Anorexia in scientific journals and the press: cultural models, critical points and lines of development

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1. Introduction

In this article we set out to identify the cultural models structuring the discourse on anorexia in a part of the Italian scientific and journalistic output in the period from 2000 to 2005.

The hypothesis is that such cultures influence and "organize" the operations of intervention and prevention of those who deal with anorexia and that, at the same time, they orient the expectations and the demand of the social system.

The idea underlying the research is that any professional operation that can be carried out and is carried out by associations, institutions, and all the operators involved with anorexia, can (and must) be set in a "context" of which all the *culturally* significant coordinates are known, and that interventions, projects and prevention policies can therefore attain a clear and perceptible form and choose a genuinely incisive sense, which springs from and responds to the expectations, demands, conceptions and whatever else can be attributed to the life and feelings of the community and of the scientific culture towards a "social event" like anorexia.

The research therefore aims to identify places and cultural areas where there is a particularly strong social "demand" linked to anorexia, interpretable in relation to what is "offered" by the context. Finally, it is hypothesized that a knowledge of the image of anorexia conveyed by the scientific and information press can grant opportunities for dialogue between experts, operators, institutional interlocutors and open the way to transformations and negotiations of meaning about the representation of anorexia. Dealing with this does not entail just describing the forms of suffering or types of treatment, but also asking oneself about risk factors or resources involved in a particular culture and about prevention, and therefore about the possible forms of protection, which would require "political" intervention in the culture in order to be put into effect.

2. Methodology

2.1 Choice of scientific sources and collection of articles

It was decided to consult, from an interdisciplinary angle, articles on anorexia found in the following Italian journals:

- *L'Arco di Giano*: this is the leading journal of *medical humanities*: a systematic, not occasional, encounter between disciplines and different practices connected to health. The journal tries to look in the two opposite directions of the natural sciences and the human sciences, to cover the whole field of health care.
- *La Rivista Telematica di Psychomedia - Psychomedia Telematic Review:* in the English and Italian versions it prints articles, links and further reading hints of specific thematic areas in the psychology field.
- *Psicologia Della Salute*: four-monthly journal of health psychology and sciences; health psychology concerns research, application and monitoring of interventions related to promoting and maintaining health, prevention and treatment of illnesses, analysis and improvement of health control systems and the drafting of health policies
- The journal *Costruzioni Psicoanalitiche:* seeks to give voice to reflection on topics which, starting from the foundations of psychology, moves in various directions, also embracing fields not strictly connected to therapy, but to society in a broad sense, with the transformations and events through which this is expressed.
- *Psychotherapy and human sciences:* prints contributions from psychoanalytic sources alongside those representing disciplines like psychology, psychiatry, sociology, anthropology, philosophy, education, and history.

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- *Psichiatria di comunità:* a three-monthly journal which covers human and social problems, from the same political angle as community action, to stimulate debate, gather proposals and translate them into projects.
- *Studi Junghiani*: founded officially in 1995, it has the aim of favouring the deepening of knowledge of the various orientations and numerous theoretical and clinical interests in the domain of analytical psychology. Also open to debate with psychiatry, philosphy and anthropology.
- *Psicobiettivo:* sets out to make a contribution to the search for points of contact and of convergence between different psychotherapeutic orientations, respecting the reciprocal differences. It responds to a need widespread today in the field of psychotherapy: that of overcoming drastic conceptual and practical contrasts between the various approaches, in favour of "paradigms of complexity" that posit the need for multiple viewpoints that are complementary to each other.
- *Terapia Familiare:* an interdisciplinary journal of relational research and intervention. At the centre of its interest is the study of the individual in his/her family and social relations. It is the oldest journal of studies and research on the family.
- 16 articles published between 2000 and 2005 in the 9 journals considered, constituting a text of 142 pages.

2.2 Choice of daily papers and articles

For the research it was decided to consult Italian daily papers from 2000 to 2005 through the archives of the papers themselves and of Lexisnexis made available by the Senate Library. It was decided to consult the top three national dailies: *La Repubblica*, *Corriere della Sera* and *La Stampa*. *Corriere della Sera*, published in Milan, is currently the most read paper in Italy with an average circulation of over 840,000 copies a day. *La Repubblica* is a paper belonging to the L'Espresso editorial group, published in Rome. The average daily sales calculated from November 2004 to October 2005, are slightly below 790,000 copies. *La Stampa* is currently the third biggest national newspaper, with an average circulation of about 430,000 copies[1]. An agreement to issue the paper locally together with a series of small and medium sized dailies spread all over the country (the main ones being *Corriere di Napoli, Corriere di Caserta, Cronache del Mezzogiorno, Il Domani della Calabria, Il Domani di Bologna*), has also helped its circulation in the South. The research was carried out by inserting the word "anorexia" in the search engines, which retrieved all the articles containing the word in the body of the article or in the headline. A careful reading allowed us to select only the articles focusing on the topic, discarding those in which anorexia was only mentioned or in which the word was just listed, or used in a metaphorical sense. The result was a sample of 224 articles (41 from La Stampa, 91 from La Repubblica and 92 from Corriere della Sera), which formed a text of 180 pages.

2.3 Emotional Analysis of the Text

To analyse the discourse on anorexia in the press and in the scientific literature it was decided to identify the cultural models present in texts using Emotional Textual Analysis (AET, Analisi Emozionale del Testo), a psychological tool for the analysis of written texts[2]. It is a methodology that enables the collusive dynamics present in the text to be highlighted, so as to analyse the cultural models emotionally structuring the text itself. AET therefore enables the "culture" to be analysed, in the sense of "emotional construction of knowledge" of specific contexts, objects and social relations. The analysis carried out on the texts therefore showed the collusive models with which the press and scientific literature emotionally organise the representation and knowledge of anorexia.

[1] Source of the data about the average circulation of the three daily papers mentioned: Pubblicità Italia – ADS average total data – Mobile mean for 12 months - from November 2004 to October 2005 on http://www.pubblicitaitalia.it/ads.asp.

[2] For more details see Carli R., Paniccia R. M. (2003), L'Analisi Emozionale del Testo, FrancoAngeli, Milano.

It is hypothesised that the words structuring the language output will be subdivided into two broad categories: ***dense words***, with maximum polysemy[3] if taken in themselves and minimum ambiguity of meaning, and ***non-dense words***, with maximum ambiguity of meaning and therefore with minimum polysemy. To make sense in language, the latter words need to be part of a language context. If dense words, which maintain a strong emotional meaning even when taken in isolation, are identified in a text they can be grouped according to their recurrence in the text segments.
This operation of segmenting the text and identifying the recurrent groupings of words in specific segments is possible thanks to the analysis of correspondences[4] between the dense words shown in the text and the segments of text, identified beforehand. These analyses are made possible by specific IT programmes for text analysis; in this case the software used is Max Reynert's Alceste (*Analyse des Lexèmes Co-occurrents dans les Enoncés Simples d'un Texte*). From the factorial analysis of the correspondences followed by cluster analysis[5], groupings of dense words called cluster or repertoires can be obtained. "Cultural Repertoires" are characterised by co-occurring dense words in a set of segments where the same words recur with the highest probability. The function of the co-occurrence of dense words in the same repertoire is to reduce the *infinite meanings* of each dense word; it is as if each word considered in the encounter of co-occurrence with other words loses a part of its polysemy, thus allowing different repertoires to be constructed, conveying the collusive dynamic inherent to the text itself.

3. Cultural repertoires

We will start by considering and analysing the encounters of co-occurrence starting from those between dense words that are more highly central to the repertoire, since they are the words that have contributed more in terms of statistical significance to the building of the repertoire. The hypothesis underlying the analysis is that the set of co-occurrences analysed will allow us to understand the "culture" characterizing that repertoire[6].
Figure 1 shows the factorial space (Cultural Space), defined by the intersection of three cartesian axes, called factors, that reveal the maximum total variance of the data.
The ETA has shown the presence of 4 clusters or Cultural Repertoires, positioned in the following way in the Cultural Space: to the left of the first factorial (horizontal) axis, we find R.C. 2, which is in contrast with R.C. 1 located at the opposite extreme; on the second (vertical) factorial axis, there is R.C.3 at the top, which is in contrast to R.C. 1 and 4, located in the lower part of the Cultural Space; lastly, the third factor differentiates R.C. 4 and 1.
Initially we will describe the cultural aspects characterizing each of the Cultural Repertoires that emerged with the statistical work on the text and we will then examine in greater depth the relations between the cultures present in the four repertoires for the purpose of identifying the specific Culture under analysis, as it is organized in the Cultural Space. The succession of Cultural Repertoires described reflects their reciprocal positions on the factorial plane: R.C. 1, which will be

[3] By *polysemy* we mean the infinite association of meanings and of senses attributable to a word taken in isolation, outside the language context which reduces its polysemy. It is obviously an "emotional" polysemy, which is transformed into the "sense", cognitively speaking, of the word itself when it is part of a language context.
[4] Like all methods of factorial analysis, the analysis of correspondences makes it possible to extract new variables - factors – that have the property of summing up information in an orderly way. It also allows us to draw up graphs to represent - in one or more spaces – the language entities grouped by co-occurrence.
[5] Set of statistical techniques whose aim is to identify the grouping of objects (in our case, of dense words) with two complementary features: within them, the maximum similarity between their constituting elements (the words belonging to each cluster); among them, the maximum difference.
[6] The analysis of instances of co-occurrence starts by considering the etymology of the dense words making up the clusters or Cultural Repertoires. As Carli and Paniccia (2002, p. 169) underline, "using the etymology of the words serves to orient the researcher, within the polysemy of the dense word, by identifying emotional areas where the mind can make associations". To this end it was decided to use the following dictionaries: Devoto G., *Avviamento all'etimologia italiana*, Le Monnier, Firenze, 1989; Cortellazzo M., Zolli P., *Dizionario etimologico della lingua italiana*, Zanichelli, Bologna, 1984; Castiglioni L., Mariotti S., *Vocabolario della lingua latina*, Loesher, Torino, 1966; De Mauro T., *Grande Dizionario italiano dell'Uso*, Utet, Torino, 2003.

taken first, is a cluster we have called a “joker” because, being in contact with all the factors, it helps to define all the other repertoires, by difference.

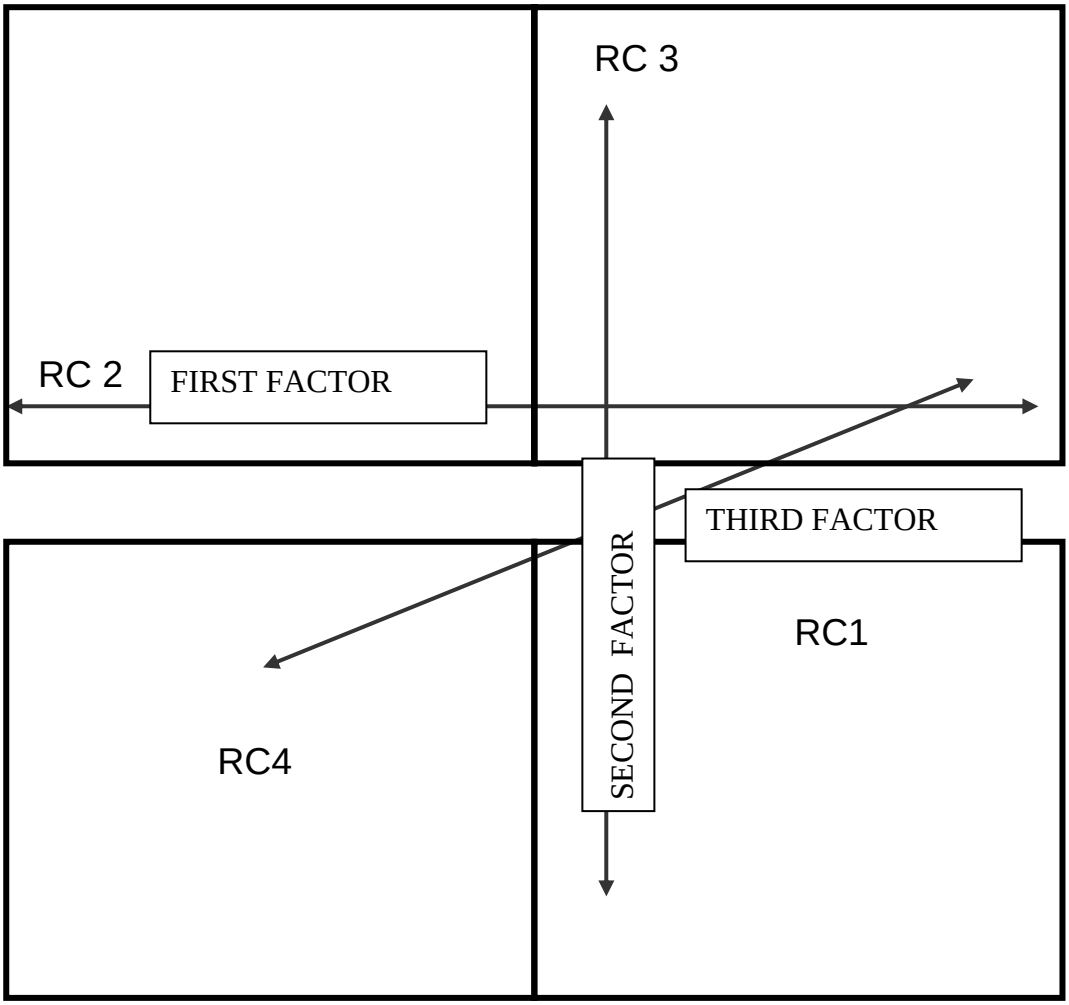

Fig. 1 Factorial (or cultural) space

3.1. Cultural Repertoire 1

It was decided to start with the analysis of RC 1 because it is the largest of the four making up the Cultural Space; of the total text analysed, 42% belongs to this repertoire.

The word that contributed most to making up this repertoire is **bulimia**, often described as the other face of anorexia, as one of the two extremes of the food disorder swing: a "morbid sense of hunger", as opposed to the anorexic's resistance to hunger[7]; fullness as opposed to emptiness. The word has a Greek origin, from *boulimía:* "devouring hunger", from "*limós* (hunger), *bôus* (ox)", which certainly evokes the invasive and compulsive aspect of the desire for food underlying bulimic behaviour.

Going down the scale of recurrence in the repertoire, the polysemy of the first word is reduced with **CLINICAL CENTRE**: there is a marked contextualization which places bulimia in a medical dimension.

BULIMIA CLINICAL CENTRE

Clinical derives from the Greek *klinikē* "bed", by extension "medical art". CLINICAL CENTRE in the sense of Clinic, "hospital sector run by a clinician; hospital" (1818 G. Rasori). Hospital comes from the Latin *hospitalis*, hospitable, welcoming towards "ospiti", where *hospes* means foreigner, outsider, extraneous person. The medical context is faced with something extraneous and transforms it into something known, giving it a name, identifying it, and then in every successive instance, recognising it and acting on it. So in the medical context, bulimia is seen as a disorder, detached from the norm-normality which medical action tries to re-establish.

BULIMIA CLINICAL CENTRE
CARE

And **care**, the word that forms the next instance of co-occurrence, specificies th

e action. **Care** as in: "subject the sick person to the treatments needed to cure him/her", treat an illness, a wound etc to heal it, (sec.XIII Pietro Ispano, volgar.), but also procure (av. 1347 B. Da S. Concordio) and be concerned (av. 1294 B. Latini).

The instance of co-occurrence manages to outline all the elements of the medical intervention: the place of the treatment, the action of caring and the object of this action, the illness. And it is precisely with **medico** doctor that the pardigmatic circle of the clinical intervention closes. And "medico" introduces a principle of authority based on the competence to care/cure.

BULIMIA CLINICAL CENTRE
CARE MEDICO

"Medico" from *medeor* (*mederi*), medicate, treat, heal. In a figurative sense it also means come to the aid of, make provision for, remedy. But here the presence of the word "medico"(physician) seems to underline the total handing over to medicine of the task of dealing with bulimia. The medicalization to the disorder seems in this culture to represent the main way to deal with an extraneousness which would otherwise be unknowable.

Bulimia, like "eating disorders" in general and "anorexia" (words that later come into the cluster being analysed), seem definable because they are situated in a specific context, that of medicine. From these first dense words, what takes shape is a well-defined and familiar relationship of emotionality based on standard medical practice, here seen as strong in its immobility, rigidity and unchangingness.

The appearance of a professional figure - the physician – seems to accentuate the role played by the power of those who treat compared to the sick who suffer (a picture that becomes clearer with the words "suffering and illness" in the next instances of co-occurrence), in guaranteeing the unchangingness, the conditions and rules necessary to face illness and close "the gap" with the

7 DSM IV shows the following criteria for bulimia: a) Recurrent gorging; b) Recurrent and inappropriate compensatory behaviour to avoid weight gain, like self-induced vomiting, abuse of laxatives, diuretics, enemas or other medications, fasting or excessive physical activity; c) Gorging and the compensatory behaviour take place on average at least twice a week, for three months; d) Levels of self-esteem are unduly influenced by body shape and weight; e) The alteration does not manifest itself only during episodes of Anorexia Nervosa.

norm. It is a power that cures if the sufferer entrusts him/herself to it: this entrusting is taken for granted when one has reached the extreme and can no longer tolerate what is happening.
The picture seems to open up to a fifth instance of co-occurrence:

BULIMIA CLINICAL CENTRE

YOUNG

CARE MEDICO

The word **giovani (young)** from *iŭvene* – "of a person between adolescence and maturity" (13th cent., TF)- pins a face, though still impersonal, on the illness, identifying the sector of the population most affected by disorders in eating behaviour[8]. The word "kids" present further ahead in the repertoire will reinforce and complete the identification.
Leaving the detailed analysis of instances of co-occurrence here, it can be surmised that the construction of emotional sense outlined so far gives us an initial overall vision of the culture present in the repertoire. The overwhelming presence of nouns underlines the strength of the "doing" aspect, of intervening at the medical level: "**suffering"** – **"illness"** – "**hospital"** – "**admission"** reinforce the determination of the medical intervention and the fragility of the object being treated; "**eating disorders**" – "**anorexia**" complete the diagnostic dimension, identifying the objects of medical practice; the words: "**serious**" - "**increase**" – "**alarm**" - "**health**" highlight the aspect of urgency that medicine has to deal with. Eating disorders are mentioned as a medical problem of vast proportions that medicine is called on to deal with. Professional competence gives no sign of medical solutions, or specific medical action, but seems justified by the importance of the social mandate that confers a great social responsibility on medicine as a discipline with a "strong power". Words like "specialist, doctor, profession" underline this.
On checking this first cultural area, we find confirmation in the type of verbs found in the cluster. Some of these, like "**strike**", seem to point to the firmness of medical practice that has to defeat illness and "**cure**" (also present in the repertoire) those who are "struck", evoking one of the two faces of the medical role proposed by Fornari: on the one hand, the paternal role of treating; on the other, verbs like "**help**", "**plan**", "**collaborate**", "**advise**" seem instead to reflect the maternal function of caring. In English the same distinction is made between *to cure* and *to care*.
Let us try to sum up what has emerged: the progressive restriction of the polysemy of the dense words give rise to the hypothesis that this Cultural Repertoire – the most representative of the Culture being analysed – embodies a representation of anorexia, and of eating disorders in general, as conceivable only within a medical context, an exclusive aspect in the confrontation with the extraneous that only medicine can understand, antisepticize and make predictable.
What is suggested is a culture typical of a form of medicine that restores and does not develop, which relates to illness by seeing a beginning and an end more than a space or an open movement, which concentrates on the final product rather than looking at the process.
It suggests a medical culture that bases its intervention on the double separation: of the subject from the illness, of the person's body from the living context. This double separation is caused by the urgency ("alarm", "serious") of the medical treatment, because there is the danger of death; it is a culture that forgets the multifactoriality of the determinants of health and the evidence that health treatments are only one among many factors that affect it.
The emotional dynamic structuring this repertoire proves to be centred on the medicalization of the eating disorder, which seems to ignore the need for intervention in the relational, social and economic context not only of individuals but also of the community that has to cope with eating disorders. The image of anorexia therefore seems to be emotionally saturated by the intervention of treatment by the specialized medical power.

3.2. Cultural Repertoire 2

This repertoire represents slightly over 15% of the text.
The first dense word we meet is **body "corpo"**. From the Latin *corpus*, form, image; from the Indo-Germanica root *kar*, make, compose, which seems linked to *karp*, beauty. From the Greek *kra-inò* create, compose.
The etymology refers firstly to a "formal" aesthetic dimension, but at the same time the word evokes the "substance" in the act of creating, naturally part of the generative, reproductive capacity

[8] Il DSM IV indica l'età di insorgenza tra i 12 e i 18 anni nel 95% dei casi.

of the human body. What also springs to mind is the traditional dichotomy of body and mind, or spirit. The body as in “a totality of the organs that make up the material organic part of man and animals” (inizio sec. XIII, Rinaldo d’Aquino). The body as the symbol of the “material”, of the “earthly”, and therefore “transient”, “fleeting”, as opposed to the “divine”, the eternal. And **symbol** is in fact the word that makes up the first instance of co-occurrence:

BODY SYMBOL

“Symbol” from the Greek *symbolon*, sign, from which one recognises, argues, presumes; but also convention, pact; linked to the verb *symbállein* put together, composed of *syn*, with, and *ballo*, throw, and in composition, place, put. “Material element, object, figure of animal or person etc , considered to represent an abstract entity” (av. 1542, G. Benivieni). The first instance of co-occurrence seems to suggest from the emotional standpoint a specific function given to the corporeal: that of putting together, of containing , of holding within itself meanings and representations. “The body that represents”: think of the symbolic meanings tied to the female body in different times in history and in different societies; think also of the “empty” body of the anorexic.

But let us look at the next word associated: **identity.**

BODY SYMBOL
IDENTITY

This is another term that seems to expand the role given to the body in the construction of one’s identity. Reporting the words on the order in which they appear, what is again highlighted is the role played by the “body” as the “symbol” of one’s “identity”, the latter - as is shown in the next instance of co-occurrence - being “social”, a “social” symbol, a social-aesthetic ideal. **Social** (from Latin *sŏcius*, companion) as in “company of people, union, group” to which one belongs or from which one is excluded as something extraneous. In this cultural dimension it therefore seems that the body represents the vehicle of social acceptance, the symbol of an identity constructed on the basis of an appearance.

BODY SYMBOL
IDENTITY SOCIAL

The subjective dimension seems to be sacrificed here for an ideal, a representation that sanctions a social likeableness with which one “identifies”.

The fourth instance of co-occurrence seems to specify the object of the culture being examined: **feminine.** It is the female body that is emotionally and symbolically identified. The culture evokes social meanings tied to the image of the woman’s body; the body of the social-aesthetic ideal woman is often the obligatory reference point for female identity. “Feminine” from the Latin *fēmina*, with the same root as *fellare* in the sense of nursing, giving suck, and of *fecundus*, fecund, and from the Greek *phyo,* I produce: the feminine is what gives suck, feeds, generates, gives birth.

BODY SYMBOL
FEMININE
IDENTITY SOCIAL

This female dimension seems to be in stark contrast with the descriptions of anorexic bodies reported in the literature. There is often talk of a sexless body - far removed from the symbolic ideas of roundness linked to fertility and reproductive capacity - of an annulment of the feminine traits of one’s body as a solution to the problem of identity.

BODY SYMBOL FEMININE
GOD CULTURE MYSTICAL
IDENTITY SOCIAL

The next words seem to define more clearly the symbolic dimension outlined so far: “**god**”, “**culture**” and “**mystical**” seem, on the one hand, to predefine the sense of a female identity impressed on a body that nurses and feeds, and on the other hand, to represent a power (the word “patriarchal” helps to convey its meaning) that removes, sacrificing femininity to the divine. God, from the Latin “resplendent”, “celestial” and form the Greek *thyo*, “sacrifice”. Mystical comes from the Latin *mistycus*, mysterious, arcane and from the Greek *myein*, close, hold back; but also worship, veneration.

The contrast mentioned at the outset between the spiritual and the corporeal dimension is repeated. The anchorage to the divine removes femininity from the body: controlling the body deprives it of its reproductive capacities.

The aspect of sacrificial religiosity seems to be confirmed by the next dense words: the "**renunciation"** of one's selfish **"desire"**, "**suffering"**, "**humility"** and "**humiliation"** mark the road towards "**salvation"**, "**eternal life"**, beneath the "**gaze"** of God.
Words like "**paradox"**, "**contradiction"**, "**tension"** evoke the risk of conflict inevitably present in the act of renunciation, as an attempt to suffocate the human side, a body sacrificed to the supernatural, a human ambivalence in the use of one's own body as the tool-symbol for an exclusive relationship with God.
Conflictuality, ambivalence and tension are often described in the literature as key elements of the anorexic personality, in which self-starving behaviour is reinforced in the maniacal feeling aroused by the unyielding control of the body, until it becomes the only source of consciousness of the self. *"The non-satisfaction causes an intense physical feeling, perhaps confused with pleasure, which confers an experience of immortality that living in the external world cannot change"* (Favaretto & Santonastaso, 1999).
In anorexia the control of the body and the vital senses therefore seems to be carried out in the attempt to achieve an aesthetic perfection in a transparent, ethereal body that enables one to take control of one's existence. But the incessant struggle with the body, the annulment of one's femininity and one's female passions, takes on the significance of the young woman's challenge of death, since controlling one's hunger and wasting away to a skeleton contribute to the feeling of power with respect to natural instincts and to achieving "eternity".
As has already been said in the opening paragraphs, psychiatrists and psychoanalysts have often underlined the religious, ascetic and mystical dimension of anorexics and similarly some historians (Bell, 1985) have looked for analogies between the behaviour of modern anorexic teenagers and that of ascetic medieval saints: the search for privation, the denial and frustration of the needs of the body, the control of the instincts, the tendency to sacrifice, the distorted perceptions due to fasting, the aspiration for immortality, the relation with an ideal image, the nearness to death. Other scholars (Favaretto & Santonastaso, 1999), in contrast, do not believe the phenomena can be seen as overlapping. The different cultural context they belonged to would, if anything, mean they could be placed in two separate ethnopsychiatric categories: "sacred disorder" in the case of the saints' abstaining from food, and "ethnic disorder" in the case of anorexia.
As well as theoretical divergences, the culture suggested by the cluster seems to reveal the sense of a universal language strictly connected to the human world and concerning some fundamental values of identity (such as the subject's relationship with otherness, with food, with pleasure) that anorexia seems to express.

3.3. Cultural Repertoire 3

The 3rd Cultural Repertoire represents 22 % of the text.
The first dense word is **patient**; it derives from the Latin *patientem*, from *pati* 'suffer' (composted of *sub-* and *ferre*, bring under, support, sustain, tolerate), and literally means "one who suffers, supports, tolerates physical and moral pain". By extension 'patient' is "person affected by an illness and subjected to the care of a doctor" (av. 1320, Crescenzi volgar.). Unlike Repertoire 1, organized on the emotional-symbolic plane around the nosographic categorization, based on the diagnosis, here the emotional dynamic organizing the representation of anorexia starts from the recognition of a subjectivity, known to be suffering and therefore in need of being cared for. Patient, in this sense, evokes, at a symbolic level, the client in the medical universe. This client is by definition *impotent* and *incompetent* in treating "illness", and for this reason turns to the care of an expert – the physician – handing over to him/her the task of intervening. The etymology of the word helps in interpretation: "patient" shares the same root as "passive"; the patient is therefore the one who suffers from dependence, "who suffers an action or wants to suffer it" (1304-08, Dante).
We are faced with a subjectivity evidently characterized as needing care for the purpose of putting an end to the suffering and to return to a state of normality.
Going down the order of recurrence in the repertoire, we find the word **therapy**.

PATIENT THERAPY

Therapy, from the Greek *therapeia* 'service', from the verb *therapeuo* 'I take care, I serve, I assist, I heal'. The term refers both to "placing oneself at the service of somebody, therefore offering to take care", but also to "treating, healing" intervening in a medical sense. Patient and therapy are closely connected words on the literal and symbolic plane; they intermesh and outline the context in which

the professional action will take place between a therapist and a subject-patient. The first places at the service of the second his/her knowledge and skill for the purpose of "treating" and "taking care". It is a professional action that involves therapeutic techniques the application of which presupposes a handing over or responsibility and an acceptance by the expert.
Let us see the second instance of co-occurrence:

PATIENT THERAPY
GROUP

Group, from the Latin *cruppa* 'set of people united by natural bonds, shared interests, purposes or ideas' (av. 1808 M. Cesarotti). The polysemy of the co-occurring words seems to reduced to a therapeutic action that sees the patient in terms of a group, a number of people united by suffering.
The fourth word in order of recurrence is **relationships**.

PATIENT THERAPY
GROUP RELATIONSHIPS

The word "relationships" literally means relation, bond between two or more people (from the Latin *relatio*, from *referre* 'refer'). Suffering is therefore linked to what keeps the group united: bonds, relationships. Consequently, the therapeutic action is the intervention centred on relationships within the group. This suggests that the focus shifts from the individual to be treated towards the relational sphere in which the therapy will be played out. In particular, the analysis of the relationships within groups mainly underlies psychological intervention of a systemic-relational kind and represents its building blocks. Unlike other theoretical approaches, the systemic approach in fact sets out to observe what happens when two or more people interact with each other and how the resulting interactive sequences affect their behaviour and their relationship. From this point of view, interaction is therefore closely linked to communication: when one interacts one communicates and a communication disorder can determine the appearance of psychopathological phenomena in the people interacting (Telfener & Casadio, 2003).
Relational therapy replaces the word "patient" – the single bearer of illness or disorder – with the expression "designated patient", to indicate those who act as a loudpseaker for the malaise of all, and who, through their own suffering, signal the dysfunctional nature of the system-group (Telfener & Malagoli Togliatti, 1991). The symptom (a term found later in the instances of co-occurrence) comes to assume a specific function in this perspective: with the symptom, the designated patient seems to pay for the suffering of the whole system of which s/he is part. S/he sacrifices him/herself to guarantee an equilibrium, though temporary, in a vicious circle of relationships which underlies and feeds the symptom itself. This is to be seen as an epiphanic way of announcing something that one is manifesting and it conveys a moment-state of suffering (Telfener & Casadio, 2003).
In the next instance we find the definition of the natural group in which the therapeutic intervention takes place: the family. It is the natural group which first won the attention of the systemic approach, suggesting an alternative unit of analysis from that of the "individual-centred" approach typical of medicine, psychiatry and some psychology.

PATIENT THERAPY
GROUP RELATIONSHIPS
FAMILY

Family, from the Latin *familia* (from *famulus*, *famiglio*, servant), derives from *faama* 'house, the members of the house united by blood ties. It is in the family group that the suffering seems to originate and the systemic therapeutic intervention is directed at it. The family becomes a patient. From the relational viewpoint, one talks about "anorexic families", characterized by their internal organization and the particular ways of communicating, focused on food. According to the systemic-relational literature, these are families that beneath an apparent balance and calm, conceal a deep degree of dissatisfaction, which on the behavioural plane, is expressed in the illness of the child, the weakest element on which the parents focus their attention and control. On an affective and relational level, their relationship dynamics play an important role in the origin and continuation of the eating disorder. On this point, it is useful to remember that in the literature, anorexia is often defined as a form of healing, the solution to relational problems in the family.
The symbolic dynamics structuring this repertoire therefore configure anorexia as "family suffering" and the object of systemic-relational therapy. The next words confirm and expand this: "**symptom"**, "**emotion"**, "**cognition"**, "**assessment"**, "**clinic"**, "**psychopathology"**, "**disorder"**, **"intervention"**, "**diagnosis"**, "**dysfunction"**, "**psychotherapy"**.

These are clinical categories underlying the knowledge-seeking and intervention of psychotherapy in general, and therefore also of relational psychotherapy, using in some cases a terminology that is strictly medical (symptom, assessment, disorder, diagnosis, dysfunction). Remember that the dense word that most contributes to the construction of the repertoire is 'patient'; if to this we associate the others listed above, what emerges with great clarity is the symbolic organization of anorexia, typical of this repertoire. The target of the therapy is not the single individual but the family, in the sense of a network of relationships built around the anorexia symptom. It is on the family that first diagnosis, and then intervention, concentrate. On the symbolic plane, therefore, one sets up a professional clinical action designed to overcome the suffering generated by the family psychopathology and to restore normal conditions, i.e. absence of disorder. The verb "**adapt"** (*ad- aptare*, make suitable) present in the repertoire confirms this idea. The anorexic family represents a difference from a predefined model of family operation; it must therefore be 'healed', bringing it back to normal functioning.
The psychological intervention seems to be based on the same premises as the medical one: disorders, dysfunctions and deviances are observed and assessed, comparing them to a 'norm', codified in this case by the psychotherapist. There are no words that signal attention to the resources of individuals and contexts and to the cultural dimensions in which anorexia is manifested: we pass from anorexia as an individual pathology to anorexia as a family pathology. This transition marks an evolution, though problematic, compared to Repertoire 1. Here too the emotional dynamic structuring the image of anorexia is defined as the acceptance of responsibility by an experienced therapist, who in this case is the relational psychotherapist. To use another dense word in the repertoire, this is a **strategy** (from the Greek *strategos* 'army commander', composed of *stratos* 'army' and *agein* 'lead'), evoking on the symbolic plane a model of action pre-established in the relationship of asymmetry, made necessary and socially recognized because it seeks to correct a dysfunctionality.

3.4 Cultural Repertoire 4

The 4th Cultural Repertoire represents about 21 % of the text.
Following the same criterion used previously, we start from the word with the highest frequency in the Repertoire. The others will follow, forming the first instances of co-occurrence.
The first dense word is **thin**/ '**magro'**, from the Latin *macru*, from the root *mak*- long, i.e. developed in length; scrawny, skinny, (sec. XIII, Canzone del fi' Aldobrandino); small, tenuous.
The word firstly refers to thinness as an ideal which, especially in the West, and perhaps all over the industrialized world, appears increasingly to be an imperative. On this, the literature identifies the 1960s as the period when diets and thinness started to become a real "mass cultural obsession" (Bennett & Gurin, 1982). Attention is also drawn to the close relation between increasing thinness and the growing number of women who are graduates or work as managers or in the professions, identifying the flat, androgynous body as the means to reach male privileges and social prestige.
But the idea of "thinness" also evokes the slim, **slim**, **small,** body of a **child** (words found later in the repertoire) of the anorexic. It is useful to remember here that in German the term used to indicate anorexia is *Pubertätsmagersucht*, which can be translated as "young mania for thinness" or, with today's more common expression: "thinaholic".
But here is the first instance of co-occurrence:

THIN FAT

From the emotional standpoint, this represents a dichotomy, a game of opposites, the swinging of the scales in relation to the weight.
It is a dichotomy where "the needle of the scales" has always shifted at the service of different social and cultural "weights". In fact, various studies show that in the majority of human cultures, fatness has been preferable to thinness, especially in women (Gordon, 2000). In societies with limited resources and wealth, the **fat body** has always been the object of admiration as a symbol of wealth and of abundant reserves of food. And again, the woman's fat body, her shapeliness, is symbolically associated with the value of procreation, of fertility: this cultural insight comes from biological data.
But in present western societies, in which obesity is a social as well as medical problem of vast proportions, fatness tends to assume different symbolic meanings: it is increasingly blamed for all

sorts of deplorable qualities. Fatness is culturally associated with stupidity, laziness, shabbiness, lack of will-power (Gordon, 2000).
The third word of the Repertoire is **beauty.** The second instance of co-occurrence helps to understand that in the dichotomy just mentioned the aesthetic ideal is at stake. Beauty lies between being fat and being thin. This is an "ideal" characterized, from the Sixties up to now, by thinness, in contrast with the real average body weight, on a social background where external appearance and image have an increasingly important role.

THIN FAT
BEAUTY

"Bello"/(Beautiful) comes from the Latin *bellu* (m) "pretty", short for *bonus* "good", and also, "proper". The connection with "bene"/(well) is also to be remembered. Along with the aesthetic dimension, the etymology therefore introduces an ethical plane on which we find contrasting pairs such as "good/bad", "well/badly". It is easy at this point to hypothesize the symbolic value that the external aspect, which "makes a pleasing impression"(1224 S. Francesco D'Assisi), assumes in dynamics of social acceptance (**"like"** and **"look"**, present in the cluster, are consistent with this interpretation: the first in its meaning to "be likeable", 13th cent. Bondie Dietaiuti, the second as "turn the gaze to see").
Going ahead wth the analysis of the third and fourth instance of co-occurrence, we find two words that reinforce the idea of beauty as "a social ideal". The first, **model,** from the Latin *modu* (m), measure, but also example, prototype. This term evokes a dimension of the ideal which by definition is outside human reality (it is interesting to notice a new interplay of opposites between ideal and real) and it is therefore unreachable, escaping direct perception, existing only in the imagination (av. 1640, C. Achillini), "uniting all the "**perfection"** (next word present in the cluster) that the human mind can conceive" (1650 G.F Loredano) and therefore something "finished, completed, excellent, equal to the supreme being who has no defects", "**dream"**.

THIN FAT
BEAUTY FASHION MODEL

The second, **fashion 'moda',** also from the Latin *modu* (m) shape, manner, measure, "habit and custom in vogue" (1666, L. Magalotti: Dardi 200), highlights the role of the social dimension in defining aesthetic canons, and examples to follow.
If one stops to think about the cultural dimension that is being outlined, one cannot ignore the theoretical contributions describing anorexia as the attempt to achieve an ideal, this time aesthetic, socially sanctioned, accepted and acceptable. While repertoire 2 was guided by a "divine" value, here the value is totally "earthly": one seeks a "standardized" stereotyped beauty, put forward as a common social value, in "fashion".
In this Cultural Repertoire anorexia therefore seems to be depicted as the result of an adaptation to the social expectations concerning "**women"** (present in the next instances of co-occurrence), and almost becoming their caricature. On the other hand, even indirect caricature is a form of social protest: in anorexia, dieting is often interpreted as a silent hunger-strike (Orbach, 1986).
The next instance of co-occurrence defines the context of **eating** and here its function in achieving the ideal aesthetic appearance. Light food and fatty food, getting fat and losing weight in relation to what one eats, the role of "**diets"** in losing "**kilos"**, a healthy diet, a low-calorie diet, the obsession with fats. The etymology also refers to chewing, swallowing, guzzling and by extension, putting in, introjecting, and also consuming and devouring.

EAT THIN
FAT
BEAUTY FASHION MODEL

In the next instances of co-occurrence there emerges yet another polarity, with the verb **vomit** describing the vortex that sucks in the anorexic, trapped between swallowing and expelling, filling up and emptying, introjecting and "throwing out with violence" (1673, P. Segneri).

EAT THIN
VOMIT FAT BEAUTIFUL
MIRROR SCALES MODEL
MUSCLE FASHION

The line of interpretation taken so far is confirmed by the next dense words found in the repertoire: while **muscle** refers to one of the aesthetic canons of a certain ideal beauty, **mirror** and **scales** are tools of control to check that those canons (weight, distribution of curves...) are being respected. For the anorexic they become an instrument of power over her own body and authentic arms in her battle against hunger.
Alongside the polarities already identified, two others can be recognised: getting fat/getting thin and winning/losing. One gets the impression that the juxtapositions translate, in emotional terms, into a **"war"** that the anorexic "**fights"** against herself, in the name of a power conferred by controlling her own body. The etymology of the verb "guardare" (look), already mentioned, as "be on guard" (sec. XIII Uggieri Apugliese), "examine", "closely observe" (av. 1292 B. Giamboni), "defend" (13th cent I. Mostacci), also refers to the anorexic's obsessive, controlling attention to her own body. On the other hand, this war does not seem to be *personal*, but in a *social* dimension that offers canons and imperatives to obey. Although the emotional dimension outlined seems to be entrapped in the mesh of control of the social reality, one can make out in it the glimpse of a meeting with this reality, which will be an encounter of opposites that could be combined, of dichotomies that exist to be overcome.

3.5.Cultural Space

We will now proceed to give an overall vision of the emotional dynamics characterizing the image of anorexia. The following graph shows the positions and the dimensions in the factorial (or cultural) space of the four repertoires just analysed.

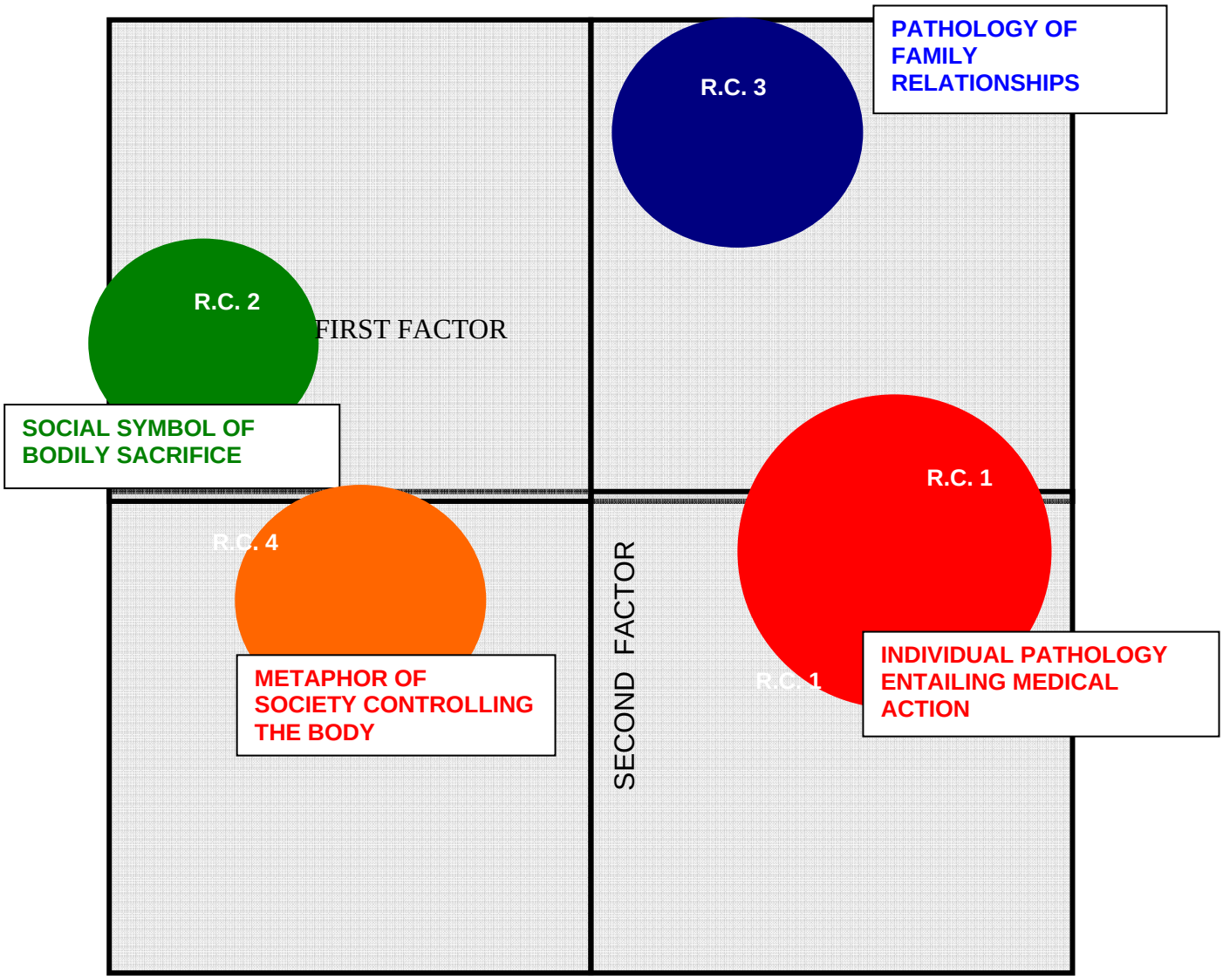

Fig. 2 Position and size of Cultural Repertoires in the Cultural Space

What possible meanings do the four Cultural Repertoires assume, as they are positioned in the Cultural Space?
On the **first factor** – the horizontal axis – there is R.C. 1, to which, as we have said, 42% or the text belongs: this is the largest repertoire of the Culture under analysis, and it makes a decisive contribution to the definition of the symbolic dynamic and also organizes knowledge of the "anorexia event" on the other two axes of the Cultural Space. The 1st Repertoire is characterized by a representation of anorexia as an *individual disorder*, the object of medical intervention, to which the healing power has been delegated by social mandate. The '"extraneousness" of those who present a "demand for intervention" is codified according to the *nosographic categorization* which is the province of medicine. Anorexia (like bulimia) is conceived *exclusively* as "deviant behaviour", as a "gap in normality" which medical action sets out to restore. On the symbolic plane, the physician represents the power that "saves" and "repairs", that restores the *status quo.* As we have already shown, this kind of *medicalization of the eating disorder* entails a double split, of the illness from the subject and of the subject's body from the context of life; this denies the social, cultural and relational dimensions in which the anorexic behaviour is generated. It is a problematic representation conveyed by the three *daily newspapers* examined, which therefore strongly

influences the construction of the *public image* of anorexia, seen as an ***individual pathology involving medical action.***
On the same factorial axis, but in the opposite position, we find R.C. 2, whose symbolic dynamic is typical of the *journals with a more clearly interdisciplinary approach* (L'arco di Giano", "Psicoterapia e scienze umane", "Costruzioni psicoanalitiche"). This repertoire, which represents 15% of the sentences in the text, establishes a representation of anorexia on the theme of the body as the social symbol of the female identity and, at the same time, in anorexia, as its negation: renunciation and sacrifice of one's corporeal nature to satisfy a desire for transcendence and eternity. Unlike R.C. 1, centred on the individual, here anorexia is seen as a *social dynamic.* It is triggered by the collective imagination underlying gender membership, in particular as the representation of a bodily nature that sees the progressive annulment of feminine traits, tied on the symbolic level to fertility and nourishment. They are replaced with signs of sacrifice, renunciation and humiliation of the body, the escape route from a pre-established female identity, and at the same time, a challenge of human limits and the desire for immortality. From the emotional angle, anorexia proves to be the **social symbol of bodily sacrifice.**
In the upper section on the **second factor** we find R.C. 3, representing 22% of the text. The symbolic dynamic organizing this repertoire presents anorexia as the ***pathology of family relationships***, an interpretation that significantly characterizes the group of *journals of the psychology area*. It is in the family that the symptom of anorexia originates, so it is on the family that the treatment relationship concentrates. This sets out to overcome the suffering generated by the family-based psychopathology and to "cure" the disorder, getting the family to work properly again. On the same axis, this "relational" interpretation is in contrast with the "individual" interpretation provided by R.C. 1, but with two aspects in common: the focus on the "treatment relationship" and on the "cure as the outcome" – the first aspect – places this view in the intervention perspective which holds that deviance, disorders and dysfunctions are such compared to a 'norm' marking a predefined goal that is not measured – and this is the second aspect – with the variability of the *social and cultural dimensions* of the contexts in which anorexia is manifested. From the therapeutic viewpoint outlined, the family system represents a "monad", within which pathological dynamics are generated. It is the family here that is identified as being a "pathological subject". Still on the 2nd factor, in the opposite position compared to R.C. 3, we find R.C. 4. This repertoire, represented by 21% of the sentences in the text, defines the image of anorexia which, unlike R.C.3, recuperates the *social and cultural dimension* in which anorexia is manifested. It seems that the standpoint of the 3rd Repertoire, represented by the focus on relationships that construct the anorexic symptoms, on the one hand, and that become the object of treatment of the psychological intervention of a relational type on the other, is opposed in R.C. 4 to a *relational interpretation expressed in social and cultural terms.* Here the social ideal of beauty is the precipitate of an interplay of opposites, of an emotional polarity between thinness and fatness, between what is socially desirable and what is not, in which social control is exercised over the body. Anorexia and anorexic symptoms are configured as the product and social process of an ideal that is so standardized that it becomes a caricature. In other words, a culture based on the controlling power of the mind over the body is taken to extremes. Anorexia therefore becomes the ***metaphor of social control over the body****.* This is one interpretation of anorexia, typical of R.C. 4, which on the **third factor** – imagine it perpendicular to the first two factorial axes – differs from that expressed by R.C. 1. While the latter organizes the image of anorexia around the individual and nosographic category which legitimates the medical intervention on the body of the sick person, in R.C. 4 anorexia becomes a social category metaphorically expressing control and power over the body.

4. Concluding comments

From the analysis carried out, we can obtain information on the potentialities for developing the image of the "anorexia event" found in the scientific literature and the journalistic press.
By dividing the Cultural Space along the 2nd factor (the most complex of the three because three out of four repertoires enter into relationship with it), different hypotheses can be made about the representations of anorexia, expressed by the relations between clusters, which outline the possible developments.

R.C. 1 and 3, though with different premises, represent *what is done* concerning the "anorexia event", i.e. the intervention measures. There are "powers" that treat the serious disorder on an individual level. It was seen that also the family system, constructed by RC 3, is emotionally described as a *pathological monad* that denies all "extraneous" elements, bringing into the repertoire the stereotyped style of the family relationships.
We examined some *intervention cultures*, of *shouldering the burden* of the anorexic disorder, based on symbolic premises that configure the intervention itself as the cure for the disorder. From this standpoint, a social or community action aimed at prevention and promotion of health is not conceivable. What is important is the treatment, socially legitimized by a social mandate that delegates to the expert, physician and/or psychologist, the task of bringing change and restoring normality. Moreover, this action evades the emerging question underlying the relation between the social context and the expert in curing, and therefore annuls the possibility of *situating* the "anorexia event" in the social sphere, so as to re-orient and re-think the strategies of intervention. The expert completely takes the place of the "social" component, taking on the responsibility for the intervention.
R.C. 2 and 4, on the other hand, represent two "social" interpretations of anorexia, which are complementary: R.C. 2 is organized around the theme of the sacred, seen as the sacrifice of femininity and escape from belonging to a pre-established gender; R.C. 4 is on the theme of the external nature of the body. There is the meeting and clash with a social ideal, itself standard and pre-defined, which represents the profane dimension of the social event of anorexia. These are "social" images which herald possible evolutions and developments of the culture under analysis.
R.C. 4 contains, to a significant degree, movements (possible lines of development of the image of anorexia) found in the Cultural Space (in the passage from the 2nd factorial axis to the 3rd): from the representation of an individual pathology to a relational-family-based pathology, to a social vision that seems to view anorexia as a means of social control over the body. Here the intervention measures, envisaged or envisageable in view of the emphasis given to the social dimension, could be considered **measures of prevention and of health promotion: to recuperate and integrate the corporeal sphere with the social dimensions** and with the canons that they offer/impose. As mentioned above, this is an interpretation that seems to be almost totally lacking in the specialistic journals and to be present to a negligible degree in the daily papers, but that indicates possible lines of development of the image of anorexia and eating disorders in general as "complex social events".
A contribution to developing the image in this direction also comes from R.C. 2 which is organized around the symbolic dimensions of the sacrificial negation of the body, broadening the vision and at the same time signalling a difficult but possible evolution, triggered by the cultural dynamics of R.C. 1. The symptom of anorexia, which clearly characterizes the individual body, "stands for" something else, and becomes a clue of the critical social situation tied to a historical—cultural representation of the female.
We are talking about lines of development that seem to be **possible integrative actions** between the different versions of the "anorexia event" that restore its complexity, recuperating the aspects that characterize R.C. 2 and R.C.4. These aspects both reveal the effort of a confrontation with an "extraneousness" made unclear by the use of the nosographic category, as is found in Repertoire 1, the largest and most *dominant* of the culture being analysed.
These aspects envisage the possibility of complex *interdisciplinary* intervention measures, not designed exclusively to restore the state of normality or to make the symptom disappear, but that deal with the social and cultural meanings and the roles that eating disorders play in our society.
From the culture examined in this research, therefore, there emerges a possible evolution in the knowledge of the "anorexia" event which represents both an opportunity to develop epistemologies and professional practices of a scientific kind: it emerges that in a complex vision of anorexia, there are some aspects to be added which imply a reciprocal integrative action between the demand of the social system and the intervention practices of the human and social sciences.
The attempt to deal with a complexity of this kind could help in implementing intervention and prevention measures that are not "substitutes" for the social context, but are oriented to knowing the social demand and therefore using the resources of the context itself. These measures are not guided by "a-historical" factors based on supposed universality and a-critical towards the social system in which they are implemented, but instead, they are designed to interpret the demands

made not just by individuals but also by the social context, related to the world of eating disorders and therefore also tied to issues of the body, food, and the woman's role in society.
It is therefore possible to orient intervention and prevention policies by placing anorexic behaviour in a *temporal* dimension, that is, by historicizing and contextualizing eating problems, in search for the individual and social meanings they assume.

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