

Chapter 2

Disciplined Bodies

The body as the place wherein are transcribed dominant and subordinate relationships/and of medicated, measured and exhibited bodies/informed, disciplined, colonised, homogenised/docile bodies/invalids of civilisation/bodiless bodies/each society talks about bodies, shapes them, guides them, marks them/updates them, disciplines them/celebrates them, and bring them to reason,

Paola Bianchi

The body and its manifest forms of psychological suffering cannot be separated from its ascribed meanings in a given social context. Hard manual labour down through the ages has gone into translating the body into what we know today. Additionally it has fashioned its sufferings.

Paradoxically, whenever something is most individual and solitary, pain – both physical and psychological pain is meant – is regulated by a kind of historical and social “grammar” that permits the pain itself to become objectified. A combination of signs becomes an expression of something else or a symptom of an abstractly defined something, known as an illness. This is based on a syndicated dictionary and a semiotic and clinical language which the care professions (“normative” professions nonetheless) make available to sufferers, reassuring them there is a logical meaning to their personal suffering.

In this chapter, we will attempt to investigate the idea of a “socio-genesis” in psychological disorders. Our opening hypothesis is that the so-called “professionals of the psyche” (psychologists, psychotherapists and psychiatrists), have favoured and made credible the grammar of a (psychiatric) language that has occasionally lost its original meaning, but in response to a widespread need for normative control, continues to be taught and therefore spoken.

For instance if today a certain kind of malaise becomes translated into a psychological, rather than an existential or religious, disorder, it is because we have become used to taking this kind of interpretation for granted. We might ask ourselves how

this could have happened. If it is true that illnesses are the result of a meeting between clinical observation and specialist language, in order for a new symptom to prevail, a socio-cultural reality that is very receptive to the new proposed interpretation must also exist for it. A kind of “tacit agreement” between common sense and the scientific world is a prerequisite. Drawing up the rules that decide whether a type of behaviour is healthy or sick is not the sole and only task of scientists; the definition of where the boundaries between normality and pathology lie is arrived at when social meanings and values are shared by extended groupings of people. The symptom in and of itself is a neutral event, becoming a negative one only when it gets given the unique meaning of a potential pathology.

We will discover that when technical and specialist terms become assimilated into general vocabulary, the cultural mutations that these new definitions undergo acquire the status of objective realities, they are born “en-bodied” (given similar attributes to those of physical bodies) and they are forever consigned into existence. If the illness corresponds to a series of definite signs, these are not the result of deductions garnered from a scientific theory that has “discovered” it. Rather these signs appear to benefit from a blending of the scientific paradigm and the experience of social intervention and investment in the paradigm itself. And yet an awareness of something being discarded between the “discovery” and the “construct” of the medical-based diagnosis has little impact on diagnostic and therapeutic praxis in which identifying a syndrome is normally carried out using a kind of “bar code reading” capable of “revealing” and freezing into existence those symptoms that correspond to the ticked boxes.

Eating disorders and body image identity disorders specifically, may not so much be the result of empirical evidence, but rather correspond to personal experiences that, however painful and socially reprehensible they might be (at least in some forms) “viscerally” preserve the same tangled web of social values, expectations and portrayals that underscore the prevailing culture.

During possession rituals of a Hawaiian loa or an Ethiopian zar (names identifying incarnated spirits), we cannot understand the contortions of a “body gone mad” cannot be understood by analysing the movements of the muscles involved. Such phenomena can only be accessed through the symbolism that that culture has made its own. We can understand some spectacular shaman sessions (particularly those that involve real body transformations) only to the extent we are prepared to concede the body new senses. This example, in addition to those described in the previous chapter, should suffice to reinforce the notion that body experiences are relative and situational, and that labels like normal and pathological have no meaning in this context. Which is another way of saying that psychology cannot exist in the absence of an anthropological, historical and sociological background that gives it meaning.

Any equivalent interdependency between different forms, deviancies and normative contexts transforms any kind of relevant knowledge into something absolutely relative.

The psychological knowledge we have inherited is continually evolving, continually fighting against the expiry of its sell-by date. We can read about and document the nature of mental disorders in years gone by, but we cannot “take possession of”

hysteria like the nineteenth century did, or of melancholia in the form known during the eighteenth century. “We can never clearly learn the imagination” or the flow of life “of another people or of another era as though it were our own” (Geertz 1988). Different times and different contexts make the fruits of imagination difficult to translate into the present, and every attempt to reproduce them is “dangerous” because it demands access to a world built on different lines to ours, lines that only a given sensibility could produce, and that therefore can only be understood in part. So pathologies appear alongside historical processes that have brought them about, and because they are the “functions” of their context to a degree, they tend to have different sets of specific symptoms, which correspond to changes in social and historical conditions.

In an analysis of symptoms of psychosis, Vandereycken and van Deth (1994) quote how spectacular forms of hysteria have “disappeared”, and how fixations and hallucinations with religious components: “God made me do it” have become technological ones: “rays from outer space are controlling me” as striking examples of historical variations in psycho-pathological phenomena.

If the concepts of health and illness – and by extension, the healthy and unwell body – change through time, this is also in part due to the importance the moral and social authorities attach to medicine (this in itself is the result of politics going hand in hand with the body throughout history). “Deviancy” “illness” and “disorders” cannot be discussed without implicit references to social structures of the kind in which certain phenomena can be regarded solely as “deviancy” “illness” and “disorder” and nothing else. “The fact is that throughout recorded history, mental disorders reaching epidemic levels or which were particularly fascinating have illuminated a specific aspect of human nature in conflict with the times” (Jaspers 1913). The symptoms of a disorder reveal/uncover the normative criteria regarding that epoch and often translate into a misrepresentation of the dominant cultural values. What strategy could a government wanting to retain power better legitimise than making concessions to those opposing them? Allowing internal enemies to exist whilst keeping control over them and portraying their protests as specific forms of behaviour is the safest way to reinforce the dominant party. This is affirmation through denial, behaviour that completely reflects the reality of the times, since it complies with generally held definitions of normality even through opposing it, and yet is pigeonholed as antisocial. Whatever form deviant behaviour takes, it allows the individual to be antisocial in ways that society “approves”, “determines”, and sometimes acknowledges as consequential.

Devereux (1978) succinctly sums up this idea: “Don’t go mad, but if you decide to, behave *this* way!”, as though there exists a guidebook for becoming “ill”, a standard formula known to those who use it and recognisable to any observer.

Besides, using the term “illness” says much about definitions of reality within individual interpretations. Describing the phenomenon within a perspective that implies it can be rectified disqualifies it from an alternative explanation. Jasper underlines this perfectly: “An analysis of the social and historical conditions in which humankind lives demonstrates that psychic manifestations vary, along with changes in these conditions. The history of illnesses can be envisioned against a

background of the history of societies and of the evolution of intellect. This shows how the perspective of scientifically identical illnesses changes, and above all how they have their own *Zeitstil* (particular style for that era) that comes to the fore in certain circumstances and in others, almost disappears” (Jaspers 1913, p. 232).

Meditating on Jaspers’ statements, might we not then ask ourselves whether certain phenomena can remain silent for long periods, only to re-emerge when conditions permit. Maybe he meant that the nucleus of the disorder, remaining constant, springs forth in different eras, adapting to and making compromises with historical realities, and thus metamorphosing into an alternate strain. If this is the case, then labels and medical definitions, despite the fact they document realities that have perhaps always existed, might create new syndromes (by cataloguing them) or cause them to disappear from collective consciousness, depending on whether or not they concur with the patient’s and society’s repertoire of medical language through the power of “performance”. Let us examine this in more detail.

2.1 The Socio-genesis of Psycho-pathology

According to the “socio-genesis” perspective, refining observational skills, perfecting measuring instruments, the “discovery” of new knowledge, does not cut the mustard. Processes placing them in the medical domain must correspond in equal measure with common sense, meaning a construct of wisdom as defined by the parameters of joined-up reasoning throughout history. Common sense is ordered, systemised knowledge, separated out through experience, as opposed to the immediate end result of experience.

When defining realities the act of recognition is constitutive rather than consequential. “Things become real only after we successfully agree on a definition of reality with others”. So medical language should dialogue with common language; without an interaction between two minds, two speakers, an event can neither become accepted nor declared “true.” “A phenomenon that is labelled in the healthy-unwell category, becomes a reality only when it becomes defined as an object beyond Self (*She has an illness*), and the sufferer is placed in a social role that the she and others recognise as being such” (Vandereycken and van Deth 1994). At this point, the illness becomes a metaphor, and is enriched through illustration and through stimulating the imagination. It represents requests and cultural affirmations, and at the same time disparages them and turns them into parodies of society (anorexia as a parody of the unrealistic skinniness that modern culture demands).

The conception of psychopathological phenomena’s “socio-genesis” (De Swaan 1982) attributes the majority of psychiatric disorders to a social matrix; anorexia and bulimia nervosa are considered to be “cultural syndromes” that were discovered, or perhaps “invented” at the end of the 1800s and were appropriately placed in the medical domain only during our generations.

How can this happen? We stated that the language of psycho-diagnostics offers interpretations and expressive scripts to sufferers of the disorder, and that “patients”

behave in conformity with these. In fact, when these become recognised and acknowledged, the repertoire of syndromes that makes up the so-called “illness” end up becoming normative. In other words, they end up prescribing ways to be and act, as well as suggesting narrative styles to express them and any ideas they might have about themselves. The phobic, drug addicts, anorexics, footballers, transsexuals, models and the religious (in short anyone identifying with a stereotypical group), draw upon quintessential elements for their self-image and self-respect, and end up interpreting roles, having emotions, being idiosyncratic, and developing coherent self-representations. They do this through “social mimicking”, that often cause people to identify with characteristics of the groupings to which they have been assigned.

The commitment that people bring to bear on faithfully representing the stereotype they have given themselves or that has been given them, identifying themselves with their assigned roles, can be interpreted in different ways. Accentuating the positive, it can be described as coherence, stability, motivation, professional behaviour, trustworthiness; negatively speaking: “obstinacy”, “recidivism”, “compulsive disorder”, “ill will”, and so on. Different names, catalogued in different ways, for identical phenomena. Some examples ...

In a recent research project, we compared responses about attitudes to food and the body given by a group of young women with eating disorders, compared with a group of models and a group of athletes. Those taking part were from clinical situations, (therefore women diagnosed as anorexic or bulimic) reported that they experience feelings of inadequacy and insecurity regarding their bodies, as did the other groups. Roughly equal numbers of members from each group tended to perceive other people as unfriendly and critical toward them. Only the athletes found their focus on physical improvement comforting, and it helped limit their fears of negative aesthetic comments. The research revealed that although bulimics, athletes and models all undertake similarly severe forms of control and food restriction, consider their diet to be either more or less important depending on the level of criticism (individual or public) they undergo from social actors they interact with.

Athletes and models seem to internalise alimentary self-control “norms” appropriate for the professional contexts in which they operate, and thus displace the boundaries that might merit clinical intervention for them. The model who says: “ten out of ten for self-control!” shows us she takes pride from behaviour that meets with her public relations agent’s approval and confirms her professional dedication. It also appears to absolve her from guilt feelings by justifying it: abstinence is not perceived (by herself or by others) as the dark shadow of her vanity, but rather as an essential step on the road to success.

What differences then exist between a young girl that is forced by her parents’ concerns about her emaciated condition to have to undergo (as often happens) appointments with a weight specialist, and her peer, that thanks to precisely the same body, can become a catwalk model? Maybe the sole difference lies in what we describe them as; it requires just a change of scene to transform a patient into a model congratulating herself on her role. Goffman, the sociologist, might say we are dealing with “cuts of material coming from the same bolt” (Goffman 1983).

Nevertheless these are two “career” routes pointing toward the same end result, but that the public rewards in different ways entirely.

We become deviants (in various forms: the bulimic, transsexual, obsessive or anorexic) in ways very similar to how we become confirmed professionals, top models or the footballer of the moment. What makes the difference is the manner of reaction rather than the specifics of the action. We might talk of the “socio-genesis” of psychopathological experiences in this regard ... since we are not talking about something inside the head of someone unusual, but rather about a collective process in which everyone plays their part. Whether the spectacle meets with the public’s approval or exasperates it, their presence, right there and then, makes the scene real.

The idea that “normal” and “abnormal” are not different “things” but rather the reflection of an opinion, does not lack implications, and therefore is not easily received. Normal, as in healthy, as a statistical average, or a social adaptation, provides its own criteria, discourses and institutional practices. Individual abnormality is systematically evaluated against the natural, rather than the historical-social, order, so that normality is permitted to legitimise free will only so far as it declares socio-political dissent, sexuality that opposes conventional morality (not to mention many forms of punitive repression in therapy, such as castration and electro-convulsive shock treatment) “mental illnesses”.

Often the nominal empiricism of various psycho-diagnoses – wrote James Hillman – does not require any richer and profounder knowledge than that provided by mastery of nosographic vocabulary. In this instance “definitions and psycho-diagnostic practices receive sustenance from bodies they are named for them, ultimately sucking parasitic life from the very thing that epitomises them” (Salvini and Faccio 2002).

Those beguiled by the fascination and persuasiveness of such phenomenology may yet feel somewhat perplexed. Every illness’ behaviour presupposes an adherence to a socio-cultural model whence derive the regulations that the illness deciphers. In more or less latent and implicit forms, the development of the illness occurs through a learning process, as we have already established. The very concept of normality which gives form to its antithesis deviancy, as it evolves in accordance with social and historical contexts (which in turn develop from the conformity of everyday behaviour), presupposes an endorsement that changing variables do not necessarily bestow. As soon as the illness is defined and recognised, a paradox emerges.

Let us instead suppose that a cultural epidemic arises from the shared influence of minds that activate certain patterns of thought and behaviour, almost a common matrix of the mind, so that it becomes irrelevant whether it prove capable of guiding individual sensibility and of finding common ground. Moreover, if thought, instead of being an entity located in the individual, is a conversation of two minds whose sum exceeds individual limits, and yet which individual processes alone can help us decipher? Perhaps it does not even involve alternatives, and perhaps we are not in a position to decide which the best solution is. It may be that coexistent and complementary hypotheses are involved, whose truthfulness in either case is neither greater nor lesser than what we are prepared to grant it.

For these reasons, we will not take the medical approach to disorders associated with body identity for granted. A medical approach to the problem is also necessary because it represents the most commonly used language for talking about the body and its disorders, as well as being one of the most widely available; also, the offspring of a particular cultural system; it was developed in a specific epoch and is validated by an accepted “way of thinking”. In order to examine questions involving alimentation and the body, the medical interpretation, with its methodology and approach, seems the appropriate choice for a clear-cut and unyielding viewpoint. Without pausing, we will attempt to convince the reader that even though we cannot think about a phenomenon without having a point of view, a neutral point of view is untenable (unless it is in turn developed at the centre of a collective symbolic process and therefore, being a part of its very nature becomes “alienated”).

2.2 The process of Bodies Medicalization

In order for any outbreak – deemed pathological a posteriori – to become known, it always needs to be identified with a given prototype (suggested by an historical and normative context, of course). Described in “clinical” terms, the examples of Charcot’s “frenzied” already cited, or the “possessed” from witchcraft trials, some of the women, (the so-called “possessed” or the “frenzied”) play out enactments that correspond to descriptions and theories about them, as a consequence of their belief systems, the kind of institution they find themselves in, and interpretations of various happenings. Clinicians and researchers discovered these occurrences, and labelled them as so-called self-fulfilling prophecies, or so-called psycho-pharmaceutical or “secondary deviancy”, also known as the “labelling effect”. These people, by totally identifying with their offence, tended to throw themselves completely into their given roles, provide the proof and quickly play out the kinds of behaviour suggested by the illness. Pirandello gives us a surprisingly accurate description of this psychological process in “The Outcast” and again in many other novellas, “The Nail” for example. An individual encouraged to act out his life story using available diagnostic schema, those suggested to him by the therapist, for example, will tend to reinterpret the facts and to reprocess them to get them to coincide with a theory designed to explain them, providing the proof to confirm it. And amazingly, this always happens ... it is a form of self-validation that allows a person to understand their disorder, and the clinic to legitimise its own set-up.

The words of S. give us an unexceptionable example: “I have fond memories of my first time as an anorexic ... I felt very good. I was very strong, had lots of energy. I felt good about myself, good with others. The worst time was the time just before this winter began: I was fat, ugly, didn’t like myself, I felt unhappy, this thing seemed hopeless ... I don’t know how to describe it, it was like someone was telling me to do something ... and when it’s done you ask: “Why did I do that?” But you don’t know why you have to, and it happens ... and happens ... It’s bigger than you ... it’s not that you say I’ll eat now, then throw up, it just happens ... come the

moment it seems to solve things, understand? Everyone sees me fat, so what am I supposed to do? I eat and throw up, then I tell them: “Well, I’m bulimic that makes me fat”, it seems to hide the problem ... and until I understood that was the problem, I couldn’t get shot of it, that’s it for me .. if work went badly, it was coz I’m bulimic, if people stared at me, it was coz I’m bulimic, if my mother didn’t look at me it was coz I’m bulimic, and they’re strong feelings and you feel bad about it ... it’s like you’re in a circle, and there’s no end, you go on going round and you say, what’s in it for me? The feelings are strong ... you’re not happy, you soon get tired a bit, because it doesn’t make sense”.

“Bulimia” explains “bulimia”. Once the “illness” is identified, it takes on a life of its own; it comes to be perceived as a condition where the individual has limited control. The more the person identifies with it, the less they feel weighed down by their own “failures”. Inevitably a dependency on the expert, with his repertoire of “healing” knowledge, is formed. The therapeutic experience follows the illness’s natural pattern and success is attributed to external factors (appropriate diet, the practitioner’s skill), and should it proceed awkwardly, to internal factors that the therapist is not wholly responsible for (lack of commitment or character). And in a few words, we have managed to sum up a long-drawn out process, namely how psychological distress becomes a medical issue.

But what would have become of S.’s experience had she been born several centuries previously? Most likely, in the absence of an example of “bulimia”, her behaviour and emotions would have been explained away and justified by some other means. Perhaps examples of the work of religion or a devil (as some of the texts studying the historical origins of eating disorders and the development of meanings abstinence and excesses in the consumption of food in various times would suggest).*

Insanity, even insanity of the body, begins to develop as a problem with the advent of a profession (medico-psychiatric) that begins to show an interest. These “normative” professions once they introduce the question of clinical evaluation make it a possibility and self-legitimise it. Diagnostic-clinical activity has found increasing favour throughout history and this might be the result of an exponential increase in evaluative procedures and to giving psychological and psychiatric supposition an institutional forum (Salvini 2012 and Faccio 2012).

Their place has become assured thanks to a “concession” to Medicine, in its turn the fruit of an increasingly recognised medico-scientific authority capable in the first instance of describing and subsequently, explaining reality.

The Birth of Insanity

(taken from Salvini 1998)

Certain professions and their accompanying portfolios of knowledge were developed and endorsed from the beginning of the 1700s onwards, when judicial, administrative and economic reorganisation of the body social and of the State required a great leap forward in discipline. Great historians such as Michel Foucault have expounded accurate and exhaustive reconstructions to show how, in the developing industrial world of this period, educational institutions, the judiciary, administration, means of production and the military once in place, became the stimulating

laboratories of a new and eloquent normative order, in accord with the work of modernisation in national states.

In fact as numerous historians and sociologists including Norbert Elias have shown, the effects of this “civilising process” and modernisation demanded a widespread normative-ideological consensus and precise social control, which included how to catalogue, evaluate and treat the rejects, or those individuals unable to live up to moral sexual and work imperatives (Elias 1988). The “civilising process” opposed all traditional forms of punishment, exclusion and repression practiced by “the Ancient Regime”, not only creating more humane punishment, philanthropic aid, cure and rehabilitation, but also admission to mental institutions, schools for the disabled and the disadvantaged, morality being determined by the psychiatric professions, and so forth. For example, medical, judiciary, sanitary and pedagogic control of “perversions” was developed for the overall protection of the species and society.

None of this could have been accomplished without the contribution of specialised professionals that worked alongside normative historical ideologies. In fact, specialists in mental illnesses, paediatricians and criminal anthropologists were the precursors of current clinical professions of the psyche. Throughout the XIX century, they produced an innumerable quantity of books, opinions, advice, programmes, and technical instructions, all designed to demonstrate the “natural and biological” foundations of every moral norm, transforming rebellious behaviour into circumscribed objects of knowledge. From the moment they first began, the clinical sciences of the psyche’s main considerations and objectives, from Esquirol to Mantegazza, from Schreber to Freud, from Krafft Ebing to

*see Vandereycken and Van Deth (1994) and Faccio (1999) for further information.

Tardieu, all the way to Lombroso, would passions, crime, and perversions, casual non-reproductive sex, rather than the study of insanity. During this period, the huge task of diagnosis began to catalogue every eccentricity, strangeness, and deviant violation that resembled insanity and to list him or her in a register of the normal and the pathological. As Alphonse de Lamartine noted: “classifying men and things became this era’s obsession. The word has reshuffled its cards”. “The Illuminist era” – wrote James Hillman – “dreamed of classifying the world of the mind by category, in similar ways to the world of trees and animals with their subsections, genus and species”. We might add that in successive eras psychiatric positivism attempted the same using every means at its disposal, from the craniometrical techniques, biotyping, cellular typing through to descriptive psychopathology using extensive illness classifications that include every variable. “Throughout the seventeenth and eighteenth centuries” – states Hillman – “it was fashionable to isolate peculiar disorders. Nearly all the terms that we know so well were coined then: fetishism, autism, catatonia, claustrophobia, exhibitionism, homosexuality, masochism”. We might add terms that have fallen into disuse to this list, such as dementia praecox, sub-morose personality, algolagnic, presbiophia, disteleotimic neurosis, and oniroid-agglutinan, zoerastia and many more besides.

2.3 New Labels for New Deviancies

The body is not excluded from this disorder specialisation syndrome: ortorexia and binge eating are the most recent, and in the past, we found neurasthenia, vegetative disorder, somatisation disorder, stress syndrome, vegetative dystopia, and vegetative neurosis. With similar linguistic exuberance, each affliction gains a name, and once named, acquires status. For every person that in varying degrees disturbs the peace of our socio-cognitive moral order, we are ready with terms that not only reflect a moral and derogatory opinion, but also make sense of different experience by means of pseudo-medical explanations. In the field of naming illnesses, the boom in the proliferation of psychiatric disorders has only recently reached its apex, and needless to say, the body is the new protagonist. There can be no better place to find examples than in the Diagnostic and Statistical Manual of Mental Disorders, or DSM, published by the American Psychiatric Association. Whereas the first 1952 edition listed 60 categories, the fourth edition (or DSM-IV) considers more than 350. Self-evidently, many of the disorders described have overlapping criteria and insubstantial symptoms, as the category “eating disorders not otherwise specified” is one that lists all hybrid forms, namely those that do not satisfy criteria for anorexia or bulimia. Not included is uncontrolled eating disorder* or Binge Eating Disorder (BED) which is now considered an “autonomous voice”, something it will undoubtedly become in future versions of the manual. Amongst the partly discernable consequences, the extensive range of categories casts yet more shadows upon the difference between illness and good health, between people and patients.

A simple example confirms this: amongst the newer pathologies, we find dysmorphic or dismorphofobic disorder (Body Dysmorphic Disorder or BDD). As we will later discover, amongst its characteristics are spending “excessive amounts of time” in front of the mirror, and a major concern about the size and the shape of some part of the body. But “who can tell us – to use an inquisitive journalist’s catchphrase – where the dividing line between ‘illness’ and ‘vanity’ lie?”

In her recent book, “The Broken Mirror,” Katharine Phillips, a psychiatrist from the Brown University School of Medicine – who contributed to the establishment of BDD criteria –

*Uncontrolled eating disorder is characterised by the recurrence of bingeing episodes in the absence of regular inappropriate compensatory behaviour typical of bulimia nervosa

states that more than five million Americans (men and women) are sufferers. She admits that “the difference between BDD and a normal concern about appearance can be a question of degree” But this did not dissuade both her and the American Psychiatric Association from classifying it as a disorder – nor from its being included in DSM-IV.

The idea that lack of body satisfaction is not just the prerogative of someone diagnosed as a “clinical” subject finds many backers. A recent research project conducted using more than 400 university students found that as many as 98 % of female and 90 % of male students expressed anxiety about at least one part of, or about a feature of their bodies (Faccio 2011, in the course of publication).

These percentages seem to suggest that body dissatisfaction now has become the norm. 14 years ago, when Frazier and Lisonbee posed similar questions, they obtained much lower figures: 50 % for females and 30 % for males. Normative and aesthetic tyranny exacts very high prices using the currency of hard work, stress, continuous concentration, selfish isolation, we could almost be talking about a kind of “normopathy”. The pathological importance that self-characteristics permeates the fabric of our social system, and stokes the fires of instigation of a collective dysmorphophobia, an angst-making sense of not being attractive, of not being accepted, constituting pre-clinical situations. In fact from this “cultivable terrain” that exemplars of anorexia, bulimia and binge eating emerge. They are then consigned to the specialist, in the naively belief that they are very different leaves to the branches that produced them.

Coming back to the list of novelties, let us consider premenstrual dysphoric disorder (PMDD), whose characteristics are irritability, tension, feeling wretched, lethargy, headaches and increased weight. What transforms these common symptoms into an illness is the time factor; these normally appear a week before menstruation and disappear several of days later. Are irrelevant and transitory symptoms really indicative of an illness? Is a (flawed) correlation between normal body rhythms and hormonal changes grounds enough for revealing a pathology? With PMDD, the dividing line between normal and abnormal becomes yet more muddled.

This is also evident in the growing number of illnesses associated with now infamous eating disorders. As we will discover, the first one to become widely recognised in the 1970s was anorexia nervosa, whose symptoms include an extreme fear of putting on weight, amenorrhea (lack of menstruation) and the infamous body image disorder, which will get its due share of attention. Sufferers think they are malformed even when underweight and emaciated. Psychiatric commentaries from the 1980s then identified tracts for diagnosing bulimia nervosa, whose characteristics include binges or chronic eating habits and persistent preoccupation with weight and body form. Both these disorders present real problems for sufferers, but because these symptoms can occasionally turn up in healthy people, psychiatrists are obliged to evaluate “the context in which the eating takes place” as prescribed by the manual. What is considered “excessive consumption for a typical meal can be considered normal for a celebration or a meal during a party”. In an article in the *New England Journal of Medicine* called “Running: An Analog of Anorexia?” Alayne Yates writes that even routine gym exercising can be symptomatic of illness. Too much, or in psychiatric terms, compulsive exercising, indicates an “activity disorder” – writes Yates. The problem is not the moment the behaviour happens (like with PMDD) nor is it the context (like with bulimia nervosa) but its purpose. In Yates’ view then even “excessive” jogging to lose weight or to keep it under control represents a symptom of pathology.

This remarkable concentration on different kinds of body disorder goes hand in hand with a generally increased interest in biological positivism. In truth, the two provide reinforcement for one another. This new subdivision suggests that the characteristics of pathologies, that were once thought to be discrete and changeable, are in fact inflexibly determined by a kind of biological programming. In other

words, the disorder and consequent erratic behaviour is activated by biochemical deficiencies, often caused by genetic defects. Serotonin is the neurotransmitter that is most often cited in this regard. Katherine Phillips connects dysmorphophobia with “an abnormality in the serotonin-producing neurotransmitter, that is, a depletion of this substance in the inter-synaptic space” (Phillips 2006; Cash 2006). Other psychiatrists have attributed eating behaviour disorders, compulsive exercise disorder and indeed PMDD to low serotonin levels. In support of the serotonin-producing hypothesis, it is stated that that patients feel better once their serotonin levels are increased by administering SSRI (Selective Serotonin Reuptake Inhibitors),* the most commonly prescribed of which is Prozac. Since patients with BDD seem to respond, the hypothesis that altered brain chemistry may play an important role in such clinical scenarios is confirmed. In ‘Listening to Prozac’ (Kramer 1993) Peter Kramer, the psychiatrist, puts forward the same circular interpretation: the existence of the “illness” is confirmed because the treatment instigates a positive pharmacological response.

An interesting point here is that the paradigm: if the treatment works, the disorder is reconstituted inside the same parameters of reality the chosen treatment possesses, is not disproved using this argument. In other words, that biochemical determinants are the basis for the development of differences is confirmed. Here is a system that refuses to be invalidated. The ethno-pathogenesis model assumes that in order to determine cause, correct diagnosis is essential. In this case, however, “effectiveness” of treatment, even though the reason it works remains unknown, permits confirmation of the neuro-chemical hypothesis, for lack of evidence to the contrary. Meaning that the intervention itself and its effects both suggest, and at the same time confirm, the genesis of the new illness. From the point of view of someone suffering from an illness involving the senses as well as their own body features, the whole thing makes choosing the right interlocutor to turn to an even more complex proposition.

Would people worried about a physical circumstance, such as depleted eyebrows or a mismatched nose for example, be correct in referring themselves to a psychiatrist for a psycho-pharmacological consultation, or to the psychotherapist who can clarify the reasons why their body form and features are a source of concern, or to the plastic surgeon to get the problem fixed? Each professional mentioned would treat the request as appropriate for their specialist discipline, and would regard as essential the knowledge that motivated their going to the marketplace. Each of them would redress the problem based on its causes: eliminate anxiety, increase serotonin, modify the body, and operate on the tissue, skin and bones. Each specialist can offer resolution and – equally so – demonstrate a high success rate.

This further confirms the statement that no scientific discipline, whether in psycho-diagnostic or neuro-scientific fields, can lay claim to an exhaustive and definitive body of knowledge about human behaviour, its conditions and cognitive processes. It is equally true that any observers glancing through their own front window are forced to make generalisations, explain what they see in terms of their education, knowledge and professional identity. An implicit tendency to

generalise and selective blindness are possible errors, and can happen in any branch of knowledge.

*These substances increase levels of extra cellular serotonin, by inhibiting pre-synaptic cells from reabsorbing neuro-mediators. Some existing examples are: citalopram (Celexa, Cipramil, Emocal, Sepram, Seropram), fluoxetine [Prozac, Fontex, Seromex, Seronil, Sarafem, Fluctin (EUR)], fluvoxamin (Luvox, Faverin), paroxetine (Paxil, Seroxat, Aropax, Deroxat, Paroxat), sertraline (Zoloft, Lustral, Serlain).

The Corporeal Identity
When the Self-Image Hurts

Faccio, E.

2013, XVIII, 170 p., Hardcover

ISBN: 978-1-4614-5679-7