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Subjective and physical dimensions of bodily self-consciousness, and their dis-integration in anorexia nervosa

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ABSTRACT

The present investigation concerns the multidimensionality of self-consciousness. I will specifically address this general issue by focusing on bodily self-consciousness and by considering how one is conscious of one's body through consciousness of both its physicality and its subjectivity. Here, *physicality* is defined as the belongingness to the physical world; *subjectivity* is defined as the fact of being a subject of conscious experience. Once subjectivity and physicality are differentiated from each other, the difficulty is to clarify the integration of these dimensions of bodily self-consciousness into a single experience of one's body: how does the consciousness of one's body integrate one's consciousness of one's body-as-subjective and one's consciousness of one's body-as-physical? In this investigation, I describe different forms of bodily self-consciousness in ways that shed light on the intermingling of subjectivity and physicality. I argue that being conscious of one's body-as-subjective involves experiencing one's belongingness to the physical world; conversely, being conscious of one's body-as-physical involves experiencing it as one's own; either way, such forms of bodily self-consciousness involve experiencing both the subjectivity and the physicality of one's body. The hypothesis here is that the imbalance of these dimensions relative to each other would be pathological. I will thus underline the normal multidimensionality of bodily self-consciousness by considering its pathological breakdown as it happens in anorexia nervosa.

"The hopeless dream of being—not seeming, but being . . . The gulf between what you are with others and what you are alone. The vertigo and the constant hunger to be exposed, to be seen through, perhaps even wiped out . . . You can shut yourself in . . . Or so you thought. But reality is diabolical. . . . No one asks . . . if you're genuine or just a sham . . ." (*Persona*, by Bergman, 1966).

1. Physicality and subjectivity

The present investigation concerns the multidimensionality of self-consciousness. Here, I will specifically address this general issue by focusing of bodily self-consciousness and by considering how one is conscious of one's body through consciousness of both its physicality and its subjectivity. For the present purposes, *physicality* is defined as the belongingness to the physical world; *subjectivity* is defined as the fact of being a subject of conscious experience. Here, I will take the distinction between the subjective and physical dimensions of bodily self-consciousness as a disquieting starting point. Indeed, differentiation is not separation and once subjectivity and physicality are differentiated from each other, the difficulty is to clarify the integration of these dimensions of bodily self-consciousness into a single experience of one's body: how does the consciousness of one's body integrate one's consciousness of one's body-as-subjective and one's consciousness of one's body-as-physical? Answering this question involves understanding the "paradox of human subjectivity" by which one is "being a subject for the world and at the same time being an object in the world" (Husserl, 1934–7/1970, *Krisis*, §53).

In the following, I intend to describe different forms of bodily self-consciousness in ways that shed light on the fact that subjectivity and physicality are intermingled with each other. To anticipate: being conscious of one's body-as-subjective involves experiencing one's belongingness to the physical world, which implies that physical dimensions are intermeshed with subjective ones; conversely, being conscious of one's body-as-physical involves experiencing it as one's own, which implies that subjective dimensions are intermeshed with physical ones. In the following, I will characterize different ways in which physicality and subjectivity are intertwined in bodily self-consciousness. I will underline such intertwinements by considering their pathological breakdown as it happens in anorexia nervosa. The underlying hypothesis is that we are normally conscious of our body neither as purely subjective, nor as purely physical; rather we are normally conscious of our body as an intertwinement of subjective and physical dimensions: bodily self-consciousness is normally multidimensional. The imbalance of these dimensions relative to each other is pathological.

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2. Anorexia nervosa

An anorexic subject asked to describe herself in whatever way she wished provided the following self-description, mentioned as prototypical by the interviewers: "I've been depressed all my life. I have no self-esteem. I hate myself. I don't think I'm good enough. I don't think I can meet up to my brother's achievements. I don't tell anyone how I'm feeling. I punish myself a lot. I don't feel I have any good qualities even though people tell me I have a lot. I talk to myself a lot, like a repeated ritual, like whenever I eat or do something wrong, I say I hate myself over and over again. I drive myself very hard with little sleep and little food. I have to keep working and doing things. When I'm out in school and out in public, I act totally different and no one knows I'm depressed. My parents just found out that nobody knows anything about me. I don't know. I don't think I'm good at anything. That's it" (Bers, Blatt, & Dolinsky, 2004, p. 306). That is the phenomenology that I will further investigate here.

Anorexia, from *an* "without" and *orexis* "appetite, desire", literally stands for "lack of appetite". Anorexia nervosa is classified among eating disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition* (DSM-IV, 2000). Eating disorders also include bulimia nervosa and eating disorders not otherwise specified. Anorexia is specifically characterized by (A) a refusal to maintain body weight at or above a minimal normal weight for age and height, (B) intense fear of gaining weight, (C) disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight, (D) amenorrhea in women (men make up approximately 10% of anorexia nervosa, which is then associated with decreased libido and impotence—note that for the sake of grammatical simplicity, in the present investigation of anorexia, I only refer to women, but see e.g. Weltzin et al., 2005). Anorexia is associated with an important secondary symptomatology, including low body temperature (hypothermia); low heart rate (bradycardia); low blood pressure (hypotension), reduced immune system function, intestinal and urinary problems, excessive sensitivity to cold, insomnia, danger of osteoporosis, etc. Comorbid psychiatric symptoms include major depressive disorder or dysthymia (50–75%), obsessive-compulsive disorder (25%), sexual abuse (20–50%), substance abuse (12–18%), bipolar disorder (4–13%). The prevalence of anorexia is approximately 8 for 100,000 in the general population, and approximately 1% among female teenagers. The peak onset is between 15 and 19 years old (Bulik, Reba, Siega-Riz, & Reichborn-Kjennerud, 2005). Anorexia is thought to have the highest mortality rate of any psychiatric disorder: approximately 6% of diagnosed anorexic subjects eventually die due to related causes (Herzog et al., 2000). Moreover, the suicide rate of people with anorexia is higher than that of the general population and is one of the main causes of death for these subjects (Pompili, Mancinelli, Girardi, Ruberto, & Tatarelli, 2004).

3. The self and the body in anorexia

An anorexic subject is easily recognizable. Thin and starving, "her eyes are often sunken, her face cadaverous. Her facial bones look as though they are trying to break through her stretched and fragile looking skin. Her hands may be red and swollen and look too large for her body. Her gums may be receding and there may be a layer of baby like hair, lanugo, over her face and body. The thinness of her body, of bones lacking adequate lubrication and supporting muscles, makes one wonder whether movement itself is possible. Where can her energy come from and how can the pain be tolerated? Yet she might present herself as being well, as though this state of extreme thinness is not connected to her as a person at all, or if it is, it is a desired, not an unwanted state" (Farrell, 1995, p. 10–11).

At first glance, as this quote attests, anorexia seems to be obviously a bodily pathology. Consequently, many models of anorexia focus on the *body* with the aim of understanding, explaining and treating anorexia. However, the specific status of the body and bodily consciousness in anorexia has proven to be surprisingly difficult to establish. On the one hand, it is generally acknowledged that in anorexia "the first symptom is a disturbance in body image of delusional proportions" (Bruch, 1962, p. 188). On the other hand, it is also acknowledged that the pathology is pervasive and that the primary disturbance in anorexia is "the perception of the self, not simply that of the body" (Sours, 1980, p. 343, quoted in Bers et al., 2004, p. 295; see also Bers et al., 2004, p. 312). Such tension reveals a widespread Cartesian conception of the body and self as dissociable from each other, conception following which the anorexic subject would seek the destruction of her body for the sake of reaching a *disembodied mind*.

Other voices are heard though, according to which "anorexia springs from the all-too-painful realization that I *am* my body" (Lester, 1997, p. 485). To integrate this claim together with the conception of anorexia as a *search* for subjectivity (Knockaert & Steenhoudt, 2005, p. 284), for a "sense of identity and selfhood" (Bruch, 1978, p. x), the notion of a *multidimensional bodily self-consciousness* is particularly helpful. Indeed, to better understand how the anorexic subject might coherently seek self-*preservation* by operating body-*destruction*, without falling into any self-body dualism, one needs to rely on the aforementioned distinctions between different dimensions of bodily self-consciousness. The claim would then be the following: anorexic subjects would suffer from an intolerable tension between the subjective and physical dimensions of her bodily self-consciousness (Legrand, in press-a). Unpacking this claim is the aim of the present investigation of anorexia.

To the best of today's knowledge, empirical studies have failed to provide any coherent data about the extent of the disturbance of the body representation in anorexia. An impressive amount of different questionnaires exists (for reviews and evaluations of some of such measures, see Cash & Grasso, 2005; Probst, Pieters, & Vanderlinden, 2008; Probst, Vandereycken, Vanderlinden, & Van Coppenolle, 1998) but this diversity prevents rather than helps the comparison of results with each other. All together, it appears that measures of affective and socio-cultural components of the body image yield significantly larger effects than measures of the perceptual components of the body image (Cash & Deagle, 1997; Skrzypek, Wehmeier, & Remschmidt, 2001). To evaluate this perceptual component, there exist as well a number of different methods, most involving body size evaluation. Again, results are heterogeneous (for a review, see Farrell, Lee, & Shafran, 2005) and in this domain, "research results are rather inconsistent and the true nature of body image disturbance is still not very well understood" (Skrzypek et al., 2001, p. 220; see also Farrell et al., 2005). Far from dismissing the investigation of anorexic disturbances of body experiences, this messy situation rather justifies further explorations (Shroff & Thompson, 2006). Before going into that here, a word needs to be said about the main models of anorexia which are currently on stage.

4. Models of anorexia

The conception of anorexia is multi-faceted, from spiritual connotations linking it with ascetism (Bell, 1985) to its commercial appropriation by the media. However, its underlying causes and mechanisms remain largely unknown (see e.g. Kaye, 2008). The following factors are most often mentioned: presence of eating