



Secret Hunger: The Case of Anorexia Nervosa

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Abstract

Anorexia nervosa is currently classed as a mental disorder. It is considered as a puzzling condition, scarcely understood and recalcitrant to treatment. This paper reviews the main hypotheses relating to the aetiology of anorexia nervosa. In particular, it focuses on family and sociological studies of anorexia. By reflecting on the hypotheses provided within these domains, and on the questions that these studies leave unanswered, this paper suggests that anorexic behaviour is understandable and rational, if seen in light of ordinary moral values.

Keywords Anorexia · Eating disorders · Family · Sociological analysis · Moral values · Mind–body dualism

1 Introduction

Since its first descriptions, anorexia nervosa has been considered as a mental disorder, and it is still classified as such in the DSM and the ICD (APA 2013, pp. 329–354 and 338–345; WHO 2018).

There are several other forms of self-imposed starvation (hunger strike, hunger art, religious fasting) (Dresser 1984). Self-starvation or at least extreme forms of dieting are also central to some sports and professions (for example rock climbing, ballet, modelling in the fashion industry). None of these others have been classified as mental disorders.

One likely reason for this difference is that anorexic starvation appears difficult to understand and outright irrational. There appears to be no intelligible purpose in the anorexic starvation, no paradigm of socially intelligible values and purposes.

In this paper I argue that, contrary to what might look like, anorexia is not irrational, and it is not unintelligible either. Anorexia makes sense in light of a certain moral background. Many analyses of anorexia have missed this point or have not given it sufficient weight.

This paper will be structured as follows: in Sect. 1 I provide a brief description of anorexia. In Sect. 2 and 3 I summarise those that I believe are the most insightful accounts

of anorexia. In Sects. 4 and 5 I identify some questions that these studies leave unanswered and show how certain moral beliefs and values play a key part in the genesis of anorexia. In the final section I consider a remaining question around the anorexic's 'real' control over her choices. For easiness I use the pronouns 'she' and 'her', as the condition still affects mainly women (1–4% of women compared to 0.3–0.7% of men in Europe according to Keski-Rahkonen and Mustelin 2016), but it must be recognised that men also suffer from eating disorders, and that of course body dissatisfaction can manifest itself in different ways.

2 Anorexia Nervosa: A Brief Account

Anorexia nervosa is described as a mental disorder characterised by significantly low body weight, resulting from diet, and often accompanied by purging (self-induced vomiting, abuse of laxatives) and excessive exercise. The behaviour is triggered by the sufferer's fear of weight gain, which often is associated with a denial of the seriousness of the emaciation (APA 2013, pp. 329–354 and 338–345; WHO 2018).

Since the first descriptions, anorexia has been presented as a mental disorder.

In 1694 Richard Morton provided one of the first known descriptions of anorexia. In his *Treatise of Consumptions* he described anorexia as "A Nervous Atrophy, or Consumption [which is] a wafting of the body without any remarkable Fever, Cough or shortness of breath [...] The Causes which dispose the Patient to this Disease, I have for the most part

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observed to be violent Passions of the Mind [...] This Disorder as most other Nervous Diseases is Chronical, but very hard to be cured, unless a Physician be called at the beginning of it.”¹

Nearly two centuries later, in 1874, Lasegue in France named it “*anorexie hysterique*”, and then “*anorexie mentale*” (Bruch 1974, p. 213), and William Gull around the same time in the UK named it *anorexia nervosa* (Gull 1888).

These names have remained unchanged, as has the idea that the condition is a mental illness, and no somatic cause has been found for the condition (although genetic factors have been identified as correlated to higher susceptibility to anorexia—Wang et al. 2011; Trace et al. 2013; Boraska et al. 2014; Treasure et al. 2015; Bulik et al. 2016).

Dealing with anorexic patients is notoriously difficult. Sufferers declare that “they are just not hungry”, but they constantly fight against hunger; the anorexic keeps dieting despite the painful consequences of starvation (hypothermia, low blood pressure, often cramps, intestinal problems, insomnia, amenorrhea, just to mention a few).

To other people’s concerns, sufferers typically respond by denying that anything is wrong. Anorexics are usually secretive about their dieting and are very resistant to the idea of changing and getting help: they do not want to gain weight; they skip meals and say that they have eaten already, they claim that they are full, they might wear loose clothing to hide their emaciation and implement several strategies to keep on dieting.

Anorexics are often described as ‘difficult to handle’, ‘incomprehensible’, ‘manipulative’, ‘deceitful’, or, in the kindest accounts, as victims of a mental disorder, lacking in responsibility and agency. If they refuse help and food, they are said to be incapable of deciding, and, on this basis, they have usually been subjected to involuntary treatment notwithstanding their capacity to understand the material facts (Clough 2016).

Anorexia is a puzzling condition: it is scarcely understood and difficult to treat (Zipfel et al. 2015; Khalsa et al. 2017; Brockmeyer et al. 2018); it has the highest rates of mortality amongst mental disorders (Fichter and Quadflieg 2016; Arcelus et al. 2011) and even when not lethal, it is associated with serious morbidity.

At least since the mid 1960s, clinicians, psychologists and sociologists have formulated various hypotheses about the possible causes of anorexia.

Some consider the extreme behaviours that we see in anorexia as, quite simply, the result of a mental illness. A similar approach has been used in all the cases that have been brought before the English courts: where it had to be decided whether a person could be lawfully force-fed, or lawfully

withdrawn from therapy, invariably the sufferers were said to be ‘compelled’ to refuse medical treatment and food *because* of the underlying mental disorder (for an account of these cases, see Giordano 2019).

Other scholars have proposed richer analyses of the experiences and behaviours of anorexia sufferers: they have examined the condition from a sociological perspective (as a problem related to social changes particularly after the ‘economic boom’); from a feminist perspective (as one of the consequences of patriarchal oppression or of media pressure and other forms of ‘lookism’) (Orbach 1978, 2005; Dolan 1994); from a relational perspective as the result of dysfunctional family dynamics (Selvini Palazzoli 1963; Selvini Palazzoli et al. 1998).

From these other perspectives, anorexia is not just an intra-psychic condition, a mental health problem of the sufferer, but a relational issue, a coping mechanism in highly problematic families, or a defence mechanism in stressful social contexts: whereas the sufferer might have personal and individual vulnerabilities, the causes of her conditions are to be sought in the relationships between the sufferer and the environment (family and society).

These analyses have been more insightful and complex than those that just appeal to the psychiatric diagnosis as an explanation for people’s experiences and behaviours. However, even those are somehow incomplete. This is not to be intended as a negative criticism: it is a feature of the most promising hypotheses that they raise further interesting questions.

In the next section I summarise the main findings of these studies, and then discuss the outstanding questions that they leave unanswered.

3 The Family of the Anorexic

Since the earliest studies, it has been recognised that family dynamics are determinant in the genesis of anorexia. Anorexia is considered, under this perspective, as a coping mechanism (Selvini Palazzoli 1963; MacSween 1995, ch. 2.4; Briody Mahowald 1992).

One of the first systematic studies of the eating-disordered family was provided by Salvador Minuchin. According to Minuchin, eating disorders appear in a particular family, which he called ‘psychosomatic family’. This family is typically characterised by rigidity, enmeshment, overinvolvement, and conflict avoidance. Although not being the sole causes for the disorder, such dynamics are, he believed, an essential element in the development of eating disorders (Minuchin 1981; Eisler et al. 2003, p. 292).

Hilde Bruch, one of the pioneers of eating disorders studies and therapy, similarly argued that anorexia is a cluster of

¹ Kindly provided by Walter Vandereycken.

symptoms that emerge in response to dysfunctional family dynamics (Bruch 1980, pp. 72–90).

Today it is believed that eating disorders are likely to be caused by both biological and psychosocial factors (multifactorial) (Treasure et al. 2015). However, the relevance of family influence on the future anorexic/eating disorders sufferer remains little disputed. Families with an anorexic member are normally described as highly problematic, manipulative and incapable of deep and stable affective bonds (Lackstrom and Woodside 1998, pp. 107–108).

Colleagues commonly comment that we ‘must be tired of working with those people’ or ‘how do you stand it?’ This attitude reflects *a general belief that eating-disordered families are manipulative and resistant to change*. In some instances our colleagues see the individual with the eating disorder as a *victim of her disturbed family* or at the opposite extreme as a *scheming manipulator* who is purposefully destroying her long suffering family in her search for attention (Beaumont and Vandereyken 1998, pp. 4–5) (my emphasis).

In a landmark study of anorexia nervosa, Mara Selvini Palazzoli, while discussing the family of the anorexic, wrote:

To the superficial observer, this may look like quite an ideal family. Generally, parents are completely dedicated to their work or to the house, they have a high sense of duty and of social and conventional norms...[T]here was, in all cases, a permanent state of underlying tension...a marked inclination to endless and unnerving arguments about the most futile issues, which is symptomatic of a hidden aggressiveness which needs an outburst...[T]he dominant figure, in the family of the anorexic, is the mother: the father is often emotionally absent...secretly or openly underestimated by his wife. Even in cases in which the father, thanks to his *intolerant and dictatorial behaviour*, seems to be the *dominant figure*, the mother wins...stubbornly *playing the part of the victim*...The daughter easily becomes *the victim of the mother*...the daughter is the ideal baby of an invasive, intolerant and hypercritical mother [...] (Selvini Palazzoli 1963, pp. 61–62) (my emphasis).

A few years later, Hilde Bruch in her seminal work *Eating Disorders: obesity, anorexia nervosa, and the person within* (Bruch 1974), reported a number of cases that appeared remarkably similar to those described by Selvini Palazzoli.

Brian Turner talked about ‘the anorexic family’ (Turner 1984) (rather than the anorexic person) and noted that these families are invariably characterized by contradictory requests of their daughters: on the one hand, these families value competitive success, for example in school and professional life; on the other hand, they also encourage

submission rather than the autonomy and independence that are necessary to obtain the valued success (Turner 1984, p. 192).

Since these earlier studies, there has been extensive research on anorexia and family dynamics, and all seem consistent in presenting anorexia as a coping mechanism in dysfunctional dynamics particularly ‘vertical’ dynamics (parents to children) (Witton et al. 2007; Vidovic et al. 2005; Lock and Fitzpatrick 2007; Tan et al. 2003; Dimitropoulos et al. 2015; Lafrance Robinson et al. 2015; Rienecke Hoste 2015; White et al. 2015).

Wider social contexts appear similarly problematic.

4 The Society of the Anorexic

Up until the 2000s, eating disorders were nearly exclusively found in Western countries (Gordon 1990) or westernized societies such as South Africa and Santiago (Chile) (Beaumont and Vandereyken 1998) or countries that are becoming economically emancipated, such as China (Beaumont and Vandereyken 1998; Selvini Palazzoli et al. 1998). Although the prevalence in low-income countries seems to be on the rise, eating disorders still seem to be more prevalent in high-income Western countries (Erskine et al. 2016; Pike and Dunne 2015).

For this reason, eating disorders have been regarded as ‘culturally bound syndromes’—that is, a cluster of signs and symptoms only found in a particular culture or group of cultures (Nasser 1997, p. 14). Nasser argued that “cultural forces are responsible for this modern morbid phenomenon” (Nasser 1997, p. 106).

There seems to be growing evidence that eating disorders affect people across the socio-economic spectrum (Mulders-Jones et al. 2017; Mitchison et al. 2014; Goeree et al. 2011); however, anorexia is still more prevalent in high and middle socioeconomic segments of society (Darmon 2009; McClelland and Crisp 2001).

One of the factors that explain the upsurge of anorexia in economically emancipated societies, according to a number of researchers, is the change in the social role of women. In these societies, expectations of women have, particularly since the 1900s, been conflicting (Komarovsky 1946; Novack & Novack 1996).

Mara Selvini Palazzoli writes:

Basically, nowadays the woman is asked to be beautiful, elegant and well-kept, and to spend time on her looks; this however, should not prevent her from competing intellectually with men and other women, having a career, and also romantically falling in love with a man, being tender and sweet to him, marrying him and representing the ideal type of lover-wife and oblatinal

mother, ready to give up her degrees...to deal with nappies and domestic stuff. It seems evident that the conflict among the many demands...represents a difficult challenge for adolescents, especially the most sensitive... (Selvini Palazzoli 1963, p. 75)

Susie Orbach also noted that in economically emancipated societies women are typically subjected to contradictory expectations: on the one hand autonomy and independence and, on the other, femininity, nurturance, deference and dependency (Orbach 2005). These roles are incompatible and the crisis generated by this conflict is faced by refusing food, which is, under this perspective, a defence mechanism that enables the sufferer to remaining in a limbo between childhood and adulthood.

What happens within families thus often naturally mirrors social changes and values, which families, consciously or not, internalise and by which they begin to shape family dynamics.

MacSween similarly argued that the crisis of the anorexic is not due to her own disorders: it is rather the social world that is lacerated by conflicting expectations about the behaviour of adult women (MacSween 1995, chs. 2, 3).

According to Crisp, faced with impossible demands, the anorexic refuses food, unconsciously refusing in this way to become a woman. She opts for a small body, where smallness is symbolic of a rejection of adulthood, with the conflicting demands it carries with itself (Crisp 1977). Food refusal allows the person to exercise some control over her life and over others (Lawrence 1979, p. 93).

MacSween conducted a number of interviews with anorexic patients. She asked them why they believed they had become anorexic, and the most common answer was that they felt powerless in their environment and they needed to exercise control over at least one portion of their life; the girls were not only blaming parents; they said they were sensitive to the expectations of peers and even of their own expectations of themselves (MacSween 1995).

Psychological control is still today considered as one of the main causal factors of anorexia (Surgenor et al. 2002, 2003; Tan et al. 2003; Foreich et al. 2016).

These accounts are illuminating but, as I anticipated earlier, they leave some questions unanswered. One of these is why we suffer, if others or society at large have unrealistic expectations of us. Answering this question requires an analysis of the moral values that underpin the relationships in these cases.

5 Why Expectations and Disappointments are a Moral Issue

In the analyses of anorexia summarised earlier, anorexia is presented as a defence mechanism against the high and contradictory demands that come either from within the family,

or from society at large. The vulnerable adolescent, overwhelmed by these demands, unable to fulfil them, opts for a small body, a body that she can control and master.

One underlying assumption here is it is natural or understandable to be upset, when others set inappropriate expectations of us, and depending on what the expectations are, and who sets them, the suffering can be psychologically devastating.

But not all expectations cause suffering and upset. If I expect that, once you have read this paper, you should change your mind about anorexia, my wish might well remain unfulfilled. You have no reason to feel inadequate or bad because you are letting me down. I have no moral claim to your appreciation, and you would not let me down by disagreeing with me. My expectations would be entirely 'my problem', as it were, not yours.

The 'suffering' of the anorexic, well described in the literature, is a suffering that is linked to the sense of disappointment: the anorexic blames herself for not living up to expectations, which at times are internalised (see for example MacSween 1995). Others, likewise, are also disappointing, because they set unrealistic expectations and overlook the sufferers' needs.

The root of the suffering in these dynamics is thus not the set of expectations per se, but a moral norm: the sufferer has accepted the expectation as a legitimate one, and has accepted that disappointing those who have legitimate claims is something we should feel bad about.

This might be obvious: most of us would agree that there are legitimate moral claims within close relationships, and most of us would take it as a sign of moral decency that people feel bad when they let down some significant other.

What is less obvious is that the relationship between 'victims' (the object of expectation) and 'persecutors' (the person/s who set the expectations) is circular and specular: victims and persecutors are not juxtaposed to each other (as suggested in the literature); they are one and the same.

The victim feels bad or inadequate or even guilty because she lets others down; but those who set expectations let the victim down too. The victim's suffering speaks of the others' expectations: it says that those expectations lead to emotional pain, and if it is true that disappointing others is wrong, then those others too can be expected to set appropriate demands, to change their expectations, to meet the sufferer's emotional needs. But in the same way as the anorexic might be unable to fulfil others' expectations, so might those others. In one sense, those others can also be said to be 'victims' of the sufferer's unrealistic expectations.

The circularity of expectations and blame is well illustrated by the description of the 'colleagues' comments, offered by Beaumont and Vandereycken (cited earlier in the paper): some see the sufferer as a victim of the disturbed family; some see the anorexic as a manipulator,

and the family as a victim (Beaumont and Vandereyken 1998, pp. 4–5). Many shift from one account to the other. The clinicians capture the dynamic in place in the families observed, but are somewhat absorbed in that dynamic: rather than unpacking it, they participate in it, as evidenced by their own expressions of frustration, irritation, powerlessness, accusations...

Of course relational rupture within families is unlikely to result just from a mismatch between expectations; much can lead to feelings of disappointment and inadequacy. But suffering is only at a superficial observation a response to ‘inappropriate expectations’. The ‘sufferers’ suffer because they accept (perhaps unknowingly) a determined set of moral beliefs, according to which disappointing others is *prima facie* morally wrong, and interact with others accordingly. The root of the problem is not the expectations, but the moral beliefs that are intertwined with them, the moral logic that underpins the relationships.

It might be that we do have a moral obligation to meet certain expectations, particularly within close relationships; it is possible that certain moral codes have positive function in the fabric of family life or in the fabric of society. Indeed, it might be hard to challenge the moral dynamics here because the moral values at stake are perhaps commonly accepted and might serve some important function. In this sense, the continuity between ordinary moral values and those that are in place here makes it difficult to unpick and challenge these.

However, without explicit acknowledgement of the moral dynamics at stake here, it is difficult to move beyond the frustrating tensions that are well described in the literature. One might change the expectations, but without challenging the system of moral values that give shape to the dynamics of expectations/disappointments, the risk is to fall foul of the similar dynamics in some other way, or to replicate the dynamics in the clinical encounter.

There is another question that remains only partly answered in the literature.

The literature suggests that anorexia enables the sufferer to retain control over the self, through control of food intake and of her body shape, and at the same time to retain control over others (Surgenor et al. 2002, 2003; Tan et al. 2003; Foreich et al. 2016).

But why does self-starvation enable such control? Again, this question cannot be answered without explicit acknowledgement of a certain moral background.

6 Starvation and Control

Gilbert Ryle wrote:

There is a doctrine about the nature and place of minds which is so prevalent among theorists and even among laymen that it deserves to be described as the official theory. [...] The official doctrine, which hails chiefly from Descartes, is something like this. With the doubtful exceptions of idiots and infants in arms every human being has both a body and a mind [...] Human bodies are in space and are subject to the mechanical laws which govern all other bodies in space [...] But [...] the workings of one mind are not witnessable by other observers; its career is private [...] Underlying this partly metaphorical representation of the bifurcation of a person’s two lives there is a seemingly more profound and philosophical assumption. It is assumed that there are two different kinds of existence or status. What exists or happens may have the status of physical existence, or it may have the status of mental existence (Ryle 1949, pp. 13–14).

Different terms are used to refer to the ‘mental capacities’ or ‘mental entity’: soul, spirit, reason, intellect, will. The terms ‘soul’ and ‘spirit’ normally have a religious flavour, whereas many contemporary philosophers use the terms ‘reason’ or ‘rationality’, often considered as to be the faculty that distinguishes humans from other animals. Many influential contemporary speculations on personhood rely on a similar conception of the human being, as a being that, in its ‘complete’ or ‘higher’ form, possesses ‘mental’ capacities—self-awareness, capacity to consider itself as the same being over time, and so on (for example, Harris 1992; Parfit 1976; Engelhardt 1996).

It must be noted that various philosophers and philosophical schools (for example non-Cartesian monism, structuralism and post-structuralism) objected against this type of metaphysical dualism (for example, Searle 2004; Ayer 1990; Inwagen 1980, pp. 283–99).

Despite this, the dualistic conception of the human being has been fundamental for Western thought and culture, and the association between body and baseness recurs in all eras: in the Greek thought, in Christianity, in the patristic doctrines, in Scholastic philosophy, in the different confessions of Christianity (Catholicism, Protestantism, Puritanism, Calvinism); in Humanism and Renaissance, with their flourishing of Neoplatonic and neo-Aristotelean theories, in modern philosophy and in contemporary society as well. Christianity in particular hallowed the idea that moral perfection has to be found in the detachment from the world and ascension to God, and fasting, together with other forms of self-inflicted suffering (sleeplessness, isolation and various other forms of mortification) became one of the most effective ascetic techniques since at least early Christianity (3rd and 4th Century AD) (Murchu 1983).

Max Weber discussed how this metaphysics and the corresponding ethic are not only religious but also secular, and discussed how pervasive they are in contemporary society (Weber 1977). More recently Krogovoy has shown that they are still ubiquitous, and has argued that they are likely to impact on the way people perceive their physical impulses, including *hunger* (Krugovoy Silver 2003, p. 137). Fasting has been associated (and is still associated) with ideas of *control* and *purity*. Fasting is ‘detox’; it ‘cleanses’ the organism: this, of course, means that eating is always, more or less, a form of pollution. Not only a historical search for the value of religious fasting, but a simple google search will show hundreds of health farms that advertise fasting in similar terms.

This is not to suggest that anorexics fast for religious reasons (for an analysis of the phenomenological similarities and differences between anorexic starvation and other forms of starvation see Vandereycken and Van Deth 1994, chs. 2, 11). This is instead to suggest that control of hunger can become a coping mechanism because of a certain metaphysical and moral background, which is likely to be implicitly accepted in the systems in which the disorder appears.

Not coincidentally, studies have found that typically people with anorexia are particularly sensitive to the ethic of perfectionism, discipline, austerity, hard work, spirituality, guilt, and especially the belief that the submission of the ‘physical’ to the ‘spiritual’ is a manifestation of moral integrity (for example, Lawrence 1995, pp. 32–5; Duker and Slade 2003).

Control of food intake is central to eating disorders, together with compensatory practices, such as self-induced vomiting, abuse of laxatives, and diuretics. Interestingly, these are also called ‘cathartic’ practices. These are practices through which the person purifies herself of food. It is the value placed on self-control and austerity, and the role of fasting in achieving these, that seems to be the dominant background of the psychology of anorexics.

According to the literature, anorexic symptomatology also enables a level of control over the surrounding environment. Again, it is possible to understand why this is so in light of certain moral values.

Anorexia is not the only form of starvation that enables control over others: political hunger strikers use of a similar strategy, as do, more commonly, charity appeals (Burman 2007, ch. 12). In these appeals and advertisements images of extremely emaciated people, particularly children, in extreme conditions of suffering are displayed. Their suffering elicits compassion, but it does more than this: the suffering empowers the viewers, giving them literally godly powers to sanction life or death (‘if you donate...’); but it equally disempowers the viewer, making the moral choice obvious (‘simply text...’). Who could be so callous to deny 1 lb£ that could save a life?

The displayed suffering has leverage because of the blame and guilt that are attached to the failure to do something for others, especially something that costs so little to us and that has considerable benefit for others. Thomas Szasz noted that guilty feelings are important mental constraints, and that blame and guilt are powerful instruments of social control (Szasz 1984). These types of call (the hunger strike, the charity appeal, and similar others) thus tap into a moral belief that is present in one form or another virtually in all moral codes: we should do something to minimise other people’s suffering, and failing to do so is condemnable. It is not hunger per se that enables control: it is the guilt and blame that it elicits that does.

Unlike other forms of self-harm (for example cutting, where the person typically hides the scars) anorexia is *exhibited*: the thinness is proudly worn. Whilst anorexics are usually secretive about their feeling of hunger, their food rituals, the extent of their dieting, their exercise regime, they hide to make sure that others do not interfere with their choices: their thinness, however, is clearly visible.

The impact of anorexia over the surrounding environment is strong. Anorexics elicit anger and even some degree of secret admiration (Geerling and Saunders 2015). Even at the death’s doors often anorexics refuse medical treatment: their stubbornness elicits frustration as well as fear, usually both in the families and in the clinical teams. Ultimately, anorexics succeed well in disempowering others.

Control of appetite, hunger, exhibition of suffering, can be a strategy of control, a defence mechanism, only in contexts in which it is accepted that we should feel sorry for other people’s suffering and do something about it, and in which a moral logic is articulated around this belief. Absent the moral belief the coping mechanism would be useless.

As we have seen earlier, in systems in which this moral belief is accepted, it is unclear who is causes the suffering and who is the victim, who should do what, who is empowered and who is disempowered. The anorexic is clearly weak, emaciated and frail, and if it is true (as it probably is) that what triggers anorexia is her sense of powerlessness, she is also disempowered. So are others, though. As we have seen earlier, a similar moral belief triggers the circularity of expectations disappointments and reciprocal blame and guilt, which is likely to cause the unnerving arm wrestling between the anorexic person and others, and which is well known to families, sufferers and therapists.

Acknowledging the moral values that underpin anorexia is important because it contributes to explain one seeming paradox of anorexia: the more starvation weakens the person, the more emaciated the person is, the more she feels stronger and powerful. This also contributes to explain why the longer anorexia is unresolved, the harder it is to treat it; this contributes to explain why so called ‘food orgies’ are experienced as shameful, and why the anorexic who gives

in and eats often quickly resorts to ‘cleansing’ practices: she needs to throw up and get the control back in place.

This is also important because it may provide one alternative key of action with anorexics and their families: rather than working on food intake and rehabilitation, or even on the family and social dynamics per se (on what is demanded of whom) it might be necessary to concomitantly delve deeper in the moral beliefs that render the starvation strategy functional to the systems in which the anorexic lives.

This does not pretend to be an exhaustive analysis of anorexia: it just attempts to add to the existing analyses. Other factors (psychological, genetic, cognitive, social, cultural, familial) are also likely to play a role in anorexia. Neither I am suggesting that the sufferer is conscious of the moral values and dynamics that shape anorexia, or that she fasts to become ‘morally good’ or to deliberately hurt others. What I am arguing is that it is difficult to understand how self-starvation could be a strategy to regain overall sense of control over one’s life and over others, without explicitly acknowledging the fundamental part played by moral pressure.

7 Don’t Anorexics Lack Control?

Another claim that is found in the literature is that the control that anorexics exercise is not real: it is ‘apparent’. In actual fact, anorexics are out of control.

Other groups of ‘starvers’, it might be argued, can stop when they want to: the hunger striker can stop if she wins her political battle; the dancers, models, climbers, runners and so on, can change professions and adopt healthier eating patterns.

Anorexia is different, it might be believed: typically, an anorexic begins a diet, and at that stage her choices are deliberate, but then somewhere along the way she loses control of the diet, and she spirals down in the grip of the anorexia.

This argument, if true, does not invalidate the previous analysis: it might well be that the strategy is successful as a ‘defence mechanism’ for the reasons explained earlier, even if the anorexic becomes at some point unable to stop dieting.

Nonetheless, it is worth reflecting on this argument for a number of reasons. One is this: if it is true that anorexics are out of control in their continued starvation, there might be little point in working on the underpinning moral values (which I have suggested, can be important in tackling anorexia). More importantly, if the claim is true, then it is justifiable to intervene with anorexic sufferers even if this goes against their wishes (for example, to impose hospitalisation and medical treatment). Under my perspective, these interventions are not necessarily unethical, but they are not straightforward either (Giordano 2019).

The idea that eating disorders sufferers do not have control over their experiences and behaviour is one that has had

significant pull in the literature and has taken several forms: some have for example argued that anorexia is a form of addiction, particularly as it shares important phenomenological similarities with addictions (Godier and Park 2015). Others have argued that anorexics lack free will: because of mental disorder, they form overvalued ideas which lead them to act in the way they do (Phillipou et al. 2017).

Philosophers have tried to provide various accounts of the freedom of will when people seem to deliberately engage in self-harming or seemingly irrational conduct. An analysis of the notion of free-will is beyond the remit of this paper, and I have discussed these various theories elsewhere (Giordano 2005). However, it is important to consider these broad concerns, at least briefly.

One of the most famous theories of autonomy, which focus on the ability to control our actions, desires and will, is that proposed by Harry Frankfurt (Frankfurt 1971). Frankfurt argued that we are autonomous when we exercise some control over our desires, not just over our actions. We might, for example, desire to smoke, lit up a cigarette and smoke: there is an apparent coherence between action, desires and will (I want a cigarette, I do not want to stop smoking, and I smoke). Alternatively we might have clashing desires and will: we might desire to smoke, but wish we didn’t have that desire—we might desperately want to quit perhaps, but our desire to smoke is so strong that we keep smoking. In neither case, Frankfurt argued, we are autonomous. The lack of coherence between orders of desires is a clear indication of lack of free will; but so is the coherence, when the coherence is only between ‘lower’ desires and actions.

These types of accounts of autonomy are called ‘multi-tiers’: they recognise that we have not only different types of desires (we might desire to smoke and to sleep at the same time, and cannot do both) but different levels of desires and volitions; some are more basic, and some are more important.

The smoker who wants to quit to take care of his health has two orders of desires: at one basic level he wants to smoke—he has a desire for a cigarette (first order desire). At a higher level he wants not to have that desire (second order desire). The smoker, in this account, is autonomous if and only if he can form higher order desires and if he is able to act accordingly.

If people are unable *either* to form second order desires, *or* to act accordingly, they are not autonomous. Later, a similar model has been proposed by Gerald Dworkin (Dworkin 1988) and David DeGrazia applied it to psychiatric conditions (DeGrazia 1994).

Let us apply this model to anorexia: on this account, one could say that the anorexic has a first order desire to be thin (although if one see ‘desire to control’ as the prime mover of anorexia the account might change significantly—I will come to this in one moment). She might

or might not have a second order desire to get rid of that first order desire to be thin. She might want to be thin, and that is all she wants. In neither of these two cases, it could be argued, the anorexic is truly autonomous. To be autonomous, the anorexic should want to get rid of her desire for thinness, and take some steps to conform her actions to her higher order desire or volition, and show some success at this.

There are various problems with these accounts of autonomy. One is that the claim that one is not conforming to a higher order desire or preference presupposes that there is a clear hierarchy of desires and volitions, and that others can make a judgment about this. But it is unclear how we can make that judgment over other people's desires and volitions. Jehovah's Witnesses refuse whole blood products based on one single interpretation of the bible, not even shared by the majority in the Judeo-Christian tradition: it is not clear whether their desire or volition to obey such interpretation, which might cost one's life, is to be placed in the first or in the second order.

A related problem is that it is not clear that the first order desire of the anorexic is *to be thin*: as we have seen earlier, one underlying drive may be the need for control over life and the surrounding environment (similarly, it is not clear that the first order desire of the smoker is to smoke; his desire might be to release stress, for example).

Several other groups of people (models, athletes, artists) use extreme forms of food control, and depending on how we construe the 'first order' desires, these might or might not fail the multi-tier autonomy test. Climbers might find themselves counting calories because one extra pound will be felt on a tough route. A few extra pounds might represent a serious risk: it is perfectly rational for the climber to want to calibrate to the gram the ratio between muscle mass and body fat. Some might regard their desires and volitions as silly, irresponsible or irrational, and others might regard their purposes as understandable and admirable. Whether or not they fail the multi-tier test of autonomy depends on what kind of items we decide to place on the first or on the second order of desires.

Moreover, conflicts between orders of desires and volitions affect us all, and none of us is immune from making choices which we know too well that are not good for us. Most likely none of us has the control of the will that some claim anorexics lack. Obese people are likely to will not to will to eat, but nobody has so far seriously suggested that the obese is affected by a mental illness and should be compulsorily hospitalised and forced to diet. Many of us might wish we had different inclinations, desires and volitions in many areas of our lives—we might wish we did wish to stay with our unfaithful partners, we might wish we did not care so much for our job as to let it impact on our health or family life, and so on.

Perhaps the multi-tiers models are correct; perhaps extreme or self-harming or risky behaviours are symptomatic of mental illness and are proof of lack of autonomy: but if we accept this, we are committing ourselves to the view that many of us, probably most of us, lack autonomy in many ways, at pain of selectively pathologising some forms of conduct over many others.

8 Conclusions

Anorexia is one of the few, and perhaps the only, form of harmful dieting practices that since at least the 1600s has been attributed to a disorder of the mind. Other potentially harmful eating practices such as intermittent fasting, nutritionally dubious diets or starvation for artistic purposes, sport-related reasons, or career purposes are not considered as mental disorders.

There might be various reasons why anorexia has been treated as a mental illness. One likely reason is that the purposes and goals of anorexics appear unintelligible and irrational. It seems difficult to contemplate that one could give up their health and life just for the sake of thinness, or that even one could bear with the distress and extreme pain caused by prolonged starvation.

I have argued that, if seen in light of a certain moral background, anorexia does not appear irrational: however, this challenges ordinary values that are widely accepted. I have suggested that the continuity between ordinary values and those expressed through anorexic behaviour somehow risks thwarting the efforts to unravel anorexia, but that without a serious reconsideration of the moral dynamics at stake in contexts where anorexia appears, it is difficult to see how anorexia can be understood. In this sense, anorexia is not a challenging condition just because it is hard to treat: it is a challenging condition because it calls us all to reflect on and question the repercussion of moral values that many of us share.

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