FROM VIRTUE TO VICE

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FROM VIRTUE TO VICE
Negotiating Anorexia
Richard A. O'Connor and Penny Van Esterik

From Virtue to Vice

Negotiating Anorexia

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berghahn
NEW YORK • OXFORD
www.berghahnbooks.com

Published in 2015 by

Berghahn Books

www.berghahnbooks.com

Library of Congress Cataloging-in-Publication Data

From virtue to vice : negotiating anorexia / by Richard A. O'Connor and Penny Van Esterik.
p. ; cm. — (Food, nutrition, and culture ; volume 4)
Includes bibliographical references.
ISBN 978-1-78238-455-7 (hardback) — ISBN 978-1-78238-456-4 (ebook)
I. Van Esterik, Penny, author. II. Title. III. Series: Food, nutrition, and culture ; v. 4.
[DNLM: 1. Anorexia Nervosa—psychology—Personal Narratives.
2. Anorexia Nervosa—etiology—Personal Narratives. WM 175]
RC552.A5
616.85'262—dc23
2014033557

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library.

Printed on acid-free paper.

ISBN: 978-1-78238-455-7 hardback
ISBN: 978-1-78238-456-4 ebook

To our daughters and our interviewees, who gave so generously of their time, wisdom, and experience.

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Acknowledgments

Anorexia hijacked our careers. We both had other plans. But when anorexia came crashing into Richard's life, he fought back with the tools of his trade. Then Penny joined him as co-conspirator. This horror, we declared, cannot stand. That gave us a project with a purpose.

We all seek purpose, but not everyone has the privilege to pursue it. We have been graced by supportive families and generous colleagues. Our research began when Amorn and Carolyn O'Connor thought that understanding our family crisis might help others. Since then their unfailing support has inspired our work. Amorn's two brothers contributed their academic expertise: as a philosopher and editor, John sharpened our arguments; and as a neuroscientist, Daniel kept biomedicine salient. We have also benefited from Chandra Van Esterik's support and John Van Esterik's critical skills and close involvement.

Many colleagues have graciously heard us out and contributed their expertise. We are particularly indebted to Gustaaf Houtman, Leif Jonsson, Deb McGrath, Donna Murdock, Jim Peterman, Woody Register, Jim Scott, Jerry Sullivan, and Nikki Tannenbaum. Leeat Granek's interviewing talents enriched our Toronto cases, and we thank Dagmar Gundersen for typing up interviews. Early in our work, Anne Becker, a major figure in eating disorder research, graciously welcomed our fledgling efforts. We are also deeply indebted to the insights of Rebecca Lester and Megan Warin, which have advanced our work. So too have a series of research grants from the University of the South as well as the encouragement of its students.

We have dedicated our book to our daughters as well as our interviewees. The volunteers who generously and courageously told us their stories gave us a gift we now pass on to readers.

Introduction
Negotiating Anorexia

To this day, I really don't know why, all of a sudden, I decided to have these weird eating patterns and not eat at all. Exercise so much. I think that I was just a perfectionist, just wanting to make my body even more perfect. But the thing is, a skeleton as a body really isn't perfect. So I don't know exactly what my train of thinking was.

Anorexia mystified Becca. The usual explanations did not work: she had no weight to lose ("*people would always tell me how skinny I was*"), no festering trauma, no troubled psyche. An upbeat person ("*I'm very energetic and very bubbly*"), she had a strong family ("*really loving and supportive parents*") and got along splendidly at school. A top athlete, she made excellent grades and had good friends. Life was going great. Then anorexia struck. Neither Becca nor her family nor her therapists knew why.

While a clinician would rightly diagnose atypical anorexia nervosa, Becca's case is not unusual. Many cases defy the type. Indeed, perhaps most do because the diagnostic criteria are insensitive to cultural differences (A. Becker 2007), indifferent to adolescent development (Lester 2011), compromised by comorbidities (Rosling et al. 2011: 309), and inadequate for research (Agras et al. 2004: 518). Yet the real problem is not an ill-conceived type. It is trying to type a moving target. Anorexia is a fluid *relationship* with us, its interlocutors, not a stable object in nature we can mark, measure, and conquer. What medicine struggles to do—pinpoint a single disease in nature—takes the wrong road.

We began interviewing the recovered like Becca, confident that anthropology knew the right road. Medicine, we thought, was missing anorexia's cultural logic. Now we question anthropology too. Its confidence in culture is misplaced: anorexia is a practice, not a culture; an activity, not a symbol; an accident, not a statement. What interpretive anthropology struggles to do—weave anorexia into culture's web of meaning—takes yet another wrong road.

Negotiating Anorexia

The right road engages anorexia as it is. That path opens when we give up pigeonholing to negotiate with what we encounter. That give-and-take is not new—it is how skilled clinicians engage difficult diseases (Lester 2007: 382; Luhrmann 2000), and how some cure anorexia even though medicine has no cure (Clinton 2010). These individual successes reveal an institutional failure: why does medicine not adopt what these successful practitioners do? Such an approach made other diseases curable. Why not anorexia? Lesser hurdles aside, the real impediment is epistemological: the negotiating that can cure anorexia undoes the subject/object divide. That Cartesian distinction—separating subjective opinion from objective fact—anchors biomedicine. It is how modern medicine trusts what it knows and justifies what it does. That is not easy to negotiate.

In organizing its efforts, medicine readily sees disease as a discrete object separate from the patient as a curable subject. How well that division works varies: it is at its best against an invading organism, like a parasite or bacteria; it gets befuddled by cancer, an affliction where the patient's defenses cannot distinguish a healthy cell (self or subject) from a cancerous one (other or object); and it is defeated by mental illnesses like anorexia that interweave person (self) and pathology (other).

Anorexia's self/other ambiguity throws medicine into an ethical and therapeutic minefield. Were the disease an invader, like an infection, doctor and patient would join forces. Yet anorexia is a civil war. The aggressor is the sufferer's will, a tyrant that starves her body. Treatment cannot excise her will like a tumor and get a healthy person back. Worse, intervening can feed a will fed on opposition. Here, where curing-by-conquest medicine fails, negotiating beats warring.

Negotiating adapts to an ecological truth: humans are immersed interactively in nature, so we cannot change our doings and surroundings without also changing ourselves. An anorexic person[1] tries to deny that truth. Aiming to change only her body, she accidentally changes her very being. Treatment faces the same truth. Both sufferer and caregiver get caught up in what Bateson (2000: 313, 315) would call "an unusually disastrous variant" of Cartesian dualism. When one part of an "internally interactive system" tries to assert a "unilateral control over the remainder," its victories die quickly.

Negotiating Disciplines

Negotiating also adapts to the intellectual truth that disciplines divide up knowledge and proselytize for their piece. That cuts up anorexia, making one syndrome many—an emaciated patient to a physician, brain circuitry to a neuroscientist,

socioeconomic correlates to an epidemiologist, lived morality to a philosopher, freelance asceticism to an anthropologist. Who has it right? That is the wrong question. It is better to keep all this useful knowledge in play. To do that we recognize anorexia's multiplicity and, by negotiating disciplinary differences, consider what biomedicine, the clinic and anthropology each has to offer.

What Biomedicine Offers. By dividing spirit from matter, Descartes made the mother distinction that now breeds endless others: mind vs. body, religion vs. science, subject vs. object, nurture vs. nature, culture vs. biology—and many, many more. And each of these world-halving distinctions creates its own lesser world (e.g., biology as a discrete realm) that itself gets divided again and again (e.g., biology into botany and molecular biology). Following that logic, biomedicine breaks any disease apart, expecting to find its cause amid the pieces. That misses anorexia fourfold.

First, breaking up anorexia's mind-with-body oneness makes the disease mental *or* physical, nurture *or* nature, culture *or* biology—or some mix of these supposedly separable entities. Yet anorexia is a biocultural hybrid that is inherently inseparable along mind/body lines. To be sure, the disease is divisible—later we will describe how activity and constitution function as parts—but biomedicine force-fits it into Cartesian dualism. Like a frog halved with a meat cleaver, its pieces do not add up, and they hide how the organism actually works.

Second, life's surface spawns anorexia, but modern medicine posits underlying causes. That puts Plato's rationalism over Aristotle's empiricism, the clinician's logic over the sufferer's experience, and anorexia's true nature *behind* appearances. We disagree. The anorexic's practices and feelings create anorexia. It is the offspring of a conspicuous activity, not a symptom of some deeper hidden disorder.

Third, while anorexia arises through the relation of its parts, medical specialization presumes one or another separate part is causal. So the cause is mental or nutritional or genetic or hormonal. Here relentless reductionism breaks anorexia's whole into ever-smaller pieces, confident that the pathology is one bad piece or another. Yet that is like separating hydrogen from oxygen to study water—what you are studying vanishes. As a whole, anorexia is greater than the sum of its parts.

Fourth, while moral sentiments drive anorexia, modern medicine divorces health from morality. That is a point of secular pride. In this ontology, where humans become amoral pragmatists, exposing the anorexic's self-serving motives (beauty, power, attention, resisting adulthood) explains or even cures the disease. Yet this misunderstands not just the sufferer but our species. Humans evolved out of group life, so our healthy functioning gives us a moral sensibility that we can neither fully control nor easily explain. When medicine posits amoral motives instead, it makes anorexia's roots and resilience incomprehensible.

The logics we have just described—dualism, rationalism, reductionism, secularism—distort anorexia. A purist might thus dismiss this medical knowledge as

inherently flawed. But that would be a waste. Knowing the flaw, we can make allowances to salvage findings. That is what clinicians do every day.

What the Clinic Offers. A single profession, modern medicine leads one life in healing and another in research. Ideally the two are complements, or research serves the clinic. In practice, however, the two pull in different directions: where research fragments to analyze, the clinic connects to treat; researchers seek universals while healers address variety; and whereas the lab's one truth is replicable, the clinic's bottom line is whatever cures.

With anorexia the lab often follows its logic rather than the clinic's needs. Ever more specialized, today's research gets farther and farther from the clinic's real people. Take a top journal and try to find a three-dimensional sufferer, someone with values and agency, family and friends. Instead you find systematic depersonalization. The person vanishes into indices and averages. Lost too are clinical successes that lack controls. Take the work of Louis Mogul. A practicing clinician, his 1980 article connected anorexia to asceticism and adolescence just as we have. In 2001, when O'Connor spoke to eating disorder clinicians where Mogul once practiced, no one had even heard of him. His clinical breakthrough—approaching anorexics as ascetics—had vanished. Apparently adolescence and asceticism were too big and nebulous for the lab. Here research fails to engage anorexia as it is, as the clinic does every day.

What Anthropology Offers. Anthropology prides itself on engaging reality as it is. Seeing wholes in life, the field studies them naturalistically. Culture, the whole that distinguishes the discipline, is just one among many. Here, as a theory, holism posits life's interconnectedness. Instead of isolating elements as lab logic does, it insists on "seeing any characteristic in terms of others" (Durrenberger 1996: 367). Take the strict dieting called restricting. Our informants wove that practice into cultural notions of virtue, achieving, progress, and propriety. In their lives restricting was being good. How ironic then, that outsiders would suppose it was *looking* good! Of course that is how reductionism distorts: by isolating anorexia, stripping away the context that explains it, the disease becomes an inkblot open to any interpretation. To avoid such grievous errors, anthropologists apply holism religiously. It is proper procedure, a method to use everywhere rather than just a theory to apply selectively.

Necessary and useful as holism is, anthropology overuses it. Because holism virtually "defines anthropology as a discipline" (Durrenberger 1996: 367), professionals find the interconnectedness in every case. Sometimes that works (e.g., holism shows anorexia's restricting has wider moral meanings); other times it does not (e.g., as an activity the syndrome stands alone and is not cultural). To analyze anorexia incisively, we therefore apply holism selectively rather than categorically.

In this study the critical whole is the person. To get at that reality we interviewed recovered anorexics to get their insider perspective. Taking a person-centered

approach, we studied life-cycle, social, and cultural impacts holistically and treated conventional biomedical knowledge discursively, using it to fill in the larger holistic picture.

Reworking Descartes. Despite their different methods, biomedicine, the clinic, and anthropology get at related truths. So medicine's lab research and anthropology's fieldwork are often compatible. Only when one method's hardliners exclude other ways can we not learn from each other.

Had medicine never isolated anorexia, we would know too little to even begin this book. But since isolating has found no cure, now we should try contextualizing. To that end we rework Cartesian evidence freely, seeing what the facts can say about the biocultural realities the context suggests. So while we analyze our interviews naturalistically, seeking operant wholes, we relate those findings to biomedical knowledge. We might devote a book to how biomedicine distorts anorexia, but that will not cure anyone. What is needed instead—or at least what anthropology can offer—is to use biomedical knowledge constructively rather than just deconstructing its claims.

Context and Emergence

Anthropology offers the clinic and biomedicine a rich sense of life's interconnectedness. That holistic sensibility, the fruit of culture-crossing fieldwork, may not suit all maladies, but it is vital for studying anorexia. Here, to use holism incisively, we distinguish context from emergence. We have just said restricting (a behavior) is closely connected to virtue and achieving (cultural notions). If these traits and restricting are simply *associated*, leaving their differences unresolved and other connections intact, then here holism adds only context. Yet should these traits coalesce into a coherent lifestyle—if the truly virtuous and achieving must restrict eating—then these traits and behavior *integrate* with each other and thereby separate from their erstwhile surroundings. That closure creates a new, lesser whole that stands apart from its once wider web. That is emergence.

The Principle of Emergence. Characterized as "the whole is greater than the sum of its parts," emergence is when otherwise discrete elements (parts) integrate into a system (the whole) that takes on a character all its own. Emergence recognizes how life organizes itself in complex systems within systems, a truth that ecology stresses. Called by various names,[2] ordinary thought uses emergence no less than science does. Take the popular notion of personality. That idea says a person has a distinctive enduring style (a personality—the whole) quite apart from ever-changing events (the parts) that make up a life. That explains how the same event (e.g., death of a parent) can cripple one person, empower another, leave yet a third unmoved, and so on. So an event's impact (how it functions in the person's

life) depends on the emergent nature of the whole (the personality), not the universal nature of that part (all deaths are troubling). That upends reductionism: what happens (the response to death) cannot be reduced to the part (the death itself) because its impact depends on the emergent whole (the personality).

Anorexia as Emergent. Emergence makes anorexia out of willful starving. Someone who once ate freely begins to feel hunger as weakness and fasting as strength until starving feels virtuous and rewarding.[3] Once those associations form, then like any brain pathway, they grow quicker and surer with use. An ascetic practice (the whole) thereby comes to generate the thoughts and feelings (the parts) that make the practice increasingly compelling and eventually inescapable. Once that loop closes, little else matters. Loved ones' pleas, medical interventions, and even one's own hesitations and bodily needs are all outside the loop, irrelevant to the system.

Once closed, this deadly loop is exceedingly hard to break. How does a mere arrangement of parts overcome all manner of interventions? Were anorexia an invading organism, the answer would be obvious—it is fighting for its life. Indeed, that captures how vigorously and ingeniously the syndrome resists intrusions. Yet the disease is neither literally alive nor actually alien. Whence then such remarkable powers? There are reductive and emergent answers. The reductive ones posit some prior biological, psychological, or cultural dysfunction behind the starving; then, only curing that underlying problem will stop the disease. The emergent answer says the cause is *in* what is immediately apparent: sustained starving reorganizes the person bioculturally into a starver. There need be no deeper problem.

Were it a contest, the emergent answer would win on two principles. One is "first do no harm": in presuming a hidden pathology it cannot specify, the reductive answer unleashes suspicions that harm sufferers and their families (e.g., Vander Ven and Vander Ven 2003; Way 1995). The other principle is Occam's razor: reductionism's long, tenuous causal chain supposes unknown links to distant causes in an unknowable past, whereas for emergence the causal chain is short and clear, invoking direct links to immediate causes in a known present. All else equal, that makes emergence better science than reductionism (O'Connor and Van Esterik 2008).

Yet all else is not equal. Our evidence supports emergence strongly. Every interviewee kept an ascetic practice. That common denominator quite plausibly turned them into ascetics—you become what you do. Where there were deeper problems, no one attributed recovery to their resolution. Indeed, nothing we heard suggests underlying biological, psychological, or cultural causes overpowered the person.

Clinical experience also supports emergence. Reductionism assumes a simple mechanical system with linear response, which would make anorexia easy to treat: if the syndrome is nothing but the sum of its parts, removing the right

element should cure the disease. Yet endless efforts have manipulated anorexia's every imaginable aspect, all to no avail. That failure is diagnostic. So too, small inputs (e.g., dieting) can produce large results (the syndrome, an entirely new way of life) while big inputs (major interventions like hospitalization) can have little or no result (e.g., many relapse after release), pointing to the workings of a complex non-linear system (Martin 1994). As an emergent whole it has great autonomy and resilience.

An Activity Disorder

What pulls a person's parts into an anorexic whole? Anorexia taps the human capacity to get lost in a challenging activity. Here, the syndrome develops an inner gravity, pulling the actor in an ever-expanding involvement. Bit by bit, the ascetic practice rises to meet ever-greater challenges (e.g., cut another hundred calories, run a mile more) until starving becomes "not a 'state of mind' . . . but rather a state of the body" (Bourdieu 1990: 68). Then the person goes wherever the activity takes her. Leaving family, friends, and reason behind, she withdraws to an island of inner involvement where spirit (one's self, will, identity) gets entangled in matter (one's body, the food one does and does not eat), creating a biocultural hybrid that takes on a life of its own. Because that life develops out of starving and exercising as activities, we call anorexia an activity disorder.

While the activity creates the disease, two other realities converge to make that happen. One is local virtue: anorexics-to-be reorient their lives through an act of moral willing (Mattingly 2010) that exaggerates surrounding moral discourses (achieving, control, healthy eating).[4] The other converging reality is the person's constitution: while growing up, people who later develop anorexia show remarkable capacities for sympathy, self-denial, and achieving. Taken together, these three realities—activity, virtue, and constitution—interact to spawn a fourth reality, anorexia. What typically pushes the three together is adolescence.

A Developmental Disorder

Though many cultures orchestrate how children become adults, modernity makes adolescent growth a do-it-yourself project. Anorexia is one way it gets done wrong.[5]

Anorexia as Misdirected Development. Ideally adolescence builds on the past to open the future. To quote Erikson (1964: 91), there should be "a progressive continuity between that which [the young person] has come to be during . . . childhood and that which he promises to become . . . between that which

he conceives himself to be and that which he perceives others to see in him and to expect of him." That is how adolescence expands outward, opening doors. Anorexia goes the opposite way: life collapses into a narrow goal-directed domain (restricted eating, intensive training, obsessively healthy living) where the person overdoes the regulatory virtues (self-denial, self-control, perfectionism) that success requires. Our interviewees were successful children, suggesting their well-developed regulatory strength. Adolescence then exaggerates this controlling. Like a coup, one moralistic faction seizes the person and tyrannizes the rest with its puritanical control and virtue.

What causes the coup? Anorexics grow up as conspicuously good children (Bruch 1962: 192). Then, when youth culture invites wrongdoing, moralistic over-controlling would seem to *defend* a virtuous self against temptation—at least, that is what the Cartesian individual/society opposition supposes. Yet the same behavior might as readily follow from an individual/society synergy where anorexia *expresses* who you are by the values you live (discipline, self-denial, willpower, toughness, individuality, relentless effort). Here anorexia would be a mechanism of identity rather than defense.

Is anorexia defensive or expressive? In theory defense withdraws in weakness from surroundings that the expressive engages in strength. In practice all real cases are mixed and ambiguous (the anorexic withdraws *and* engages, is weak *and* strong). Judging by the clinical literature, where troubles abound (sexual abuse, parental death, dysfunctional parenting, etc.), anorexia is defensive: controlling eating rescues an out-of-control life. Although that fits a few cases in our sample, we more often found expressive anorexia: our interviewees were asserting their identity and values as youth do. That positions anorexia in adolescent development gone wrong.

Modernity's Misdirecting Developments. Whereas defensive anorexia might occur in any place or day, expressive anorexia has distinctively modern roots. In the late nineteenth century, as rapid social change eroded customs that once organized everyday life, choice expanded rapidly. In that openness two movements arose that now invite eating disorders. One is sports: some cases in our sample develop directly out of athletics, and every one exemplifies the achieving, toughness, and relentless effort that contemporary sports inculcate. The other movement, virtuous eating, counters declining customs with stricter eating and bodily control. In this "compensatory control," restrained eating takes on "independent moral functions, denoting good character" and makes dieting "a moral statement at a time when more conventional statements have less meaning" (Stearns 1997: 64, 247).

Is this moralistic eating some cult? Now widespread, virtuous eating typifies the upper middle class and is so well established that Giordano (2005: 8–9) can attribute eating disorders to "the consistent expression of values that have

ancient roots in Western culture." As such these "are not the *symptom of an underlying mental disorder*. . . . They are . . . ordinary morality, which is just being *taken seriously.*"

Repositioning Anorexia

Explaining anorexia by its surroundings challenges three schools supposing darker, deeper or wider causes. One school posits a prior trauma. Early on that trauma was distinctive—malignant mothering, a cold father, sexual abuse—but evidence kept overturning specifics; by now any trauma will do. When someone like Becca objects, insisting her prior life was happy, she gets told she is "in denial." We believe Becca: our evidence roots anorexia in a present practice, not prior trauma.

A second school makes anorexia a woman's disease. That forgets male anorexics, perhaps one in three (Woodside et al. 2001), and dismisses cases that originate in athletics, healthy eating or self-improvement—all gender-neutral practices. True, anorexia strikes more women than men, but then its gateway practices involve women more than men. Here anorexia is no more a woman's disease than the gender ratio reversed (Keyes et al. 2008: 25) makes alcoholism a man's disease. What is gendered is the entry, not the disease.

A third approach, biomedicine, now attributes anorexia to a "multifactoral" convergence of causes (A. Becker et al. 2004; Collier and Treasure 2004). That captures an important truth, for a host of factors do combine to make anorexia. But what we have found, emergence, says differing parts (e.g., different personalities, opposite motives, various events, disparate social situations) can make the same anorexic whole. What is decisive is the activity, not the ingredients. In looking outside the activity, factor analysis overlooks the internal gravity that makes the disease.

Negotiating Knowledge and Theory

Opening with Becca's type-defying case highlighted how current thinking fails to address anorexia as it is. That failure, we argue, is ultimately epistemological: contemporary Cartesian dualism hides the ways the disease works. As anorexia will not change to suit us, our epistemology must change to suit it.

A Holistic Epistemology. For Descartes, knowledge begins by separating mind from body. By setting humans apart from nature, that dualism makes us subjects who can see and study the world as an object. For Bateson (2000) that separateness is illusory. Humans are always in the world. In fact, that immersion is how

we can know life empirically even as we live it ecologically. In that oneness, where mind and body constitute each other, humans are historically contingent biocultural wholes, hybrids that arise from and then interact with their surroundings. That is true for a single person or our entire species, a small group or a vast civilization. At any level, humans move in nature as it moves in us. Bateson discerned this all-embracing ecology decades ago, Goldschmidt (2006) recently applied it to nurture, and we now apply it to anorexia.

How do we get from this sweeping epistemology to anorexia's particularities? Theory builds bridges. In theorizing we have no stake in any particular theory. All we care about is making sense of three bodies of evidence. Our primary body is what our interviewees said and did. Our secondary ones are the biomedical literature and the following anthropological findings:

- Contemporary eating can evoke pride, shame, guilt, or anxiety in a distinctively modern moral discourse (Counihan 1999; Mintz 1993) that invites eating disorders.
- Culture-of-thinness explanations fail in the field. Any dieting done for looks pales beside anorexics' religious meanings and moral motives (Banks 1992, 1996, 1997; Lester 1999; O'Connor 2000). These enact local scripts (Gooldin 2008; Lester 2007; Pike and Borovoy 2004), not media manipulations.
- An anorexic practice does not enact the wider culture directly but creates its own micro-worlds out of embodied experience (Gooldin 2008; Shohet 2007; Warin 2010) and Foucauldian technologies of self (Lester 1997).
- Studying anorexia ethnographically questions misplaced medicalization (O'Connor and Van Esterik 2008) and shows how clinical settings can reproduce the disorder they aim to cure (Gremillion 2003; Lester 2007; Shohet 2007) or create new relationships that stabilize the disease (Warin 2005, 2006).

In applying these and other findings we are empirical pragmatists: as empiricists we anchor anorexia in an observable activity and its concrete consequences; and as pragmatists we act like Lévi-Strauss's (1966) bricoleur, a French handyman who makes do with whatever is at hand to fashion something workable. Here, culling evidence widely, we negotiate theory pragmatically.

Pragmatic Theorizing. Like other complex diseases, anorexia gives ambiguous evidence. As a relationship with researchers that changes as their queries do, the syndrome is too fluid and various for any single explanation. That puts theorizing at a crossroads. Is one explanation better than many? Is our goal epistemological consistency or empirical engagement? To balance the two we work within a biocultural epistemology while shifting theory and method as anorexia's particulars do.

Meaning as Hermeneutics: In today's anthropology, culture as meaning neatly captures anorexia's moral impetus and its projects of virtuous self-improvement

(dieting, training, healthy eating, bodily control). It does not, however, explain the pathology. As we will see, anorexia's cause is an activity, *not* culture; what unfolds is accidental, not symbolic; and the pathology's engine is experience, not meaning.

Experience as Phenomenology: Anorexia develops out of what anorexics experience. To get at this reality we built on the phenomenology of Bourdieu, Merleau-Ponty and Csordas. Bourdieu (1990) captured how starving, like any serious practice, follows its own internal logic. From Merleau-Ponty (1964) we learned how anorexia's sympathies and mis-development can have ontogenetic origins. And Csordas's (1994: vii) cultural phenomenology, by "synthesizing the immediacy of embodied experience with the multiplicity of cultural meaning," showed how adolescence, eating, the body, and appearance are all discourses that energize anorexia.

History as Bioculturalism: Hermeneutics unlocks meaning as phenomenology does experience, but neither theory can account for anorexia's persistence. Bioculturalism does. It theorizes how the symbolic and the physiological join synergistically to create a hybrid that then lives on. Like any emergent whole, it persists by adapting to changing conditions. Indeed, once established, the disorder makes the meanings and experiences that keep it going. That is the horror—ending what began the disorder need not end the affliction.

Cross-Activity Comparison: Our pragmatic theorizing risks cherry-picking. While hermeneutics, phenomenology, and bioculturalism each has its own rigor, moving between the three allows us to pick and choose what we explain. Are we choosing what fits our argument and ignoring the rest? After all, by saying that anorexia is an activity disorder and misdirected development, we make general claims about activities and development. Can we test these holistically? In anthropology comparing cultures usually does that cross-checking, but that will not work if anorexia's context is an activity, not a culture. What rigor demands, then, is comparing activities.

Compare three activities—monasticism, elite athletics and breastfeeding. All irreversibly change the person, altering one's very being as anorexia does. Like anorexia, each is a clearly bounded, well-focused, demanding activity that, when pursued wholeheartedly, remakes the person in its image. How? All create their own tight little world within the larger looser one, pulling the person away from existing persona and into a new way of life. Here monasticism and elite athletics share anorexia's unbending asceticism. Monk, top athlete or anorexic—all three live by strict regimens that grow to organize every moment of every day. All three also find that just working to get better tightens rules and kills compromises. Then, when the regimen demands more than the body should bear, a devotee pushes through pain to be a better person morally (monks) or competitively (athletes) or both (anorexics).

Breastfeeding is the odd activity out. It is as commonplace as the others are exceptional, as life-affirming as they are life-denying. Yet breastfeeding enacts developmental change just as our interviewees' mis-development does. In both cases that change is a life-cycle transition that our era no longer celebrates or even facilitates. Worse, modernity has shattered customs that once enabled breastfeeding and socialized eating. Worse still, that loss has opened both activities to the over-controlling and endless perfectionism that incites anorexia and impedes breastfeeding (O'Connor and Van Esterik 2012). Our companion volume, *The Dance of Nurture: Embodying Infant Feeding*, further unpacks the biocultural processes that make breastfeeding life-giving and anorexia life-taking.

The Plan of the Book

Where biomedicine isolates anorexia and thereby narrows it, our project contextualizes and thereby widens it. Section I studies the disease in itself. It explores how quite various motives initiate the disease, which then follows its own inner logic. Over time, restricted eating and excessive exercise bootstrap the actor into anorexia as a self-sustaining disease. Section II then looks at how adolescence and coming of age evoke an anorexic response. That response taps traditions of virtuous eating, bodily discipline, and appearance that Section III explores as the anorexic's ascetic response to modern life. In Section IV the recovered tell us how they escaped anorexia and stay healthy.

Notes

1. Some prefer "anorexic person" to "anorexic," distinguishing the person from the disease. We use the longer phrasing occasionally as a reminder that we are talking about whole people who happen to be anorexic. Why not drop the dubious term altogether? Our project would suffer. Imperfect as it is, anorexic is clear and succinct. It eliminates a distinction that does not always matter to advance an argument that does.
2. Our term, emergence, comes from biology. The principle goes by Gestalt in psychology and metaphysical holism in philosophy. It is fundamental to hermeneutics, systems theory, chaos theory, and anthropology's holism.
3. In studying Ethiopian hermits, Bushell (1995: 554, 560) found that after the initial discomfort, fasting can lead to "disappearance of the pain, discomfort, and dysphoria of hunger, and their replacement with feelings of well-being, tranquility, and even euphoria." Apparently ascetic practice reprograms the person's drive/reward architecture, uncoupling "the (most probably endogenous opioid-mediated) experience of reward from the object of reward." Not eating then produces the rewarding experience once gained from eating.

4. Mattingly's phrase captures how self-improvement projects can end up as anorexia. Moral willing would seem to exercise a somatic mode of attention (Csordas 1993) and, with success, progressively reshape one's identity (Holland and Eisenhart 1990).
5. A. Becker et al. (2004: 82) saw "strong evidence" for psycho-developmental factors in anorexia's etiology. Collier and Treasure (2004) saw developmental and biological explanations displacing social and cultural ones.