

## Chapter 10

## Like a Natural Woman: Celibacy and the Embodied Self in Anorexia Nervosa

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Anorexic women are notoriously disinterested in sex. The accepted clinical interpretation of this voluntary celibacy is that it is closely associated with the rejection of food. In most understandings, the anorexic's preoccupation with food is interpreted as a sublimation of her sexual conflicts, and her food behaviors are then read as symbolic enactments of sexual fantasies, fears and/or aggressions. Because of this, theorists of anorexia generally try to get at the "real" issue (i.e., sex) by starting with the observation and description of "sick" food behaviors, and then decoding what they must say about female sexuality and the anorexic's relationship to this standard of health.

In this chapter, I argue that the central contemporary medical and professional understandings of voluntary celibacy in anorexia reflect and reinforce certain constructions of female sexuality which not only efface the anorexic woman's subjective experience of her illness, but may even perpetuate it. Here, I flip the conventional wisdom about anorexia on its head. I consider, in other words, not what it means to be *thin*, to say no to *food*, but rather, what it means to be *celibate* and to say no to *sex*. I am particularly interested in what a closer examination of the way this "problem" of celibacy in anorexia is constructed in the literature might tell us about the channeling of female sexuality into culturally appropriate forms contingent on certain understandings about healthy womanhood.

## PATHOLOGY AND CULTURE

The chapters in this volume consider the voluntary abstention from sex from a variety of perspectives, including its relationship to systems of morality, ritual purity, institutions, and access to the sacred. One of the themes that seems to emerge is that celibacy can be, and often is, used as a means of altering the subjective experience of self, whether this is a personal choice or an institutional mandate. In all cases, the relationships between cultural understandings of sexual behavior and the proper selves allowed in a given context (be it prison, nunnery, or religious community) are central to the practices of celibacy.

Celibacy among anorexic women is no less culturally informed than other forms of celibacy. We must remember that the labeling of any behavior pattern as deviant or pathological is more than a simple description of fact. In the process of identifying the pathological, the cultural norms of health and normalcy, and the dominant standards of appropriate living, including sexual life, are reinforced. The designation of dysfunction or pathology can, then, (and often does) become a vehicle for moral evaluation. This is perhaps particularly central in the consideration of mental illness, where a disordered or damaged "self" is often identified as being at the root of the pathology. The treatment of mental illnesses—including anorexia nervosa—often involves such things as lengthy psychotherapy, medication, and behavior modification, all targeted at bringing this fractured or diminished self back in line with the accepted standards of health and proper behavior. The practices and experience of anorexia, then, as well as the dominant understandings of the causes and treatment of the illness—speak not only to individual psychological concerns, but also (and perhaps more significantly) to cultural understandings of gender, self, sexuality, and sociability, and can serve as a productive window on these issues.

This chapter is meant to be an orientation and a starting point for exploring celibacy within the anorexic condition. It does not attempt to be a comprehensive or extensive discussion of the issues raised. Rather, it is meant to be a first step, a sounding of ideas that require further investigation.

### NOT ANOTHER BITE

Anorexic women certainly appear to be "sick" and in need of a "cure." The anorexic woman denies herself food, suppresses her appetite, and becomes dangerously thin. She is terrified of becoming fat, and the thought of gaining even an ounce is unbearable; it is enough to throw her into a deep,

and even suicidal, depression. She structures her whole life around food and eating, and she controls, measures and accounts for every morsel of food and every drop of liquid that enters her body. She views her emaciated frame in the mirror--skin and bones and dull eyes and lifeless hair to those around her--and sees fat. Lumpy, bumpy, disgusting, ugly fat. She must become thinner. Streamlined. Strong. Straight. As her illness progresses, she becomes more and more withdrawn and sullen, her zest for life leaving her, until she is a withered, pale, tired creature. This is the daily reality for thousands women who simply shut off from life and slowly starve themselves to death, all the while protesting that they will be happy, they will be free, they will truly be alive, if only they can lose just five more pounds.

There is an overwhelming abundance of literature on eating disorders. Publications focusing on anorexia and bulimia touch on many aspects of the illness and its treatment: drug studies<sup>1</sup>, life histories and personal accounts<sup>2</sup>, therapy techniques<sup>3</sup>, cognitive and psychological profiles<sup>4</sup>, and cultural influences<sup>5</sup>. Despite this diversity of perspectives, a number of general themes emerge--a set of core understandings that appear to cut across these sometimes contradictory viewpoints. These understandings illuminate the continuing influence of the psychoanalytic perspective on the contemporary theorizing of eating disorders and treatment, and they articulate a continued preoccupation with the anorexic's *dislike of sexuality* as the core pathology. Moreover, they reveal key cultural assumptions about voluntary female celibacy.

These basic understandings, as I read them, involve: (1) recognizing that most anorexic women have no desire to be entered by a penis or receive little or no pleasure from heterosexual intercourse, and the construction of this aversion to sex as the central problem of the illness; (2) pathologizing this attitude towards penetration by a penis, and assigning of the cause of this pathology to ignorance about sexual matters, experiences of sexual abuse, endocrine depletion, immaturity, hormonal imbalance, or some other feature which would explain this otherwise bewildering ambivalence towards the male organ (3) decoding the anorexic's sick food behaviors as symbolic expressions of this pathological conflict about the penis, behaviors which are read as highly sexualized: food symbolizes the penis or the mother or a baby, the mouth represents the vagina or the anus, eating is either orally-sadistic or sexually erotic or both, and the anorexic girl's body is variously the mother or the phallus; and (4) postulating a course of treatment which takes this "stubborn resistance" to penile penetration as its target, reading as evidence of health and recovery the anorexic woman's acceptance of "mature" female sexuality and her embracing of the penis as the source of sexual pleasure.

These understandings of the anorexic woman's relationship to food and sex are rooted in early psychoanalytic conceptualizations of healthy gender development.

#### EATING DADDY'S BABY AND THROWING UP MOMMY

We see, then, a syndrome the main symptoms of which represent an elaboration and acting out in the somatic sphere of a specific type of fantasy. The wish to be impregnated through the mouth which results, at times, in compulsive eating, and at other times, in guilt and consequent rejection of food, the constipation symbolizing the child in the abdomen and the amenorrhoea as direct psychological repercussion of pregnancy fantasies. This amenorrhoea may also be part of the direct denial of genital sexuality (Waller, Kaufman, and Deutsch, 1940:15).

When Freud first tackled the "enigma" of anorexia nervosa in the early part of this century (1918), he proposed a complicated model of oedipal fantasies and forbidden desires which were, he argued, sublimated and articulated in the anorexic girl's bizarre food behaviors. He suggested that little girls live a masculine life until the traumatic and earthshaking discovery that they do not have a penis, that they are "mutilated." This discovery leads them to a violent rage against the mother who has betrayed them by not giving them a penis, and not preparing them for this devastating revelation. Until this time, Freud tells us, the little girl had enjoyed a phallic sexuality with her love object being the mother, and she fantasized about having a baby by her mother. But the discovery of her lack of penis, and the resulting penis envy, propels the girl headlong into the oedipal phase, where she seeks refuge with the father and directs hatred at her faithless mother.

In this model, food becomes a powerful symbol for the acting out of oedipal conflicts. Food becomes simultaneously the mother who is being rejected and a symbol of the penis the girl does not have, but can "enjoy" (Freud 1918) through sexual intercourse. The anorexic, according to Freud, has fantasies of oral impregnation by her father, and food becomes a sexualized symbol of this wish. At the same time, food represents the "poison" transmitted to the girl through the (now hated) mother's breast, leading to an ambivalent food-relationship and either anorexic or bulimic food behaviors (or both) as the pathological expression of this conflict.

Hilde Bruch summarizes the traditional analytic approach and its articulation in treatment as follows:

One of the first reports of the psychoanalytic treatment of a patient with anorexia nervosa...revealed intense father-fixation and the desire for a child from the

father; this was looked upon as the psychic motivation for the [patient's] vomiting. The intense food refusal, however, was interpreted as relating to the wish for a penis, something not observed in ordinary neurotic vomiting. The anorexia picture was thus viewed as having developed out of the conflicts between the desire to be a like a man and the desire for a child from the father (216).

In other words, the anorexic girl is presented as neurotically fixated on being entered by a penis or, failing this, symbolically enacting her desires through food. She paradoxically desires to be like a man while at the same time wants to have a child by the father, a child who then becomes a substitute for the coveted penis. So great is the girl's envy of the male organ, in fact, that, ironically, even the *rejection* of food is read as the wish for a penis.

Later psychoanalytic thinkers, building upon this idea of food representing the penis, turned the interpretation a bit, reading food refusal, not so much as a desire for pregnancy as an expression of infantilism--a rejection of adult sexuality and a desire to return to the idyllic time of childhood. In this understanding, the anorexic woman's refusal of food is read as the attempt to achieve a regressive state in which self-induced starvation--leading to a repression of appetite, sexual drive, and signs of physical maturation--enables her to avoid both the maturational issues of sexual development, independence, and autonomy (and therefore to remove herself from the conflict she encountered in trying to become a woman separate from her mother), *and* the frightening prospect of healthy adult female sexuality. In this perspective, the object symbolized by food is interpreted, not only as the penis, but *also* as the mother, and the anorexic's refusal of food (the mother) indicative of her struggle to separate from the mother and establish an independent identity. Food in this model represents femininity, nourishment, growth and feminine sexuality; its rejection represents the anorexic girl's refusal to accept her womanhood.

But on another level food continues, in this model, to represent the penis. The anorexic rejects food, which represents the threat of a penis entering her, and as a result her body loses its feminine contours and she stops menstruating, effectively staving off so-called mature sexuality in favor of an immature, infantile state. This "irrational" fear of sexuality is symbolized in the anorexic woman's food behaviors, her refusal of food expressing an unfounded anxiety about impregnation and an immature response to the natural process of female sexual development.<sup>6</sup>

While these various articulations of the psychoanalytic perspective on eating disorders may seem somewhat antiquated to the reader, I suggest we must take this traditional construction of anorexia nervosa very seriously. This is suggested not because it is necessarily consistent with the

real-life experience of anorexia nervosa, but because, despite decades of strong and impassioned feminist critique (e.g., Bordon 1992; Orbach 1978, 1986; Wolf 1991), it remains the core of medical theorizing of anorexia even today. These concerns are clearly articulated in a number of recent works where implicit assumptions attached to the question of celibacy seem to play a central role in the interpretation of anorexic food behaviors. While the pieces I will discuss here may not be strictly representational, neither are they exceptional in their terminology, interpretations, or use of psychoanalytic concepts.

#### GETTING FIXED: SEX THERAPY FOR “DYSFUNCTIONAL” ANOREXICS

In their article “Sexual Dysfunction in Married Female Patients with Anorexia and Bulimia Nervosa,” Simpson and Ramberg present case studies of five married eating-disordered women who had “a primary diagnosis of sexual aversion along with other psychosexual dysfunctioning” (1992: 44). The husbands of these five patients, the authors observed, showed “remarkable tolerance for their sexual avoidance,” but nevertheless were more enthusiastic than their wives at the prospect of intense therapy for their sexual “problems.”

The project was to provide intense, in-depth sex therapy to the five eating disordered women and their husbands. All of the women entered into the therapy process stating that they wanted to be able to stop treatment on demand, a standard therapeutic procedure which is, interestingly, read by the authors as showing “great resistance” to the therapeutic process (Simpson and Ramberg 1992: 45). Although the authors note that the women “seemed to participate enthusiastically at first,” as the therapy sessions proceeded, many of the women reported feeling increasingly anxious.

Two of the five women had been the victim of incest or rape, but all five reported “marked similarity in their approach to sex” (Simpson and Ramberg 1992: 46). They were, the authors tell us, “ignorant of certain basic sexual facts and they found nudity--especially their own--disconcerting and somewhat distasteful.” The authors conclude, then, that “their sexual aversion may have been due, in part, to their ignorance,” because, “despite their current or former marital status, they all were reluctant to participate fully in intercourse, they all had difficulty responding sexually, and they all were anorgasmic” (p. 46). Since the authors do not compare this sexual “dysfunction” of these women with normal (i.e., non-eating-disordered) women, it is difficult to evaluate just how outside of the realm of so-called average female sexuality these women lie, if indeed, they do. Nevertheless, the reeducation of

these women continued, and in four of the five cases the researchers were able to involve the husbands in the therapy. They found that each of the husbands “colluded with his wife to support the wife’s dysfunction, exhibiting unparalleled patience with her avoidance” (p. 46).

Through the presentation of the case material, we learn what would seem to be important pieces of information about the women involved in the study. Mrs. A., for example, had been sexually abused by an uncle at the age of 12. The authors describe her present sexual dysfunction as an inability to relax during sex, and the continued failure to lubricate when stimulated by her husband, despite the fact that she was able to achieve pleasure through masturbation. Mrs. B described sex as gross, sick, and disgusting, and reported that her aversion to sex started as an adolescent, when peers teased her and called her “whore.” Mrs. C’s “severe sexual aversion” also seems to have links to her childhood. She was raised by grandparents who had instilled in her “fear and disgust” about anything sexual. One of the hallmarks of Mrs. D’s dysfunction was “a frequent fantasy was of her being naked and sexually active with an unknown man, not her husband,” which was apparently deemed troubling by the researchers (Simpson and Ramberg 1992: 51). And Mrs. E. evidenced her dysfunction in having been “promiscuous” in high school, gotten pregnant, had an abortion, and was now timid and inhibited in her sexual relations.

From these five case studies, the authors conclude that, in addition to the primary diagnosis of anorexia and/or bulimia nervosa, “all five also exhibited problematic personality characteristics...and strongly entrenched defensive and resistive characteristics. They all knew how to avoid painful introspection, how to resist the therapeutic process, and how to continue in their well-established, self-destructive behavior patterns” (Simpson and Ramberg 1992: 53). These women, the authors clearly suggest, are manipulative (pp. 47, 51), oppositional, resistive, and antagonistic (p. 48), obsessed with controlling themselves and others (p. 49), testy, hostile, angry, anxious, and irritable (p. 49), infantile (p. 50), and oblivious to the way the world “really” works (p. 51). Simpson and Ramberg concluded that these women use their food problems in various ways as excuses for avoiding sex with their husbands and for manipulating others into pampering and indulging them.

Simpson and Ramberg (1992) are representative of much of the new scholarship dealing with a purported sexual dysfunction in women with anorexia or bulimia, and we can see here a number of flaws in their reasoning and the destructive influence of sexual stereotypes on women struggling with eating disorders. First and foremost, it remains unsubstantiated that any of these women even *had* a sexual dysfunction in the first place,

and we are continually led to wonder how different from other women these women really were. All report anxiety and some difficulty lubricating, lack of sexual desire and “failure” to be sexually excited by their partners. But is this necessarily dysfunction? And if a woman is not sexually interested in or excited by her partner, are we certain that the problem lies with her?

Clearly, in each case reported by the authors, the so-called dysfunction originates outside of the woman herself, and her aversion to sexuality might legitimately be read as a reasonable response to an externally troubling situation. In the case of Mrs. A, we are told that her husband feared her infidelity if she were to enjoy sex—a very traditional conceptualization of female sexuality which seems to have contributed to the manifestation of hysteria in Victorian times and continues to underpin drastic practices like clitoridectomies and infibulation today. It would seem possible, then, that Mrs. A's dislike of sex may have been, at least in part, a way of preserving her marriage and reassuring her husband of her loyalty. Mrs. B had horrible memories of being called a whore as an adolescent when she began experimenting with sex and so withdrew from her sexuality so she would be seen as a “good girl.” Mrs. C was raised by strict grandparents who drove it into her head that sex is bad and dirty and disgusting, and she has yet to be able to shake this association. Mrs. D was clearly unhappy in her marriage, and it is often difficult to find pleasure in the bedroom when the rest of a relationship is falling apart. And Mrs. E sought affection and companionship through sexual promiscuity, a behavior pattern which she recognized as destructive and was trying to mediate through her reluctance to engage in sexual relations when they were unpleasant for her.

This is not to say necessarily that these women are normal, healthy, or untroubled. Obviously, their feelings about sex appear to be unsettling for both them and their partners, in varying degrees. But it is obvious from the authors' presentation and their choice of language that they interpret the central problem here as the desire of these women not to have sex with their husbands. They blame the women and paint them as stubborn, childish, manipulative and controlling, while their poor, deprived husbands are presented as gentle, understanding and remarkably tolerant (Simpson and Ramberg 1992: 44, 46, 47). This understanding of these women's attitudes towards sex clearly influence not only the interpretations given to their food behaviors—which are reduced to being nothing but clever excuses to avoid “healthy adult female sexuality”—but also the therapeutic environment itself. It is, to me, very revealing that all five women terminated the therapy. The authors, of course, present this termination as resistance, manipulation, immaturity and cowardice.

HOW SICK CAN YOU GET?: EATING DISORDERS AND SEXUAL  
“PERVERSION”

Phrophecy Coles articulates in clear and startling form the influence of such interpretations on how eating behaviors are understood and how anorexic and bulimic women are themselves constructed in her 1988 article "Aspects of Perversion in Anorexic/Bulimic Disorders." In this article, Coles categorizes anorexia as a form of sexual perversion, and illustrates her point with a colorful comparison between the eating behaviors of an anorexic patient and the cross-dressing and masturbation of a male transvestite. Coles suggests that "the bulimic state seemed to be very similar to a state that a transvestite had described to me when he stood in front of a mirror dressed in women's clothes and masturbating," and she wonders, "Would it make sense to claim that anorexia and bulimia are a form of perversion?" (p. 138).

The core of her theory is that anorexia and bulimia evidence "a primitive sexualisation of the body ego, which was used to ward off psychotic anxieties concerning loss and annihilation"(1988:139). The parallel with the "perversion" of the transvestite comes in anorexia, she explains, when "the mouth [is] used as compulsively as the genitals" (p. 141) in the pursuit of the "phallus," which is, she argues, the "psychic representative of desire and narcissistic completion" and is the same for both sexes (p. 141).

Coles, in line with the psychoanalytic tradition, locates the heart of this "perversion" in the child's relationship with its mother. "There seems," she writes, "to be evidence that there is a narcissistic mother with strong infantile needs of her own...A narcissistic mother with her own unresolved 'castration' difficulties can use her son in a phallic way...whereas a mother is less able to use her daughter in this way, and the daughter can experience her mother's phallic disappointment with her" (1988: 143). The effects of this "phallic disappointment" are, Coles tells us, devastating for the girl. "The pre-oedipal difficulties seem to prohibit a development towards heterosexual maturity," she clarifies. "Freud...spoke of an 'aversion to sexuality' by means of anorexia. I believe that it is not so much an aversion to sexuality as a refusal to give up more infantile forms of sexuality, that 'food and eating become equated with forbidden sexual objects and sexual activities'" (143) In other words, like Simpson and Ramberg (1992), Coles argues that food and eating are symbolic of adult sexuality, and the rejection of food the expression of the infantile wish to remain immature and childlike.

When the girl discovers that she lacks the anatomic penis, Coles tells us, she rejects her "faithless mother" and seeks a "haven of refuge" in her

father, a bonding which makes the girl reluctant to surrender her early masculine life in favor of her natural feminine development (1988: 142). Anorexic girls are particularly tenacious in this “resistance. “They refuse,” Coles continues us, “to accept the unpalatable fact of their ‘castration’ and instead take refuge in an identification *either with the phallic mother or with the father* (142, emphasis in the original), and the anorexic girl constructs an “identification of herself as a ‘castrated’ man” (p. 144) because, in Glasser’s (1985) words, she had not been able to identify with “the psychological attributes of the father...in her heterosexual need to separate from her mother” (quoted in Coles 1988: 144). Instead, she uses a “phallic identification with her father as a way of attacking her mother, which had at the same time the unwelcome attribute of seeing herself as this hated, ruthless, cold and unfeeling person” (p. 144). Coles adds that the anorexic woman’s “failure to negotiate successfully her oedipal difficulties leaves her unable to maintain satisfactory relationships with men” (p. 144).

Perhaps the most revealing section of the essay comes when Coles discusses some of the transference and countertransference dynamics of her therapeutic relationship with a young anorexic woman. Coles is perplexed by the woman's having “complained that coming into therapy had made her bingeing worse,” (137), and tagged this to the client’s inappropriate expectations of and feelings towards her therapist:

Her rage against me I experienced most vividly at the end of sessions...as she got up she would swing her body across the room like a fashion model. Her tight jeans revealed her emaciated buttocks as she thrust her flattened stomach forward, and she would bend her stick-like body in a straight and rigid way into her large handbag to look for her car-keys. I had the feeling that she was enacting a primitive phantasy of relating in which her emaciated phallic body entered me (or the handbag) and attacked me for my neglect. The whole enactment seemed highly sexualised as she showed me her slim body. This observation seemed to be confirmed in her constant complaints that she was sexually harassed by men. She would excite and provoke men with these body movements, but she would angrily reject them and turn away. I believe she was repeating the original experience of a mother who provoked her and stimulated her and whom she experienced as rejecting her. (pp. 144-5)

The obvious question here is whether this primitive fantasy and the sexualizing of the interaction is coming from the client or from the therapist herself. It is particularly disturbing that, like Simpson and Ramberg (1992), Coles here presents the anorexic woman as a sort of tease who excites and provokes men with her body movements only to reject them angrily and turn away. Indeed, we are led to wonder if it might be the case that the fantasies and sexual feelings of the *therapist* are being projected

onto the anorexic woman, who is then attacked as manipulative and full of rage, the depth of her sexual problems read in the degree of sexual stimulation she excites in her caregiver.

There is more. Coles concludes that this sexualization of the anorexic's body turns back upon itself in an autonomous orgy. Through her anorexia, Coles says,

[Miss B] used her whole body as a phallic object to both attack and impregnate herself in a fantasied coupling which excluded vulnerability and dependence upon other people, in much the same way as the transvestite achieved a self-sufficient intercourse while dressed as a woman...In anorexia and bulimia a primitive and perverse acting out is going on; the whole body is experienced in primitive sexualised images; but because the action takes place principally "inside" the body, the sadism and primitive sexualisation of the ego can be more easily concealed. (1988: 146)

It is clear that her client's eating behaviors and the recounting of these behaviors in the therapy sessions were explicitly sexualized in the mind of the therapist. It is not difficult to see, then, how the client's requests for help and detailed discussion of her bingeing in the pursuit of recovery might be read from this perspective as a form of exhibitionism, a replaying of the fantasied coupling on the therapists' couch. We, of course, have no indication that this elaborate portrait of the anorexic's secret sexual life has anything at all to do with the woman's actual subjective experience of her illness. Regardless, the client is painted as an eminently sexual being, using her sexual powers to control and manipulate others, including her therapist.<sup>7</sup>

The basic interpretations outlined here find expression in countless other contemporary works. Mogul, for example, presents a case study of a woman whose first, aborted pregnancy marked the onset of her anorexia nervosa and whose second, desired pregnancy marked the "recovery from anorexia and the beginning of a happy family" (1989: 65). Identifying the essence of anorexia as a conflict about mothering, Mogul suggests that pregnancy not only offers anorexic women a second chance to repair their own childhood emotional deficits, but also gives them the opportunity for the "significant restructuring of their feminine identities and senses of themselves as separate and worthwhile parents and persons" (p. 72). The anorexic conflict, Mogul seems to suggest, is washed away under a flood of maternal affection and motherly pride. "I have a baby, a house, and a dog," Mogul's client reports, glowing and ecstatic in her "recovery" from anorexia. "I am in love with my husband and enjoy making love...Here I am a housewife; but I know what I'm doing. I'll ask for an academic extension; eventually I'll finish my degree..."

I have become normal" (p. 85) Mogul reports that today this client is "at home busy and satisfied caring for their three children" (p.86) and deems her a true success.

Zerbe (1992b) highlights the fact that, culturally speaking, passivity is valued in women, and uses this to argue that passive, dependent women actually have a *stronger* superego structure than do independent, assertive ones. In other words, following Zerbe's logic, dependence and passivity (that is, being in synch with gender expectations) are signs of female "health," whereas deviation from the traditional norms (showing strength and independence and, perhaps, resistance to certain therapeutic procedures) are sure evidence of illness. To this premise she adds that, because a woman's genital experience is "diffuse," clitoral, vaginal, and anal sensations are often confused. As a result, "sexual inhibitions may be derived from the linkage of early toilet training practices, anal inhibitions, and their spread to vaginal experience" (p. 60). This "early anal and genital inhibitions to touch," she suggests, might then "spread to the vagina, contributing to the sexual repressions of the girl" (p. 61). This, Zerbe argues, helps to explain the otherwise "irrational" dislike of penises and penetration expressed by so many anorexic women, and their "resistance" to the passivity of the female role--a sure indicator of mental illness.

Tuiten and his colleagues refer to the "sexual dysfunction and immaturity" of anorexic women "as manifested in low sexual interest, inhibited sexual behavior, disgust towards sex, and fear of intimacy (1993: 259). Hardman and Gardner (1986: 55) note that the women they worked with refused to maintain a normal level of sexual activity, that the "unrealistic" and "paranoid" fears attached to their anorexia interfered with both physical and emotional intimacy. They characterize these woman as throwing "temper tantrums" as part of a "game to prove themselves superior and special," a project they identify as a "delusional type belief." Andersen (1985: 146-7) includes "decreased sexual attractiveness" in his list of sexual problems associated with anorexia nervosa. And Schneider identifies bulimic activity as "self-imposed oral rape" (1995: 183).

We can see, then, that in the contemporary literature, the so-called "sexual aversion" of eating-disordered women is anything but an uncomplicated assessment of an individual's distress, but, rather, is a culturally loaded interpretation of women's sexual feelings and behaviors as measured against some standard of "normal" female sexuality. This avoidance is attributed in the literature to sexual abuse, ignorance, punitive sex education, anal associations, hormonal imbalances...*anything*, but a legitimate ambivalence about men or heterosexual sex.

### IMPLICATIONS FOR TREATMENT: WHERE DO WE GO FROM HERE?

The problems with these constructions of sexuality in anorexia are fairly obvious, and need little illuminating. In all these essays, there is a clearly articulated heterosexist formulation of sexuality which is predicated on the penetration of the man's penis into the woman's vagina. If a woman does not want to be penetrated or does not derive pleasure from her partner's penis, she is identified as sexually dysfunctional. If she resists this classification, evidences little enthusiasm over designs to "fix" her condition, or expresses anxiety about aggressive sexual therapy, she is labeled as childish, stubborn, defensive, immature, rebellious, manipulative, and controlling. Once she has been shamed into treatment, she is conditioned to see the mother figure as "bad" and the penis as "good," and is persuaded to give up her immature, childish attachment to the "bad" mother in favor of a mature and adult attachment to the "good" penis, which she is then free to "enjoy." This thrill at sexual intercourse will be a natural development, it is supposed, once all the pathologies have been resolved and cleared from the path and the woman's true sexuality is allowed to shine through. There are no excuses now. In all of these studies, in fact, the implication is that all these women *really* need in order to get well is a good roll in the hay.

This is an extraordinarily troubling situation. If anorexia and bulimia are indeed linked to anxieties about sexuality and ambivalence about developing female bodies and the reactions they draw from others, it would seem that therapeutic environments such as the ones described in these essays are not safe places for these women. It is any wonder that so many of Simpson and Ramberg's (1992) patients left the treatment, or that Cole's (1988) client reported that coming to therapy made her bingeing worse? These women are encouraged--that is, if they *really* want to get well--to submit themselves to the authority of caregivers who take as their central project the reconditioning of these women to fit the traditional construction of "femininity" *against* which they may be struggling with their anorexia in the first place. But the rub comes in theoretical subsumation of the anorexia itself into this framework and its interpretation not as resistance to traditional constructions of femininity, but as the ultimate expression of it. Anorexic women are not strong, independent, and self-possessed; they are childish and immature and controlling. In the meantime, their bodies are always at center stage--talked about, examined, measured, weighed, poked, closely watched by an army of therapists and hospital staff for any sign of change no matter how small. The femaleness of the anorexic's body--its shapely contours or the lack thereof--is on everybody's mind. In other words, the anorexic woman is

caught. She cannot win. She will be forced into a corseted model of femininity, regardless of how tight the fit. The choice is laid before her: remain childish and infantile in your illness, or accept our standard of femininity (in which celibacy or the rejection of heterosexual intercourse is not condoned) as the criterion of health. The dominant construction of voluntary celibacy in women with eating disorders, then, has direct implications for treatment, and the prototype of the anorexic woman outlined in this orientation dictates the kind of treatment she receives and the model of “recovery” she is induced to accept.

We must seriously reconsider the way in which these things are talked about and what kind of implications this holds for the way the configuration of behaviors labeled as anorexia are understood. How might a reorientation of our understandings of sexual avoidance in anorexia affect this understanding? What would happen if the anorexic’s notorious aversion to sexuality--which she is traditionally conditioned to give up in favor of more “mature” sexual delights--were read, not as expressions of infantilism and immaturity, but as part of a larger, sophisticated design to define and preserve a self which is culturally valued and desired? What if, rather than painting sexuality as the core “pathology” which is then symbolically expressed in food behaviors, *both* are read as articulations of a more fundamental concern, having to do, for example, with body boundaries and the reshaping of the self (Lester 1995, 1997)? The traditional understandings of anorexia and bulimia would, I suggest, be radically challenged. I suggest that if we look deeply into the traditional models of eating disorders, if we tease out the gendered cultural assumptions imprinted on the very core of these theories, we will be called to significantly reevaluate our received knowledge about this illness and the psychodynamics of those who suffer from it.

<sup>1</sup> Hudson, et al 1985 and 1989; Pope, Keck, McElroy, and Hudson 1989; Grignaschi, Mantelli, and Samanin 1993; Merola et al 1994; Leibowitz 1990 and 1992; Broocks, Liu, and Pirke, 1990; Brewerton et al 1992

<sup>2</sup> cf. Robertson 1992, Szekely 1988, Lawrence 1988, Messinger 1986, O’Neill 1982, Chernin 1981, Liu 1979

<sup>3</sup> cf. Zerbe 1992, 1993, 1995; Yager, 1985

<sup>4</sup> cf. Butow, Beumont and Touyz 1993; Spignesi 1983; Srinivasagam 1995; Striegel-Moore, Silberstein, and Rodin 1993; Swain, Shisslak, and Crago 1991

<sup>5</sup> Andersen and DiDomenico 1992, Banks 1992, Brumberg 1989, Ford, Dolan, and Evans, et al. 1990, Hall, Tice, and Beresford, et al. 1991 King and Bhugra 1989, Waller and Shaw 1992.

<sup>6</sup> See, for example, Bruch 1973 and 1978, Levenkron 1981, Woodman 1980 and 1982

<sup>7</sup> It is perhaps worth mentioning that this essay, which appeared in the prestigious journal *Psychoanalytic Psychotherapy*, is an amended version of

a paper that won the 1987 John Kelnar award offered by the Lincoln Clinic and Institute for Psychotherapy. In other words, Ms. Coles' essay was judged by a panel of her peers to be exceptional and commendable for articulating current, relevant and significant research on anorexia and bulimia.

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