972), "The Pathology of Eating Group" (Garrow et al., 1975), Rollins and Piazza (1978), Norris (1979) - see Appendix I) sought to establish standardized objective diagnostic schedules for the disorder. Based on extensive quantitative studies of the central features of patients, already diagnosed as anorexics and enrolled into a professional treatment program, all these authors reported a combination of physical and mental signs and conditions that taken together could be classified as "anorexia nervosa." Hence, a primary objective was to rule out the presence of what was considered as "real" psychiatric⁴⁴ or physical illnesses. Empirical and measurable signs such as food refusal, weight loss, and menstrual disturbances were emphasized by most authors, but they differed significantly in other respects. Such differences resulted in separate diagnostic conclusions. Importantly, Bruch's concepts of fat phobia and body image disturbance, although articulated in a different way, were now seen as determining factors for the syndrome.

Lastly, the development of a distinct network of actors in American psychiatry in the 1970s who adhered to strong empirical descriptive analyses and classification systems in

⁴⁴ The diagnoses of these were already established in the DSM-II from 1968.

clinical practice came to influence the work of building diagnostic systems of anorexia nervosa in a significant way in this period. This network has been termed the neo-Kraepelinian movement (Blashfield, 1984). There are several reasons why it is important to examine the development and content of this movement: i) due to its influence on the independent, organizational and practical tasks of American psychiatry in this period; ii) its significant links to the development of the expanding DSM system - the DSM-III in particular, and therefore; iii) its influence on the scientific and clinical practices related to anorexia nervosa in the last decades. The global aim and influence of American psychiatry and its nosology will also provide insight into the question of “culture-boundness” and mental illness. The following examination of the focus and development of psychiatric classification systems since the nineteenth century will simultaneously act as a genealogy of the network of classificatory practices and perspectives which started to expand in this period. The tracing of this particular network will therefore illuminate the history of one of the many processes which has been influential in the forming of the present anorexic network, and give insight into the many processes of translation and transformation of psychiatric classification systems throughout the century.

3.2. The classification of mental illness, the neo-Kraepelinian movement, and the DSM system

As we saw in chapter one, the emphasis on the classification and recording of disease may have prevented the “discovery” of anorexia nervosa in certain countries in Europe during the nineteenth century, particularly in Germany where medical scientists preferred

experimentation and classification rather than the identification and search for causes of disease for a longer period than their counterparts in France and Britain.

Nevertheless, classification of mental illness became a major interest in psychiatry in the last part of nineteenth century, and in the beginning of the twentieth century these ideas were introduced, accompanied by the strong influence of Freudian thinking, into American psychiatry (Blashfield, 1984). The German psychiatrist Emil Kraepelin (1856-1927) is the main personality behind these classificatory ideas. He has therefore been regarded as the “originator” of the classification system whose basic structure is still dominant in the contemporary psychiatric DSM nosology. Kraepelin’s main arguments were that mental disorders represent underlying disease states, hence, adhering to a medical model of psychiatry and; that mental diseases could be isolated by grouping together those patients whose disorders had a similar course. His approach to classification was therefore descriptive, anti-Freudian⁴⁵, and motivated by Platonic essentialism (Menninger, 1963). That is, Kraepelin believed that the most productive step in the study of psychopathology was to make careful behavioural observations and descriptions of patients, and from these observations, the symptoms of different disorders could be discerned. In this way, Kraepelin believed that there exist a fixed number of essential, or ideal, diseases which affect the patients as approximations of these “ideal types.” It is therefore the job of medical scientists, according to Kraepelin, to discover these essential diseases and their basic forms as

⁴⁵ Kraepelin saw Freudian psychoanalysis as “metapsychology at its worst,” and was strongly opposed to the mentalistic and nonempirical orientation of Freud and Freud’s followers (Kahn, 1959, in Blashfield, 1984).

expressed through patients' symptoms (Kraepelin, 1904, in Blashfield, 1984). Hence, his intention was not to create new classifications. As an author of *textbooks*, which mobilized international interest in Kraepelin's works⁴⁶, Kraepelin organized his chapters around the major categories of psychopathology as they were generally accepted by contemporary authorities (Blashfield, 1984). Interestingly, however, Blashfield (1984) notes that it was through the sixth edition of his *Textbook of Psychiatry* (1899, 1902), where he translated the two concepts *manic-depressive insanity* and *dementia praecox* (later replaced by "schizophrenia"), that Kraepelin gained his widespread influence. These concepts were surrounded by international controversy in this period⁴⁷, and Kraepelin's status as an authority among British and German psychiatrists made his contribution to the debate trustworthy and the concepts were subsequently established as distinct mental disorders. Kraepelin's classification system came to influence the official classifications in many countries. However, neither the French nor the British psychiatrists were so impressed by them as the Americans, to whom Kraepelin's system was introduced by the Swiss physician,

⁴⁶ Blashfield (1984) argues that it was not so much his revolutionary ideas nor the diagnostic concepts Kraepelin proposed, but the clarity of his writing which stimulated such wide-ranging interest in his textbooks.

⁴⁷ The reason for this controversy was a discussion about whether to accept the concept of "manic-depressive disorder" as an amalgamation of two descriptive concepts (mania and melancholia) that had been separately recognized for over 2,000 years; and "dementia praecox" which represented a new descriptive concept that had many parallels to the well-recognized concept of dementia paralytica (paresis) (Blashfield, 1984).

Adolf Meyer (1866-1950) in the beginning of the twentieth century⁴⁸ (Menninger, 1963).

Meyer, as the Director of the Pathological Institute of New York, became influential in the New York State Commission on Lunacy's (1909) publication of a classification and a statistical table for mental illness in the United States⁴⁹. As Menninger (1963) argues, "at the time that this classification was adopted in New York there were about as many statistical outlines in use in this country as there were mental hospitals" (Menninger, 1963:466). Hence, both nationally and internationally there existed a multitude of different local psychiatric classification systems. Most of them, it should be noted, were to a large degree influenced by or based upon Kraepelin's principles (Gaines, 1992). The various treatment centres, such as public hospitals, clinics, asylums, or sanitariums, which were usually governed according to the wealth of their patients (Janet, 1932, in Menninger, 1963), developed their own classification schemes and psychiatric terms according to the therapeutic practices and control mechanisms employed at each particular place. For instance, the French psychoanalyst, Pierre Janet, directed sharp criticism against psychiatric classification and its

⁴⁸ Meyer, however, became later increasingly sceptical of the Kraepelinian approach to classification, which may be seen as a reflection of the general lack of interest in classification in psychiatric thinking during the interwar period (Blashfield, 1984). Meyer developed and offered a nosology based on a unitary principle of "ergasia". Due to his influence by the Freudian approach he rejected the German biological model, and proposed a model which saw psychiatric disorders as "reaction sets" or reactions to multicausal life stress. He therefore rejected the idea that mental disorders were disease entities with established courses. Meyer's great influence in this period, together with that of Harri Stack Sullivan, also reflected a 'philosophical' view of presenting problems in that it provided an etiological theory for the disorders in the nosology (Gaines, 1992).

⁴⁹ Before this date, a statistical nosology had been proposed for use by American psychiatrists by the American psychiatrist, Nicols, in 1869 after his attendance at the International Congress of Alientists in Paris in 1867. A series of twenty-one statistical tables was prepared and used unofficially for several years, but never formally adopted. In 1889 the Association of Medical Superintendents of American Institutions for the Insane (which in 1892 became the American Medico-Psychological Association and in 1921 the American Psychiatric Association) adopted the classification of the British Medico-Psychological Association (Menninger, 1963).

name confusions at the beginning of the twentieth century. He demonstrated with this how psychiatric concept and classifications are strongly related to the practical and material situation in which they are applied and meant to operate:

If a patient is poor, he [sic] is committed to a public hospital as a “psychotic”; if he can afford the luxury of a private sanatorium, he is put there with the diagnosis of “neurasthenia”; if he is wealthy enough to be isolated in his own home under constant watch of nurses and physicians he is simply an indisposed “eccentric” (Janet, 1932, in Menninger, 1963:29).

In 1913, however, the Committee on Statistics of the American Medico-Psychological Association (which in 1921 became the American Psychiatric Association, or APA) proposed a national standard - the *Standard Classified Nomenclature of Disease* - which was adopted by the Association four years later. In the official report of the Committee it is proclaimed:

Your Committee feels that the first essential of a uniform system of statistics in hospitals for the insane is a generally recognized nomenclature of mental diseases. The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects but differ enough to prevent accurate comparisons. Some states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science of psychiatry and reflects unfavourably upon our Association, which should serve as a correlating and standardizing agency for the whole country (. . .) your Committee has endeavoured to formulate a classification that could be easily used in every hospital for the insane in this country and that would meet the scientific demands of the present day (May, 1917:246/247, in Menninger, 1963:466).

The urge to become more scientific, i.e., to reveal and describe the “reality” of “insanity,” “madness,” etc., and to depart from the magical and religious connotations related to what was seen as the *ontology*, or reality, of what today is seen as the general form of “mental illness,” has persisted and becomes visible if we look at the various changes in

terminology of this assumed "ontological entity". Menninger (1963) shows how "possession" (demonologic) became "bewitchery," "bewitchery" became "madness", "madness" became "lunacy", "lunacy" became "insanity", "insanity" became "psychosis" (Menninger, 1963:29). However, he argues, "the failure to recognize the essential characteristics of mental illness persisted in spite of a succession of categorical name changes (. . .) Some of us hope that this generation of psychiatrists will solve the name-calling problem by substituting for these appellations the categorical term "mental illness" (Menninger, 1963:29). This hope for a final "purification" of mental illness, however, has always been accompanied by a proliferation of hybridization or translation work. Thus, despite the increasing national and later international standardization work of the APA, the strength and durability of its nosologies can only be made comprehensible if we look at its investments in form, its intense mobilization of actants, its infrastructural network capacities, and its creation of allies among a series of different agencies.

Although heavily influenced by the Kraepelinian classification system, the APA saw the need to reduce the hundreds of Kraepelin's diagnostic entities to twenty-two⁵⁰. Small modifications of this list were made from time to time until a new and revised and considerably extended edition of the nosology was published in 1934 by the Association. It had by now increased to twenty-four main groups and eighty-two subdivisions (Menninger, 1963).

⁵⁰ The American psychiatrist Ernest Southard, for instance, who was about to be elected as Chair of the APA, stated that since the classification of mental diseases was not a natural but an artificial one, it should be made as practical and as simple as possible. Southard's proposal of a eleven-point classification scheme, however, was never discussed by the APA after his sudden turn in opinion about nosologies - as artifacts (Menninger, 1963).

Although the official 1934 classification of APA led to “erroneous conclusions” and inconsistent handling of patients, it was not until these concerns became a national issue through the official classification’s adoption in the treatment of Army patients during WWII that it became subjected to further revisions. Diagnostic classification systems had become of crucial importance to the armed service because the diagnostic terms had direct implications for discharging men from service (Menninger, 1963). As the chief of the Neuropsychiatry Consultant Division of the Office of the Surgeon General, and thus experiencing the practical difficulties of the classification system, the American psychiatrist, William Menninger, became an influential actor in the numerous attempts to revise the psychiatric classification picture in this period. His pragmatic and simplistic approach, combined with Meyer’s model of “reaction type”⁵¹ (Gaines, 1992), and his enrollment of a range of co-workers in the construction of a new classification system, Menninger developed an alternative system which also was in line with the new interests of Freudian theories of personology and psychodynamics. Furthermore, his psychobiological approach was intended to replace the Kraepelinian preoccupation with pure classification with an emphasis on “treatment and prevention,” which was more in line with the therapeutic, probabilistic and governmental economy of the time⁵² (Castel, 1991). Viewing Menninger’s classification as a “magnificent achievement” in the process of simplifying and clarifying the “*essence*” of

⁵¹ Meyer emphasized that some phenomena were symptomatic *reactions* rather than disease *entities*.

⁵² Castel (1991) sees the preventive tradition of American psychiatry as founded on the works of Gerald Caplan, and sees it as a question of “widening the intervention of the psychiatrist, if need be by giving him or her new roles to play, making the psychiatrist into an adviser to ruling politicians or an auxiliary to administer ‘decision makers’” (Castel, 1991:286).

“mental illness,” Menninger’s psychiatrist brother, Karl Menninger (1963), recognizes that “the classification, as it was originally drawn up by my brother and his advisers had to run the gamut of military and civilian concurrences, with the result that many compromises and modifications had to be introduced” (Menninger, 1963:474).

Menninger’s classification proposal was subsequently adopted for use, although with certain individual modifications, in the U.S. Army, the U.S. Navy, and the Veterans Administration System (Blashfield, 1984), and in 1949 the official report of the APA’s Committee on Nomenclature and Statistics admitted that a change in their 1934 classification was imperative:

(. . .) The Committee was in unanimous agreement that the present (former) nomenclature of the APA needs extensive revisions. (. . .) The report of the Chairman of this Committee, dated December 1946, summarized 15 objections to the revised psychiatric nomenclature adopted by the Army, and subsequently by the Veterans Administration. These objections are essentially those which were expressed in 1945 against the Army’s adoption of a new system of nomenclature, in 1946 against the Veterans Administration’s similar plan, and since that date against any change in the present diagnostic nomenclature of the American Psychiatric Association. Since these objections were voiced three years ago, and since two large organizations have experimented with a new nomenclature in the interim period, it was felt highly important to learn from those two organizations the extent of accuracy of the predicted difficulties voiced in the objections (. . .)

Reports from the Army and Veteran representatives indicated that the new systems of nomenclature have been found more satisfactory by both clinicians and statisticians. The dire prophecies of utter chaos previously expressed have failed to develop, and after three years experience with the new nomenclature, both organizations have found their modifications superior to the present APA nomenclature (in Menninger, 1963:475).

At the same time there was an additional confusion confronting the APA and the work toward a national unification of psychiatric classification: “The national office of vital statistics” had never used the APA nomenclature but the International List of Diseases and

Causes of Death, which the United States was bound to use as a standard for the statistics of the nation by treaty with other members of the World Health Organization (WHO). While it was argued by the APA Committee on nomenclature that the International List was much more similar to the Army and Veteran nomenclature than to the former APA nomenclature, there had long been a common dissatisfaction in the United States with this List, or the International Classification of Disease system (ICD), because of its lack of attention to “mental illness.” Prior to the proposal of WHO to include an international psychiatric classification in ICD-6 in 1951, this system did not include any category of what were understood as “mental illnesses” because it was only concerned with “causes of death” (APA, 1994). Chronic brain syndromes, various personality disorders and transient or situational reactions of interest to U.S. clinicians were lacking in the ICD system before 1951 (Gaines, 1992). The outcome of these processes was the publication in 1952 of APA’s *Diagnostic and Statistical Manual of Mental Disorders, first edition*, or DSM-I, whose predecessors (DSM-II (1968), DSM-III (1980), DSM-III-R (1987), DSM-IV (1994)) have become the major *official* diagnostic manual for both psychiatry and psychology on an international scale (Maser et al., 1991), together with the ICD nomenclature.

The classification movements in the United States also stimulated similar organizing movements in international psychiatric classification. A committee, chaired by the British psychiatrist E. Stengel, was formed to review the classificatory systems used in various countries. The committee found that there was a great variety of different psychiatric diagnostic systems across and sometimes within different countries. While the WHO had included a classification of psychiatric diseases in 1951, only five member countries

(Finland, Peru, New Zealand, Thailand, and the United Kingdom) had adopted this classification (Blashfield, 1984). Stengel's review was strongly in favour of the American DSM-I, a proposal which, with energetic help from American psychiatrists, stimulated a process which in turn resulted in a substantial mental disorder section in the ICD-8 in 1967. The second edition of the DSM (DSM-II), published in 1968, became almost identical to the ICD-8, and hence, a wide-ranging network of an official classification system had been established.

During the 1960s, however, "anticlassificatory" protests began to develop against the "diagnostic climate" constructed by the DSM system. These attacks, which came from large groups of psychologists, sociologists, and psychiatrists themselves, were based on the ideas that psychiatric diagnosis, as usually practised, was unreliable and therefore unsatisfactory; that classification was associated with the medical model, thereby contributing to a general pathologization of all aspects of psychiatric thinking and organization; and that diagnosis had the negative consequence of assigning labels, thereby potentially creating self-fulfilling prophecies (Blashfield, 1984).

In reaction to these protests, a *neo-Kraepelinian movement* (Klerman, 1978) developed in the 1970s that represented the reaffirmation of Kraepelin's interest in description and classification. Klerman (1978) has suggested that the ideas implicitly assumed by this movement could be summarized by nine propositions:

1. Psychiatry is a branch of medicine.
2. Psychiatry should utilize modern scientific methodologies and base its practice on scientific knowledge.
3. Psychiatry treats people who are sick and who require treatment for mental illness.
4. There is a boundary between the normal and the sick.

5. There are discrete mental illnesses. Mental illnesses are not myths. There is not one, but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialities, to investigate the cases, diagnosis, and treatment of these mental illnesses.

6. The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.

7. There should be an explicit and intentional concern with diagnosis and classification.

8. Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Further, departments of psychiatry in medical schools should teach these criteria and not depreciate them, as has been the case for many years.

9. In research efforts directed at improving the reliability and validity of diagnosis and classification, statistical techniques should be utilized.

(From Klerman, 1978).

. Coauthors with central Neo-Kraepelinians, 1965-1969.

Coauthors with central Neo-Kraepelinians, 1970-1974.

Psychiatric Institute (see figure 3a, 3b, 3c⁵⁴). These actors had already established themselves as leading personalities in their respective institutional settings and within American psychiatry in general (Klerman, 1978).

In 1972, the publication of a journal article in the *Archives of General Psychiatry* titled “Diagnostic Criteria for Use in Psychiatric Research” received profound scientific and clinical attention. The article was written by Feighner, Robins, Guze, Woodruff, Winokur, and Munoz, and is usually referred to as the “Feighner report” or the “Feighner paper”. The importance of this paper is evident in the exceptionally large number of citations it received in subsequent psychiatric literature. For instance, from 1972 to 1982 the Feighner paper received about 1,650 citations. The first authors who began referencing the paper soon after its publication were directly connected with the “invisible college” of the neo-Kraepelinian movement, which began to constitute a scientific movement with world changing power (Blashfield, 1984). Importantly, the paper led to the formulation of the *explicit* form of the diagnostic criteria that were adopted in the DSM-III. This demonstrated the great influence of the neo-Kraepelinian movement in this period (Blashfield, 1984). Hence, the fact that the Feighner report included anorexia nervosa as one of the 16 categories believed to have sufficient evidence to be considered valid in a diagnostic system (see Appendix I), indicated that a significant step had been taken in the acceptance, re-construction and establishment of anorexia nervosa as a real and objective mental disease. As we will see, there were only small differences between the criteria for anorexia nervosa presented in the Feighner report

⁵⁴ These figures are presented in Blashfield (1984).

and those which later were negotiated by the working group on eating disorders and presented in the DSM-III (see Appendix I and II). The important shift in perspective from the earlier editions of the DSM was that in terms of diagnosis, the identification of symptoms was transformed from an interpretation of *symbols of distress* into a biological reading of *signs of disease*, which also had implications for the ways in which psychiatric work was employed. Gaines (1992) argues:

This change to a biological model also dramatically redefines the nature of psychiatric work. The new focus directs the psychiatric gaze and its work toward a single conceptual dimension of the afflicted, the somatic. Moreover, biological explanations lead to the *representation of the afflicted in a purely biological discourse*. (. . .) The person and the disease become increasingly isomorphic (Gaines, 1992:10).

However, in arguing that this is *actually* happening Gaines seems to imply that there is such a thing as pure nature to act as constraints on things, and in this sense he contributes to the persistence of the notion of a divide between nature and culture, purification and translation, body and mind, in psychiatric classification debates. As argued above, we need to make visible the simultaneousness of these processes and ontologies, and then we can start to talk about the implications of psychiatric classifications.

That being said, a further important aspect which may have influenced the pressure to include eating disorders in the DSM system was the close cooperation between the work on the DSM-III and the simultaneous development of the ICD-9. The fact that anorexia nervosa by now had clearly demonstrated a high mortality rate (which earlier was a precondition to be included in the ICD nosology), which was seen as a cause of certain psychosomatic disturbances in the individual, made it, if not acceptable, practically necessary

to include anorexia nervosa as a disease category in the ICD-9 (1978).

It should be noted that most of the members of the working group on eating disorders for DSM-III were supporters of the neo-Kraepelinian movement (Katherine Halmi, Albert J. Stunkard, James M. Ferguson). Bruch, who was not associated with the neo-Kraepelinian movement, was elected as a member due to the recognition of her as the most experienced and knowledgeable expert in the field. Her book *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within*, published in 1973, had by now become the most important source of reference in the discussion of anorexia nervosa, comprising the intensive work she had begun in the 1960s.

Hence, throughout this decade there seems to have developed a large and powerful network of various interests and resources, all working in the direction of enrolling and unifying a large number of heterogeneous and dispersed actants into a standardized system. With the inclusion of anorexia nervosa in the Feighner paper the anorexic network, which to a large degree had been formed within a psychodynamic framework (due to the influence of Bruch), had now been linked to the empirically directed classification work which started to proliferate when the work on the DSM-III was initiated in 1974. The enrolment of the diagnostic, therapeutic and scientific questions related to anorexia nervosa into this particular network of classification work had significant impact on the scientific practices employed on the syndrome in this period. Most research on anorexia nervosa in the 1970s was performed as laboratory work, or what Knorr-Certina (1981) calls the creation of an “artificial reality,” and statistical surveys. Following the theoretical and diagnostic framework proposed by Bruch, questions of “family dysfunctions,” “developmental issues,”

“cognitive and perceptual dysfunctions,” and “socio-cultural factors” were now transferred into the experimental setting of laboratories equipped with the technical and statistical means, or “inscription devices,” and “negotiation space” (Callon & Law, 1982) necessary to “render nature visible” (Fuchs, 1992).

3.3. The search for body image disturbance

While “weight loss,” “age of onset,” and “loss of menstruation” (amenorrhea) were seen as uncomplicated measurement units in the diagnostic picture of anorexia nervosa, the most problematic issue that arose when it was decided that the syndrome was to be included in the DSM-III was the empirical establishment of “body image disturbance” and “pursuit of excessive thinness” as distinctive and pathological features in the definition of anorexia nervosa. As discussed in chapter two, these two criteria had become broadly accepted as theoretically defining anorexia nervosa as a “real” mental disorder by the 1970s, and were therefore in need of intense investigation and experimental research to demonstrate empirically the “reality” of their existence.

Hence, techniques to measure body image disturbance in anorexic patients became a major preoccupation in cognitive and experimental psychiatry during the 1970s. Three different measuring techniques, sometimes used in combination, and/or together with the so-called body image self-report questionnaires (See Strober et al., 1979), were used to measure either the overall body size and shape, or different “target areas” of the body. These techniques were: 1) “Movable Caliper Technique”; 2) “Image-Marking Technique”; and 3) “Distorting Photography/Video Technique”.

The first study on body image disturbance in anorexia nervosa appeared in 1973 when Slade and Russell used the movable caliper technique (see figure 4.) to measure 14 anorexic patients' body image disturbance⁵⁵.

Dr. Lisa J. Fabian uses the Adjustable Light Beam Apparatus to adjust the width of light beams to match her own estimate of the width of her cheeks, waist, hips, and thighs

Figure 4: Source Thompson (1996).

The method was based upon the description by Reitman and Cleveland (1964) who used the technique to assess body image perception in schizophrenic patients. It required the subject to estimate the width or depth of specific “body regions” by adjusting movable calipers or beams of light from two reference points in space (Touyz & Beumont, 1987). The subjects were seated in a dark room and asked to estimate the dimensions of body regions as well as the size of an inanimate object. The data obtained were compared with the actual dimensions recorded previously. Measures of body perception accuracy were then derived for each body region using the formula: Perceived size/Real size multiplied by 100.

⁵⁵ In 1987 the study was cited over 80 times in important scientific literature (Touyz & Beumont, 1987).

Compared to the control group, which was said to be “remarkably accurate” in estimating its body widths, Slade and Russell (1973) concluded that anorexic patients tended to overestimate significant body dimensions (face, chest, waist and hips). The anorexic patients were, however, not said to overestimate the inanimate object (e.g. blocks of wood). They also reported that the tendency to overestimate body shape decreased with weight gain, and that those patients who continued to overestimate their body size at discharge were the most likely to relapse after leaving hospital. Throughout the 1970s, a total of 11 Caliper method experiments (including Slade and Russell’s) had been carried out, although with inconsistent results. Several of the studies using this method found no significant differences between anorexic patients and control groups, or found that overestimation was due to secondary factors related to the anorexic condition (e.g. denial of illness), or the sampling of control groups (Crisp & Kalucy, 1974; Garner et al., 1976; Goldberg et al., 1977; Button et al., 1977; Casper et al., 1979; Ben-Tovim et al., 1979;).

A second method was introduced by Askevold in 1975 (the “Askevold method”). His “Image-marking method” implied that the subject stood in front of a sheet of paper, which was attached to a convenient wall, and was asked to imagine that she was standing in front of a mirror and could see her reflection. With a pencil in each hand she was instructed to mark the place where she “saw” points which correspond to widths of specific body regions. This method was believed to differentiate better between anorexics and controls, which had been a major problem with the Caliper method. However, the four studies that have employed this technique could not establish consistent findings.

Several authors also started to utilize modern technology in their development of

sophisticated methods for estimating body image disturbance. Garner et al. (1976), Garner & Garfinkel (1977), Garner, Garfinkel & Moldofsky (1978) and Garfinkel, Moldofsky, Garner, et al. (1978), for instance, drew on the “Distorted Photograph Technique,” first used by Glucksman and Hirsch (1969), who measured body image disturbance in obese individuals, and found that anorexic patients overestimated their body size compared to controls. This technique involved the subject’s estimation of her size using a projected photograph which can be distorted along the horizontal axis. The image can be made to look anywhere from 20% “thinner” to 20% “fatter” than its actual size. Other studies started to utilize video techniques for the same purpose (Allenbeck et al., 1976; Touyz et al., 1984, 1985).

The increasing debate about the “psychopathology” of anorexia nervosa, and the emphasis within psychiatry to establish this empirically, led to a further expansion of emphasis and research on body image disturbance in the late 1980s and 1990s⁵⁶. A variety

⁵⁶ E.g., Distorting Videocamera (Freeman et al., 1984; Brodie et al., 1989); Distorting Mirror (Brodie et al., 1989); Figure Rating Scale (Stunkard et al., 1983; Thompson & Altabe, 1991); Contour Drawing Rating Scale (Thompson & Gray, 1995); Breast/Chest Rating Scale (Thompson & Tantleff, 1992); Body Image Assessment (Williamson et al., 1989); Color-A-Person Body Dissatisfaction Test (Wooley & Roll, 1991); Extended Satisfaction With Life Scale-Physical Appearance Scale (Alfonso & Allison, 1993); Body Mapping Questionnaire and Colour-the-Body-Task (Huon & Brown, 1989); Body Satisfaction Scale (Slade et al., 1990); Body Esteem Scale (Mendelson & White, 1985; White, 1990); Body Shape Questionnaire (Cooper et al., 1987); Self-Image Questionnaire for Young Adolescents Body Image Subscale (Peterson et al., 1984); Overweight Preoccupation Scale (Cash et al., 1991); Goldfarb Fear of Fat Scale (Goldfarb et al., 1985); Body Image Automatic Thoughts Questionnaire (Cash et al., 1987; Cash, 1990); Mirror Focus Procedure (Butters & Cash, 1987; Keeton et al., 1990); Physical Appearance State and Trait Anxiety Scale (Reed et al., 1991); Feelings of Fatness Questionnaire (Roth & Armstrong, 1993); Body Image Ideals Questionnaire (Cash & Szymanski, 1995); Appearance Schemas Inventory (Cash & LaBarge, 1996); Body Image Avoidance Questionnaire (Rosen et al., 1991); Physical Appearance Behavioral Avoidance Test (Thompson et al., 1993); Physical Appearance Related Teasing Scale (Thompson et al., 1991); Perception of Teasing Scale (Thompson et al., 1995); Physical Appearance Comparison Scale (Thompson, Heinberg et al., 1991); Sociocultural Attitudes Towards Appearance Scale (Heinberg et al., 1995); Feedback on Physical Appearance Scale (Tantleff et al., 1996); Body Exposure in Sexual Activities Questionnaire (Faith et al., 1993).

of different methods, including those mentioned above, were applied and tested but the conclusions drawn from these studies have usually been as inconsistent as those produced in the 1970s (Thompson, 1996). Nevertheless, body image disturbance has become the most robust diagnostic criterion of anorexia nervosa in recent decades due to the concept's wide support and therefore further translations into various psychiatric and psychological theoretical frameworks, self-report questionnaires, feminist theories, and further experimental practices.

Based upon Bruch's tripartite perceptual/conceptual model, these body image studies were accompanied by a series of empirical investigations on "distortions in internal perceptions" (such as recognizing of hunger, satiety, and other bodily sensations or feeling states) and "conceptual disturbances" (distorted thinking patterns of one's self and one's external environment - or "faulty thinking" (Garner & Bemis, 1982)). For instance, a study of conceptual disturbances by Garner and Bemis (1982) formulated various predisposing factors they saw as determinants for the disorder. These, they argued, "follow a common cognitive pathway in that they lead to an unyielding pursuit of thinness and its associated fear of weight gain and of food" (Garner & Bemis, 1982:14). Thus, while it became difficult to establish the presence of strictly perceptual body image defects in anorexics compared to "controls", support for the "fat phobic" determination could be sought and translated into cognitive-behavioral disturbances, and fat phobia as a core psychopathological criterion was further translated and hardened into a factuality.

Related to these experimental studies was the vast inquiry within neurological and

endocrine medicine on anorexia nervosa in the 1970s⁵⁷. Hormonal imbalance, dysfunctions in the satiety centre of the hypothalamus, pituitary-thyroid imbalance, lesion in the limbic system of the brain, and irregular output of vasopressin and gonadotropin were often postulated and tested as potential causes of anorexia nervosa. Although these tests have produced support for the presence of disturbances in hypothalamic functions in patients with anorexia nervosa, there was (and still is) great uncertainty about the hypothalamic or hormonal etiology of the syndrome. As Mecklenburg et al. (1974) conclude:

At least three possibilities exist. It may be that starvation damages the hypothalamus, that psychic stress somehow interferes with hypothalamic functions, or that the manifestations of anorexia nervosa, including the psychological aberrations, are relatively independent expressions of a primary hypothalamic defect of unknown etiology (Mecklenburg et al., 1974, in Brumberg, 1988).

Research on endocrine and neurological abnormalities in the anorexic syndrome can be related to the potentialities for pharmacological treatment which expanded in the 1970s. A whole spectrum of pharmacological medications has been tested and used on anorexic patients either to stimulate the appetite and weight gain of the patient (e.g., chlorpromazine, lithium carbonate, insulin, cyproheptadine, cortisone, anterior pituitary extracts and implants, ACTH, testosterone, and ovarian extracts, anticonvulsants: diphenylhydantoin), to stabilize her/his psychological distresses such as depression and anxiety (e.g., chlorpromazine, tranquilizers, benzodiazepines, tricyclic antidepressants, lithium carbonate, electroconvulsive

⁵⁷In Garfinkel's review book "Anorexia nervosa: a multidimensional perspective", the chapter "Hypothalamic Pituitary Function" is the longest chapter is situated in a prominent place in the book. This chapter also has the longest list of references: 233, compared to 82 references in the chapter "Sociocultural factors" and 79 in the chapter "The role of the Family" and 100 in the chapter "Perceptual and Conceptual Disturbances".

therapy), or to restore the patient's nutritional state to normal (e.g., vitamins and minerals, anticonvulsants, potassium supplements). It is widely agreed, however, that medication alone can not constitute the only therapeutic endeavour (Garfinkel & Garner, 1982).

This acknowledgement can be seen in relation to the great emphasis which developed in the late 1970s on the "multidimensionality" of anorexia nervosa, and the increasing number of disciplines involved in the debate. The first handbook on anorexia nervosa, *Anorexia Nervosa*, was published in 1977 (Vigersky (ed.)), and included a whole range of psychiatric aspects which had accumulated within the network since the 1960s. The authors in the book also give an indication of the various actors' expert status in the debate (Garfinkel, Garner, Bruch, Halmi, Eckert, Casper, Crisp etc.). What became further striking in the last part of the 1970s was that several of the most central biomedical and psychiatric actors started to enlist a variety of different areas associated with anorexia nervosa into their own models and research work. For example, Katherine Halmi, whose area of expertise is biomedicine and endocrinology, has also been involved in a series of epidemiological studies, treatment assessment studies, and studies concerning body image and perceptual distortions⁵⁸. The two Canadian psychiatrists David M. Garner and Paul E. Garfinkel, the most renowned experts on anorexia nervosa since the late 1970s, have been involved in or conveyed studies ranging from "Hypothalamic-pituitary function in anorexia" (Garfinkel et

⁵⁸ See "Anorexia Nervosa: Demographic and clinical features in 94 cases" (1974) in *Psychosomatic Medicine* 36 (1); "Selective pituitary deficiency in anorexia nervosa" in Sachar (ed.) *Hormones, behavior and psychopathology* (1976); "A follow-up study of patients with anorexia nervosa: an evaluation of prognostic factors and diagnostic criteria" (1975) in *Life History Research and Psychopathology* 4:290; "Anorexia nervosa: Recent Investigations" (1978) in *Annual Review of Medicine* 29:137; "Classification of eating disorders" (1983) in *International Journal of Eating Disorders* 2 (4):21-26).

al., 1975), to “Body awareness in anorexia nervosa: Disturbances in “body image” and “satiety”” (Garner & Garfinkel, 1977; Garfinkel et al., 1978), “Sociocultural factors in anorexia nervosa” (Garner & Garfinkel, 1978; Garner et al., 1980), “Treatment of anorexia nervosa using operant conditioning techniques” (Garfinkel et al., 1973), “The outcome of anorexia nervosa: Significance of clinical features, body image and behavior modifications” (Garfinkel et al., 1977), etc. On the basis of this intensive investigation, Garner and Garfinkel published their most famous and widely cited book *Anorexia Nervosa: A Multidimensional perspective* (1982). Arguing that anorexia nervosa can only be understood and treated as a “multidimensional disorder,” this conceptualization can be seen as having formalized, and thereby hardened, the expansive character that the anorexic network had taken during the 1970s. The syndrome had now enrolled a range of different scientific interests, varying from endocrinology, psychoanalysis, cognitive and behavioral psychology. At the same time they made sure that the anorexic standardization package, which had been distributed and adopted to a whole variety of different research fields, remained within the diagnostic framework established within the psychiatric division, making the network controllable and consistent.

Hence, the scientific work employed on anorexia nervosa throughout the 1970s had grown significantly and consisted now of a whole variety of different actants, stabilized theoretical factualities, methodological and therapeutic resources. In this sense, the network which was formed in this period can be seen as having produced an anorexic standardization package of anorexia nervosa. As such, the syndrome and its diagnostic framework became robust and stable through their enrollment in a series of collective works across many different academic disciplines. While the theoretical concepts of “body image disturbance”

and “fat phobia” were now enrolled into a range of different scientific work situations to produce their “true” existence and thereby ensure the theoretical diagnosis of the syndrome, these processes, rather than purifying the true nature of these concepts⁵⁹, have nevertheless contributed to their robustness. This robustness can be seen as a result of the fact that these two concepts could now travel across the network without losing their form on the way, that is, they constituted now a set of “immutable mobiles” (Latour, 1986). This implies that they were readable, communicated something meaningful and important, and that they were “combinable” (Latour, 1986). The outcome of these processes of standardization was that the anorexic standardization package, or the anorexic network, had become difficult to oppose. The receiver of these powerful processes of scientific communication was now confronted with a whole body of persuasive materiality: literature and a network of expertise, professional organizations, distinct local “cultures” of laboratories, articles and journals, numbers and scales, influential nomenclatures (e.g., DSM-III and ICD-9), and pieces of technical apparatus. However, it has now become visible how the strength of the anorexic network was formed through chains of collective work and linking of multiple actants, rather than a consistent process of unification and objectivity. This, in turn, directs attention to that, in fact, there are other possible representations, other ways of knowing and practicing (Fujimura, 1992).

That being said, in order to “raise the world”, such black-boxed entities must be

⁵⁹ In fact, the many experimental studies employed in this period did not conclude any support or evidence for the “existence” of body image disturbance in anorexia nervosa compared to “normals” (Garfinkel & Garner, 1982).

consistently re-constructed and applied in various disciplines and practices, and are to a great extent contingent upon the manipulation and forging of alliances with non-scientists - "the outside world" (Latour, 1987). For example, to be anorexic, fat phobic, or to have a body image disturbance, is only possible within particular constituted or "associated networks" (Ward, 1996). As I will show below, processes of "popularization" of anorexia nervosa started to take shape during the late 1970s, a process of enrolment of the outside world which expanded significantly throughout the 1980s and 1990s, which in turn emphasizes the link between science and culture, or what Hacking (1988) calls a feed-back effect of scientific classification and people's everyday life.

3.4. The popularization of anorexia nervosa

The standardization package of anorexia nervosa allowed for the adaptation of the diagnostic, theoretical and methodological tools to various local experimental and disciplinary conditions. Members of diverse disciplines were thereby enrolled into a common network of practices and contributed to strengthening the initial claims about the syndrome (Fujimura, 1992). This strength, however, poses questions about ways to get insight into the content of the package and contest powerful knowledge claims for "outsiders" of the network. As Latour (1987) argues, once a strong network has been formed around a claim, the claim can only be contested by insiders who have the requisite material resources and allies. For non-scientists, the anorexic network that had developed from the 1960s was both difficult to approach and reject. As Malson (1998) holds, despite the expanding psychiatric and medical manufacturing of studies on the syndrome, the general population remained

largely uninformed and excluded from the debate. Very few had ever heard about the syndrome, and even fewer had actually seen a “case” themselves. However, the SSK literature emphasizes the degree to which scientific knowledge claims depend upon the manipulation of the outside world and the forging of alliances with non-scientists. Hence, these practices participate in the extension of the labs into the world where scientific work can be developed and where concepts and standardization packages are used and make sense to the users.

The expansion of the anorexic network into the outside world since the 1970s demonstrates how scientific knowledge claims are installed and interact within the everyday knowledge and practices of people in a particular associated network (Ward, 1996), again illustrating the network-boundness of anorexia nervosa. The following discussion will therefore demonstrate how the standardization package of the syndrome travelled and affected the general public, enrolling various worlds and their members into a common network, which again had the capacity to affect scientific and therapeutic practices. The popularization of anorexia nervosa was accomplished through wide-ranging distribution and establishment of different textual and material devices (e.g., fiction and nonfiction books, magazine and newspaper articles, movies, support organizations, mobilization of feminist literature and action, and alternative treatment facilities).

For instance, in the last part of the 1970s Bruch started to write for the larger public. The books *The Golden Cage* (1978) and *Conversations with Anorexics* (1988)⁶⁰ became

⁶⁰ This book was edited after Bruch’s death by D. Czyzewski & M. A. Suhr.

national and international bestsellers, and were attempts to explain and account for the “mystery” of anorexia nervosa. *The Golden Cage* follows a linear developmental and explanatory form - from making sure that the reader understands the irrational and pathological characters of the syndrome, “how it starts,” how it may develop into a fatal illness, and lastly, how the “skinny girls” secure recovery through careful psychotherapy. Bruch explains typical psychopathological characteristics, family responsibility and preventive awareness:

Whatever their inner feelings, or however inaccurately they interpret or report them, anorexics do not suffer from lack of appetite, but from the panicky fear of gaining weight. In order to avoid the most dreaded fate, that of becoming “fat,” they brainwash themselves (this expression is used by nearly everyone) to change their feelings. (. . .) Anorexia nervosa, once the full-fledged picture has developed with all the tragic consequences of isolation and nonparticipation in adolescent development, is such a serious illness that every effort should be made to recognize it in its initial stages - or better still, to become aware of the psychological antecedents as warning signs of defective development (. . .) True prevention requires that their pleasing superperfection is recognized early as a sign of inner misery (Bruch, 1978:4/56).

And, about the “pleasure” of successful therapy:

Therapeutic work with these girls is admittedly difficult, slow, and at times exasperating. In a way they have to build up a new genuine personality after all the years of faked existence. There is nothing more rewarding than seeing these narrow, rigid, isolated creatures change into warm, spontaneous human beings with a wide range of interests and an active participation in life. During the illness they looked and behaved as if they were constructed from the same erector set, mouthing the same stereotyped phrases from the same broken record. It is truly exciting to see the emergence of highly individualistic personalities after these years of sterile self-absorption (Bruch, 1978:149).

The significant shift in form, from scientific to a more artistic and “emotional” form, may have attracted scholars and academic students interested in Bruch’s genealogical work or in need of an introductory narrative. More importantly, however, the book enrolled new

populations into the anorexic network, groups of people whose interest had been stimulated by a massive spread of articles about the syndrome in newspapers and various magazines (see below). In her last two books Bruch had changed her narrative style significantly. She now always referred to “her” or “she” (as opposed to “he” in her earlier works) when referring to the “anorexics,” and used personal narratives when referring to her patients’ feelings toward their bodies, food, starving, their families, etc.⁶¹ Nevertheless, there is no doubt in the text who is the expert on interpreting the true nature of these narratives - the authoritative “knower” is Bruch herself. For example, there are no citations or references to other authors in these books; which gives the impression that what Bruch tell us *is* the complete and true explanation of the syndrome. It is as if Bruch’s arguments are so strong that there is no need to support them with references to other authorities. They are true in themselves - revealed through a long period of therapeutic experience, hard study and intimate conversations. Through this medium, groups of lay people as well as academics built further trust into her claims.

American psychiatrist Steven Levenkron was another scholar who used prose in an attempt to distribute knowledge about anorexia nervosa to the wider public. In 1978, his fictional book *The Best Little Girl in the World* became a best-seller (reprinted in 1979 and 1981). On the cover the reader is promised the complete truth about the “anorexic mystery”: “Revealing a young girl’s darkest fantasies and the triumphant story of her return to the sunlight of reality,” “She was a five-foot-four, ninety-eight-pound monster!”. And the

⁶¹ Particularly in her last book *Conversation with Anorexics*, which was published after her death in 1984.

reviews state: "This will no doubt be a book of major importance this year as more and more information about this strange disorder becomes known" (Warren, in *Books Today* 1978), "It is an important book because little is known about this complicated psychological phenomenon that strikes thousands, and Levenkron succeeds in unfolding the mystery" (*Syracuse Post Standard*, 1978). On the cover of the reprint of 1981 it is stated black on red: "The bestselling novel about the obsession that kills - ANOREXIA NERVOSA." In 1981 a movie was made based on Levenkron's book. The advertisement said simply, "A Drama of Anorexia Nervosa" - which implied that the audience was now familiar with the disease.

Parts of this distribution of knowledge to the general public must be seen in relation to the increasing production, and consumption of books of fiction and autobiography, movies, and articles in women's magazines and newspapers that have taken place since the 1970s. Already in 1970, Carol Amen wrote an article in the *Science Digest* called "Dieting to Death," where she warned American parents to seek professional medical intervention as soon as a sign of the dangerous disease was noticeable, because there was "no safe leeway for home-style cure attempts" (May 1970:27-31, in Brumberg, 1988:9). In 1974 *The New York Times* published its first article on anorexia nervosa, "Children who Starve Themselves." The article was basically an overview of state-of-the-art medical treatment influenced by New York City and Philadelphia clinical practices (Brumberg, 1988).

Teen and women's magazines during the 1940s, 50s and 60s stressed the importance for the modern (young) woman to diet and keep her body slim and attractive in order to be successful, first of all as a potential wife, and secondly as a self-confident career woman (Brumberg, 1988). The 1970s, however, were the decade where the same magazines, in

addition to a series of “educational” guides and self-help books, started to see the potential profits in focusing on the fatal risks associated with the dieting imperative. Now it was possible for a reader to admire super models wrapped in a promising aura of colourful happiness and success advertising diet coke on one page, while being presented on the next with the touching confession and a grotesque black-and-white picture of a half-naked emaciated anorexic girl⁶².

Articles on anorexia nervosa became regular features in women’s and fitness magazines throughout the 1980s and 1990s, even to such a degree that the commercial industries have begun to make jokes about the syndrome in various advertisement campaigns⁶³. These magazines have also seen the profitable benefits in engaging in a reflexive debates about the “anorexic trend” among fashion models in the 1990s, and the effects this may have for the increasing tendencies of eating disorders among young girls⁶⁴. In the late 1990s, however, this “reflexive trend” has been replaced by statements about the

⁶² Between March 1974 and February 1984, Brumberg (1988) notes, the Reader’s Guide lists almost fifty articles (American) on anorexia nervosa. Examples: Sam Blum, “Children who Starve Themselves” in *New York Time Magazine* (Nov. 10, 1974:63-79); Majorie Stein, “Dieting to Disaster,” *Mademoiselle* 78 (Jan., 1974:8-10); “The Self Starvers”, *Time* (July 28, 1975:30-31); Kathryn Lynch, “You Can Overdo Dieting,” *Seventeen* 34 (March 1975:106-107); Beverly Solocheck, “Why Some Girls Starve Themselves,” *ibid.* 37 (June 1978:140-168); Elissa Koff and M. Patricia Boyle, “Thin is Beautiful Until,” *Wellesley Magazine* 67 (Winter 1983:4-6); C. Michael Brady, “The Dieting Disease,” *Weekly World News* 4 (March 22 1983:23).

⁶³ For instance, in 1998 the fashion brand “Guess” portrayed an “anorexic”-like model wearing her Guess watch around her super-thin upper arm saying: “Put on some weight!” (Frank, January 1998).

⁶⁴ For instance, in the beginning of the 1990s the Norwegian women’s magazine *Det Nye* published several articles on the “anorexic slaves of fashion” and the risk this may cause among teenage girls to develop an eating disorder (*Det Nye*, March 1993). Furthermore, in 1998, the Norwegian fitness magazine, *Shape*, started to use graphic soft-ware tools to “fatten” the models on certain pictures (*Dagbladet*, April, 1998).

“myths” of fashion’s effect on the development of eating disorders⁶⁵.

The 1980s also witnessed the emergence and significant focus on “confession” practices among a “new” category of people: “recovered anorexics.” In 1981, Sheila MacLeod’s autobiography⁶⁶ *The Art of Starvation* was published and received immense attention⁶⁷. MacLeod, herself a recovered anorexic with an academic background from psychology, intended to offer a deeply self-analyzing, self-reflective, self-revealing and self-healing story about the inner feelings and secrets, the grotesquely real and dark sides of the syndrome, primarily interpreted in the light of Selvini-Palazzoli’s and Bruch’s theoretical frameworks and Freudian psychoanalysis. She confesses her defeat to the biological drifts she had repressed through her starvation:

(. . .) My nocturnal escapades sometimes included visits to the school kitchens, where I ate bananas, leaving a mound of their skins conspicuously on one of the tables, and quantities of ice cream, which I scooped up in handfuls, defiling the common stock with the unhygienic touch of my individuality. Now I think of an animal or a small child depositing its excreta in the wrong place so as to annoy its owner or parent. I ate like an animal too - furtively, quickly, and as if in fear of discovery, but without enjoyment. It is clear that there was a vengeful aspect to this behaviour, and one that was heavy with oral aggression. I think that in my secret eating I was saying, speech also being an oral activity, all the resentful and hostile things I wanted to say about the school and about my life in general. My secret eating was expressing what my secret writing (a misplaced oral activity) could not:

⁶⁵ For example, at a conference on heroin addiction among youth held by the Association of Chief Police Officers in Britain, the editor of British Vogue, Alexandra Shulman, argued: “I don’t believe that fashion images promote the use of drugs per se any more than I believe that we encourage eating disorders per se” (quoted in *Ottawa Citizen*, June 1998).

⁶⁶ Other autobiographical accounts are: Cherry Boone O’Neil, *Starving for Attention* (New York, 1983); Aimee Liu, *Solitaire* (New York, 1979); Sandra Heater, *Am I Still Visible? A Woman’s Triumph over Anorexia Nervosa* (Whitehall, Va, 1983); Camie Ford and Sunny Hale, *Two Too Thin: Two Women Who Triumphed over Anorexia Nervosa* (Orleans, Mass., 1983).

⁶⁷ The book was republished in 1983, 1984, and 1989.

my hatred towards those who oppressed me, my desperate sense of isolation. It was also expressing, on the most literal level, my determination to survive (MacLeod, 1981:99).

Despite her recovery, she also talks about the permanency of an anorexic identity:

I am not cured, in any real sense, and I doubt if there are many anorexics who would claim otherwise for themselves, whether they have received treatment or not. I don't usually go around looking like a skeleton, but I have had two minor relapses to date. In addition, certain patterns in eating, thinking and feeling remain, which can only be described as anorexic (MacLeod, 1981:143).

The 1980s also saw an expansion of novels written about the miseries (and happy recovery) of anorexia nervosa⁶⁸. Most of these novels are close to formulaic, usually following an attractive, intelligent adolescent girl from a dual-career family through her confusion about her desire for autonomy and control, family tensions, and her strong desire to be slim(mer). Rarely, however, is there any mention of the physical and emotional discomfort, battles, persuasions, and humiliations these girls and their therapists usually go through during the various stages of treatment practices.

The expansive public interest in anorexia nervosa was significantly influenced by mass media coverage and revealing of several celebrity "victims" of anorexia nervosa (Brumberg, 1988). The disclosure in January 1983 that the thirty-two-year old popular singer Karen Carpenter had died of heart failure associated with her anorexia nervosa confirmed

⁶⁸ Some examples of novels about anorexia nervosa are Deborah Hautzig, *Second Star to the Right* (New York, 1981); Rebecca Joseph, *Early Disorder* (New York, 1980); Ivy Ruchman, *The Hunger Scream* (New York, 1983); Margaret Willey, *The Bigger Book of Lydia* (New York, 1983); John Sours, *Starving to Death in a Sea of Objects* (New York, 1980) (Sours is also an expert psychiatrist on anorexia nervosa, see chapter two of the present study); Emily Hudlow, *Alabaster Chambers* (New York, 1979); Isaacsen-Bright, *Mirrors Never Lie* (Worthington, Ohio, 1982); Leslea Newman, *Good Enough to Eat* (Ithaca, N.Y., 1986); Margaret Atwood, *Lady Oracle* (New York, 1976). The latter book does not deal with anorexia nervosa explicitly, but focus on the issue of food and identity.

that the syndrome could be fatal rather than just annoying (Brumberg, 1988). Meanwhile, in Britain, the tabloids had started to speculate about the “anorexic” Princess of Wales, and her sister, speculations which received their final confirmation when Princess Diana made her famous testimony on TV before a whole world in 1995. The public has also been engaged in discussions about Jane Fonda’s bulimia; a number of fashion models’ anorexic “normality”; athletes’ anorexic “doping” strategies (e.g., gymnasts, figure skaters, female cross-country skiers, male ski jumpers, etc.); and actors’ and pop/rock stars’ eating and dieting problems. A significant public-commercial preoccupation with lay people’s personal testimonies has also become evident in recent talk show narratives and “read my story” articles in various women’s magazines.

The formation, expansion and intensive work of various support organizations⁶⁹ from the late 1970s have played a crucial role in the work of encouraging self-confessions, accompanied by their purpose of offering emotional, economic, and educational support to the anorexics and their families. For example, the American Anorexia and Bulimia Association (AA/BA), founded in 1978, has become one of the most significant actors in the work of keeping anorexia nervosa and bulimia in the public eye in order to obtain funding for research and therapeutic progress (Brumberg, 1988). The organization publishes newsletters that note conferences, publishes excerpts from speeches given at professional meetings, reviews new books on the subject of anorexia nervosa and bulimia, reports on

⁶⁹ E.g., the National Association of Anorexia Nervosa & Associated Disorders (1976), *Anorexia Nervosa & Related Eating Disorders* (1979), the National Eating Disorders Organization (1977) the American Anorexia and Bulimia Association (1978).

research done on the “doctoral level or higher,” and lists successful publicity efforts by name and date of publications. Thus, co-operative links between these organizations and the various scientific actors or communities working on the topic of eating disorders have usually been facilitated to enlist political and financial actors in the competition for funding, research and treatment resources (Brumberg, 1988).

These organizations have therefore become crucial centres for the mobilization of action directed both toward politicians, the public, and the “anorexic self.” In 1985, for instance, the AA/BA lobbied the United States Food and Drug Administration against over-the-counter sales of Ipecac⁷⁰, arguing that according to AA/BA sources this drug was abused by an estimated thirty thousand young women. The organizations have strongly emphasized the need for educational tools to prevent eating disorders, and argued for the inclusion of eating disorders in school book curricula and as an integrated part of the education of adolescents, and their parents. For instance, the most influential support organization for women with eating disorders (IKS) in Norway has been involved in the collaborative work between the Public Health Service and the Department of Church, Education and Research in the production of course material and information pamphlets about the syndrome (NOU, 1992).

These organizations have also functioned as important promoters and distributors of the growing number of self-help literature. In 1984, for example the AA/BA, in conjunction with Columbia University Press, published the self-help guide *When Will We Laugh Again?*,

⁷⁰ A laxative drug used by anorexics and bulimics because of its “speedy emetic action” (Garfinkel & Garner, 1985).

edited by Barbara P. Kinnoy in collaboration with Estelle B. Miller and John A. Atchley⁷¹. For educational use, a series of videos have been produced to increase the awareness of eating disorders among students and parents (e.g., *My Girlfriend Did It* (1995); *The Famine Within* (1992); *This Is My Life* (1992)⁷²).

While there had been established an effective line of feed-back between support organizations like AA/BA and medical and psychiatric science, these support organizations also functioned as a centre for feminist activists who had become involved in the anorexic debate from the late 1970s. For instance, in 1986 in New York, the American feminist psychologist and therapist, Susie Orbach⁷³, organized, in collaboration with the AA/BA, a Speak-Out against eating disorders. The purpose was to bring the experience and pain of “victims” of eating disorders to a larger audience through the presentation of personal statements and testimonials (Brumberg, 1988).

⁷¹ Some additional self-help titles are: Steven Levenkron, *Treating and Overcoming Anorexia Nervosa* (New York, 1982); Elaine Landau, *Why Are They Starving Themselves? Understanding Anorexia and Bulimia* (New York, 1983); Peter Lambley, *How to Survive Anorexia* (London, 1983); Janice M. Cauwels, *Bulimia: The Binge Purge Compulsion* (New York, 1983); Suzanne Abraham and Derek L. Jones, *Eating Disorders: The Facts* (New York, 1984); Ann Erichsen, *Anorexia Nervosa: The Broken Circle* (London, 1985); Marilyn Lawrence, *The Anorexic Experience: From Dieting to Compulsive Eating* (Topsfield, Mass., 1985). This book, written by the British psychologist, Lawrence, who was one of the first feminist authors on anorexia nervosa, is known in Britain for the major feminist book on eating disorders (MacSween, 1993); Susan Kano, *Making Peace with Food: A Step-by Step Guide to Freedom from Diet/Weight Conflict* (Allston, Mass., 1985); Geneen Roth, *Breaking Free From Compulsive Eating* (New York, 1985); Lindsay Hall and Leigh Cohn, *Bulimia: A Guide to Recovery* (Santa Barbara, Calif., 1986); Terence J. Sandbek, *The Deadly Diet: Recovery from Anorexia and Bulimia* (Oakland, Calif., 1986); Patricia M. Stein and Barbara Unell, *Anorexia Nervosa: Finding the Life Line* (Minneapolis, 1986); Barbara G. Bauer et al., *Bulimia: A Book for Therapist and Client* (Muncie, Ind., 1986); Sharon Sward, *You Are More Than What You Weigh* (New York, 1995).

⁷² These videos are referred to at “Cath’s Guide to Eating Disorders on the Internet”.

⁷³ Orbach is recognized for her early feminist international best-sellers on eating disorders: *Fat Is a Feminist Issue* (1978) and *Hunger Strike* (1986).

What we can conclude from this is that throughout the 1970s and 1980s the anorexic standardization package, consisting of a widely accepted diagnostic nosology (the DSM-III diagnosis); a psychopathological theoretical framework and; sets of medico-psychiatric therapeutic strategies, had travelled and linked together many different actants and social worlds - creating an associated anorexic network. The anorexic package had made it easier to exchange resources and ideas across different academic disciplines, organizations and lay communities, thereby making the network of anorexia nervosa expandable and durable. Theoretical and diagnostic concepts (e.g., body image (disturbance), fat/weight phobia, weight conflict, eating disorders, anorexia nervosa, bulimia, compulsive eating, etc.) and therapeutic strategies were widely dispersed and now constituted a framework of common-sense knowledge among people in the Western world. Enabled by the robustness of the anorexic standardization package, chains of infrastructural communication work between different scientific communities, political and economical agencies, the anorexics themselves and the general population, had brought these communities together in a strong and encompassing actor-network.

This is not to say that the network of anorexia nervosa had become stagnant or unchangeable. As we have seen, the enrolment of more actors and the frequent interaction between them had made particular room for anorexics themselves, or “recovered anorexics” to engage more directly in the network. Autobiographies and various narratives by people who had experienced self-starvation became recognized as important contribution to the general understanding of the syndrome - narratives which were enrolled and translated into powerful arguments within significant feminist communities from the late 1970s.

This particular enrolment of anorexic voices and the engagement of feminists in the discourse had a crucial feed-back effect upon the ways in which treatment programs and centres were organized after the late 1970s. As Brumberg (1988) writes, “before the late 1970s most medical facilities placed individual patients with anorexia nervosa in a general medical setting or in pediatric or adolescent unit. In the present decade (1980s), however, the concept of eating disorders provides a functional way of organizing comprehensive treatment” (Brumberg, 1988:21). Special residential facilities, either within hospitals or free-standing, are devoted strictly to patients with eating disorders. These facilities are usually organized around a coordinated approach that integrates different medical and psychotherapeutic interventions. Some prestigious university-affiliated teaching and research hospitals operate eating disorders units, as do the important and increasing interests in the private-for-profit treatment institutions and centres (Ewick, 1993). For example, for a \$ 25 registration fee the Counselling Centres of America Inc. advertize, they offer an introductory daylong “Eating Disorders” seminar, publicized through a full-page newspaper advertisement that asks the question: “Does someone you love have anorexia nervosa or bulimia?” The ad explains that eating disorders can “destroy victims” and “tear a family apart.” In this seminar the Counselling Centres hope to provide introductory information on treatment approaches and “strategies for family survival” that will lead, ultimately, to a regularized outpatient treatment program in their offices (Brumberg, 1988). An ad for another residential treatment centre, the Remuda Ranch in the United States, claims that “each guest” (note: not patient, client or other clinical terms) “actively participate in every phase of her recovery” and promises to send the guests home to their families “live happy,

healthy and productive lives” (in Ewick, 1993:138). These trends in *commodifying* treatment practices, or “social control,” of anorexia nervosa in a period of increasing decarceration, Ewick (1993) argues, represent not only

a new set of exchange relationships, between profit-seeking corporations and deviant/consumers, but also the redefinition of social control, from something valueless to deviants to something valuable. (. . .) Commodification (. . .) suggests a process that generates new forms of power and constitutes new subjects. (. . .) By offering social control to private consumers, commodification has transformed some varieties of discipline and control into a luxury commodity available to those who can afford it, or alternatively, to those who can afford private insurance coverage (Ewick, 1993:138/140).

Drawing on Foucault’s notions of “technologies of the self” and the “individuation,” and “self-policing subjects,”⁷⁴ Ewick argues that social control of deviance in consumer culture is promotive, rather than reactive, voluntary rather than coercive, and is based more on choice rather than on constraint, and has led to a more “democratically representative population of deviants,” due to the imputed interest of self-labelling of “sickness” among the wealthy part of the population (Ewick, 1993:145).

The consumer treatment industry has therefore gained an important share in the anorexic network⁷⁵, which in turn has implications for the question of diagnosis and classification. In the United States, private treatment centres like the Remuda Ranch have become increasingly popular in the treatment of anorexia nervosa and have enrolled some

⁷⁴ These concepts are used by Foucault to explicate how disciplinary control “circulates through progressively finer channels, gaining access to individuals themselves, to their bodies, their gestures, all their daily actions” (Foucault, 1980:151).

⁷⁵ The particular interest in anorexia nervosa among the private consumer industry may be understood on the basis of the assumption that anorexia nervosa is most commonly found among girls from middle- or upper class families.

of the most renowned experts on the syndrome. These processes have in turn stimulated questions about the relation between diagnosis, insurance coverage and hospitalization. For example, recent statistics of anorexia nervosa show that the syndrome has the highest mortality rate of all mental disorders. Nevertheless, insurance companies are usually reluctant about reimbursement due to the usually long and expensive treatment practices, and because the conviction of the “normality” of extreme dieting among women and adolescent girls in our society usually creates doubts about the “realness” of the syndrome (Life magazine, Desember, 1997). The DSM criteria have therefore become crucial for the evaluation and justification of reimbursement practices, functioning as the only “true” and objective measurement scale of the determination of whether a person is “sick” *enough* to deserve financial support, which in fact produces strong limits on the choice of proper treatment.

For those who can afford longstanding and expensive treatment in private recovery centres, however, classification schemes and diagnosis loose some of their compelling importance as a means for therapeutic supervision because it is up to the subjective self or her/his family members to rule out a self-induced definition of the syndrome based upon the individual’s assumed ability to judge over his/her own or others well-being (Castel, 1991). In this sense, we may again notice the contours of changing categories of deviant or risk populations, nosologies, and knowledge production. For instance, Beumont et al. (1994) have recommended a distinct alteration in the diagnostic understanding of eating disorders which emphasizes the need for elevating the importance of body image disturbance and fat phobia in the diagnostic definition of the syndrome. They therefore proposed a replacement

of the term “eating disorders” with the term “dieting disorders” before the publication of the new DSM-IV (1994). The reason for this focus, they contend, was their particular concerns with the general employment of too strict diagnostic practices induced by the DSM-III-R system. The diagnostic criteria of anorexia nervosa have not changed significantly between the DSM-III-R and DSM-IV. However, arising in the 1980s, a debate which has received increasing attention in recent years, is the one between psychiatrists and medical doctors, on the one hand, and feminists, on the other. Each of these communities have been engaged in a process of trying to purify the syndrome as either “(psycho)pathological” (medico-psychiatric actors) or a reflection of “female normality” (feminist actors). This divide brings in the question of a nature/culture divide, scientific realism and social constructivism/cultural feminism, in the debate about anorexia nervosa, and the implications such dividing perspectives may have for the various actors involved in the network. The next chapter will examine these questions, and discuss the degree to which actor-network theory can be useful for actors engaged in discussions about marginalized or silence(d) voices in such networks.

Chapter 4

Anorexia nervosa: Psychopathology or caricature of the ills of our culture? Actor-network theory, translation work and marginalized empowerment

Anorexia nervosa is a fascinating and most complicated disease insofar as mental, as well as somatic, functions are considerably changed and impaired by it. In this sense it is a truly psychosomatic disease (Ploog, 1984:1).

Anorexia is the peculiar consequence of a culture fascinated by individual competition, dietary management, the narcissistic body and the presentational self (Turner, 1990:166).

I don't feel that anorexia *is* a pathological state. I mean my feeling is that it's a desperate search to find one's own identity to put it in a nutshell (Tricia, in Malson, 1998:147).

Now I know about it (anorexia), I wish there was more sort of, not education about it, but it's not a slimmer's disease. It's not just you know, it doesn't always start out as a diet. Well it often does but it's not just vanity. It's not just girls who want to be you know particularly thin. You know, it's not a vain thing (Laura, in Malson, 1998:143).

Throughout this study I have argued for the necessity of exploring the network and the ways it has expanded and made stable in order to make claims about the dynamics of power, and the moral and political implications of the network without having to draw on *a priori* statements about macroscopic and dualistic social forces (e.g., gender, class, race, etc.). This last chapter will therefore be organized around two central purposes: first, it will explore the recent scientific growth and stabilization of the anorexic network, addressing the epistemological debate between psychiatric and biomedical realism and cultural feminism/social constructivism which can be seen as a dividing outcome of recent processes within the network. Simultaneously, these processes will automatically direct attention to the

various implications of knowledge construction and stabilization of anorexia nervosa in recent years.

The central argument here is that the expansion of the network has resulted in a seeming divide between two powerful centres of translation: i) Actors within psychiatry and biomedicine whose practices are concentrated around the stabilization of the syndrome as a “psychopathology”; and ii) feminist actors who have predominantly seen anorexia nervosa as an extreme version of our culture’s preoccupation with (female) slimness. As such, this divide can be seen as constituting a present “crisis” in the debate about anorexia nervosa: first, because it draws attention to the resulting marginalization or invisibility of the anorexic selves within the network - selves who are continuously subjected to various attempts of purification within the scientific discourses; and second, because it points to the fact that what is actually produced within the network is a multiplicity of hybrids between nature and culture, pathology and normality, and as a result, multiple anorexic selves. I will therefore argue that an actor-network approach can be used to make this crisis visible, and in turn point out the usefulness of such an approach in research projects with critical and reflexive objectives.

The first two sections will demonstrate the expansion and attempting purification processes of psychiatry and feminism, proposing that their shared emphasis on body image disturbance and fat phobia can be used to traverse the seeming split between nature and culture, purification and translation in their work. The last section of this chapter will discuss questions about marginalized selves and prospects of the usefulness of an actor-network approach in further feminist studies on anorexia nervosa.

4.1. Anorexia nervosa as psychopathology?

As we saw in the previous chapter, a significant part of the scientific work on anorexia nervosa in the 1970s was directed toward the “revealing” of body image disturbance through various kinds of laboratory work. This, the psychiatric researchers hoped, could establish the existence of a “true” psychopathology of the syndrome. However, no clear conclusion could be drawn from these studies. Garfinkel and Garner (1982) conclude:

In summary, there has been recent interest in the objective measurement of body image in anorexia nervosa. However, many questions remain regarding both the basic mechanisms responsible for the findings and their precise meaning. (. . .) Despite the advantages of the more empirical measurement techniques, the recent literature on body image has been hampered by methodological shortcomings (Garfinkel & Garner, 1982:147/139).

In the present decade too, when the issue of body image (disturbance) itself has expanded and been transformed into a distinct research field, although still related to the anorexic network, the acclaimed experts on the subject, the American psychologists, Cash and Deagle, introduce their “meta-analysis” as follows: “Although body-image disturbance is among the diagnostic criteria for anorexia nervosa and bulimia nervosa, the nature and extent of this disturbance have not been precisely defined” (Cash & Deagle, 1997:107).

Nevertheless, the concept of body image disturbance has become an “immutable mobile,” a necessary and robust criterion, together with the “relentless pursuit of thinness,” for the persistence of Bruch’s primary anorexia nervosa in the three editions of the DSM nosology (see Appendix 2).

That being said, while DSM-III (1980) had formalized the syndrome as an accepted mental disorder, the expansion of many different local scientific and clinical practices during

the 1980s indicated that the diagnostic entity had to be negotiated and retranslated so further to adjust to the particular interests and conditions enrolled in the various social worlds now preoccupied with the syndrome. These various practices came to stimulate a further debate about the diagnostic structure of the syndrome in the 1980s. If we look at the diagnoses of anorexia nervosa in the three last editions of the DSM nosology there have been certain notable changes. For instance, after pressure from the many influential psychiatrists involved in the anorexic network, DSM-III-R (1987) replaced a weight loss criteria of 25 per cent in DSM-III to 15 per cent of original body weight, which made it possible to diagnose more individuals as anorexics. The new criteria also put limits on the problem of subjective judgments in the diagnostic setting of the clinic or laboratory, because a looser weight loss criterion would make up for the vagueness and objective uncertainty of the other criteria, like body image disturbance and fat phobia, again making it easier to diagnose more people as anorexics.

Although not directly related to the diagnostic debate, the scientific approach to the concept of body image disturbance also shows how diagnostic concepts to a large extent are part of a long process of translation work and the forming of alliances between different actants. For instance, when a whole range of studies on body image disturbance (or perceptual studies), employed throughout the 1980s and 1990s, demonstrated that most women actually do not overestimate their body size, or feel too fat, the response was to retranslate the site of “distortion” from perceptual mechanisms to affective/cognitive coloration: the contribution to perception of the mind’s eye (Cash & Deagle, 1997). According to this model, it is not that the anorexic individuals actually *see* themselves as fat;

rather, they evaluate what they see by painfully self-critical standards. Lack of self-esteem and self-worth now became the cause of women's body image problems (Thompson, 1996). The divide between the individual's (the woman's) "faulty thinking" or "flawed reasoning" and the actual reality from which she/he is incorrectly processing "data" are sustained, together with the divide between normal and pathological. This significant change of perception of a particular concept was not solely due to a new "discovery" in the syndrome, but to a translation and negotiation of interests into a modified but still psychiatrically acceptable version of the concept - ensuring its pathological stability.

Hence, a particular problem developing from most research on anorexia nervosa in this period was that the diagnostic schemes and measurement tools used did not provide adequate means to make clear-cut distinctions between "normal" and "pathological." During the 1980s, therefore, a whole range of different studies and measurement scales were produced to elucidate this problem - to demonstrate the obvious: that anorexia nervosa was indeed a psychopathological condition. The founding of *the International Journal of Eating Disorders* in 1981, and its further authority within the field, demonstrates both the stabilization of the anorexic network in this period, and the priorities given to particular research areas. This journal has become the main discussion forum for central issues related to eating disorders, and has to a large degree contributed to the stabilization of the leading categories upon which our understanding of eating disorders is based, and to which a growing research activity has been directed. In the first four years of its publication the *International Journal of Eating Disorders* received over 270 submissions and experienced a 50 percent rise in the number of subscriptions (Brumberg, 1988). And from 1989 to 1997

the journal had published 772 articles, with as many as 111 articles in 1997, and 109 in 1993, the year preceding the publishing of DSM-IV.

The editorial board of the journal has consisted of the most prominent psychiatric and endocrine experts on eating disorders since the 1970s⁷⁶. Each volume is expected to include the main target areas of research on eating disorders. Various aspects of "body image (disturbance)", for instance, are always a recurring themes in each volume or edition of the journal. Between 1989 and 1997 the journal has published 98 articles on body image related subjects, at an average of 11 in each volume⁷⁷. From 1994, the journal also started including

⁷⁶ E.g., M. Strober (editor-in-chef), A. Andersen, D. Garner, P. Garfinkel, K. Halmi, A. Stunkard, P. J. V. Beumont, R. C. Casper, D. B. Herzog, H. G. Pope, K. M. Pirke, J. Polivy, J. L. Katz, A. Crisp, K. D. Brownell, W. S. Agras, J. Yager, B. T. Walsh, G. F. M. Russell, G. I. Szmulker, J. E. Mitchell. Most of these actors have also been involved in the production of the diagnostic criteria of eating disorders in DSM-III, DSM-III-R and DSM-IV. The working group on DSM-III-R were Katherine Halmi, David B. Herzog, J.I. Hudson, Harrison G. Pope, Robert L. Spitzer, B. Timothy Walsh, and Janet B. W. Williams, and the working group on DSM-IV were B. T. Walsh, P. E. Garfinkel, K. A. Halmi, James Mitchell, and G. Terence Wilson.

⁷⁷ A sample of articles are: "The Effect of Mirror Confrontation and Size Estimation Feedback on Perceptual Inaccuracy in Normal Females who Overestimate Body Size" (Goldsmith & Thompson, 1989); "Menstrual Cycle, Body Image, and Eating Disturbance" (Altabe & Thompson, 1990); "Body Image Satisfaction in Homosexuals and Heterosexual Women" (Herzog et al., 1992); "Semantic Differentials for the Assessment of Body-Image and Perception of Personality in Eating-Disordered Patients" (Steinhausen & Vollrath, 1992); "Selective Attention to Food and Body Shape Words in Dieters and Restrained Nondieters" (Green & Rogers, 1993); "Aging-Related Concerns and Body Image: Possible Future Implications for Eating Disorders" (Gupta & Schork, 1993); "Fat Phobia: Measuring, Understanding, and Changing Anti-Fat Attitudes" (Robinson et al., 1993); "Feelings of Fatness Questionnaire: A Measure of the Cross-Situational Variability of Body Experience" (Roth & Armstrong, 1993); "Is the Selective Information Processing of Food and Body Words Specific to Patients with Eating Disorders?" (Perpina et al., 1993); "Depressed Mood and Concern with Weight and Shape in Normal Young Women" (Cohen-Tovee, 1993); "Perfectionism traits and perfectionistic self-presentation in eating disorder attitudes, characteristics, and symptoms" (Hewitt et al., 1995); "Distorting reality for children: Body size proportions of Barbie and Ken dolls" (Brownell & Napolitano, 1995); "Pictorial Adaption of Stroop Measures of Body-Related Concerns in Eating Disorders" (Walker et al., 1995); "Is Body Focus restricted to Self-Evaluation? Body Focus in the Evaluation of Self and Others" (Beebe et al., 1996); "Relationship of Weight, Body Dissatisfaction, and Self-Esteem in African American and White Female Dieters" (Caldwell, Brownell, & Wilfley, 1997); "Impaired Color Naming Food and Body Shape Words: Weight Phobia or Distinct Affective State?" (Green et al., 1997); "Disordered Eating Patterns, Body Image, Self-Esteem, and Physical Activity in Preadolescent School Children" (Sands et al., 1997).

a “subject index” in the introduction to each volume, indicating an increasing enrollment of different life spheres, psychiatric, endocrine, psychological and social categories into the scientific field of eating disorder. A series of studies has therefore been conducted to measure the relevance and relation between anorexia nervosa and various deviant/risk behaviors, conditions and categories: “drug use,” “death,” other mental or physical disorders (e.g., obsessive-compulsive disorders, attention-deficit hyperactivity disorders, depression, anxiety, personality disorders, hypothalamic dysfunctions), “sexual orientation,” “sexual abuse,” “narcissism,” “self-esteem,” “self-evaluation,” “self-criticism,” “perfectionism,” “self-punishment,” various “risk factors,” “racial differences,” “pregnancy,” “menstrual cycle,” “aggressive family communication,” “family control,” “parental attitudes,” “marriage,” “biochemistry,” and different treatment strategies (e.g., psychotherapy, pharmacological medication, nutritional counselling, self-help groups, family treatment, etc.). The authors of most of these articles aim to produce supportive evidence for the (psycho)pathological traits of anorexics and bulimics compared to “normals.” Aspects of the “anorexic self” is usually presented to reveal a distinct pathological “anorexic identity,” where “perfectionism,” “self-control,” “narcissism,” “self-criticism,” and “self-esteem” are all traits linked to the person’s restraints on food intake and the body. This “self” is portrayed as obviously sick and in need of professional diagnostic guidance, therapy or medication. That is, the anorexic self is seen as a portrait of the conglomerating “hyper-realities” of our culture: caught in a self-absorbing spiral of too much perfectionism, narcissism and self-control, on the one hand, due to a fundamental lack of self-esteem, on the other. Only when these dysfunctions are cured on an individual basis, the articles show, the body will retrieve

its *normal* physical strength and beauty. The paradox, however, is that these descriptions of the “anorexic self” seem to converge with that which is emphasized as constituting the proper treatment strategies of the syndrome. The “technologies of the self”⁷⁸ (Foucault, 1988) employed by the self-starvers on his/her body in order to create a culturally accepted self intersect with those self technological aspects advocated in most (psycho)therapeutic and self-helping contexts. As Ewick argues, this “homology reflects the fact that both the condition and its treatment embody certain cultural beliefs and practices regarding the self as an object of social practice” (Ewick, 1993:152).

While these aspects demonstrate the still intensive and expanding translation work within the anorexic network, the psychiatric and biomedical production of knowledge on anorexia nervosa has continuously tried to emphasize the nature pole of the phenomenon, arguing for the existence of a purified (psycho)pathological reality. The multiplicity of handbooks, review books⁷⁹ and journal articles published in recent decades have predominantly directed attention toward and explicitly argued for an intrinsic (psycho)pathological or purified explanation of anorexia nervosa. For instance, in the introductory chapter to the book *The Psychobiology of Anorexia Nervosa* (1984), the German endocrinologist, Ploog, writes:

⁷⁸ Foucault defines the “technologies of the self” as “permitting individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1988:149).

⁷⁹ E.g., Garfinkel & Garner, 1982; Darby et al., 1983; Stunkard & Stellar (eds), 1984; Pirke & Ploog, 1984; Andersen, 1985; Garner & Garfinkel (eds.), 1985; Beumont et al., 1987-88; Brownell & Foreyt (eds), 1988; Garner & Garfinkel (eds.), 1988; Schneider et al. (eds), 1989; Hsu, 1990; Abraham, 1992; Herzog & Vandereycken, 1992; Woodside, 1995; Yager (ed.), 1996; Jimerson & Kaye (eds.), 1997.

Anorexia nervosa is a fascinating and most complicated disease insofar as mental, as well as somatic, functions are considerably changed and impaired by it. In this sense it is a truly psychosomatic disease. It also possesses all the characteristics of an addiction as far as course and outcome, coping strategies, subjective feelings, and psychopathology are concerned (Ploog, 1981). A deviant psychic development, usually starting around puberty, becomes evident in a growing rejection of food. This in turn leads to a reduction in weight and a state of malnutrition marked by a number of serious somatic symptoms. Several of these symptoms, such as drop in temperature, the discontinuance of reproductive functions, and changes in the intermediate metabolism, are indicative of the existence of that physical state in which the remaining energy potential is used as sparingly as possible in order to prolonged survival. These observations are based on a large number of case studies in which physiologic, metabolic, and endocrine malfunctions in anorexia nervosa patients were investigated (Ploog, 1984:1).

Although Ploog's biomedical model of the "vicious circle" of anorexia nervosa includes the aspect of "social climate," and other authors in the book acknowledge that "the illness appears to develop from a variety of psychosocial and sociocultural stressors" (Ebert et al., 1984:58), the importance of the physiological, metabolic and endocrine aspect of anorexia nervosa predominates the various assessments. As a result, the conclusions drawn from the various studies presented in these articles are explicitly vague and indefinite, and the studies have rarely been cited or referred to.

In contrast, Garfinkel and Garner's book on the *multidimensional* perspective on anorexia nervosa (1982) has become one of the most widely cited books in the field⁸⁰. This can be explained by its enrolment and therefore acceptance of a whole spectrum of academic disciplines into the network (e.g., cognitive, family, social, and biological psychology, medicine, and sociology). The multidimensional perspective since has become the leading model for the understanding of anorexia nervosa (Bordo, 1990; Hof, 1994). Thus, in his

⁸⁰ In 1993, the book was cited in 29 significant articles.

review of the anorexic history up to the present, the American psychiatrist, M. Strober⁸¹, concludes:

It is hardly surprising that investigative approaches to this problem have become more technical and specialized in recent years and that simplistic, unicausal models of etiology no longer receive serious consideration. As new hypotheses have been developed, the need for a cohesive *biopsychosocial* [my italic] framework that unites data and research methods from a broad range of scientific disciplines has become more widely accepted (Strober, 1986:243).

The multidimensional model was proposed by Garfinkel and Garner to emphasize the interaction between various *predisposing and sustaining* factors, and *initiating or precipitating* events. They argued that the evaluation of the illness should be based upon an approach which saw it as a *process* where a whole range of individual/psychological (e.g., perceptual, conceptual, and hypothalamic pituitary dysfunctions), familial, and cultural factors (i.e., “pressure toward thinness”) are involved. However, due to the problem of producing clear distinctions between the normal and the pathological in anorexia nervosa, most authors on the syndrome have tended to push their statements toward the nature pole of the model so to secure the syndrome as a (psycho)pathological entity. Although the cultural aspect of the syndrome has become an inherent component of its explanatory schemes, demonstrated by the fact that most psychiatric handbooks and articles now usually include a section of cultural components in the table of contents, it has nevertheless become necessary for most psychiatric authors to translate the cultural aspect to make sure that it does not threaten the notion of the syndrome as a psychiatric *disease*. As such, most

⁸¹ Michael Strober has been the Editor-in-Chief of the International Journal of Eating Disorders since its foundation in 1981.

psychiatric and biomedical authors adhere to an understanding of the syndrome which emphasizes what is considered as its deep and more serious connection to the internal psychological and physical organization of the individual.

Nevertheless, much research directed toward the establishment of the core criteria of the disorder started to raise questions about the distinction between “true” anorexia nervosa and “normal dieters.” As mentioned above, studies on body image disturbance have rarely found any clear differences between anorexics and “normals.” Together with the growing influence of cultural feminism in the anorexic discourse in the 1980s and 1990s and the increasing focus on indicating particular “risk groups,” these processes contributed to the more explicit integrating of the social into the scientific debate on anorexia nervosa.

Hence, in the late 1970s and the beginning of the 1980s, Garfinkel, Garner, and various co-workers were involved in a series of inquiries concerning the question of “socio-cultural factors in anorexia nervosa”⁸². A number of self-report questionnaires (e.g., the Eating Attitude Test (EAT) (see Appendix IV) (Garner & Garfinkel, 1979), the Eating Disorders Inventory (EDI-1, EDI-2) (Garner, Olmsted & Polivy, 1983; Garner, 1991), the Setting Conditions for Anorexia Nervosa Scale (Slade & Dewey, 1986), The Interview for Diagnosis of Eating Disorders (IDED) (Williamson, 1990), and Mizes Anorectic Cognition Questionnaire (Mizes & Klesges, 1989), were being utilized in a series of studies to assess risk groups (e.g., various athletes, models, homosexuals, dancers, etc.), questions of epidemiology and an anorexic personality, and the influence of socio-cultural factors in the

⁸² See Garner & Garfinkel, 1978; Garner & Garfinkel, 1979; Garner, Garfinkel Schwartz & Thompson, 1980; Garner & Garfinkel, 1980; Garner, Garfinkel & Olmsted, 1983a, 1983b.

etiological picture of anorexia nervosa (e.g., Garner & Garfinkel, 1980; Norring, 1990; Smead & Richert, 1990). These self-report inventories have therefore been applied in psychiatric and psychological research to measure objectively symptoms commonly found in anorexia nervosa (e.g., attitudes toward body, intake and attitude toward food and weight, amount of exercise, etc.). Hence, these studies are constructed and used to make it possible to draw a sharp line between “normals” and “extremes” in the research sample.

For instance, in an attempt to examine the hypothesis that increased cultural pressure to diet is one of the factors facilitating the development of anorexia nervosa, Garner and Garfinkel studied a population of professional dance students and fashion models employing the EAT index (Garner & Garfinkel, 1980). Garfinkel and Garner compared these two categories with a group of already diagnosed anorexic female university students, and a small sample of music conservatory students⁸³. Those who scored over a certain “cut off score” (>30) were taken to clinical interviews and examined in relation to the diagnostic criteria proposed by Feighner et al. (1972)⁸⁴. Garfinkel and Garner concluded that the combination of expectations of slimness and competitiveness in both the dance and the modelling contexts increased the chance of developing anorexia nervosa⁸⁵, and that anorexia nervosa may occur along a continuum. Nevertheless, Garfinkel and Garner argue that

while the disorder represents a continuum which may gradually tend toward

⁸³ The latter was included due to the assumption that they experience “high performance” while their careers are not dependent on the maintenance of a thin body shape.

⁸⁴ The DSM-III had not yet been published at the time of Garfinkel and Garner’s study.

⁸⁵ Competitiveness in itself was not taken as a sufficient factor due to the absence of anorexics in the conservatory student sample.

normal, there is a real merit in distinguishing the full-blown syndrome with changes in the hypothalamic-pituitary axis from very mild forms. The distinction is partly, but not entirely, related to severity both in terms of starvation effects and likely in psychological predisposing and perpetuating factors (Garfinkel & Garner, 1982:33).

Now socio-cultural factors were generally accepted as being important for understanding *why* individuals start a process of starvation or dieting, how the social could act as a causal “trigger” for the development of anorexia nervosa, and how these factors could be important in the construction of prevention strategies and risk assessment. The acceptance of these three premises implied that the socio-cultural could not be excluded nor ignored from the explanatory model of the disorder. The strong emphasis on socio-cultural factors, however, made it necessary to create a model which still could include and justify the psychological and physiological “*effects*” of starvation as equally, or more significant, for the understanding of anorexia nervosa. As such, the construction of a multidimensional model would direct the attention away from the search for a *unicausal* relationship, and rather present and justify the syndrome as a disease in terms of its pathological *effects*. While a sole focus on effects of starvation might have devalued the explanatory strength and support of a psychiatric model of anorexia nervosa, this problem was solved by translating these assumed biological and psychological effects into an argument for further research on what could be seen as potential *protective* and *predisposing* factors, such as “less disturbed interpersonal and familial functioning, hypothalamic pituitary functions, social supports, ability to trust in others, a more internalized sense of self-worth, healthy autonomous ego functioning, and a more abstract level of conceptual development” (Garfinkel & Garner, 1982:33). Hence, what was initially assumed as physical effects of starvation could be

retranslated into the model as possible “causal,” that is, predisposing factors, which in turn would strengthen and create support for the argument that anorexia nervosa was to be seen as a true psychopathology.

In this sense, concepts of body image disturbance and fat phobia were further enrolled into series of experimental research, and findings were, as we have seen, linked to and explained in terms of cognitive/affective models and developmental psychological frameworks in order to translate the concept into a psychopathological understanding (Bordo, 1990).

Against these attempts to purify self-starvation as a *disease*, feminist accounts, which started to proliferate in the 1980s and 1990s, have criticized the hegemonic “disembodied, individualistic and detached” perspective of the psychiatric model (Brown, 1993), pointing to *culture* “as not simply contributing but *productive* of eating disorders” (Bordo, 1990:50). However, according to an actor-network approach, seeing culture as the pure mover of anorexia nervosa is to ignore the many heterogeneous processes of enrollment and translation work that take place between both the nature *and* culture poles, subjects *and* objects, in the construction of syndromes and in concepts to describe these syndromes. As such, the feminist critique is itself part of the anorexic network but fails to see its own situatedness, closing its eyes to its own and its proclaimed opponents’ negotiating and translatory practices.

4.2. Anorexia nervosa as a cultural-political construct?

While the feminist project has centred around a compelling denunciation of psychiatry's dominance in the construction of knowledge about anorexia nervosa, the engagement of feminism in the anorexic network is itself based upon the already manufactured and black-boxed "facts" about the syndrome - such as the high prevalence of anorexia nervosa among females, the "dramatic escalation" of anorexic incidences in the last half of the twentieth century, and the characteristics of "excessive pursuit of thinness" and "body image disturbance." These factualities have been translated into the already existing theoretical framework of feminist literature and practices since the mid-1970s. As such, feminists became a part of the anorexic network by enrolling the anorexic standardization package (re)constructed and expanded within psychiatric practices since the 1960s, although transforming its content to match the main tenets of the feminist project/protest: the condemnation of macro-social ideologies of "patriarchy," "capitalism," and "rationalism." The anorexic syndrome was used thereby as evidence of the extreme effects of patriarchy, and anorexic behaviours were read as impassionate and complicated social or political protests against these very compelling ideologies (Orbach, 1986).

However, the great influence of feminist actors in the anorexic network cannot be traced to the legitimacy, unity or "truth" of their social constructivist claims. Rather, the move of feminism from its initial working on the margins of the anorexic network to become part of the powerful "centres of translation" (Callon et al., 1986) must be seen in relation to their ability to enrol and form alliances with a whole variety of different actors in the debate, the distribution and enrolment of the "feminist package" into different social worlds, and the

further feed-back effect of this distribution on the anorexic network.

Thus, the feminist contributions to the anorexic network can also be traced to the work of Bruch and to a greater extent Selvini-Palazzoli, who not only have influenced the psychiatric but also the feminist work on anorexia nervosa. For example, Selvini-Palazzoli (1974) refers to early feminist (psychoanalytic) interpretations of the female body (e.g., Karen Horney) in her discussion of how “a host of cultural and social pressures (. . .) tends to aggravate the inner conflicts and all those generic predispositions to neurotic and psychotic reactions” (Selvini-Palazzoli, 1974:35). However, both Bruch and Selvini-Palazzoli shared a psychiatric view which interpreted the syndrome predominantly as a problem of individual deviance or deficiency⁸⁶. Nevertheless, Selvini-Palazzoli’s and Bruch’s ideas and their particular focus on gender in anorexia nervosa encouraged and gave accountability to the many feminist claims which started to develop in the late 1970s and early 1980s. The two first articles on anorexia nervosa appearing under the feminist label in the mid-1970s, Boskind-Lodahl’s *Cinderella’s Step-Sister: A Feminist Perspective on Anorexia Nervosa* (1976), and Lawrence’s *Anorexia Nervosa: The Control Paradox* (1979), were to a great extent articulated within the psychiatric terminology of Bruch and Selvini-Palazzoli. However, Lawrence’s (1979) contribution raised an important question about the medical-psychiatric therapeutic practice, and in particular its reduction of therapy to simply

⁸⁶ The chapter, “Anorexia Nervosa and the Contradictory Roles of Modern Woman,” in Selvini-Palazzoli’s book, which is only two pages long, does not seem to be more than a brief reminder of the cultural context in which anorexia nervosa seem to flourish, but it is not taken as an essential explanatory factor in itself, as has been asserted by the many contemporary feminists (see Orbach, 1978, 1986; Gilligan, 1982; Chernin, 1981, 1983, 1986a, 1986b; Szekely, 1987, 1988, 1989; Hepworth & Griffin, 1990; Bordo, 1990; MacSween, 1993).

weight gain, an issue also emphasized by Bruch (1973, 1978) and Selvini-Palazzoli (1974).

She writes:

There is no problem in psychiatry which arouses quite so much anger, hostility and desperation as anorexia nervosa. I have seen a number of young psychiatric registrars pledge themselves to the 'curing' of a particular anorexic and end up behaving in the most brutally authoritarian manner! Part of the problem is that doctors' therapeutic goals usually centre around regaining weight without sufficient regard for the issues which cause weight loss in the first place. More importantly, I think, doctors fail to understand the paradox (Lawrence, 1979:100).

These initial feminist accounts did not receive much attention from the psychiatric and medical establishment. However, it was when some feminist actors started to make alliances and distribute their work to a wide public audience, whose interest had been enrolled through the popularization of the anorexic problem during the 1970s, that feminist claims started to become recognized and black-boxed. For example, like Bruch's *The Golden Cage*, Orbach's international best-selling self-help guide *Fat is a Feminist Issue* (1978) received enormous attention, both within the feminist academic community, in the wider public, among feminist activists, and in the mass media. Combining her personal experience and interest in "compulsive eating" and female psychology into an argument about the social and political dimensions of starvation and overeating, Orbach sets out to explore the meanings of "fat" and "thin" in our consumer culture. Still trying to answer the question of "domineering mothers" and the typical conflict ridden mother-daughter relationship, although outlined through a critical feminist anti-psychoanalytic approach, Orbach argues that the anorexic girl has given in to the patriarchal/cultural dictum of slimness and female beauty, but that the symbolic meaning of her rejection of food must be seen as a protest against the demand resting on her to be desirable and meet the bodily ideals of sexualized

childbearing females. Thus, she argues, anorexic women express the tensions about acceptance and rejection of the constraints of femininity, and the wish for acceptance stemming from a feeling of unwantedness and hence unworthiness (Orbach, 1978:174). Orbach therefore warns against that which she sees as the Western patriarchal consumer economies' conspiracy production of anorexic identities:

Women are urged to conform, to help out the economy by continuous consumption of goods and clothing that are quickly made unwearable by the next season's fashion styles in clothes and body shapes. In the background, a ten billion dollar industry waits to remold bodies to the latest fashion. In this way, women are caught in an attempt to conform to a standard that is externally defined and constantly changing. But these models of femininity are experienced by women as unreal, frightening, and unattainable. (. . .) The anorexic, however fat she sees herself, is, in fact, conforming to society's demand for women to be thin (Orbach, 1978:8/179).

Susie Orbach's and other feminist works published in the first half of the 1980s, produced at the margins of the traditional psychiatric network of anorexia nervosa, reached a different but nevertheless wide and engaging audience (e.g., interest and support groups, other feminists, lay people, self-starvers themselves, their family members, friends, etc.). Titles like "Womansize: The Tyranny of Slenderness," "Hunger Strike," "The Obsession," "The Art of Starvation," and "The Hungry Self" signaled a more accessible and engaging narrative compared to traditional scientific accounts of the syndrome. Many of these feminist books, whose authors were usually recovered anorexics, compulsive overeaters, or excessive dieters, gave voice to the frustration and anger many women had long felt about their relation to their bodies and selves - "that the medical profession just doesn't get it" - and gave alternative, less "alienating" models in which to make sense of one's feelings and experiences with dieting and starvation (Lester, 1997:481). For example, the American

feminist Kim Chernin's book *Womansize: The Tyranny of Slenderness* (1983) was the outcome of her own experience with dieting and the "slimness culture" in American society. Her conversational approach, following Bruch's psychotherapeutic method, emphasized the women's ritualistic relation to food, thoughts about body control and slimness, and so in turn could "articulate the questions that have not yet been answered by textbooks or the conventional therapeutic approaches" (Chernin, 1986b:4).

However, during the 1980s, feminists' preoccupation with the issue of eating disorders started forming a distinct and large academic network when the initial arguments and works of Boskind-Lodahl, Lawrence, Orbach and others were enrolled into and distributed to a variety of feminist and academic disciplines (e.g., sociology, anthropology, cultural studies, women's studies, history and literature, and philosophy). This expansion of interest and reconstruction of knowledge contributed to the hardening of feminists' claims about the syndrome and the formation of what can be seen as a feminist standardization package on anorexia nervosa (Lester, 1997), consisting of a set of conversational and interpretative tools, a socio-political theory of the "patriarchized female body," often set against the "real-life," or lived experience of *being* a woman. The anorexic syndrome was seen as consisting of everything important to feminism: the cultural and patriarchal inscription of body control and technology (Bordo, 1990, 1992), the political and subordinated female body (Orbach, 1978), the objectification of the female body and self (MacSween, 1993), the use of body and food as social protest against patriarchy (Orbach, 1978, 1986; Gilligan, 1982), and the disembodied and alienating mechanisms of traditional biomedical treatment models (Chernin, 1986a, 1986b; Brown & Jasper, 1993; Bloom et al.,

1994). Handbooks on women's mental and physical health which started to proliferate in the 1980s, now engaged feminist experts on the syndrome as guest authors. This simultaneously worked to increase the robustness of anorexia nervosa as a particular feminist issue. In 1981, for instance, Boskind-Lodahl's article *Cinderella's Stepsister: A Feminist Perspective on Anorexia Nervosa and Bulimia* was included in Howell and Bayes's (1981) handbook *Women and Mental Health*.

In turn, these statements, or the feminist model of anorexia nervosa (Brown & Jasper, 1983), were later translated into background knowledge to support feminist arguments on a broad and general basis in the 1990s. Anorexia nervosa, and anorexic narratives started to be enrolled as symbols of general women's issues, feminist standpoints, the question of female subjectivities, and epistemology. For instance, Probyn (1993) uses her experiences of having employed an autobiographical narrative on anorexia in a paper on female subjectivity, as well as the various responses to this approach, as a starting point for a discussion about the "problematic of the self," and the support of the use of the "experiential" in feminist epistemology (Probyn, 1993:14). Furthermore, Heywood (1996), using anorexia nervosa as a metaphor of modernist literature and philosophy with its idealistic dualist components, constantly shaping and re-shaping our lives, argues:

Anorexia, mental or physical, is central to the self-definition of most women, particularly educated women attempting to gain access to the "white male power" that requires them to cancel out their bodies. If, as an inheritor of the canonical Western tradition, she internalizes a worldview that is male, a view spelled out clearly in Plato, Descartes, Hegel, and Freud, among others, a woman almost cannot do otherwise than develop a preoccupation with her body since that body has made her the negative other of culture. (. . .) This is the legacy of the generation of women born in the sixties and later. The legacy requires the mind/body split which characterizes not only Cartesian subjectivity but also the logic of eating

disorders that affect (if you include those who worry about calories, fat, exercise, and eating) virtually every woman and increasingly large numbers of men. And these cultural standards do not discriminate in terms of race and class. The ads are relentlessly democratic: anyone can attain a great body if she or he works hard enough (Heywood, 1996:33/34).

Despite the proliferation of feminist literature and practice in the beginning of the 1980s, and its continuous attacks on what it saw as the individualistic, gender and culture blind pathological model of the biomedical establishment⁸⁷, feminist actors were rarely enrolled in the debates at the psychiatric centre of translation of the anorexic network.

In their chapter on socio-cultural factors, however, Garfinkel and Garner (1982) take note of Boskind-Lodahl's interpretation of the anorexic's symptoms as reflections of contemporary women's often desperate striving to please others and validate their self-worth from external sources through their controlling of appearance and food intake. Although this can be seen as a start of the enrolment of feminist voices into the medico-psychiatric fora, Boskind-Lodahl's arguments were declared "too simplistic," and rather utilized by Garfinkel and Garner as an argument for the need to investigate the deeper and more complex affective/cognitive and biological organization of the anorexic syndrome.

Nevertheless, with the broad acceptance of the multidimensional perspective on anorexia nervosa, and the increasing emphasis on prevention strategies, which implied that questions of culture and gender had to be taken into account also in psychiatric research, feminists who now had established themselves as prominent academics and therapists on the margins of the anorexic network (e.g., Orbach, Gilligan, Chernin, and Boskind-Lodahl), were

⁸⁷ Hence, by portraying the psychiatric model as a celebration of the nature in the explanation of anorexia nervosa, feminism itself re-constructed a Great Divide within its own cultural model.

now invited to multidisciplinary conferences and as contributors in various handbooks on eating disorders.

For instance, in 1983, the organizers of a conference on anorexia nervosa and bulimia invited Orbach and Gilligan as keynote speakers to accentuate the question of gender in eating disorders (Bordo, 1990). The conference was titled "Eating Disorders and the Psychology of Women." Gilligan's and Orbach's focus on the sociocultural construction of femininity that the anorexic embodies, and their questioning of the designation of eating disorders as "pathology" provoked heated criticism from the (male) panel of commentators (the two psychiatrists, David Garner and Steven Levenkron, and the clinical psychologist, William Davis). Garner attacked Orbach for the "blame" she had attributed to the mothers of anorexic girls and the "guilt" she had inflicted on them for "choosing traditional values," while Levenkron asserted that Orbach had failed to appreciate adequately that "skinny kid in your office" - sacrificing the care of "helpless, chaotic, and floundering" children in the interest of a "rational" feminist political agenda. What the panellists saw as a complete lack of convincing theoretical distinction between "normal" and "pathological," and the feminists' refusal to adhere to such a requirement, became the most contested and fundamental issue of the anorexic debate in the years that followed.

Nevertheless, in Garner and Garfinkel's ensuing book *Handbook of Psychotherapy for Anorexia nervosa and Bulimia* (1985), Orbach was invited to write an article presenting the feminist approach to the understanding and therapy of anorexia nervosa⁸⁸, signalling that

⁸⁸ The article was called *Accepting the Symptom: A Feminist Psychoanalytic Treatment of Anorexia Nervosa*.

feminism had been placed within a centre of the translation on anorexia nervosa, although as a proclaimed opponent of the biomedical establishment. In fact, feminist works on anorexia nervosa have predominantly been published in feminist journals, separate feminist books or handbooks on eating disorders (e.g., *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa* (MacSween, 1993), *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders* (1993), and *Eating Problems: A Feminist Psychoanalytic Treatment Model* (1994), *The Thin Woman: Feminism, post-structuralism, and the social psychology of anorexia nervosa* (1998)).

The present debate on anorexia nervosa demonstrates the strong emphasis on purifying and standardizing processes communicated by influential psychiatric, medical and feminist actors enrolled in the network - examining and interpreting the syndrome according to either a scientific realist, social constructivist or postmodern model. The last section of this chapter will discuss how an actor-network perspective may contribute to a rethinking of the anorexic network, where asymmetrical dualities are debunked and marginalized voices can be put to the centre of attention.

4.3. Purification, translation and the marginalized selves: Implications of approaching anorexia nervosa with actor-network theory

Although the present study has emphasized the co-productive, heterogeneous and translatable aspects of knowledge construction, arguments of purification and dividing epistemologies are still effective. For instance, basing their *explanatory* models on various cognitive/affective, perceptual, personality, and/or sexual-developmental perspectives,

psychiatric actors have been preoccupied with the development of different methods and evaluation schemes to render that which can be regarded as the most outstanding psychopathological “truths” about the syndrome, body image disturbance and fat phobia visible. Psychiatric actors in the debate has been convinced that this will contribute to the manifestation of the true nature of anorexia nervosa as a mental disorder, and therefore a fixed category of abnormality or psychological deviance.

Anorexia nervosa has also been a popular topic among biomedical actors, who perhaps more than any other scientific actors, have tried to naturalize the syndrome and its “pathogenesis.” In their book *Solving the Anorexic Puzzle: A Scientific Approach* (1991), based on laboratory experiments with animals and clinical observations of anorexic patients, the Canadian physicians Epling and Pierce argue for a “biobehavioral” causal model of the syndrome, which they term “activity anorexia,” as opposed to a “mental” or “neurotic” disorder⁸⁹. Triggered by the “culturally imposed famine” of what they see as a static standard of beauty and health in Western societies, they further arrange their arguments to emphasize the processes of “natural selection” which automatically follow such “famines.” The famine, they hold, increases the tendency to engage in “locomotor activity” that is channelled into exercise. They see this activity as an example of a biological process of “displaced food-seeking behavior” (Epling & Pierce, 1991:180), a process which exemplifies our common drives and destiny with laboratory rats running in running wheels. Hence, according to this

⁸⁹ Epling and Pierce direct sharp criticism against the domineering and unscientific view of seeing anorexia nervosa as a mental illness: “The analysis is based on the author’s acceptance of the scientific method and the possibility of scientific accounts of human behavior. From our perspective, accounts of human behavior that rely on subjective mental processes are open to severe criticism. Unfortunately, much of the research and theory on anorexia nervosa is mentalistic and subjective” (Epling & Pierce, 1991:10).

model, the animal's or human's "baseline body weight" or "set point weight" can predicate a tendency to "start travelling for food," and thereby becoming anorexic. The lower set point weight, the higher is the risk of becoming mobile and thereby anorexic. They explain:

Loss of appetite occurs because stopping to eat small and infrequent meals is negatively balanced against reaching a more plentiful food supply. (. . .) Those animals who kept going until they reached an abundant food patch were more reproductively successful. This kind of selection has resulted in physiological mechanisms that decrease the reinforcing value of food when physical activity is high (. . .) Thus, activity anorexia may be viewed as a normal response to food depletion. Western culture has arranged an environment that triggers this response in many young women (Epling & Pierce, 1991:181).

As "cultural trends in beauty and health may naturally change over years," Epling and Pierce argue, responsibilities for preventive strategies should be concentrated around the educational practices of *local* communities (schools, self-help groups, families, etc.), focusing on the crucial role that natural processes of "physical activity" plays in the *actual* onset of anorexia, and how these processes can be controlled through techniques of local surveillance or self-governmental practices. Strategies of social criticism and change are thereby discouraged because such changes are believed to follow a "natural" evolutionary order that are "exceedingly difficult to alter" (Epling & Pierce, 1991:213).

The increasing influence of feminists in the anorexic debate, on the other hand, has contributed to a sharp criticism of the naturalization and pathologization processes employed by the psycho-biological establishments, pointing to the disembodied, individualistic and rationalist view of their scientific realism. That being said, with the many social constructivist and later postmodern models feminist actors have introduced new concerns of purification through their tendencies to determine the syndrome and its diagnosis as a

complete social construct or a discursive text. Taking as point of departure the concepts of pursuit of thinness and body image disturbance, feminist accounts present these entities as symbolic ways of expressing and communicating a female self in a powerful and meaningful way in our Western slim-fit preoccupied culture (Bordo, 1990). As MacSween argues: "Anorexic women transform the categories through which female experience is created in an attempt to resolve at the level of the body the contradictory demands of individuality and femininity which all women face in a patriarchal and bourgeois culture" (MacSween, 1993:239).

And, the hopelessness seems endless:

Like appetite, then, denial is a social force; what the anorexic woman struggles with is not her own denial but a social control. Her original resistance to her incorporation in the degraded feminine body rises up, and with phantom substantiality, controls its creator. (. . .) The reality of anorexia, then, entails a re-objectification of the feminine body, which becomes the object either of interior-but-alien appetite or interior-but-alien anorexia. The anorexic woman thinks, accepting the definition of the body as individually owned, that her body is the one thing she can control. The object status of the feminine body is, however, ultimately, inescapable. The subject in bourgeois patriarchal culture is a consuming subject; acting to satisfy its desires, in its own self-interest, is what defines it; it wants, therefore it is. Women, as the environment of the masculine subject, have, ultimately, no wholly separate environment on which to act, since they are part of the world of objects in opposition to which the individualized subject is constructed: women desire to be possessed as objects (MacSween, 1993:251/252).

I am not proposing that all these models are substantially wrong, be they of psychiatric, biomedical or cultural feminist origin. Rather, I agree with the biomedical perspective that certain physiological and biochemical processes *are* fundamentally altered

and become fatal when people starve themselves⁹⁰. I also agree with psychiatrists and psychologists that starvation may be crucially related to questions of emotion, childhood development, cognition, perception and identity. Lastly, I strongly agree that self-starvation, the ritualistic preoccupation with food, weight and body, its symbolic meanings and presentation of selves, must be seen in relation to socio-cultural and socio-economical conditions in which the self-starver (and his or her family) is situated. However, what is opposed in these perspectives is their tendency to purify *one* particular aspect of the syndrome (either represented as a pathology or as an extreme version or victim of the “slim-fit” culture), since anorexia nervosa consists of all these elements. It is a hybrid of culture and nature, culture, body and self.

As such, the last two quotes presented in the beginning of this chapter may point to the present epistemological crisis in the debate about the syndrome. For the anorexic, her starvation, her thin body, “the sensation of seeing my bones”⁹¹, her feeling of control/loss of control over food, weight and body, her visibility/invisibility, are neither seen as pathology nor a result of vanity. Hence, what is denied by the anorexics are the various images of purification communicated to them by the whole network: influential actors, mass media and the general population. As such, the strong denial demonstrated by anorexic individuals, a central aspect which itself has been translated into purified categories - either as a sign of its psychopathological character or as a symbol of a feminist protest against patriarchy (Orbach,

⁹⁰ I may even acknowledge that in some cases it may be plausible to talk about elements of predisposing character.

⁹¹ Quote from Olivia in Malson (1998:145).

1978; Chernin, 1986b), can perhaps illustrate how the strong images of purification and stereotyping of the syndrome may have implications for questions of enrolment and marginalization. Moreover, the crisis within modern epistemologies that the anorexic debate exemplifies simultaneously demonstrates the need for an alternative perspective by which to understand and interpret anorexia nervosa.

Recent feminist contributions⁹² to the anorexic debate have concerned themselves with the outcomes of the purifying tendencies of the anorexic debate. Not only have they criticized the rationalistic, disembodied, individualizing and marginalizing implications of the medico-psychiatric model, but also reflexively questioned the essentialist and foundationalist (Fraser & Nicholson, 1988) perspective of traditional feminism. The important influence of feminists within the anorexic network may point to the elasticity and heterogeneous character of such standardized networks, opening up possibilities for how even the most powerful and encompassing networks can be opposed, criticized and rejected. However, the feminist contribution has itself formed a powerful centre of translation within the network which once again leaves the anorexic *selves* "largely unexamined as a sort of black box where cultural forces somehow collide and interact to produce unpredictable constellations of behavior" (Lester, 1997:481). While the scientific realism of the medico-psychiatric model can be seen as having constructed "disembodied selves" the traditional feminist perspective has engaged in the production of categories of "de-selfed" and "docile" cultural bodies (Probyn, 1993). Every aspect of the anorexic practice and condition - the

⁹² E.g., Probyn, 1993; Lester, 1997.

anorexic's processes of starvation, ritualistic preoccupation with food, body, and weight, loss of menstruation, denial, lies, the excessive need to control different aspects of his/her life, and the experience of losing this control - have had a tendency of being enrolled and interpreted as textual or symbolic outcomes of the dominating patriarchal-capitalistic culture's fascination with dieting and slimness (Probyn, 1993). The anorexics become a homogeneous entity - helpless *victims* of a system so powerful that only revolutionary structural change, that is, the elimination of patriarchy, can do away with the tragedies of the syndrome (see MacSween, 1993).

How then can an actor-network approach be useful for further reflexive and critical projects directed toward questions of empowerment of marginalized voices in the network? What alternative does the perspective contribute to the epistemological debate between scientific realism, social constructivism and postmodernism in the debate about anorexia nervosa? While actor-network theorists share with postmodernist, social constructivist and most feminist actors a critique of the quest and celebration of pure scientific "discoveries," a search for universal laws of nature, grand narratives and the enlightenment project of modernist philosophies, there are certain aspects in these alternative epistemologies which actor-network theory opposes due to their implied social or textual determinism, which is made visible in the examination of the anorexic debate. I have argued that anorexia nervosa, its diagnosis and the production of knowledge about the syndrome are indeed social constructions, and that knowledge about it can never be separated from the signs and symbolic meanings used to represent it - and these varies according to differing temporal and spatial localities. However, the present study has also argued against approaching the study

of science and scientific knowledge uncritically, starting from a set of *a priori* macro-structural concepts (e.g., “patriarchy,” “social class,” “capitalism” etc.), which themselves have become fruitful objects of study in recent years. Such approaches fail to pay attention to the local, strategic and manipulative practices involved when different actants are enrolled and linked together in various ways to produce powerful factualities and standardization packages. Furthermore, an important aspect of the actor-network perspective, which diverges from the nominalist claims of postmodernism that all statements about truth and falsehood are equal, is the attempt to explicate how certain claims to truth in fact become more powerful and real than others. As the genealogical study of anorexia nervosa has shown, the present psychiatric diagnostic framework of the syndrome, later combined in different ways with feminist claims, has become authoritative due to a series of translation work, processes of enrollment and manipulation of different actants, and a further immutable mobility of the anorexic standardization package into various social worlds. As such, anorexia nervosa and its diagnostic package have come to constitute a real entity, forming an encompassing network with far-reaching and powerful implications for those involved, for the construction of human (and nonhuman) agency, where the influential actants involved in these processes are simultaneously responsible for the creation of a particular social order (Ward, 1996:16). Having anorexia nervosa, or being anorexic, is therefore only possible within this particular associated network, including all its interpretations, meanings, and implications. Simultaneously, placing scientific actors as *translatory* agents (in contrast to *purifiers*) within this associated network opens up for the possibility of criticizing scientific practice and its implications, and for multiple dialectic participation in the network.

We may then ask to what extent an actor-network approach can be useful for a combined rethinking of anorexics' positioning and empowerment in the network; for feminist moral and political concerns in a period where feminist epistemology itself is being subjected to significant evaluation and change; for feminist activist groups working in the field of anorexia nervosa; and with women's health issues in general. As I have already shown, there are important continuities between an actor-network approach and feminism. Feminists, like actor-network theorists, criticize the individualist, rationalist, and disembodied view of traditional science; the modernist conviction of the "naturalness" of dividing every aspect of the world into dualistic categories such as nature/culture, object/subject, etc.; and the scientific realism of scientific practice and epistemology.

That being said, while an actor-network theory cannot "solve the anorexic puzzle" once and for all, the strength of the approach is found in the ways in which widely accepted claims to truth can be accounted for and deconstructed, thereby making room for alternative and marginalized accounts to enter the debate and get the opportunity to contribute to a debunking of such statements (Fuchs, 1992; Singleton, 1996). As the present genealogy of the anorexic network has argued, in order to engage in a debate about the legitimacy, moral and political implications of particular knowledge claims, such practices require that we first explicate the network in which these claims are produced, transformed and/or made expandable. However, while the examination of how knowledge is created as powerful black boxes has become a crucial task within the sociology of science and knowledge, which in turn has levelled out distinctions between scientific and mundane knowledge claims, little attention so far has been given to the marginalized voices of such networks - those who have

been enrolled, manipulated, and translated by a few influential actors we have been following and deconstructing in their crafting of knowledge and truths (Callon, 1986; Leigh Star & Bowker, 1996).

While my own work has concentrated on a genealogical deconstruction of the production of knowledge about anorexia nervosa, primarily by following the authoritative psychiatric and feminist actors involved in these processes, I will argue that this account will be useful and significant for further investigations conducted by feminists interested in questions of local empowerment strategies, anorexic subjectivities, the question of the “non-enrolled,” and issues of reflexivity, situatedness and justification of knowledge production and treatment. As mentioned, anorexics’ denial of enrolment in the anorexic network can be seen as a fruitful starting point for further feminist studies on anorexia.

Taken as a point of departure, these resistances may direct attention away from and contribute to a debunking of the dividing and authoritative standards proclaimed by psychiatry and feminism, and these standards’ overdetermined implications for the construction, and therefore, denial of stereotyped (anorexic) selves (either mentally ill or victim of social hyper-conformity). Like actor-network theorists, the anorexic individual denies membership in a network in which purification work is overemphasized. An actor-network approach therefore may be able to envision a network where such purification work is in fact accompanied by a series of translation practices, where collective work across different social worlds, “simultaneous multiple memberships,” “partial commitments,” and “meetings across concerns” in fact constitute scientific practice and authority (Leigh Star, 1992), and where these aspects may turn denial, invisibility and marginality into empowering

experiences and actions in questions and decisions about inclusion, diagnosis, and treatment. It is to show how things could have been otherwise (Becker, 1967). As Fujimura concludes: “Examining the constructions, maintenance, and augmentation of these packages will help us to understand not only how we came to have the representations we now hold sacred but also that there are other possible representations, other ways of knowing and practising” (Fujimura, 1992:205).

Conclusion

The intention of this study has been to trace the recent genealogy of the standardization processes related to anorexia nervosa as a way of demonstrating how an actor-network approach can map out a different and more symmetrical dimension by which to understand the syndrome, and thereby opening up for marginalized voices in the network.

As we have seen, anorexia nervosa has become a popular subject within a range of different academic disciplines as well as in the general population, and the syndrome is often used as a paradigm for demonstrating the legitimacy of a particular theory or epistemology (Malson, 1998). As such, the present study has followed in the footsteps of the army of psychosomatic, psychoanalytic, behavioral psychological, endocrine, psychological and cultural feminist actors enrolled in the debate of anorexia since the late nineteenth century. However, in contrast to previous analyses of anorexia nervosa which have tried to purify the syndrome into homogeneous ontological zones of either nature or culture, the actor-network approach has emphasized the inseparable relationship between these two zones, and, as a result, the need see the work of scientific actors as simultaneously that of purification and that of translation. In this sense, employing an actor-network approach to the debate about anorexia has been intended to *negotiate* a path between medico-psychiatric realism and feminist constructivism, making visible the collective, dynamic, manipulative and expanding character of scientific knowledge production. The result is a linking together of different actants and a range of social worlds in a powerful, but still flexible actor-network.

The discussion about the culture-boundness of anorexia illustrated how the present

debate is informed by a realist-constructivist divide where the search for the “true nature” of the syndrome has been the main focus of attention, significantly ignoring the active participation and translation work taking place among different scientific actors involved in the various *processes* of diagnostic standardization and treatment practices. In order to overcome the ontologically, as well as epistemologically, dividing and purifying images communicated by scientific realism and social constructivism, I have therefore proposed the concept of network-boundness as a replacement of that of culture-boundness in anorexia nervosa. This, I have argued, will contribute to a better way of describing and understanding how claims to truth, standardized packages and common sense knowledge about a particular syndrome are in fact produced collectively, and how certain truth claims become stronger and more pervasive than others.

For instance, we have seen how Bruch’s multiple selves, that is, her careful practices of *interessement* and translation work, successfully linked various statements about “feeling fat” to a variety of different theoretical and diagnostic concepts (e.g., “body image disturbance” and “pursuit of thinness”), and turned these hybrids into a robust standardization package which enabled an expansive immutable mobilization and enrolment of Bruch’s ideas into a range of different social worlds (e.g., the neo-Kraepelinian movement, experimental and pharmacological research, feminism, support organizations, mass media, the general population, national education and health policies, etc.). As such, the present standard definitions or diagnoses of anorexia nervosa are the result of a series of textual and nontextual translation practices rather than pure discoveries of social or natural facts.

As emphasized, the diagnostic criteria of body image disturbance has been established as a robust fact, not merely because it has been discovered as a naturally occurring entity in anorexic patients, but as a result of the extensive quantity of investments in the concept as a determinant element for the definition of anorexia as a distinct mental disorder. This robustness of the concept can be seen in relation to a number of different practices tying together the anorexic network in a particular fashion: i) the concept has been enrolled in a series of experimental research since the 1970s; ii) new technical devices has been continuously produced to render the nature of body image disturbance visible; iii) new theoretical frameworks have been employed to justify the use of the criteria despite the inconclusive results from experimental research; iv) the concept has been enrolled in a number of different academic and social communities (even translated into competing communities like that of feminism); and v) the subject of body image has itself developed as a separate academic field in recent years (Thompson, 1996).

This is not to say that these concepts or anorexia nervosa itself have no bearings in reality. The strength of the anorexic network can itself be seen as a quite real constitution with quite real implications for those actors who are involved in the network. The simultaneous combination of a diversity of cultural and material components involved in and constructing the lives and deaths of self-starving individuals in the network are also experienced as quite real by these individuals, their families and friends. Hence, what is proposed in this study is that this “realness” is to be seen as resulting from a continuous linking of weak ties among a heterogeneity of actants rather than discoveries of external truths or overarching macrosocial forces.

As argued in chapter four, the dividing purification images created by psychiatry's preoccupation with rendering the psychopathological features of the syndrome visible and feminism's proclamation of weight phobia as an expression of women's "normative obsession" (Rodin et al., 1984) draw attention to the only half-written story about anorexia, and therefore to the frustration of the anorexic selves situated and resisting enrolment in the network. In this sense, the intense resistance against enrolment among most self-starving individuals, the resistance of being pathologized and normalized may point to the need of adding the other half of the story to future analyses of anorexia nervosa - the story of translation, hybridization and symmetry. This will simultaneously mean that we take as point of departure not only the powerful scientific actors in the network but those who are often end up at the margins - those who are manipulated and translated into homogeneous categories to "raise the world". This will in turn enable us to see the heterogeneity and multiple selves of the self-starving individuals - their simultaneous inclusion and exclusion in the network - and make us realize that things could have been otherwise. The present study has been intended to constitute a starting point for such *possible* and pressing assignments.

Appendix I

Diagnostic packages for anorexia nervosa in the 1970s

Dally (1969):

- a) Refusal to eat enough to maintain normal weight and/or sustained efforts to prevent ingested food from being absorbed.
- b) Loss of at least 10% of previous body weight.
- c) Amenorrhea (loss of menstruation) of at least 3 months - or if menstruation had been irregular, a period of amenorrhea of at least 6 months.
- d) Onset between age 12 and 39 years.
- e) No organic disease, serious affective disorder, or schizophrenia (Beumont et al., 1994)

Russell (1970):

- a) Behaviors aimed at achieving weight loss - starvation, vomiting, laxative abuse.
- b) An endocrine disorder - amenorrhea in the female and loss of sexual interest in the male.
- c) A characteristic psychopathology, manifested by a morbid fear of becoming fat, is often accompanied by a distorted judgment by the patient of her own body size.
- d) A specific degree of weight loss is required - 20% of standard body weight.

Feighner et al. (1972):

- a) Onset prior to age 25 years.
- b) Anorexia with weight loss of at least 25% of original body weight.
- c) A distorted, implacable attitude towards eating, food, or weight that overrides hunger, admonitions, reassurances, or threats. This could include: denial of the illness with a failure to recognize nutritional needs; apparent enjoyment of weight loss and food refusal; a desired body image of extreme thinness; unusual handling or hoarding food.
- d) No known medical illness.
- e) No other known psychiatric disorder.
- f) At least two of the following: amenorrhea, lanugo hair, bradycardia (persistent resting pulse of 60 or less).

The Pathology of Eating Group, Garrow et al. (1975) (in relation to a conference held in Berlin):

- 1) Self-inflicted severe loss of weight using one or more of the following devices: avoidance of food considered to be fattening, self-induced vomiting, use of purgatives, excessive exercise.
- 2) A secondary endocrine disorder of the hypothalamic and anterior pituitary gonadal axis manifest in the female as amenorrhea and in the male by a diminution of sexual interest and activity.
- 3) A psychological disorder that has as its central theme a morbid fear of being unable to control eating and hence becoming fat (Garrow, Crisp, Jordan, Meyer, Russell, Silverstone, Stunkard, & Van Itallie, in Garfinkel & Garner, 1988:212).

Rollins and Piazza (1978):

1. Psychopathologic disturbance as follows:
 - a) Evidence of weight phobia and/or distorted body image.
 - b) Pervasive sense of inadequacy.
2. Biological disturbance as follows:
 - a) Weight loss of 20% or more of body weight or weight loss to less than 80% of average for age and height.
 - b) Amenorrhea. (Garfinkel & Garner, 1988:214)

Norris (1979):

1. "Positive" perception of family.
2. Psychosexual unawareness of guilt.
3. Onset of illness between 13 and 15 years.
4. Any two of the following psychological features: shy, obsessional and compulsive, compliant or dependent.
5. Enmeshed with a parent.
6. Close intact family denying conflict.
7. Above-average intelligence.
8. More female children than males.
9. Change of personality at or before onset.
10. Dominant mothers.
11. Mothers anxious and overprotective or indulgent and self-martyring (in Garfinkel & Garner, 1988:213)

Appendix II

Diagnostic criteria for anorexia nervosa in DSM-III:

- a) Intense fear of becoming obese that does not diminish as weight loss progresses.
- b) Disturbance of body image, for example, claiming to “feel fat”; even where emaciated.
- c) Weight loss of at least 25% of original body weight. If under age 18 years, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.
- d) Refusal to maintain body weight over a minimal normal weight for age and height.
- e) No known physical illness that would account for the weight loss (APA, 1980:69).

Diagnostic criteria for anorexia nervosa in DSM-III-R:

- A) Refusal to maintain body weight over a minimal normal weight for age and height, for example, weight loss leading to maintenance of body weight 15% below what 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, for example, 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 women, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration) (APA, 1987)

Diagnostic criteria for anorexia nervosa in DSM-IV

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of 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 or shape is experienced, undue influence of body weight or shape on selfevaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) (APA, 1994)

Appendix III

Diagnostic criteria for anorexia nervosa in ICD-9

A disorder in which the main features are persistent active refusal to eat and marked loss of weight. The level of activity and alertness is characteristically high in relation to the degree of emaciation. Typically the disorder begins in teenage girls but also occurs in males. Amenorrhea is usual and there may be a variety of other physiological changes including slow pulse and respiration, low body temperature, and dependent edema. Unusual eating habits and attitudes towards food are typical and sometimes starvation follows or alternates with periods of overeating. The accompanying psychiatric symptoms are diverse. Excludes: eating disturbances not otherwise specified (WHO, 1978).

Diagnostic criteria for anorexia nervosa in ICD-10

- A) Body weight is maintained at least 15% below that expected (either lost or never achieved), or Quetelet's body mass index is 17.5 or less. Prepubertal patients may show failure to make the expected weight gain during the period of growth.
- B) The weight loss is self-induced by avoidance of "fattening foods", and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.
- C) There is body image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.
- D) A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea and in men as loss of sexual interest and potency. (An apparent exception is the persistence of vaginal bleeds in anorexic women who are receiving replacement hormonal therapy, most commonly taken as a contraceptive pill.) There may also be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion.
- E) If onset is prepubertal, the sequence of pubertal events is delayed or even arrested (growth ceases; in girls the breasts do not develop and there is a primary amenorrhea; in boys the genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late. (WHO, 1992).

Appendix IV

Eating Attitudes Test

Please place an (X) under the column which applies best to each of the numbered statements. All of the results will be *strictly* confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

Always	Very often	Often	Sometimes	Rarely	Never		Always	Very often	Often	Sometimes	Rarely	Never	
()	()	()	()	(X)	()	1. Like eating with other people.	(X)	()	()	()	()	()	20. Wake up early in the morning.
(X)	()	()	()	()	()	2. Prepare foods for others but do not eat what I cook.	(X)	()	()	()	()	()	21. Eat the same foods day after day.
(X)	()	()	()	()	()	3. Become anxious prior to eating.	(X)	()	()	()	()	()	22. Think about burning up calories when I exercise.
(X)	()	()	()	()	()	4. Am terrified about being overweight.	()	()	()	()	(X)	()	23. Have regular menstrual periods.
(X)	()	()	()	()	()	5. Avoid eating when I am hungry.	(X)	()	()	()	()	()	24. Other people think that I am too thin.
(X)	()	()	()	()	()	6. Find myself preoccupied with food.	(X)	()	()	()	()	()	25. Am preoccupied with the thought of having fat on my body.
(X)	()	()	()	()	()	7. Have gone on eating binges where I feel that I may not be able to stop.	(X)	()	()	()	()	()	26. Take longer than others to eat my meals.
(X)	()	()	()	()	()	8. Cut my food into small pieces.	()	()	()	()	(X)	()	27. Enjoy eating at restaurants.
(X)	()	()	()	()	()	9. Aware of the caloric content of foods that I eat.	(X)	()	()	()	()	()	28. **Take laxatives.
(X)	()	()	()	()	()	10. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc.).	(X)	()	()	()	()	()	29. Avoid foods with sugar in them.
(X)	()	()	()	()	()	11. Feel bloated after meals.	(X)	()	()	()	()	()	30. Eat diet foods.
(X)	()	()	()	()	()	12. Feel that others would prefer if I ate more.	(X)	()	()	()	()	()	31. Feel that food controls my life.
(X)	()	()	()	()	()	13. **Vomit after I have eaten.	(X)	()	()	()	()	()	32. Display self control around food.
(X)	()	()	()	()	()	14. Feel extremely guilty after eating.	(X)	()	()	()	()	()	33. Feel that others pressure me to eat.
(X)	()	()	()	()	()	15. **Am preoccupied with a desire to be thinner.	(X)	()	()	()	()	()	34. Give too much time and thought to food.
(X)	()	()	()	()	()	16. Exercise strenuously to burn off calories.	(X)	()	()	()	()	()	35. *Suffer from constipation.
(X)	()	()	()	()	()	17. **Weigh myself several times a day.	(X)	()	()	()	()	()	36. Feel uncomfortable after eating sweets.
()	()	()	()	()	(X)	18. ‡Like my clothes to fit tightly.	()	()	()	()	(X)	()	37. Engage in dieting behaviour.
()	()	()	()	()	(X)	19. Enjoy eating meat.	(X)	()	()	()	()	()	38. Like my stomach to be empty.
													39. Enjoy trying new rich foods.
													40. Have the impulse to vomit after meals.

† The "X" represents the most "symptomatic" response and would receive a score of 3 points.

* $P < 0.05$, t -test.

** $P < 0.01$, t -test.

‡ $P > 0.05$, t -test.

For all remaining items, group means differed at the $P < 0.001$ level of confidence with a t -test.

Note. The analysis reported in the body of the paper is a point biserial correlation coefficient where item score was correlated with group membership to establish the validity of individual items as predictors. The t -test results reported above simply demonstrate the magnitude of the differences between mean item scores for the AN and NC cross-validation sample.

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