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The 14th century religious women Margery Kempe and Catherine of Siena can still teach us lessons about eating disorders today

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Abstract

Background: Women today more commonly suffer the morbidity and mortality of eating disorders. Looking through the dual prisms of historical accounts and modern theory the authors examined the meaning of eating disturbance in two cases from the late Middle Ages. The historic role of women and food is explored.

Method: Widely reviewing historical sources and the current academic literature, we gathered data and considered two women, Margery Kempe and Catherine of Siena. They were empowered by their roles as religious mystics, and drew strength from suffering, distress and fasting. We briefly examined them in the context of modern diagnostic and aetiological explanations of eating disorders (particularly Anorexia nervosa).

Results: We present an account of these women's lives. The relevance these cases have for our understanding of patients, eating disorders, and expressions of suffering today is discussed.

Conclusions: Historic accounts provide a rich counterpoint to understanding our present clinical culture of theory and diagnosis. Both our subjects had disturbed eating: one probably died as a consequence of it. Subjective distress was a central component of the life that was desired by each of these women, and they were empowered by their eating disturbance. Food has immense meaning historically, and personally it had meaning for each of our subjects. This is reflected in current clinical experience. The authors suggest we may be aided by adding our cultural, historical and gender based experience of food to our modern biological understanding of eating disorders, to further illuminate the complexities of today's eating disordered patient.

Keywords: Anorexia mirabilis, Anorexia nervosa, Diagnosis, Subjective distress, DSM, Eating Disorders, Embodiment, Feminist theory, Holy Anorexics, Suffering

Plain English Summary

Women today more commonly experience eating disorders than men. In this article the authors explore the lives of two famous religious women, who lived in Europe, around six hundred years ago. Food and eating made them quite powerful, in a world dominated by men. They took pleasure in their suffering. The authors explore what meaning that might still have for us today, as we might turn a fast, and something that is part of life, into something that may be part of an illness. Fasting is still common in many religions, and valued, but what was it like centuries ago? Can we broaden our thinking about eating disorders by learning from the past? The authors conclude that we can learn a great deal from the rich heritage of our past, while remaining focused on important new developments in mental health and science.

Background

Eating is a way of life, and for life. Food is central to the experience of being human through its preparation,

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eating, sharing or denial. Unsurprisingly then, the role of food in religion is paramount. In this context, fasting can be understood as a controlled interpretation and transcription of famine – a way for a community to defy natural forces through the deliberate eating and rejection of food in an expression of autonomy [1].

In the Christian tradition, fasting can also be undertaken as penance for one's sins. Furthermore, for Christians, the act of eating (or abstaining) can be closely linked to the consumption of the eucharist (the bread believed to become the body of Christ as a part of the Christian sacrament) [2]. This very small portion of food, the eucharist, can have immense value as sustenance for some who consume it, despite being of negligible caloric value.

The practice of *Imitatio Christi*, or the imitation of Christ's life and suffering, was sometimes employed in the 14th century in the pursuit and demonstration of individual spirituality. Its expression could include physical, emotional and imaginative elements. Lochrie identifies three key exhibitions of the practice: firstly, voluntary "fasting, self-flagellation, and self-defilement", secondly, involuntary "bodily effusions and elongations, stigmata, tears and seizures", and thirdly, a life lived in poverty and self-denial [3].

Therefore the experience of suffering itself, particularly suffering that mirrored Christ's, was valued, both as an aid to achieve a higher spirituality, and to assist in reflection of the human relationship with God. It simultaneously illuminated and challenged the physicality of humanity in an attempt to escape the flesh, and achieve higher spiritual meaning and reward.

Attempts to understand disordered eating often focus on the individual narrative. By seeking to re-contextualise eating disordered subjects we can gain fuller perspective both on the individual and on a wider eating disordered cohort. Consideration of contemporary, historical and religious discourses surrounding eating, femininity, the construction of the female body, and biochemistry "transgresses the individual-society internal-external dichotomy, locating (anorexic) subjectivities within their sociocultural and gender-specific discursive contexts" [4]. In the 14th century, a Cartesian understanding of gender associated masculinity with the intellect/spirit, and femininity with the body/flesh. Masculinity was therefore seen as inherently closer to Godliness. Furthermore, women were stereotyped into dichotomous roles of purity (the Virgin Mary) or sin (Eve, Mary Magdelene).

This discourse continues to be examined through a feminist lens. An ongoing construction of the female body (and particularly female body fat) as a site of feminine excess – of uncontrolled bodily urges in the absence of intellect, of sexuality, fertility and gluttony – is demonstrated by interviews with contemporary subjects [4, 5].

While Cartesian theory presents mind and body as separate, Merleau-Ponty "proposed that mind and body were equivalent, intertwined, and inseparable", forming a "lived body" [6]. Jean Paul Sartre extends this to distinguish between the lived body (body-subject) and the physical body (body-object) – when one becomes aware of the body-object being looked at by the other, it becomes the "lived body for others" [7]. Embodiment theory considers an individual's connection to, awareness of, and satisfaction with their own body. Disturbances to one's experience of embodiment are implicated in the eating disordered subject [7].

When the body is chronically experienced through the gaze of the other (also called objectified body consciousness), an internalisation of the other's perspective can occur. This can lead to an internalisation of contemporary discourse and cultural standards [8]. In the 14th century, this could be a body-shame associated with the fleshliness/bodiliness of femininity.

Mystics in the 14th century were often women who interpreted God through the body and senses as the association of femininity with fleshliness/bodiliness could actually serve to privilege their physical expression of *Imitatio Christi*. By employing and exploiting their feminine physicality, they sought to escape it in an attempt to achieve a higher spirituality. Restricted eating was one manifestation of this [3, 9].

Furthermore, the act of preparing food and feeding others is often considered central to the female role in the Middle Ages (and in subsequent times). Refusal of food can represent a rejection of the familial bond, as food embodies the most basic provision of a husband or father's labour or money. It is also a demonstration of agency – in a medieval world defined by the patriarchal institutions of marriage, Church and Crown, a woman could control the food she put in her mouth [10].

By the late 14th century some religious women had begun to engage in extreme forms of fasting that mirror the very challenging eating disorders we see today. Colloquially known as the *holy anorexics*, this condition has been retrospectively termed *Anorexia mirabilis* – a miraculous absence of appetite [11]. Whether *Anorexia mirabilis* can be incorporated into our modern understanding of AN is a subject of great interest and scholarly debate [12]. The lives of two Christian women in the late 14th century provide a glimpse into their expression of religion through eating and fasting.

Method

This was a literature study in which the authors drew heavily from a wide range of sources outside of

traditional medical databases in order to broaden the perspective in which these women could be viewed, as the two women in question were historic religious figures. In developing the vignette for Margery Kempe, our only primary source document was her autobiography, which we explored along with subsequent literature. In contrast, in developing the vignette for Catherine of Siena, we were mindful that our primary sources were both her own letters and the writings of her contemporaries. Again we explored this along with subsequent literature.

The authors hoped to gain the broadest religious and biopsychosocial perspective within the limited scope of this task, and the historical constraints. Current approaches to eating disorders were considered by searching Medline and PsychINFO using search terms including "eating disorders", "anorexia", "fasting", "religious", "holy anorexia" and "mirabilis". Supplemental sources of information were available via online sources.

Results

Margery Kempe

Margery Kempe was born around 1373 into a middle-class family in Norfolk, England. She died after 1438. *The Book of Margery Kempe* is often considered to be the first English autobiography, and in it, Margery reports that she was married around the age of twenty and had fourteen pregnancies with at least one child surviving to adulthood [13–16].

While we have little knowledge around how Margery was regarded in her community other than what she reports to us, Margery considered herself a mystic and reports a life spent in consultation with God.

During her early marriage, Margery undertook her own penance, independent of a confessor, during which she would fast on *"bred and watyr"* and pray, although she felt this did not relieve her sins. Interestingly, this occurs as marriage and pregnancy herald significant change for Margery as she experiences a shift in agency and identity [17].

In the postnatal period after her first pregnancy, Margery reports feeling a *"dreed of dampnacyon"* as she was *"vexid and labowryd with spyritys"* for nearly eight months. She saw visions of *"develys"* that threatened to *"swalwyd hyr in"* with *"mowthys al inflaumyd"*, and encouraged her to forsake her Christianity. Margery describes several instances of self-harm – she *"bot hir owen hand so vyolently that it was seen al hir lyfe after"*, and *"roof* [tore] *hir skyn on hir body agen hir hert wyth hir nayles"* although physically bound and restrained. During this time she ate very little.

Her torment ends only after a visitation from Christ, asking *"Dowtyr, why hast thou forsakyn me, and I forsoke nevyr the?"*. After this she reports feeling *"Stabelyd in hir wyttys and in hir reson as wel as evyr sche was beforn."* Margery then returns to normal eating but is later commanded by Christ to not drink or eat meat on a Friday and subsequently vows to undertake this as lifelong. She ultimately negotiates her chastity with her husband after some twenty years of marriage by manipulating her eating habits through religious visions and consultations with Christ [13].

Of note Kempe's public presentation included frequent displays of weeping (intolerable and irritating to many) that exhibited and added to her suffering [18].

While Margery's major postpartum fast was never repeated, brief fasting and no meat or wine on certain days remained as food rules [13].

Margery's devout belief both in her God and her own mysticism, expressed through her visions, her eating, and her fits of weeping, acted as a catalyst for her multiple pilgrimages through Europe and the Holy Lands which she remarkably undertook alone [13, 16, 18].

She is honoured annually in the Church of England on the 9th November [19].

Catherine of Siena

Catherine of Siena was born in 1347 as a twin, and the twenty-third child of her mother (the daughter of a poet), and her father (a cloth-dyer). She died in 1380, and is perhaps the most famous "holy anorexic". She reported her first vision of Christ at six years of age and a year later made a perpetual vow of virginity. Fasting was well known to Catherine, as she had observed her older sister, Bonaventura, regulate her husband's behaviour by fasting. When Bonaventura died in childbirth, Catherine's parents arranged for her to marry her widowed brother-in-law – Catherine managed to avoid the marriage by imitating her sister's fast [11, 20].

Catherine joined the Dominican order, and became very influential in the history of the Catholic Church. She is credited with a role in the return of the papacy from Avignon to Rome, and was in direct correspondence with Pope Gregory XI [21]. Her surviving writings include *The Dialogue of Divine Providence*, over 300 letters and 26 prayers [22].

However, Catherine practised quite an extreme abstinence from food for most of her adult life, limiting her diet to vegetables, water, and most importantly, the eucharist which she took daily. She would often give away food, and would complain of stomach pains after eating.

In *The Dialogue of Divine Providence,* Catherine writes that "he who follows [God]…cannot faint from hunger, because the Truth has become your food", and that the eucharist "strengthens little or much, according to the desire of the recipient" [22].

Towards the end of her short life, her refusal to eat began to concern even the clergy, but her confessor, Blessed Raymond, ordered her to eat with little success. Even Catherine began to understand her eating habits as an illness at this point. Interestingly, while Catherine struggled to eat food and drink water, she was always able to receive the eucharist.

Catherine died at 33, and was canonised by Pope Pius as Saint Catherine on 29th June 1461 [23].

Discussion

In response to famine, fasting and food regulation first appeared in antiquity. They are a near-universal feature of religion, and by the 14th century, were wholly embraced by our female subjects. Today, disordered eating predominately affects women and girls.

Diagnostic consideration of our subjects today

The authors acknowledge that any attempt at retrospective diagnosis is necessarily fraught – but we can certainly examine the sociocultural milieu in which our subjects moved, and how they acted within and reacted to it. We can locate these women who *used food* to influence the outcomes of their lives within their wider sociocultural context. Without imposing a diagnosis, we could consider that one of these subjects engaged in controlled eating and the other in disordered eating. However, both employed eating purposefully to gain suffering, independence and spirituality. As Hubert Lacey argues: "What we now see as a disease produced by a complex inter-play of emotional, social, family and existential dynamics was viewed in premediaeval Europe as a miracle" [24].

Notably, following the 14th century the Catholic Church began to recognise the dangers of extreme fasting and discourage it [20]. Furthermore, Margery Kempe does warrant consideration through other psychiatric lenses for her fits of weeping, her sometimes-extreme beliefs, her severe post-natal fast (and possible associated postnatal diagnoses), and her lifelong visions and religious experiences, which were not always shared by others.

When working with the modern eating disordered patient, clinicians may be tempted to leap straight to the diagnostic criteria in DSM 5, bypassing the important opening section, *Use of the Manual*. Here, clinicians are encouraged to use their skills in considering each patient fully, within their sociocultural context, to formulate the case and arrive at a comprehensive plan. Moreover, we must not forget that the definition of a mental disorder includes an association with "significant distress or disability in social, occupational, or other important activities" [25].

Both Margery Kempe and Catherine of Siena attained pleasure and religious redemption from their suffering via *Imitatio Christi*. It allowed them to interact with, and succeed in, a world governed by male-dominated institutions. Their suffering may sit uncomfortably juxtaposed to our modern understanding of mental disorders, which was redefined by Spitzer's revolutionary concept of "subjective distress" in DSM III [26]. We cannot necessarily equate their suffering with distress. Reflecting on this through these historical figures may illuminate the inner lives of some contemporary patients. *Imitatio Christi* may be a proxy for the modern worship of a pathological ideal of the female figure, portrayed in the mainstream media, with maladaptive low weight. As clinicians, we try to reduce suffering, and are therefore puzzled when we see patients taking pleasure in suffering. However, we cannot forget that our own successes are paradoxically borne of our hard work, effort, personal sacrifice and suffering. Margery Kempe and Catherine of Siena were striving for suffering as a goal. This is not uncommon in our patients who present with eating disorders, despite the pathological mechanisms and physical destruction that underlies this desired suffering.

Models of anorexia nervosa

It is interesting then to consider Margery Kempe and Catherine of Siena in the context of a 21st century aetiological understanding. Margery may have been severely underweight for some months of her life, in a postpartum context, but ostensibly did not suffer chronic restrictive eating, whereas Catherine of Siena probably starved to death in perhaps an ultimate act of *Imitatio Christi* (both Catherine and Christ died at age 33).

It is clear that multiple contributions initiate and maintain an eating disorder, and it must always be considered within the context of a biopsychosocial frame.

Psychodynamic models suggest that unconscious conflicts from childhood are the basis of eating disorders including AN. Here it is theorised that an unconscious effort to remain prepubescent finds success as menstruation ceases with the progression to a severely underweight state. Thus maturation and sexuality are both rejected [27, 28]. Object relation theorists consider the development of AN to be related to the repression of a bad object consequence upon the early ambivalent relationship with an aggressively protective, unresponsive and controlling mother. The struggle for detachment from the controlling authority via wilful starvation represents a serious psychological developmental defect. This is associated with failure of the parents to convey a sense of competence and self-value to their children who instead believe they complement the parents' needs. In this model, the illness represents an effort to escape from their lack of autonomy and a sense of

ineffectiveness, and to establish control in an exaggerated way [27, 29]. We have limited information about both these women but we do know that both rejected their role as the sexual objects of men, and that disordered eating formed part of this narrative.

More recently strong biological contributions have been considered as drivers of both thought and behaviour in severe eating disorders. The psychobiological theory suggests that biological alterations maintain, support and exacerbate the behaviours of the eating disorder and thereby trap the patient in a cycle of pathology [30]. Some evidence suggests that AN is linked to an addiction to the body's endogenous opioids. One review concluded that the most influential biological factors in the progression and maintenance of AN are dysfunctions in the serotonin and the β-endorphin regulatory systems. [30] Because of their inherent reward properties, these neuropeptides appear to be highly addictive [31].

More recent research has focussed on other biological pathways that may govern a severe eating disorder once commenced in the context of a cultural frame. There has been a particular focus on the role of the gastrointestinal peptide ghrelin which regulates feeding and gastrointestinal motility via the hypothalamic circuit [32] but may become severely disrupted when older patients become frail, reinforcing anorexic behaviour [33, 34].

The more recent psychobiologic and biologic evidence may well fit the profile of Catherine of Siena in terms of the reinforcing nature of her severe eating disorder, which was of course coupled with religious zeal and a mystical belief in the power of the eucharist as physical nourishment.

As demonstrated, these traditional models may simply form part of our understanding and explanation, when we consider the severe eating disorders. We need to understand the parts but we also need to see the whole.

Religious fasting today

Trepanowski and Bloomer [35] identified continuing traditions of fasting across multiple religious groups in modern society. They also note the increasing interest, over the last two decades, from the health profession, of the effect from religious fasting. The historical narrative provided in these cases may assist the modern clinician in making some connections between religious traditions and food.

Conclusions

Eating does not simply sustain life in organised post-antiquity culture. Eating is embedded with deep symbolic value and a history of traditions and meaning. Captured within the religious sphere it was found to have very personal meaning for the two historic figures presented here. These extraordinary lives provide exciting examples of context and culture that shaped destinies and still reverberate today. Could we meet them we would see one, a married woman dressed in white, speaking of her discussions with God and crying to the point of public disgust. The other would be an emaciated, yet influential, woman near death. Their gender is quite relevant. Suffering has value for these figures as it does in the lives of many individuals, not just those with eating disorders. While the authors are very clear that potent psychobiologic mechanisms underscore the severe eating disorders such as AN, the illness occurs in a sociologic context with an immense historic tradition and within the personal narrative. In the eating disorder setting this can richly inform the way we approach a patient, take a history, perform a mental state examination, gather additional data, and ultimately formulate. This may lead to the best possible care and outcome. The two cases presented here provide an opportunity for reflection on our cultural inheritance, and the care we deliver via the frame of our diagnostic systems. Over five hundred years later, despite immense change in human culture, the authors were quite struck by how some themes possibly remain the same.

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IS provided the analysis and oversight of the work on Margery Kempe and Catherine of Siena. MG provided the analysis and work on the psychological and biological aspects of Anorexia Nervosa. WKB participated in medline, PsychINFO and other research, and provided oversight of all aspects of the academic work, and overall guidance for the paper. All three authors worked together on the drafts of this paper. All authors read and approved the final manuscript.

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