

A SOCIAL-PSYCHOLOGICAL STUDY  
OF EATING AND BODY PROBLEMS  
AMONG WOMEN

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A thesis submitted in fulfillment of a  
Masters degree of Arts in Psychology

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ABSTRACT

This study addresses eating and body problems among women. It has three central aims. Firstly, it is a prevalence study of the attitudes and behaviours associated with the eating disorders of anorexia nervosa and bulimia, among a sample of female undergraduate students. Secondly, it serves as a study of the nature of problems associated with eating and body affect among this community of women, with a particular focus on those women who consider themselves to have an eating problem. Thirdly, it has a theoretical aim to address the issue of the role of culture, in particular socially constructed femininity, within the understanding of eating/body problems, ranging from "normal" women's relationships to their body and eating to the severe disorders of anorexia nervosa and bulimia.

The theoretical project within this study involves a critical review of theories which are pertinent to an understanding of the role of culture and femininity, both from within and outside of eating disorder literature. This review, together with empirical evidence from prevalence studies, highlights the importance of "normal" women's experiences with their body and eating and the ideological prescriptions in which these occur, within the understanding of eating/body problems. The mainstream view of eating disorders as abnormalities, apart from the "normal", is

(iii)

challenged in this way. The need for a theory which can articulate the complex psychical acquisition of cultural femininity, which does not reduce this process to either social or asocial determinants alone, is argued.

Within the empirical study, a survey questionnaire study was carried out among 321 female undergraduate students at the University of Cape Town and interviews were held with sixteen women who reported an eating problem. This yielded quantitative and qualitative data concerning the extent and nature of eating and body problems among this community of women.

Results of the prevalence study revealed a prevalence of attitudes and behaviours associated with the eating disorders which corroborates overseas studies of this nature. Severe symptoms and symptom-clusters were relatively rare, but certain behaviours, in particular binge eating, were more widespread. Attitudes associated with concern/preoccupation with weight, body size/shape, controlling food intake and eating, were common. Almost one-third of the sample considered themselves to have an eating problem. Negativity associated with certain parts of the body, particularly thighs and the torso area, and weight was widespread, as was negativity with fatness and positivity with thinness. A relationship between negativity towards the body and eating problems was evident.

Qualitative results revealed that a range of eating/body problems are present within this community of women, ranging from "normal" concerns with eating/body to problems as severe as clinical anorexia nervosa and bulimia. Individuals tended to fluctuate along the continuum between anorexic and bulimic symptomatology as well as between mild and more severe phases of the problem. The importance of femininity, in particular the ideological prescriptions concerning the body and eating for women were strongly internalized by these women, even among those who have a feminist consciousness or subscribe to counter-ideologies. The pervasiveness of these ideologies was illustrated in this way. It became clear that the subjective experience of an eating problem is strongly linked to the behaviours and attitudes associated with "breaking the rules" of femininity, rather than the adherence to the prescriptions concerning the body and eating for women. That is, "overeating" and not following a "healthy" "slimming" diet or being "overweight" or "fat" (all of these by social standards) are experienced as the problem for women. The central conclusion therefore is that eating/body problems cannot be understood outside of socially constructed femininity and the meaning that this takes on in the lives of individual women.

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## INTRODUCTION

### Aims of the study

This study addresses itself to an important area of woman's oppression in modern day Western culture, that of her relationship to her body and to her dietary habits. Problematic relationships to eating and body have been recognized in their extreme form by the medical, psychiatric and psychological professionals. They have named these problems, anorexia nervosa and bulímia/bulimia nervosa.

In this study a central problem within the understanding of clinical eating disorders is identified as the tendency to assume that these problems are "abnormal". This tendency of dealing with severe eating disorders as illnesses alien to the normal has resulted in the neglect of the realm of the social, in particular the social construction of femininity, as will be illustrated in Chapter 2. Recent prevalence studies, as will be illustrated in Chapter 1, have found the attitudes<sup>1</sup> and behaviours associated with anorexia nervosa and bulimia to be far more widespread, especially among women, than had been expected.

1. Throughout this thesis, "attitudes" are used to refer to a broad range of cognitive and affective aspects of women's relations to their body and eating.

They are certainly not rare or "abnormal" according to statistics. It has also been pointed out by feminists and some eating disorder theorists, that there are strong social pressures concerning diets and body shape and size for women in Western culture. It has become clear that the attitudes and behaviours found among anorexics and bulimics are socially prescribed and encouraged behavioural and attitudinal norms for women. Yet the role of socially constructed femininity has not been focussed on within the literature on eating disorders. The concept of "normal" femininity has not been adequately developed within the understanding of extreme problems like anorexia nervosa and bulimia. Equally the "normal" woman who lives in the culture within which anorexics and bulimics emerge, has been ignored empirically. In particular, the "normal" woman who does not fit the standard criteria for these problems yet experiences similar problems is neglected, with very few studies having investigated women with "anorexia-like" problems (Thompson and Schwartz, 1982). More recently, eating disorder theorists have begun to address the cultural pressures concerning weight control and \* slimness and feminists have begun to produce theories of eating disorders which focus on the issue of femininity (refer to Chapter 2). This thesis aims to contribute to the investigation of these issues. It is particularly concerned with showing how the realm of "normal" femininity is central to an understanding of eating problems, from mild to more severe problems. In this respect it is both a theoretical and empirical attempt to widen the scope of the understanding of eating problems among women, from their mild to their severe manifestations.

The aims of this thesis are three-pronged. They include theoretical and empirical aims which utilize both qualitative and quantitative forms of investigation (refer to Chapter 3 for the full statement of empirical aims):

(1) The first aim of this study is to replicate a prevalence study similar to those carried out overseas with the aim to compare findings. For this purpose, a prevalence study of attitudes and behaviours associated with anorexia nervosa and bulimia among female undergraduate students at the University of Cape Town is carried out. As yet there are no reported studies of this nature within South Africa.

(2) The nature of eating/body problems among this sample of women is explored, with the aim to contributing both empirically and theoretically to the understanding of the role of "normal" femininity within eating problems, from mild to severe. This aim is carried out both quantitatively through analytical analysis of the survey data, and qualitatively through interviews with a subsample of women who consider themselves to have an eating problem. Simultaneously, the relationship between body affect and eating problems are investigated. The attitudes towards eating and the body are investigated in the light of feminist insights concerning the social construction of femininity within the ideological prescriptions concerning the body and eating.

(3) Theoretical issues are addressed. A critical review of theories pertaining to an understanding of eating/body problems within cultural context is carried out. This aims to contribute

to the development of a more adequate theoretical understanding of women's relationships to their bodies and eating which frequently manifests itself as a problem for women. These theoretical insights inform the understanding of both the quantitative and qualitative results.

### The subject of this thesis

This thesis addresses itself to eating/body problems among women in the community under research, that is, female undergraduate students. The term eating/body problems will be utilized throughout this thesis. It is used to refer to all those problems which involve an obsession with the body and eating. It thus includes mild to extreme problems, problems of a non-clinical nature through to the severe clinical syndromes of anorexia nervosa and bulimia. This term is used as an attempt to challenge the rigid categorization of between the "normal" and the "abnormal" which exist within the field of eating disorders. By using this all-embracing term, a continuum is assumed which exists between mild concerns with bodily appearance and one's diet, and severe eating disorders. In this way the continual referral to milder, more extreme, non-clinical, subclinical, clinical forms of eating disorders is avoided. The term eating/body problems allows for the acknowledgement of different extremes of these problems, while at the same time implying a continuum and an understanding of commonalities. The term eating/body problems includes the word "body", for it is maintained that at all points on the continuum, the preoccupation with eating is bound up with a preoccupation with the body and vice-

versa. / Clinicians have called the severe problems "eating disorders", not "eating/body disorders", but they have always included the understanding of the obsession with body shape/size and weight as bound up with that of the concerns with eating.

This study focusses mostly on those women who fall in the centre part of the continuum, that is, who manifest what has been termed in the literature "subclinical" eating disorders (Button and Whitehouse, 1981). An investigation of their problems forms the subject matter of Chapter 5. Although the extremes of the continuum, anorexia nervosa and bulimia are not the subject of this study, it is believed that the theoretical discussion and results presented here bear relevance to an understanding of these problems.

It is assumed that anorexia nervosa and bulimia cannot be understood outside of the "normal" realm of being a woman in Western culture. In this respect, a continuum of symptomatology is assumed whereby the anorexic's attitudes and behaviours are not differentiated from those considered "normal" for women. At no point, however, does this study claim that anorexia nervosa and bulimia are simply "dieting gone mad". It is accepted that unique factors are playing a role in determining the severity of clinical forms of the problem. This thesis is not attempting to theorize why some women become so obsessed with their eating and bodies that they are diagnosable as anorexics or bulimics. However, it must be understood that these problems are informed and shaped by the same social forces that inform and shape the problems addressed in this study, as will be discussed in Chapter 6.

## Structure of the thesis

The thesis begins with a presentation of a selected review on eating and body problems, which aims to provide the reader with both a clearer understanding of the field as well as the prevalence of these problems (Chapter 1). The central concepts which have been used to describe these problems are defined in such a way that a broad historical perspective of the area of eating disorders is obtained. Following this, prevalence findings concerning anorexia nervosa, bulimia and the attitudes and behaviours associated with these are presented for the purpose of comparison with the results of the present prevalence study. They are also presented for the purpose of evaluating how widespread the eating/body problems in their different forms are, and therefore illustrating the statistical "normality" of some of the attitudes and behaviours associated with anorexia nervosa and bulimia. Findings concerning body image, concept and affect, drawn from literature outside of the eating disorders are also presented in this chapter. Cultural and gender differences in respect to eating problems and body affect and concept are pointed to for the purpose of illustrating the role of femininity and culture within eating/body problems. Following the empirical illustration of the "normality" of certain attitudes and behaviours and their predominance among Western women, theoretical issues concerning the understanding of eating/body problems within cultural context are presented in the next chapter (Chapter 2). The theoretical section aims to articulate the role of femininity and culture within eating/body problems in

a more adequate way. In particular it aims to theorize about these problems within a cultural context in a way that does not assume splits between individual and social realms. Towards this aim, the insights of eating disorder theorists, feminists and feminist eating disorder theorists are critically evaluated. The empirical research is described in the next three chapters: Chapter 3 presents the methodology utilized within the empirical study, in which the aims, methods of research and methods of analysis of the results are described. Quantitative results are presented next (Chapter 4). In this chapter prevalence findings are presented and compared with those of other studies. The nature of eating/body problems among this community that emerge from the survey are also reported. The following chapter, Chapter 5, is concerned with an analysis of the interviews held with women who consider themselves to have an eating problem, and as such constitutes a more in-depth qualitative exploration of the nature of eating/body problems among this community of women. The thesis is concluded with a summary of the main findings of the study and the presentation of theoretical conclusions concerning eating/body problems (Chapter 6). Finally, practical implications of these conclusions, problems and limitations of this research and suggestions for areas of future research are dealt with.

## CHAPTER 1: A REVIEW OF SELECTED LITERATURE PERTAINING TO EATING/BODY PROBLEMS

### 1.1 Introduction

This chapter aims to provide the reader with an overall idea of the area of eating/body problems, by reviewing selected literature of relevance to this area. The following areas of literature will be covered:

(1) A definition of concepts which have been used to discuss eating/body problems within eating disorder literature and which are central concepts within this thesis. These concepts will be presented in such a way as to illustrate aspects of the historical development of the psychiatric field of eating disorders.

(2) Prevalence findings concerning anorexia nervosa and bulimia and the attitudes and behaviours associated with them. The popular media has in recent years been claiming that anorexia nervosa and particularly bulimia have reached the level of an epidemic (Fairburn, 1984). Fairburn (1984) in his review of the epidemiological studies of bulimia has questioned the validity of these claims. He has suggested the presence of methodological flaws within these studies, including problems with sampling procedure, methods of assessment, scope of assessment and research design. Prevalence findings are presented in a critical

way in an attempt to conclude what the actual prevalence of these problems are. Gender differences will be illustrated throughout.

(3) Findings concerning attitudes to the body. Differences between men and women in this respect will be focussed on. X

(4) Findings on the relationship between attitudes to the body and eating problems. ^

(5) Empirical evidence for the culture-bound nature of eating/body problems.

## 1.2 Definition of concepts

### 1.2.1 Classifying eating disorders

It is clear from the following examples of the "naming" of eating disorders that the categorization process has had a complicated history:

The disorder is now called the 'hunger disease', 'the diet disease', 'the affluent neurosis', 'the feeding disorder of thin-fat people', 'nervous malnutrition', 'essential dieting', 'pubertal starvation - amenorrhea', 'Kylin's syndrome', 'late pubertal cathexis', 'adolescent weight-phobia', 'dysorexia', 'bulimarexia', the 'baffling disorder', and the 'gorging-purging syndrome'. (Sours, 1980, p. 221).

The history of anorexia nervosa within psychiatry is longer than that of bulimia. Historically the psychiatric classification system for eating disorders has passed through different phases, which have been identified as the following four phases:

(1) The establishment of anorexia nervosa as a distinct syndrome from other psychiatric illnesses. There have been many claims

over the years that it is in fact a variant of other psychiatric syndromes, such as affective disorder, schizophrenia, obsessional neurosis and hysteria (Garfinkel and Garner, 1982). The confusion of anorexia nervosa with other disorders had much to do with the fact that diagnosis was initially made in a very undifferentiated fashion. As Beumont et al. (1976) point out, some psychiatrists have used the term to denote all cases of weight loss resulting from psychiatric disorder. This realisation lead to attempts to subclassify anorexia nervosa into different types (for example, Bruch, 1974; Dally, 1969). As time went on the categorization process narrowed to exclude those disorders which could be classified as any other psychiatric syndrome, like hysteria or affective disorders. Most theorists are now in consensus that anorexia nervosa constitutes a distinct syndrome set apart from other psychiatric conditions, despite similarities in certain symptomatology (Garfinkel and Garner, 1982). What has been seen to be the central defining feature is that of the preoccupation with body size/weight, slimness and dieting (Garfinkel and Garner, 1982; Crisp, 1980; Bruch, 1974; Russell, 1970; for example). Thus if these attitudes are not present, despite emaciation, weight loss or disturbed eating habits, the problem is not considered to be that of anorexia nervosa. An example of the distinction is found in a paper differentiating anorexia nervosa and conversion disorder (Garfinkel et al., 1983). Despite a similarity of symptoms, like vomiting, the two were seen to be distinct: for the conversion disorder, vomiting assumed symbolic functions (like expressing disgust), while for the anorexic it was most informed by the

desire to lose weight. The attitudinal obsessions with weight control and slimness are therefore now widely accepted as the central differentiating symptoms of the syndrome of anorexia nervosa.

(2) The distinction between anorexia nervosa and bulimia was the second diagnostic milestone. Increasing attention given to anorexia nervosa led to the recognition of a wide range of symptomatology (behavioural signs and symptoms) which did not appear to fit the narrow diagnostic schema of anorexia nervosa. In particular the recognition of binge eating as central within many of the cases, led to the need for a broader classification system. For although binge eating had always been acknowledged within anorexia nervosa, it was believed to be a peripheral behaviour rather than a central one. Another important recognition leading to problems with the rigid criteria of anorexia nervosa, was that of eating problems among normal or above-normal weight individuals. While it had been assumed that weight loss was central to anorexia nervosa the presence of similar attitudes and behaviours in the absence of substantial weight loss was problematic. Thus began attempts to subclassify eating disorders in terms of behavioural symptomatology, for example, Beaumont et al.'s (1976) distinction between "dieters" and "vomitters and purgers". This schema, although increasing the sophistication of the diagnostic category, still could not account for a syndrome in which bingeing was central. Thus began attempts to create separate syndromes within the eating disorders (for example, Palmer's, 1979, "the dietary chaos syndrome"; Russell's, 1979, "bulimia nervosa" and Boskind-Lodahl's, 1976

"bulimarexia"). A separate bulimic syndrome is now widely accepted.

(3) A third turning-point, identified in the literature, is that of the recognition of a continuum of eating disorders. Sours (1980) made claims for a continuum of symptoms within the field of eating disorders, ranging from anorexic to bulimic symptomatology. This notion has been applied on an individual level as well, with the claims that a cluster of symptoms in any one individual is not static (Vandereycken and Pierloot, 1983). For in the course of an individual's life she may pass from primarily anorexic type symptomatology to primarily bulimic symptomatology or vice-versa. These authors claim that the notion of anorexia nervosa as a unitary illness should therefore be abandoned and replaced by a dynamic dimensional model which acknowledges the possibility of change over time. A continuum notion in which the dieting anorexia nervosa state is at one extreme and the situation of extreme obesity at the other, with the bulimia nervosa syndrome occupying a pivotal position on this continuum is proposed.

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(4) Following the spate of epidemiological studies to be discussed, the relationship between "normal" dieting and the disorders of anorexia nervosa and bulimia has become an issue within the field. Growing attention has been given to the socio-cultural determinations of these disorders, with a focus on issues of the cultural obsession with dieting, slimness and weight control.

The concepts of "subclinical anorexia nervosa" (Button and Whitehouse, 1981) and "abnormal"<sup>1</sup> eating attitudes and behaviour (Cooper and Fairburn, 1983) have arisen to describe the widespread eating/body problems prevailing in non-clinical communities of women. It is at this juncture within the literature of eating disorders that this thesis must be viewed. It arises out of the recognition of the widespread nature of these problems, and their blatantly social nature.

### 1.2.2 Diagnostic criteria for anorexia nervosa and bulimia

Despite wide agreement on the distinctions between anorexia nervosa and bulimia, there is still no consensus on what actually constitutes these syndromes:

"While most clinicians readily recognize patients with anorexia nervosa, there is no unanimity of opinion regarding the clinical features necessary for diagnosis". (Garfinkel and Garner, 1982, p. 26). There have been many attempts to define objective criteria for anorexia nervosa. Some theorists have focussed on visible signs and symptoms while others have focussed predominantly on psychodynamic features (Hilde Bruch for example). Most criteria include attitudinal, behavioural and biological elements. For example, Russell's (1970) criteria which has been used fairly widely includes the following:

- (1) The patient resorts to a variety of devices aimed at achieving weight loss (starvation, vomiting, laxatives, etc.) (Behavioural);
- (2) There is evidence of an endocrine disorder (e.g. amenorrhoea) (Biological/physical);

(3) The patient manifests the characteristic psychopathology of a morbid fear of becoming fat (Attitudinal).

Some schemas include a weight loss criterion as well, as does Feighner et al.'s (1972) criteria, used primarily for research purposes, which stipulates a weight loss of 25% of the original body weight. It is clear that this criteria is more stringent than Russell's (1970).

Two diagnostic schemas for a bulimic syndrome, which have been widely used, are Russell's (1979) syndrome of "bulimia nervosa" in Britain, and "bulimia" as established by the DSM-III (1980) in America. Russell (1979) established three diagnostic criteria for the bulimia nervosa syndrome:

- (1) The patient suffers from a powerful and intractable urge to over eat (Behavioural);
- (2) The patient seeks to avoid the fattening effects of food by inducing vomiting, abusing purgatives, etc. (Behavioural);
- (3) The patient manifests the characteristic psychopathology of a morbid fear of becoming fat (Attitudinal).

Criteria for bulimia include the following (DSM-III, 1980):

- (1) Recurrent episodes of binge-eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours) (Behavioural);
- (2) At least three of the following: consumption of high-caloric, easily ingested food during a binge; inconspicuous eating during a binge; termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced

vomiting; repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics; frequent weight fluctuations greater than 10lbs due to alternating binges and fasts (Behavioural);

(3) Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily (Attitudinal);

(4) Depressed mood and self-deprecating thoughts following eating binges (Affective);

(5) Bulimic episodes are not due to anorexia nervosa or any known physical disorder.

It is clear that this diagnostic schema is broader than Russell's (1979) and allows for a diagnosis of bulimia without the presence of self-induced vomiting or laxative abuse. Fairburn (1984) maintains that bulimia nervosa may be regarded as a subtype of bulimia in which the binge eating is accompanied by self-induced vomiting or purgative abuse, and abnormal attitudes to body weight and shape.

### 1.2.3 Subclinical eating/body problems

Recent epidemiological findings have shown that the attitudes and behaviours associated with the eating disorders of anorexia nervosa and bulimia are by no means uncommon on a non-clinical level (Nylander, 1971; Mann et al., 1983; Button and Whitehouse, 1981; Clarke and Palmer, 1983; Cooper and Fairburn, 1983; Cooper et al., 1984; Pyle et al., 1983; Halmi et al., 1981; Hawkins and Clement, 1980). Button and Whitehouse (1981) were the first to use the term "subclinical anorexia nervosa" to include all those

women in their sample who experienced the "preoccupation with weight and the forms of behaviour associated with anorexia nervosa" but did not strictly fit criteria for anorexia nervosa, usually in terms of their weight not being low enough (p. 514). Given that this thesis is primarily addressing these attitudes and behaviours rather than the clinical syndromes of anorexia nervosa and bulimia, the notion of subclinical problems, attitudes and behaviours concerning body/eating in the community, require some clarification.

As a consequence of the recognition of "subclinical" eating problems, it became common to speak of "abnormal" eating attitudes or eating attitudes associated with the syndromes of anorexia nervosa and bulimia (Cooper and Fairburn, 1983; Hawkins and Clement, 1983; Mann et al., 1983; Meadows et al., 1986). For Russell (1970, 1979) a central attitude within both bulimia nervosa and anorexia nervosa is a morbid fear of becoming fat. The various attitudes associated with eating disorders that have been found to be widespread on a community level are widely accepted as being measured by the Eating Attitudes Test (EAT) (Garner and Garfinkel, 1979) (see Appendix I). The attitudes which are of most relevance within the eating disorders and among "normal" women, are illustrated by factor analyses of the EAT. It appears that a "dieting factor" followed by a "food preoccupation" factor dominates overall scores for both anorexics and "normal" women (Garner et al., 1982; Wells et al., 1985). The attitudes associated with eating disorders and referred to as "abnormal" within prevalence studies, may be isolated as the

following:

- (1) Preoccupation with dieting and weight control;
- (2) Preoccupation with food and controlling its intake, including guilt associated with eating;
- (3) Preoccupation with body size, shape and weight, including an obsession with being slim and a fear of becoming fat.

The concept of "abnormal" eating behaviour similarly derives from the clinical syndromes of anorexia nervosa and bulimia, but has been used to describe the prevalence of these behaviours within community studies of eating disorders (for example, Cooper et al., 1984). The behaviours referred to in the literature include those which are widely practised as legitimate weight control methods as well as those considered to be pathological in essence (e.g. vomiting) or in frequency of use. They include the following: Laxative use and abuse; diet pill use and abuse; fasting; diuretic use and abuse; chewing and spitting out food; self-induced vomiting; dieting behaviour and strict diets; exercise; binge eating.

#### 1.2.4 Body concepts

Given that this thesis is concerned with eating and body problems, concepts relating to the body, which will appear in this thesis require clarification. Within the literature on eating disorders, the concept of body image has been an important one. This concept has from the earliest days of eating disorder research been considered of importance to the syndrome as illustrated in the work of some of the most prominent writers in

the area (Bruch, 1961, 1973; Dally, 1969; Crisp, 1980; Garfinkel and Garner, 1982). The concept of body image within the eating disorder literature has been generally used to refer to the perceptual image which the person has of his/her body size and shape. This aspect of body image is not the concern of this research. The concept of body image has also been used to refer to the affect associated with the body. It is the second usage of this concept which is of relevance to this thesis. The level of satisfaction or dissatisfaction with the body and its appearance is one level of affect associated with the body and of interest in this study. In speaking of body affect, this study is also concerned with women's attitudes to their bodies when they are thinner or fatter, as well as their attitudes towards social ideals of women's bodies. Attitudes towards the body, concerning its salience in determining self-value, self-concept and confidence are also of interest within this study.

In summary, the central concepts within this thesis are those of the eating disorders, anorexia nervosa and bulimia; attitudes and behaviours related to these problems; and body affect. Within the clarification of these concepts it became clear that there is much confusion historically concerning diagnosis and "naming" of eating disorders. The most popular diagnostic schemas in the literature have been presented. Definitions for the attitudes and behaviours associated with these diagnostic syndromes have been provided. The concept of body affect will be used to refer to the affective attitudes related to the body, that is satisfaction or dissatisfaction concerning the body; affect

towards bodies of different shapes and sizes; and the salience of the body in the lives of the women under research.

### 1.3 Prevalence findings concerning eating/body problems

#### 1.3.1 Anorexia nervosa and bulimia

Prevalence studies of anorexia nervosa have yielded a relative consensus. Within the populations believed to be most at risk, that is, young women, the condition has been found among one in one hundred to one hundred and fifty women. (Crisp et al., 1976; Nylander, 1971). Crisp (1976) in his survey among British schoolgirls found a prevalence of one in two hundred severe cases among the independent schools, with one in one hundred among girls of 16 years old and over. In another part of the Western world, Sweden, Nylander (1971) had found similar results, one severe case in one hundred and fifty among female adolescents. Using DSM-III criteria for anorexia nervosa, Pope et al. (1984) found among three samples of female students (two colleges and one secondary school, a total of 1060 individuals) a prevalence of 1.0% to 4.2% .

★ The only study carried out in South Africa, claiming to be a prevalence study of anorexia nervosa, was carried out among Johannesburg schoolgirls by 3rd year medical students at the University of the Witwatersrand (Ballot et al., 1981). The criteria for diagnosis however was that of weight only (20% underweight). As such, their findings cannot be seen as representing a prevalence rate of anorexia nervosa but of 20% percent underweight schoolgirls, for the diagnostic criteria for

anorexia nervosa includes more than weight loss (see Section 2.2.2). They found that 2.9% of the girls were more than 20% underweight.

It has been claimed that the disorder is increasing in frequency (Duddle, 1973; Kendell et al., 1973; Willi and Grossman, 1983; Jones et al., 1980). Duddle (1973) for example found an increase in cases presented at the student health centre at the University of Manchester - from no cases in 1966/67 and 1967/68 to thirteen cases in 1971/72. Herzog and Copeland (1985) point out that it is uncertain whether these findings reflect a true increase in incidence or an increase in awareness. At any rate, findings listed till now, led clinicians and researchers to believe that the condition of anorexia nervosa was not widespread, despite its increase over the years.

A higher average prevalence rate has been found for bulimia or bulimia nervosa. But there is less consensus between the different prevalence studies. These contradictory findings are believed to be a consequence of the utilization of different measures and different criteria for diagnosis. Using Russell's (1979) criteria for bulimia nervosa, Cooper and Fairburn (1983) found that 1.9% of their sample of women clients at a family planning clinic fulfilled these criteria. However, this study did not take into account the history of bulimia nervosa, but made a current diagnosis based on current binge eating. Furthermore, it has been pointed out that Russell's (1979) criteria is more stringent than that of the DSM-III in that it requires the presence of purging behaviour (refer to Section

1.2.2). Studies using DSM-III criteria yield a higher prevalence than that found by Cooper and Fairburn (1983), from 7% to 19% (Halmi et al., 1981; Pyle et al., 1983; Pope et al., 1984). Hart and Ollendick (1985), also using DSM-III criteria, but far more stringently by including the requirement of current purging, found a prevalence of bulimia of 1% among working women and 5% among university women. A prevalence study carried out at an American university psychiatric clinic found that 4.4% of all psychiatric diagnoses made in their sample were eating disorders (Stangler and Printz, 1980). Of these 3.8% were bulimic (DSM-III criteria). It is clear that those studies which reveal the highest prevalence findings utilize DSM-III criteria, without the requirement of present purging and are illustrating a history of bulimia (Halmi et al., 1981; Pyle et al., 1983; Pope et al., 1984). The discrepancies in prevalence may therefore reflect differences in methodology, such as different criteria and eliciting past problems rather than present. They may also reflect a difference in real prevalence amongst different populations of women, indicating that certain groups of women are at greater risk of developing these disorders than others (for example, Hart and Ollendick, 1985 and Pope et al., 1984).

Table 1.1: Prevalence of bulimia among women

study	sample	criteria	%
Cooper & Fairbairn (1983)	clinic attenders	Russell (1979) current	1.9
Hart & Ollendick (1985)	students	DSM-III + purging	5.0
	working women		1.0
Halmi et al. (1981)	students	DSM-III + history bulimia	18.9
Pyle et al. (1983)		DSM-III + history bulimia	7.8
	students	DSM-III + weekly bingeing	4.5
		DSM-III + weekly bingeing weekly purging	1.0
Pope et al. (1984)	school a		14.7
	school b	DSM-III + history bulimia	19.6
	school c		8.4

The prevalence of bulimia has also been illustrated by community surveys (Fairburn and Cooper, 1982; 1984). These surveys, although not prevalence studies in so far as they do not utilize random samples, do give some idea of the extent of the problem. They also indicate how bulimia is more widespread than anorexia nervosa. In 1982, Fairburn and Cooper placed a notice in the health reports page of a popular women's magazine, requesting people who were using vomiting as a means of weight control to write to them. Six hundred and twenty women responded. They \* identified 3.1% of these as having anorexia nervosa and 83.0% as

having bulimia nervosa (Russell's criteria, 1979). These studies also illustrate that the problem is very secretive and frequently escapes any professional attention.

There is only one known study of the incidence of bulimia in South Africa. A study of "bulimarexia", Boskind-Lodahl's (1976) term for the binge-purge syndrome was carried out in Johannesburg among a group of 280 female university psychology students between the ages of 18 and 23 (Grace, 1983). Criteria used were developed from the DSM-III's diagnostic criteria for bulimia. 42 women, 15% of the sample met the study's requirements for "bulimarexia" (as well as fitting DSM -III criteria for bulimia, subjects had to be currently vomiting and/or using laxatives).

To sum-up: Those studies using strict criteria indicate a prevalence of less than 2% for both anorexia nervosa and bulimia. No study finds a prevalence rate for anorexia nervosa higher than 4%. Findings using DSM-III criteria, not stipulating current purging and allowing for past episodes of bulimia indicate a prevalence between 7 and 19%. Three different samples of scholars at American colleges illustrate a prevalence for a history of bulimia greater than 14% (Pope et al., 1984; Halmi et al., 1981). It appears that bulimia involving bingeing without purging behaviour is far more common than the strict syndrome of bulimia nervosa or bulimia with purging. Hart and Ollendick (1985) maintain that on closer examination of the prevalence studies which yielded the highest prevalence (Pyle et al., 1983; Halmi et al., 1981), less than 2% of their binge eaters vomited or reported laxative abuse.

The findings concerning the prevalence of anorexia nervosa and bulimia illustrate that both syndromes are more common among women than men (Jones et al., 1980; Willi and Grossmann, 1983; Stangler and Printz, 1980; Pyle et al., 1983; Pope et al., 1985). For example, Stangler and Printz (1980) in their survey of ✓ psychiatric problems at a student clinic found that 89.5% of those diagnosed as having an eating disorder were female. And Pope et al. (1984) found no males at either the school or the colleges surveyed who fitted criteria for bulimia.

### 1.3.2 Subclinical eating/body problems

As mentioned, the spate of questionnaire type surveys carried out from the 1980's began raising questions about the extent of the problem of eating disorders. These studies highlighted the presence of a range of "subclinical" eating problems (Hawkins and Clement, 1980; Button and Whitehouse, 1981; Halmi, Falk and Schwartz, 1981; Fairburn and Cooper, 1982; Clarke and Palmer, 1983; Cooper and Fairburn, 1983; Mann et al., 1983; Cooper et al., 1984; Fairburn and Cooper, 1984; Hart and Ollendick, 1985; Pope et al., 1985; Meadows et al., 1986). It became evident that attitudes and behaviours associated with anorexia nervosa and bulimia were widespread among certain communities of women.

#### 1.3.2 (i) "Abnormal" eating attitudes

The Eating Attitudes Test (EAT) originally designed by Garner and Garfinkel (1979) as a screening for anorexia nervosa, has been utilized with great frequency within these survey studies. This inventory can be considered as a measure of attitudes associated

with anorexia nervosa and bulimia. Results have indicated that more women score in the same "anorexic range" as anorexics and bulimics than can actually be diagnosed as such. The percentage of women in the samples under question, mostly students, scoring in the "anorexic range" on the EAT have generally been between 6% and 12% (Mann et al., 1983; Garner and Garfinkel, 1980; Button and Whitehouse, 1981; Clarke and Palmer, 1983; Meadows et al., 1986).

Attitudes related to concern with dieting, weight control and body size/shape, have been found to be widespread among certain non-clinical populations of women. As is clear from the usage of the concept of "normal dieting" within the literature this concern is considered "abnormal" only under certain conditions which differ from theorist to theorist (Button and Whitehouse, 1981; Mann et al., 1983). Both Huenemann et al. (1966) in the U.S.A. and Nylander (1971) in Sweden found that dieting, concern about fatness and desire to lose weight is commonplace among adolescent girls with a peak in the 17-18 year old bracket. The same was not found for adolescent boys. In Huenemann et al.'s (1966) study more than 50% of the girls said that they were concerned about being overweight and described themselves as fat. Their perceptions did not correlate with their actual weight. For example in grades 10 and 12 over 50% of a sample of Caucasian girls called themselves fat whereas only 25% of them were classed as obese or somewhat obese. Desire to lose weight was widespread with the amount of girls indicating a desire to lose weight exceeding the amount of girls who called themselves fat. For

example, 70% of girls in the tenth and twelfth grade desired to lose weight. This research highlights the widespread nature of concern with dieting and weight control among adolescent girls. Nylander (1971) in his Swedish study found that 50% of 14 year old and 70% of 18 year old women report "feeling fat".

Commercial studies carried out in America, indicate that both men and women are preoccupied with dieting and their weight (Toufexis, 1986). For example, according to a survey carried out in April 1985 by "Better Homes and Gardens" magazine, nearly 90% of Americans think they weigh too much. A Nielson study carried out in 1978 showed that 56% of all women 24 to 54 years old diet. Of these women, 76% acknowledge doing so for cosmetic rather than health reasons (quoted in Schwartz et al., 1982).

The prevalence of dieting and weight concern among women is highlighted by factor analyses of the EAT among both anorexics and non-clinical samples. As mentioned (Section 1.2.3), it has been found that a dieting factor dominates overall scores on the EAT (Wells et al., 1985; Garner et al., 1982). This subscale relates to an avoidance of fattening foods and a preoccupation with being thinner. Wells et al. (1985) thus conclude: "For most young women their EAT score is primarily a reflection of their score on the dieting factor." (p. 145) Both studies found that the dieting factor dominated EAT-40 and EAT-26 scores and correlated more closely with both tests than the other factors did. The predominance of the dieting factor in determining the scores of samples of both anorexics and non-clinical subjects indicates the prevalence of dieting behaviour in general as well

as its centrality within the clinical syndromes of anorexia nervosa and bulimia.

In summary, eating attitudes associated with anorexia nervosa and bulimia, particularly those related to dieting, weight control and concerns with bodily size, have been found to be common among women, particularly **young women**. It is clear that "abnormal" eating attitudes and concerns about dieting and weight control are more widespread among women than men (Huenemann, 1966; Button and Whitehouse, 1981; Clarke and Palmer, 1983). Both Button and Whitehouse (1981) and Clarke and Palmer (1983) found that none of the men in their samples scored in the "anorexic range" on the EAT and that their mean scores were almost half that of the women in the sample. A study looking at femininity and masculinity as personality traits in relation to dieting concerns, found that restrictive dieting tendencies were positively correlated with trait femininity (Hawkins, Turell and Jackson, 1983).

### 1.3.2 (ii) "Abnormal" eating habits

Binge eating has been found to be widespread on a community level, among both men and women (Clarke and Palmer, 1983; Halmi et al., 1981; Hawkins and Clement, 1980; Pyle et al., 1983). Five studies are significant in reporting the prevalence of binge eating. One of these studies was carried out among British male and female college students (Clarke and Palmer, 1983); three studies among American male and female college students (Hawkins and Clement, 1980; Halmi et al., 1981; Pyle et al., 1983) and one among British female family planning clinic attenders (Cooper and

Fairburn, 1983). Table 1.2 provides a summary of these studies' findings.

Table 1.2: Prevalence of binge-eating among women\*

	Definition of binge	Ever binge (%)	Current bingeing (%)	at least weekly (%)
Hawkins and Clement (1980)	uncontrolled, excessive eating	-	79	33
Halmi et al. (1981)	an episode of eating an enormous amount of food in a short space of time	68.1	53.8	-
Clarke and Palmer (1983)	I have gone on eating binges where I feel that I may not be able to stop	46.2	30.2 <sup>1</sup>	7.1
Cooper and Fairburn (1983)	episode of uncontrollable excessive eating	26.4	20.9 <sup>2</sup>	7.3
Pyle et al. (1983)	experience of rapidly eating a large amount of food at one time that would be embarrassing if others saw you	57.4	-	-

\* Based on Fairburn's tables (1984)

1 Currently refers to often, very often or always

2 Currently refers to an episode in the last two months

It is clear from the table that the prevalence of women who have ever experienced an eating binge ranges from as high as 68.1% to 26.4%; the prevalence of those who are currently binge eating ranges from 79% to 20.9%; the amount of women who binge eat at least weekly, range from 33% to 7.1%. Hawkins and Clement's

(1980) findings appear to be inflated in comparison with the other studies. This is surprising considering they used a definition of binge eating not unlike Cooper and Fairburn (1983) who reported the most conservative findings of all the studies. Furthermore frequent bingeing appears to be fairly uncommon, with all the studies, except Hawkins and Clement, finding less than 10% of the sample doing so.

Table 1.3 illustrates the prevalence of self-induced vomiting. Findings are less discrepant than that of bingeing. This is probably related to the fact that the definition of vomiting is less open to varying definitions. The figures for those who have ever induced vomiting or ever vomited after eating or bingeing range from 4.9% to 22.1%. The prevalence of those currently doing so range from 1.3% to 11.9%. The figures for those inducing vomiting at least weekly range from 1.2% to 1.7%. Halmi et al.'s (1981) findings appear inflated in relation to the rest in this respect, which might be due to the fact that they did not specify "ever vomit" as being self-induced or following a binge.

Table 1.3: Prevalence of self-induced vomiting among women

	ever vomit (%)	current vomiting (%)	at least weekly (%)
Hawkins and Clement (1980)	4.9	-	-
Halimi et al. (1981)	22.1	11.9	1.7
Clarke and Palmer (1983)	5.8	1.3	0
Cooper and Fairburn (1983)	6.5	2.9	1.1
Pyle et al. (1983)	7.3	-	1.2

Table 1.4 indicates that the prevalence of laxative use, though not always specified for weight control, ranges from 4.8% to 10.4%.

Those who use laxatives at least weekly ranges from 0.3% to 1.2%.

Table 1.4: Prevalence of laxative use among women

	current use	at least weekly
Halimi et al. (1981)	4.8 <sup>1</sup>	0.3
Clarke and Palmer (1983)	6.0	1.2 <sup>2</sup>
Cooper and Fairburn (1983)	4.9	-
Pyle et al. (1983)	10.4	1.2

1 includes men and women

2 at least weekly refers to often, very often and always use laxatives

Other means of weight control found among women in non-clinical samples include diuretics, exercise, 24-hour fasting and diet pills. No study found these behaviours currently being practised among more than 7% of their samples. Findings of prevalence for the use of diuretics range from 4.2% to 6.3% currently using them, with 0.4% to 2.1% doing so at least weekly (Halmi et al., 1981; Pyle et al., 1983). 4.8% of Halmi et al.'s total sample (men and women) used exercise as a means of weight control while 7.3% of Cooper and Fairburn's (1983) did so. 33.9% of Pyle et al.'s (1983) sample had ever practised 24-hour fasting, while 6.1% did so at least weekly. Halmi et al. (1981) found that 6.5% of their sample had ever used diet pills (4.5% less than once a month, 0.3% more than once a month, 1.7% at least weekly). It is evident that these behaviours are not extremely widespread, and are particularly uncommon on a frequent basis.

In summary, it is clear from the findings on the prevalence of the key behaviours associated with the eating disorders, especially bulimia (binge eating, vomiting and laxative abuse) that these behaviours are by no means uncommon. A high frequency of practice of these behaviours is however not as common, illustrating that more moderate usage of these behaviours tends to prevail on a community level. Fairburn (1984) points out that occasional binge eating is relatively common, while frequent binge eating (weekly or more) is considerably less so. Furthermore not many women who binge eat also use vomiting or laxatives, or both, to control their weight (Clarke and Palmer, 1983; Cooper and Fairburn, 1983; Halmi et al., 1981). This

suggests that the particular combination of those behaviours which make up the bulimia or bulimia nervosa syndrome is relatively uncommon, even though any one of these behaviours taken singly may occur with more regularity.

It is also evident that these behaviours are more widespread among women than men as illustrated by those studies which looked at prevalence among both (Hawkins and Clement, 1980; Halmi et al., 1981; Clarke and Palmer, 1983; Pyle et al., 1983). For example, there is a higher prevalence of binge-eating with women than men (Hawkins and Clement, 1980; Halmi et al., 1981; Clarke and Palmer, 1983; Pyle et al., 1983). Women also appear to categorize themselves as "binge eaters" more frequently than men, Halmi et al. (1981) found that 35% of the women and 7.8% of the men consider themselves to be a "binge eater". Thus differences between men and women are evident. However, these differences must be understood within the larger context of social definitions of men and women. For men the definition of an excessive amount of food will differ to that of women's definition. Thus when women define themselves as "binge eaters", more frequently than men do, they may be doing so, not because they in fact eat more excessively or more often than men, but because of their awareness that they should not be doing so. It is more socially legitimized for men to eat large amounts than it is for women and more pressure is placed on women than men to diet and be slim. These factors must be taken into account in the understanding of the prevalence findings.

An important methodological problem within these prevalence studies of the behaviours associated with the eating disorders is that of definitions, which will be further illustrated in the presentation of the present study's findings (refer to Chapter 4).

Each prevalence study utilizes a different definition for binge eating which probably accounts for the wide discrepancies in their reported prevalence of this behaviour. Different ways of defining an eating binge will necessarily yield different responses. For example, Meadows et al. (1986) demonstrate that the term is ambiguous in that they found widely discrepant prevalence rates when using different definitions of binge eating in the same study. Less than 1% of their sample responded to a definition of binge eating used by the DSM-III ("I eat and eat until I feel ill or go to sleep"), while the majority responded positively to the item "I have binges when I eat lots of fattening foods" (11.6% rated this as happening often). These definitions must affect findings concerning the prevalence of bulimia as well, given that the latter relies on the presence of binge eating. Problems with definitions occur in many other instances as well. For example, in reporting frequency of behaviours or current behaviours, for some theorists current binge eating will be at least once in the last month and for others it will be at least once a day. This too will affect prevalence findings of bulimia. The prevalence of behaviours like self-induced vomiting and fasting are also subject to this problem, as some studies do not specify the use of these as weight control devices while others do.

#### 1.4 Findings concerning body affect

There have been a number of studies investigating both men and women's attitudes to their bodies. Berscheid, Walster and Bohrnstedt (1973) carried out a survey of body image among a sample of 62000 Psychology Today readers, using a list of 25 body parts to be scored for satisfaction or dissatisfaction on a six-point answer scale. Their findings were less negative than they had expected. They found that 23% of the women and 15% of the men experience some dissatisfaction with their overall body. Almost half of the sample of women (48%) were dissatisfied with their weight, 21% of the sample are quite to extremely dissatisfied. 35% of the males were dissatisfied, with 10% quite to extremely dissatisfied. For women, the mid torso region seemed to be an area of more extreme dissatisfaction generally. 50% were dissatisfied with the size of their abdomen (19% extremely or quite dissatisfied); 43% were dissatisfied with their buttocks (17% extremely or quite dissatisfied); 49% were dissatisfied with their hips (upper thighs) (22% extremely or quite dissatisfied); 25% were dissatisfied with their legs and ankles; 26% were dissatisfied with their breasts. There were considerably less men in the sample dissatisfied with those body parts.

In a study carried out by Fallon and Rozin (1985), both men and women were required to indicate from drawings of figures which looked most like their current shape, their ideal shape, what they thought was most attractive to the other sex and what shape of the other sex they found most attractive. They found that

69.7% of the women rated their current figure as heavier than the ideal, illustrating that the majority of the women in the sample desire to be thinner and are therefore dissatisfied with their current figure. A striking difference is found for men, whose current, ideal and what they consider attractive to women is almost identical and 32.5% rate their current figure as heavier than the ideal.

It is clear from the above that women are more dissatisfied with their shape and size and certain body parts than men (Fallon and Rozin, 1985; Berscheid et al., 1973). Studies have shown that femininity as a personality trait is itself related to dissatisfaction with body image (Kimlicka, Cross and Tarnai, 1983; Hawkins, Turell and Jackson, 1983). The more feminine one is according to socio-cultural standards the more dissatisfied one appears to be with one's appearance.

A wide range of literature has highlighted the extreme concerns that women experience in terms of bodily appearance which do not appear to have the same salience for men. It has been shown that self-esteem and self-concept for women is integrally related to their concerns about bodily appearance (Kimlicka et al., 1983; Worsley, 1981; Rodin, Silberstein and Striegel-Moore, 1984 for a review). Women also appear to have a more clearly differentiated notion of what they like or dislike about their bodies than men illustrating a higher degree of concern about their appearance generally (Kurtz, 1969).

Although weight and thin/fat issues are important for both men and women's overall satisfaction with their bodies (Berscheid et al., 1973), these issues appear to have more salience for women. Jourard and Secord (1955) found that women's desire for a smaller body shape is coupled with dissatisfaction with body shape and size. They found that positive body cathexis was associated with relatively small sizes for that body part, while negative cathexis was associated with relatively large sizes. Although all those who are by cultural standards overweight tend to have a more negative body image than others (Gray, 1977; Worsley, 1981; Pearlson et al., 1981) the salience of this in determining overall satisfaction with oneself and self-esteem is greater for women. Worsley (1981) maintained that obesity and overweight is a self-discrediting characteristic only for girls. It has been found that perception of one's weight is more salient in determining overall feelings of attractiveness for women than for men (Rodin and Striegel-Moore, 1984, quoted in Rodin et al., 1984). Perception of one's weight also appears to affect women's self-concept (Worsley, 1981). Wooley and Wooley (1984), for example, found that for 63% of women in their sample weight often affected how they felt about themselves and only 4% stated that it never affected this (cited in Rodin et al., 1984). There also appears to be a difference between men and women in terms of perceptions of their weight. Looking at perceptions of weight of college undergraduate male and female students, Gray (1977) found that both men and women misperceived their weight, but females tended to perceive themselves as overweight, whereas males tended to perceive themselves as appearing lighter.

To sum-up: It is clear that physical appearance is of more salience for women than for men. For women, particularly more feminine women, body affect is strongly related to self-concept. For women weight and being thin or fat is of great salience in determining their body satisfaction, feelings of attractiveness, self-esteem and self-concept. In this context women appear to be more dissatisfied with bodily appearance, their weight and shape than men are.

### 1.5 Body affect and eating problems

Although recognizing that concern about the body is central to ✓  
the eating disorders, not many studies have actually addressed the issue of the relationship between eating disorders and body affect. Hawkins and Clement (1980) found that for women severity of reported binge eating was significantly positively correlated with negativity of physical self-image. This relationship was not found for men. White, Hudson and Campbell (1985) in a study of "bulimarexia" (Boskind-Lodahl's (1976) term for the gorge-purge syndrome) among black women investigated the determinants of binge-purge behaviour. Using the body cathexis inventory (Secord and Jourard, 1953) they found that there was a trend for women with a more negative attitude toward their weight to binge ✓  
more often. They also found that women who purged more often tended to display a more negative attitude toward their weight. Thus both purging and bingeing were found to be related to negativity of body image.

## 1.6 Empirical evidence for the role of culture within eating/body problems

It has already been shown how the disorders of anorexia nervosa, bulimia and the attitudes and behaviours associated with these are far more prevalent among women than among men. It has also been shown empirically that the body (weight and appearance) has more salience in the lives of women than it has for men. It is clear therefore that these problems cannot be understood outside of socially constructed femininity. Eating/body problems cannot be understood outside of the general milieu of Western culture and its prescriptions concerning the body and eating. The following points illustrate the culture-bound nature of the ideological prescriptions concerning eating and the body, as well as the predominance of these problems within Western countries:

(1) In terms of eating, the emphasis on diet and "healthy" "slimming" eating is becoming increasingly strong within Western culture, as exemplified in the media, magazines, radio, television and newspapers. The amount of money spent on diets and diet aids are indicative of the social emphasis on these activities. Time magazine of January 1986 states that \$5 billion dollars were spent on diet and fitness in America in 1985. Americans bought \$200 million worth of diet pills over the counter. Sales of low-calorie foods have risen by 15% annually over the past few years. At least one million attend self-help groups like Weight Watchers (Toufexis, 1986). It is clear that this trend is directed particularly at women. Garner et al. (1980) found a significant increase in diet articles in women's

magazines over the last twenty years.

(2) In terms of the body, there is an increasing cultural hatred of fat and an idolization of slimness, and more recently musculature. Again this trend appears to be directed at women, although it is becoming more unacceptable for men to be fat.

That slimness and muscular definition is idolized, is illustrated by the kinds of models appearing in the media. It is clear that the current ideal of slimness for women in Western culture is not a universal phenomenon, nor has it been the ideal in Western culture throughout its history. The cultural and historical specificity of the slim ideal has been illustrated empirically (1955; Furnham and Alibhai, 1983). Furnham and Alibhai (1983) found that British and Kenyan British women rated slimmer female figures more favourably than Kenyan women who rated larger figures more favourably. It was found that Kenyan British women were more similar to the British group in their perceptions, illustrating the strong role that cultural factors play in creating perceptions of what is desirable. They also show that British preferences for small body shapes to the point of anorexia are not uncommon. This idolization of slimness to the point of an anorexic image is illustrated in a finding by Branch and Eurman (1980) that the families and friends of anorexics actually reinforce the appearance of the anorexic by finding it attractive, as indicated by their descriptions of the anorexic's body:

We found that the anorectic patient meets with more approval than disapproval from family and friends. In fact, the respondents tended to admire the patient's appearance. The patient was described by 7 respondents as 'slender', 10 respondents as 'neat', and all respondents as 'well-groomed' and 'fashionable'. The words 'skinny', 'emaciated', 'haggard' and 'normal' were all cited once. (p. 631)

It has been shown empirically, that the ideal shape for women in Western culture has become slimmer over the last two decades (Garner et al., 1980). Garner et al. (1980) using data from Playboy centrefolds and Miss America Pageant contestants found a significant shift toward a thinner standard over the last twenty years.

(3) The idealisation of slimness and the emphasis on diet are both related to a particular socio-economic realm for they occur only in those cultures and classes where food is provided in surplus. It has been maintained that in Western societies there is an inverse relationship between high social class and low body weight which is not found in less affluent cultures, where fatness is associated with wealth and thinness with poverty (Furnham and Alibhai, 1983). Silverstone (1969) found that obesity is more prevalent among working class people in Western culture than among middle and upper class people. It appears that in Western culture the dictum "you can never be too rich or too thin" is a reality. Furthermore, it is quite clear that the diet and body modification industries are large ones in capitalist society and rely on the obsessions with the body and weight to make their profits.

(4) Clinical eating disorders appear to be empirically culture-bound in that they have been found mainly in Western societies. Cases of anorexia nervosa among non-Western cultures are rare and usually found among those who have been exposed to Western cultural influence to some extent (Prince, 1983). For example, Buchan and Gregory's (1984) case of anorexia nervosa in a black Zimbabwean, although she was born in Zimbabwe she had studied in Britain and had middle class origins. Furthermore Zimbabwe can hardly be claimed as a country free of Western influence. It has been claimed that anorexia nervosa is bound to Western culture (Prince, 1983; Swartz, 1985). In South Africa it has been claimed that the syndrome has only been found among "whites" and Moslem "coloureds". Nash (1984) reports from Groote Schuur Hospital's Department of Psychiatry in Cape Town: "...in the last two decades in this department we have seen five Moslem girls with this major eating disorder, while in the same period we have treated over 80 white in-patients and seen many more in out-patient and day unit settings. We have not seen any members of the non-Moslem Coloured or African communities." (p. 227)

Even within Western culture it appears that certain subcultures manifest eating disorders more frequently than others as a consequence of particular pressures on them. It is clear that eating disorders predominate among young, middle class women. A study comparing "black" and "white" women found that for "black" women the strongest determinant of "bulimarexia" was high socio-economic status and obesity (White, Hudson and Campbell, 1985). They found that "black" women had a significantly more positive

attitude toward their weight than "white" women, illustrating the effect that differences in culture and economic status may have on body affect. Particularly high risk groups for anorexia nervosa have been identified as those who are under extreme pressure to maintain a slim shape as well as high performance expectations, like ballet dancers and models (Garner and Garfinkel, 1980). Thus Garner and Garfinkel (1980) found that anorexia nervosa and excessive dieting concerns were overrepresented among dance and modelling students as compared with "normal" female university students. Within the dance group those from more competitive environments presented the greatest frequency of anorexia nervosa, illustrating the strength of social pressures on individuals in the causation of these problems.

(5) Another aspect of the social realm of influence as concerns eating/body problems has been recently recognized as that of the idealization of eating disorders (Swartz, 1985; Swartz, 1985a). Thus together with the idolization of the shape of the anorexic, eating disorders may have become a fashion in their own right. Certainly the greater publicity given to eating problems is believed to contribute to the widespread nature of these problems. It has been found that a college woman who purges almost always knows another woman who does so, while those who do not purge rarely know someone else who does (Schwartz, Thompson & Johnson, 1982).

In summary, it is evident that the social prescriptions and ideologies surrounding the body and eating in Western culture

arise within a particular socio-economic realm and affect particular members of these communities in particular ways. Empirical findings illustrate that ideologies related to diet and body size/shape as well as the disorders associated with these are bound to Western capitalist culture. Within this social context the ideologies appear to be more directed at women as they are part and parcel of the ideologies of femininity itself (refer to Chapter 2). The influence of these ideologies has been shown to be more powerful for women, and the problems associated with them predominate among women. It is therefore empirically evident that the cultural context, in particular one's position as a woman, is of central importance within the understanding of eating/body problems.

### 1.7 Conclusions

The literature in the area of eating disorders has indicated the widespread prevalence of attitudes and behaviours central to anorexia nervosa and bulimia nervosa among "normal" populations of women. The literature in the area of body affect has indicated the widespread nature of concerns with bodily appearance, in particular weight, among women. There is an indication that "normal" women are dissatisfied with their bodies, particularly the torso area and particularly those who are socially defined as "overweight". There is evidence in the literature that eating disorders are associated with body image concerns and negative affect towards the body. There is strong evidence in the literature for claiming that eating/body problems cannot be understood outside of the cultural context in which they occur, ✓

in particular outside of socially constructed femininity.

The question of the epidemic status of eating/body problems needs to be addressed. It is clear from the review of prevalence findings concerning behaviours and attitudes towards the body/eating, that the extreme eating/body problems are relatively uncommon. The attitudes associated with these problems are however extremely common, far more common than the behaviours. Some of the behaviours, particularly bingeing, are relatively widespread particularly in a moderate form. The realization that studies which allow for a history of bulimia illustrate a far higher prevalence of the problem, indicates that phases of extreme eating problems are common as well.

This review endorses Fairburn's (1984) conclusion that it is inappropriate to describe bulimia and bulimia nervosa as having epidemic status. It appears that neither the symptoms in their extreme form or the strict categories of bulimia, bulimia nervosa and anorexia nervosa are as frequent as has been claimed.

Although, Fairburn's (1984) scepticism concerning the claims of an epidemic status for eating disorders is appropriate, the widespread nature of the problem must not be undermined. He fails to consider the widespread nature of the attitudes, and also some behaviours, which take on an extreme form for anorexics and bulimics. This stems from a rigid notion of what constitutes a problem. If only extreme eating problems are regarded as a problem, then there is no epidemic. But concern with dieting, weight control and one's body is of epidemic status among women. ✓  
More moderate forms of the syndromes of bulimia and anorexia

nervosa are more prevalent than the disorders themselves. The term "epidemic" is inappropriate in that it implies that these problems are "abnormal" illnesses, when in fact they are informed by "normal" acceptable modes of being in the world for women. Jane Fonda has claimed in the media that 30% of women are suffering right now from bulimia (Janos, 1985). No doubt she received her statistics from the inflated prevalence figures of some of the studies reviewed. It has been shown that in fact a strict syndrome of bulimia is far more rare than this. But she is not totally incorrect: 30% of women are certainly not hospitalized or being treated for anorexia nervosa or bulimia nervosa or categorizable as such, but no doubt as many if not more are suffering, to some extent, from obsessive preoccupations with their body (size/weight) and what they feed it. If one can assume that a problem becomes a problem when perceived as such, then Cooper et al.'s (1984) finding that more than a fifth (20.6%) of their sample (female family planning attenders) considers themselves to have an eating problem is significant.

It appears that in answering the question of how widespread eating/body problems are, the issue of what is considered an eating problem is itself a contentious issue. Most of these prevalence studies, within their medical model paradigm, distinguish between eating disorders and "normal" dieting. This is problematic in that it does not provide for an acknowledgement nor an understanding of less severe eating/body problems which are evident in their findings but are ignored. These attitudes and behaviours which have been found to be widespread among non-

clinical populations of women are perceived as problematic only when they come to the attention of medical and psychiatric professionals. It is for this reason as well that the continuum of symptomatology is invisible to those who deny the widespread nature of the problem. That eating disorders become a matter for concern for the health professionals only when they have reached a certain level of physical severity is clear from the literature. For example, Wells et al. (1985) have difficulty interpreting the dieting subscale following their factor analysis of their sample of young women's results on the EAT. They maintain that a high score on this subscale is a measure of psychopathology for underweight women, but not for normal weight and overweight women. Thus whether these attitudes and behaviours are considered a disorder or not is conditional upon the size and shape of the women concerned. Wells et al. (1985) appear to forget how anorexic women become so thin. They seem to suggest that it is acceptable for overweight women to manifest obsessive attitudes concerning dieting and weight but that this is a pathology only if the woman is underweight. It is evident that clinicians are informed by and in turn legitimize the social pressure on women to conform to a socially desirable body shape and size.

The concept of "normal dieting" must be challenged, particularly as a number of studies suggest that dietary restraint is correlated with bingeing and bulimic behaviour (Boskind-Lodahl and Sirlin, 1977; Hawkins and Clement, 1980; Polivy and Herman, 1985; Wardle, 1980; Wardle and Beinhart, 1981). Following Herman

and Mack's (1975) speculation that dietary restraint may characterize a chronic deprivational state wherein individuals are trying to maintain their body weight below their biological "set-point", Hawkins and Clement (1980) hypothesized that this restraint may increase susceptibility to loss of control over eating (i.e. bingeing). Boskind-Lodahl and Sirlin (1977) found that for every one of the 100 women in their sample displaying "bulimarexic" symptoms, her first binge followed a rigid diet. Furthermore, a closer look at some of the "normal" diets marketed, shows how these encourage eating disorders (Wooley and Wooley, 1982). It is maintained, for example, that the Beverley Hills diet is "designed to accomodate the binges which are so common a feature of anorexia" (p. 59) and "the entire system relies on a preoccupation with food which Mazel readily admits" (p. 62). Thus dieting behaviour appears to be strongly related to eating disorder symptomatology like bingeing and therefore is potentially "pathological" no matter what the size and shape of the women involved.

In conclusion, claims of an epidemic status for eating disorders must be viewed with scepticism when one defines an eating disorder as a severe clinical problem which has become physiologically dangerous. However, if one acknowledges a continuum of symptomatology, the existence of less extreme disorder and the possibility of phases of eating problems, the problem is amplified. More moderate symptoms and particularly the attitudes under question are extremely widespread. To realize these as problems the literature needs to challenge its

own assumptions of what is "normal". For eating/body attitudes and behaviours associated with the eating disorders are considered to be "normal" and acceptable by medical, psychiatric and psychological professionals until they manifest as clinical disorders. Eating/body problems have been shown to manifest among communities of women, ranging from widespread attitudinal concerns, to more severe and less widespread subclinical problems, to the relatively rare extremes of anorexia nervosa and bulimia. If all of these are considered together as eating/body problems it is clear that the problem is a major one.

Throughout this review it has been evident that eating/body problems are more prevalent among women than men. From an empirical point of view it is clear that cultural issues, in particular that of being a woman, play a role in the widespread prevalence of these problems. The issues of culture and femininity are major ones to be confronted by a theorist of clinical eating disorders as well as those concerned with understanding the more moderate eating/body problems found among women in a non-clinical setting. It is with these theoretical issues that the next chapter is concerned.

## CHAPTER 2: A THEORETICAL REVIEW RELEVANT TO EATING/BODY PROBLEMS AMONG WOMEN

### 2.1 Introduction

#### 2.1.1 Aims

This chapter is made up of three sections, each dealing with a different body of theoretical work. Its overall aim is to work towards a theoretical understanding of eating/body problems among women, which focusses on the issues of culture and femininity. In Chapter 1 it was illustrated empirically that eating disorders, the attitudes and behaviours associated with them, negative body image and extreme concerns about the body and its appearance are all more widespread among women than men; that these problems are culture-bound in so far as they prevail in Western culture; and that the ideal image for women is itself bound to culture as is the pressure to diet and control one's weight. Taking into account the above observations, it is strongly believed that neither anorexia nervosa and bulimia, nor the eating/body problems in the community, addressed in this thesis, can be understood outside of the cultural context, in particular the social construction of femininity.

These three bodies of theoretical work have been selected because they all deal with the issues of culture and femininity in their attempts to understand their particular subject. These three

groups of theorists include the following:

- (1) Eating disorder theorists who have concentrated on the cultural realm in their understanding of the clinical disorders of anorexia nervosa and bulimia;
- (2) Feminists who have dealt with women's relationship to their bodies and eating as part of their theoretical work on women's oppression within a male-dominated social system;
- (3) Feminist eating disorder theorists who have drawn on feminist insights in their understanding of the clinical disorders of anorexia nervosa and bulimia.

The contribution of these three groups of theorists to an understanding of eating/body problems will be critically evaluated within a particular theoretical framework.

#### 2.1.2 Theoretical framework

At the outset, it is necessary to briefly outline the theoretical assumptions which inform the critical evaluation of the theories to be discussed. Without entering into the major debates concerning mainstream psychology, it is important to direct the reader to the metatheoretical underpinnings of this thesis which are played out especially within this theoretical section. This thesis is informed by a particular understanding of the subject of psychology and a specific understanding of its relationship to the social. It is informed by a growing body of theoretical work within and outside of psychology which has challenged the social/psychological splits which prevail in the social sciences in the attempt to develop a materialist theory of the subject. This requires elaboration.

Historically, psychology has developed as a theory and practice which neglects the social realm of the political, ideological and economic (Ingleby, 1974, 1981; Jacoby, 1975; Henriques et al., 1984; Wexler, 1981; Heather, 1976; to cite a few). An individualist notion of human subjectivity prevails in which human consciousness is privileged above material forces like the economy. An idealism which views human consciousness as something universal, that can be understood outside of the material realm and outside of history itself is evident. The human subject is conceived as an asocial ahistorical entity. The forces of history, the economy, the political and ideological structures are not seen as determinant forces for the subject of psychology. This individualist notion of the human subject is evident in the clinical arena, where psychological problems are personalized and the individual's social context is ignored (Heather, 1976; Ingleby, 1981; Kovel, 1981; Jacoby, 1975). This stance serves a conservative function, for by individualizing problems as psychiatric and psychological ones, social forces, like one's socio-economic position, are ignored and social conflicts, such as those arising in the subject's work place are smoothed over in this way (Ingleby, 1981). The individualism within psychology has been understood as both reflecting and reproducing ideologies in Western capitalist society. It has been noted that by transforming social phenomena into individualized problems maintains the capitalist status quo which demands an individualist ethic (Lichtman, 1981). Individuals, rather than their class position and the exploitative structures of capitalist society, are considered responsible for their

positions in the social system and their psychological problems. The ideology of individualism therefore extends further than psychology but also plays a particular role within it.

Within the individualist, idealist and asocial paradigm of mainstream psychology, there is a strong humanist theoretical understanding of the individual as a conscious, rational agent of his/her life (Henriques et al., 1984). Theoretical humanism pervades the social sciences in general. It is problematic in its assumption of a pre-formed, asocial human nature and in its assumptions of conscious subjectivity. It assumes an inherent human nature which perpetuates the asocial definitions of the psychological.

Attempts to account for the social within mainstream psychology have tended to result in the compartmentalization of the social within the field of social psychology. Critical social psychologists have deconstructed their own discipline, illustrating how the notion of the social is itself asocial (Hayes, 1984; Wexler, 1981). Micro-social forces, as in interpersonal relationships or group processes, have constituted the social for mainstream social psychologists. This has been at the expense of the ignorance of historical and material macro-structures. Even attempts to reconcile the realms of the personal and macro-social systems have theorized about interactions between the two, thus reinforcing the socially constructed notion of a social/psychological dualism (Wexler, 1981; Henriques et al., 1984).

Critical theorists within psychology, seeking to overcome the idealism of mainstream psychology have tended towards the incorporation of a materialist theory of the social system, in their attempts to create a materialist theory of the human subject. Beginning with the Frankfurt school, Marxism has been utilized as a social theory to analyze psychology itself and to create a materialist theory of the subject. Attempts to reconcile Marxism and Psychoanalysis have been determined by lacunae experienced within both Marxist social theory and psychoanalytic theory. The work of Lacan has been central in the theoretical alliances that have been set up between these two theories. Freud's notion of the unconscious has been re-interpreted by Lacan, in a structural-linguistic framework, in such a way that the articulation of historical and material forces determinants within the construction of human subjectivity has been facilitated (Althusser, 1971). Within Marxist theory, criticisms of its tendency towards economic reductionism has lead to a new level of theorizing about the realm of ideology. The study of ideology has developed as a major area of analysis within Marxism, occupying a central place in the theories of key authors like Lukacs, Gramsci and Althusser (Larrain, 1983). Althusser's (1971) paper which infuses his theory of ideology with the Freudian/Lacanian notion of the unconscious, has been a central work within the developing alliance between Psychoanalysis and Marxism. The notion of ideology and of subjectivity as constructed within ideology have become key concepts for a historical materialist theory of the subject.

Feminism, in its historical concentration on the personal experience of women, has been important in developing these theoretical concepts and therefore a part of the redefinition of the psychological as that which assumes the social as an integral part of it (Hayes, 1984; Henriques et al., 1984). Historically a strong movement within Feminism adhered to Marxist social theory, understanding women's oppression as integrally related to capitalism. Inadequacies within Marxism as a result of its lack of a theory of subjectivity soon became evident for feminists. Marxism was accused of being "sex-blind" in its failure to account for women's particular oppression within capitalism (Hartmann, 1979). It was in the context of realizing that women's oppression extended further than capitalist relations of production that a rigorous theory of ideology became a necessity for feminist theorizing (Coward, Lipshitz and Cowie, 1976; Coward, 1982). In this way, they have played an important role in challenging mechanistic notions of ideology as simply reflecting class relations (Barrett, 1980). Freud was rescued for British and American feminists by the central work of Juliet Mitchell (1974) and the realm of ideology, particularly Althusser's formulation (Barrett, 1980). Structural linguistics and the psychoanalytic work of Lacan has been informative in this respect as well (Kuhn, 1978). In France especially, the work of Lacan has been received and developed by feminists (Turkle, 1979, 1981). The Lacanian notion of the subject has been such a central part of the theoretical framework of the Marxist branch of the French Women's Liberation movement that they named themselves "Psychoanalysis et Politique" (Turkle, 1981). Although

strongly informed by Lacanian theory, French feminists have developed sophisticated theories of the female subject, often breaking away from Lacan (for example the works of Luce Irigaray and Julie Kristeva). At this level of theorizing, much emphasis has been placed on the realm of language. Feminists have concentrated on language and representations of women, in deconstructing the female subject in ideology, which has been a central source within this theoretical section (for example the work of Rosalind Coward, 1984; refer to Section 2.3).

The developments within Marxist, feminist and psychoanalytic theory discussed above strongly inform the theoretical assumptions of this thesis. It is these critical movements and the theories, which have grown out of them, which form the framework of analysis in which the theories under review are criticized. The central theoretical tenets may be elaborated as follows:

(1) The social is assumed to be integral to the psychological. All psychology is therefore social psychology. This does not mean that the social is something which acts upon, determines, shapes or interacts with the psychological. Rather the dualism between these two realms, the assumption of a distinction between the two, is itself understood to be socially constructed. It is not enough to posit an interactional theory which presupposes two realms of the individual and the social.

(2) In order to overcome this dualism a materialist theory of the subject is proposed which understands the subject as

constructed within ideology. Ideology itself is understood as integrally related to the historical and material realm, that is, the productive forces and the social relations which arise from these realms and which are constantly changing. Although no rigorous theory of ideology is proposed, given the controversial nature of this subject, the realm of ideology is assumed to be relatively autonomous from that of economy used in Althusser's (1971) sense (i.e. it is determining only in the "last instance"). Ideology is seen to reflect and reproduce power relations between dominating and dominated, including those of class, gender, "race" and age. Ideology is assumed to be transmitted through ideological apparatus, like the family, church, education, and others, as well as through language and representations. Althusser's (1971) notion of "interpellation" is useful in elaborating the process whereby the subject is constructed within ideology. Being "interpellated" as a subject literally means to be "hailed", to be called a subject. Thus one is "hailed" as "woman" or "man" and assumes one's subjectivity in this way. Althusser (1971) utilizes Lacan's reinterpretation of Freud to show how this process is a psychodynamic one, involving the unconscious. The unconscious is therefore social as is the subject. In this way a redefinition of the psychological which assumes the social is achieved. This theory of a subject which assumes an unconscious of a social nature redresses the idealism of mainstream psychology while at the same time allowing for an understanding of the psychological and ideological as having a life of their own. In this way the psychological is not merely reduced to the sociological as Jacoby (1975) warns against, but

nor is the subject seen as asocial.

(3) Within this theoretical framework, neither the social nor the individual are understood as pre-formed, static entities. The social is not understood as created by human consciousness, but as determined by historical and material conditions. The individual is not assumed to be born with inherent humanity, consciousness and rationality (as is assumed by humanist theorists). Rather the notion of the unconscious facilitates the awareness of contradictions between conscious, rational will and unconscious desires (Henriques et al., 1984). Psychoanalysis and Marxism both serve to undermine the humanist, idealist understanding of the social and the psychological, for "after them it becomes difficult to think of subjectivity with either consciousness or a rational ego at its centre or of history and society with the category of the individual subject, or groups of subjects or an abstract conception of Man at its centre."

(Couve, 1986, p. 93)

The female subject is the object of study in this thesis.

Following the above theoretical framework, a particular theory of female subjectivity is proposed. Within feminist theorizing two central notions of the female subject, which reflect different theoretical concerns in Feminism, are evident (Young, 1985):

(1) Humanist theorizing is pervasive within Feminism, stemming from Simone de Beauvoir's (1949) influential existential humanism. The notion of an essential humanity which has been

distorted by socialization is evident. The humanist assumptions of a rational, conscious subject leads to conspiratorial tendencies within Feminism, as power relations between men and women become construed as conscious male actions against women (Mitchell, 1974).

(2) Gynocentric feminist theorizing glorifies traditional female experiences which it believes have been repressed by male domination. Implicit in this form of Feminism is an idealization of an essential femininity and its inherent power which has not been granted expression. This theory of the female subject is also prone to conspiratorial tendencies which find expression in notions of a conscious male hatred towards women. Conspiracy theory is a logical consequence of the lack of a theory of the unconscious. Gynocentric Feminism is also subject to a biological determinism arising from its assumptions of an inherent female nature. It has been claimed that a Feminism which assumes a "natural" femininity cannot be subversive (Brown and Adams, 1979), for the notion of a natural origin is seen as existing only in so far as it is socially constructed as an opposite to the notion of culture. The nature/culture dualism is a corollary of the psychological/social dualism, that exists as a consequence of the assumption that there are essential elements of human nature which exist outside the social.

These two notions of the female subject will emerge throughout the text that follows and will be critically evaluated in the light of the alternative materialist theory of the subject discussed above. But the insights offered by humanist and

gynocentric feminists are not simply dismissed. These theories may be criticized for being conspiratorial or essentialist, but their contributions are not deemed irrelevant.

A growing theoretical body of work which strongly informs this thesis, is that of feminists who have developed a materialist notion of the female subject. These feminists do not assume a pre-formed human or feminine nature, nor do they assume a conscious unitary subject. In this thesis, the female subject is conceived as constructed within ideology, by being "interpellated" as a woman. The construction of the female subject, while involving unconscious psychodynamic processes is a historical and material entity in so far as she is constructed within ideology. The ideologies of femininity are understood to be historically and materially determined in that they arise within a particular social system, at present a capitalist one. They are also understood as reflecting and reproducing the power relations between men and women which take on a particular form within capitalism, but are also older than the latter<sup>1</sup>.

1. The relationship between male domination and the capitalist mode of production is a central debate within both feminist and marxist literature and is by no means resolved (Barrett, 1980; Foreman, 1977). These debates cannot be entered into but it must be borne in mind that this thesis does not simply assume that ideologies of femininity are to be understood as part of the material realm of capitalism alone.

In summary, the critical theoretical review which follows is strongly informed by a more general critical movement in the context of the social sciences. This theoretical movement seeks to overcome pervasive dichotomies within traditional theories concerning the individual and the social system, in particular the social/psychological dualism which arises from an idealist conception of the individual and the social system (Ingleby, 1974; 1981; Jacoby 1975; Henriques et al., 1984; Wexler, 1981). Critical psychologists have proposed the importance of adequate theorizing about the individual in a social context. A materialist theory of the subject is adopted which understands the human subject as being constructed within ideology.

The female subject is understood as constructed within the ideological realm, and therefore determined by historical and material forces. In so far as the process of being interpellated in ideology is also a psychical process whereby the unconscious is created, the female subject is not merely socialized into femininity. Femininity is not an external garment which can easily be thrown off. But nor is it an identity which is inherent in the biological sense. A note of warning is necessary concerning this theoretical framework. Although a materialist theory of the subject has been posited as an alternative to these theories, it must be stated that this theory is by no means without its own problems. It is itself still in the process of being developed. In this thesis it acts as a negative movement in which the pitfalls of the theories reviewed are criticized.

### 2.1.3 Theoretical assumptions about eating/body problems among women

The problems and lacunae which arise in the theories under review are informed by the above theoretical framework. Two central problems emerge consistently and require clarification:

(1) The abnormal/normal split. This dualism is inherent in the literature on eating disorders as well as in popular understandings of the disorders. In the present study, it is rejected as a false assumption while it is asserted that the attitudes and behaviours central to the extreme eating disorders of anorexia nervosa and bulimia are considered to be "normal". This "normality" is assumed both on the basis of statistics which demonstrate that among certain populations of women these attitudes and behaviours are widespread (refer to Chapter 1); and on the basis of the social legitimation and encouragement of these (refer to 2.3). This is not to say that extreme manifestations of these phenomena should not be treated seriously and perceived as problems, rather it is suggested that the attitudes and behaviours associated with the problem are not "abnormal" statistically and ideologically. Furthermore, while acknowledging differences between the two, the clear-cut splits between the clinical problems of anorexia nervosa and bulimia and the non-clinical associated problems are being questioned. The debate around the assumption of a normal/abnormal dualism within the medical model prevailing within psychiatry and psychology is evident within the large body of critical thought in this area (Szasz, 1961; Coulter, 1973; Ingleby, 1981; Kovel, 1981; Conrad, 1981). These issues cannot be entered into in great detail,

except to point out that criticisms directed at the medical model, inform the way in which eating/body problems are viewed in this thesis. Following the critical thought of these theorists, it is believed that illness, both physical and psychological, cannot be understood outside of the social context. Symptoms of psychological illness must be seen as arising from the social, in the same way as the psyche itself is socially constructed. The "normal" woman's relationship to her eating and body is of relevance to the understanding of a severe "pathology" within that relationship.

(2) The social/psychological and nature/culture dualism is present in much of the literature under review. That is the human subject is understood as primarily determined by society, primarily determined by psychodynamic asocial forces or primarily determined by inherent biological forces. These splits are a consequence of the inadequacies within their theories of the human subject. Following a materialist theory of the feminine subject, it is proposed that women's attitudes to their bodies and eating are constructed within the ideologies of femininity. These ideologies are understood as materially determined in so far as they are part and parcel of capitalist consumerism, serving to create a need for certain commodities, especially for women (Coward, 1984; Root, 1984; Williamson, 1978). They also reflect and reproduce the power relations between men and women as will be discussed in detail (refer to Section 2.3.1). In this way, it is evident that the attitudes and behaviours that women develop towards their bodies, which are associated with the

eating disorders of anorexia nervosa and bulimia, cannot be understood outside of the social. But nor can these attitudes be understood as purely socialized ones which can be easily undone. Women are not merely influenced by the prescriptions about femininity, rather their very subjectivity is constructed within these in a way which involves unconscious psychodynamic processes. The female subject is not simply moulded by the social, nor is she determined by inherent "natures" or by psychological processes, separate from the social.

In conclusion, a theory of eating/body problems is being sought which succeeds in articulating the issues of culture and femininity in the general understanding of eating/body problems among women. This theory in its acknowledgement of the social, requires a materialist theory of the female subject, such that eating/body problems are understood as part of the ideological prescriptions for women. This female subject must be understood as one which is not simply socialized into her feminine role. The social ideologies of femininity are not only external forces but are an integral part of the subjective, conscious and unconscious reality of women.

A central part of the acknowledgement of the social is its challenge to the dichotomy of normal and abnormal in the mainstream literature concerning eating/body problems among women. The assumption that only those who are at the extreme pole of the problem, that is who are anorexically thin and suffering electrolyte imbalances from bulimia and who are noticed by the clinicians, are those who are abnormal and ill, needs to

be challenged. In the same way as the social needs to be recognized in the psychological, so the normal needs to be recognized in the abnormal. At all points in this thesis the relationship between various forms of eating/body problems will be challenged. It must be pointed out that this theoretical section does not aim to provide a theory of anorexia nervosa or bulimia per se. It is not the aim of this section to theorize why the "normal" prescriptions for women get taken to an extreme point by some women, like the anorexic and bulimic. While this section may have implications for a theory of these severe problems, the central aim is to develop a more adequate understanding of issues of culture and femininity within eating/body problems which prevail among certain communities of women, from more moderate to more severe forms of the problem. For although the focus is on eating/body problems in the community which range from dieting to more serious problems (termed "subclinical eating disorders" [Button and Whitehouse, 1981]) rather than on the clinical eating disorders, it is assumed that the role of the "normal" must permeate all forms of the problem, even the severe forms of anorexia nervosa and bulimia.

## 2.2 Eating disorder theorists

Theorists within mainstream eating disorder literature have not ignored the issues of culture and femininity. A growing group of theorists have focussed more directly on issues of culture. Yet the degree to which these issues have been dealt with differs from theorist to theorist. These theories are critically

reviewed for the purpose of evaluating their contributions to a theory of eating/body problems. This starting point is chosen in that the insights arising from addressing the extreme eating/body problems are believed to be relevant to an understanding of these problems in the different forms which they assume in the community. The following broad positions as concerns the role that culture is believed to play have been identified:

(1) The multiple-determination position. This is believed to be the most common position, comprising those who perceive culture as something external to the "illness" yet influencing it in some way. The emphasis on weight control and slimness acts as a socio-cultural level of determination which together with psychical, familial and maybe even biological determinants creates the full blown syndrome of anorexia/bulimia nervosa.

(2) A second position perceives culture as intervening at the level of symptom formation. Symptoms are seen as being created by the social emphasis on diet and slimness which serves as a vehicle to express other familial or psychodynamic conflicts.

(3) A third position is the culture-bound theory, which understands eating disorders as bound to the culture in which they occur on all levels, diagnosis, aetiology, treatment and prognosis.

Each of these positions will be looked at with the aid of selected theories to illustrate them.

### 2.2.1 The multiple-determination approach

The most common way of articulating the role of culture within the eating disorders is that of seeing the cultural pressures as one level of determination. This mode of theorising is exemplified by Garfinkel and Garner's (1982) multi-determined theory of anorexia nervosa. In an eclectic way they acknowledge most theories of anorexia nervosa which have been proposed, maintaining that all of them have something to say for an understanding of the causes of anorexia nervosa. The emphasis in Western culture on slimness and weight control is taken seriously as one of the many determinants of the disorder. To Garner and Garfinkel, cultural pressures are so important that they even consider the continuum notion that anorexia nervosa is an extreme form of common dieting. They ask the question: "Is anorexia nervosa a distinct entity or is it simply an extreme form of a relatively common dieting disorder?" (1980, p. 647). Their answer however rejects a continuum notion, maintaining strongly that there are other psychodynamic and familial factors which are important. Rather, realizing the importance of socio-cultural factors they maintain that "although we believe that the pressure toward thinness, within the context of high performance expectations, may be important factors in anorexia nervosa, the bulk of evidence suggests that the disorder is multidetermined" (1982, p. 118). Thus for these authors there is not a single pathogenesis for anorexia nervosa. The exact aetiology cannot be specified as it is a syndrome which is a product of the interplay of a number of different determinants. Thus in any population

there will be a number of individuals predisposed to the illness but only those who have enough predisposing factors will develop the full blown syndrome. Garfinkel and Garner recognize the significance of most theorists of any repute in the area, in developing their schema of predisposing factors. They divide the latter into three groups: Firstly, individual, including conflicts around autonomy, identity, separation, perceptual disturbances. These are drawn mainly from psychodynamic theorists like Bruch and Selvini-Palazzoli. Secondly, family determinants, including parental age, social class, performance expectation, family history of eating disorders, possible genetic components, specific parent-child relationship, and so on. And thirdly are the cultural determinants, most importantly, the pressure for thinness and performance expectations.

The multiple-determination theory is important for two reasons:

(1) In that it acknowledges that socio-cultural factors may play as important a determining role as any other. It focusses on that level which has been historically neglected to quite a large extent in the literature. For even amongst those theorists who recognize cultural pressures, there is a tendency to gloss over them by emphasising psychodynamic factors (e.g. Crisp, 1980; Bruch, 1974).

(2) In their presentation of a picture of anorexia nervosa which does not rely on one aetiology. There is theoretical space provided for the recognition of multiple determinations for the full-blown syndrome of anorexia nervosa, and presumably bulimia as well. In this way the understanding of how different realms

of the person's life may interact together to facilitate the development of an extreme eating disorder is developed. The potential for articulating the differences between more moderate and more extreme eating/body problems is therefore developed.

This theory may be criticized for its liberal tendency to lump theories together which are often informed by contradictory metatheoretical assumptions. In this way a potential for contradictions within the broad theoretical framework is created. The multidetermined position is also lacking, in that little attempt has been made to develop a theory of how the emphasis on slimness and performance expectations function within the aetiology. Rather these are perceived as merely another level of determination, which acting together with particular family configurations (e.g. dominant mother) and particular personality constitutions (e.g. striving for autonomy or needing to be perfect) will create the full blown syndrome of anorexia nervosa. Thus the level of the social is largely a descriptive level, that is, it is assumed that it plays a role, but how it does so is not clarified.

Schwartz, Thompson and Johnson (1982), who also propose a multi-determined position, elaborate the role of culture in a more complex way, by outlining different levels of its intervention. They perceive a continuum of degree of involvement of the cultural level within the aetiology of the syndrome. For these theorists, like Garner and Garfinkel, the cultural refers to the emphasis on diet and slimness in society. They describe two

extreme paths at the opposite ends of this continuum. At the one extreme, is the primarily individual path to anorexia nervosa in which culture plays no role in the aetiology, while at the other extreme is the primarily cultural path in which the cultural emphasis on diet and slimness is of most importance in the aetiology of the syndrome. Thus for these theorists there are those who would be anorexic in any culture in any historical era, and the fact that there is a social emphasis on weight control and slimness has nothing to do with the problem; while for others the syndrome cannot be understood outside of the social pressures as it is caused primarily by the latter. As they state:

At one extreme are individuals whose life adjustment is set in earliest life by constitutional and/or early developmental trauma. These are the individuals with classical and deep seated anorexia and who conform to our most traditional ideas about the disorder and its aetiology. These are people who we might suspect would make an anorexic life adjustment no matter what the cultural press and forces towards food, eating, body size and weight. At the other extreme are those whose eating problems seem to be a direct function of specific factors and forces in the contemporary culture. (1982, p. 33)

It is the second group which Schwartz et al. (1982) believe accounts for the rising incidence in anorexia and bulimia nervosa.

Schwartz et al. (1982) go further than Garner and Garfinkel in analyzing the symptoms of the eating disorders within a cultural context. They maintain that the symptoms are socially determined (presumably only for those at the more social extreme of the continuum) in that they represent prescribed roles, behaviours and attitudes for women. They draw an analogy with hysteria which they believe was an extreme form of the weakness and helplessness inherent in the socially prescribed role for women

in Victorian times. The anorexic too attempts to satisfy present social images of femininity to an extreme degree. This level of theorizing is similar to that which will be looked at next, as exemplified by the work of Selvini-Palazzoli (1985). This work is important in that, like Garner and Garfinkel, these theorists allow for an understanding of many different paths to anorexia nervosa, while at the same time allowing space for the action of cultural forces on both an aetiological and symptomatological level. In this way they go further than Garner and Garfinkel who posit the action of culture at an aetiological level only.

To sum-up: The multiple-determination approach is important in its focus on cultural forces. It is also important in its presentation of multiple levels of determination which allow one to articulate the relationship between extreme and moderate eating/body problems. But this level of theorizing is problematic and inadequate in the following ways:

(1) It is fraught with the psychological/social dualism. The level of the social is only that level which is most obviously social - emphasis on slimness and weight control. The social is therefore boxed off as an isolated level of determination acting outside of the family and the individual. For Schwartz et al. (1982) it is an intervention. Though recognizing the social nature of the symptoms, these theorists still assume a division between the psychological and the cultural, which for them is exemplified by the two modes of arriving at anorexia nervosa - the psychological and the social. The implication is that for some anorexics symptoms are not linked to the cultural sphere

while for others the symptoms and causation are more culturally determined. Thus for the less culturally-determined anorexics, the problem with food may have been set in early days with infant feeding, while for the more culturally linked forms, early conflicts may create emotional difficulties which in later life will be articulated within the cultural pressure to diet taken to an extreme form. The social is therefore conceived as something which is not inherently a part of the problem but is something that intervenes from outside, intervening more for some than for others.

(2) The role that culture plays is described, not analyzed. These theorists may acknowledge that cultural pressures play a role as one level of determination, but do not elaborate how the different levels act together and how culture in particular acts within the creation of an eating disorder. This stems from a generalized inadequacy within psychology, as forementioned, that of the lack of an adequate theory of the construction of subjectivity within ideology.

(3) Despite these theorists' understanding that the attitudes and behaviours found among anorexics/bulimics are "normal" in certain groups of people, a normal/abnormal dualism is still assumed. An adequate way of articulating the "normal" in relation to the extreme problems of anorexia nervosa and bulimia is not facilitated by the strict adherence to medical model terminology.

(4) The issue of femininity within the understanding of these problems is ignored to a large extent. Besides pointing out that there is more pressure on women than men to conform to slim shapes and greater emphasis on diet for women, little elaboration of the role that being a woman plays within these problems is attempted.

### 2.2.2 Anorexia nervosa as a cultural symptom expressing psychological distress

A level of theorizing which understands the (symptoms) of anorexia nervosa as largely being created by the emphasis on slimness and dieting is another position which attempts to articulate the relationship between culture and eating disorders. Unlike the theorists discussed above, culture is not so much perceived as a factor of causation in the syndrome, but rather as the major force in creating the symptoms. Aetiology is largely perceived as familial and psychodynamic. The role of culture is at the level of symptom-formation. As mentioned above, Schwartz et al. (1982) are moving towards this position when they speak about the similarities between hysteria and anorexia. Both are considered to be "normative" types of behaviours for women in different historical eras. The symptom for the hysteric and the anorexic is understood as the utilization of "normal" behaviours for woman in an extreme form in order to express other conflicts. In another paper by Thompson and Schwartz (1982) in which they look at anorexic-like problems in the community, they express the view that: "A mental illness in a given culture may be simply a quantitative increase in behavior which is otherwise accepted as

normal by that culture." (p. 48) For these authors anorexia nervosa "may represent an extreme form of an increasingly common mode of life-organization and psychological self-control in women." (p. 49). This mode of theorizing is important in that it brings the symptoms back to the "normal". It allows one to view a seemingly isolated "pathology" within normative, culturally legitimated behaviours and attitudes. It does not simplify eating disorders as mere dieting taken to the extreme but allows the connections between "normal" dieting and anorexic behaviour to be articulated more adequately.

Selvini-Palazzoli (1985), working in a similar framework to Schwartz et al., theorizes the importance of culture and feminine fashion in the creation of eating disorders in the 1985 edition of "Transcultural Psychiatric Research Review" in answer to the question "is anorexia nervosa a culture-bound syndrome?" (refer to Section 2.2.3) Using a systemic hypothesis her central thesis is that anorexia nervosa is primarily a problem created by a dysfunctional family situation, but the "thin look reigning in Western culture has supplied anorexics the instrument to express covertly their relational distress." (1985, p. 202). Her systemic hypothesis allows her, she believes, to answer three important questions concerning anorexia nervosa, culture and femininity: Firstly, why do only a small percentage of a large amount of women who diet become so thin?; secondly, why is the incidence of anorexia nervosa increasing in western culture?; and thirdly, why are the large majority of anorexics female? The first question is answered with reference to the family, in

that the anorexic in her problematic family situation uses the dieting in a game of protest with her family - "the anorexic scenario, a deadly family game with prescribed moves for each member" (1985, p. 202). Thus, what the anorexic woman does not have in common with other dieters is her conflictual family problem. In answering the second question, she refers to the fashion of thinness, for "the probability of triggering the emergence of anorexic behaviour ..increases exponentially when this widespread fashion interacts with the large number of families organized in the way described. " (p. 202). Furthermore she goes on to show that using food as a family game can only occur in a culture in which food is easily available, thus accounting for the lack of eating disorders in third world countries. Finally, the third question is answered with reference to the fact that for women the emphasis on slimness is far more evident - " The feminine image that fashion has prescribed is that of a slender body." (p. 203). 

In summary, Selvini-Palazzoli in this short paper has made considerable advances in elaborating the articulation of culture, femininity and eating disorders. By assuming that "each specific culture furnishes a certain type of discomfort the means to express itself" (p. 204) we can understand why there prevails in Western culture, not only a fairly high (relative to other cultures) incidence of anorexia nervosa but a very high prevalence of symptoms, attitudes and behaviours in a less extreme form. This level of theorizing is important in its understanding of symptoms within a social context, thus

overcoming social/psychological and normal/abnormal splits to a certain extent.

A number of inadequacies and problems are evident:

(1) The issue of femininity is not adequately addressed.

Selvini-Palazzoli does not develop her third question and answer, which would clarify how the fashion of slimness comes to play a role in the life of both "normal" dieters and anorexics. How does the trigger of fashion work to set off anorexia in the female dieter? It is proposed that an analysis of the construction of femininity is needed to fully understand how fashion is imbued with the power to set off more serious eating problems for women.

(2) Selvini-Palazzoli's dysfunctional family theory is problematic in that it still boxes anorexia nervosa into a particular aetiological category. In proposing one aetiology for anorexia nervosa the possibility of other aetiological factors, not directly related to family conflicts, is precluded. In this way the woman who develops an extreme disorder is immediately assumed to have a problematic family context. The possibility of other means of arriving at this point are not allowed for.

(3) Inherent in her theorizing is the classic psychological/social dualism. For culture is perceived to be playing a role at the level of symptom-formation only. Causation is attributed to familial and psychodynamic issues which are seen as separate from cultural issues. Thus, although situating the symptoms culturally and socio-economically, Selvini-Palazzoli does not do the same with her aetiological level of understanding.

### 2.2.3 Anorexia nervosa as a culture-bound syndrome

This appears to be the most promising theory challenging the issues of culture, given its stated intention to understand eating disorders within the social context at all levels (symptoms, aetiology, diagnosis, prognosis). In 1983, Raymond Prince, basing his proposal on empirical evidence concerning the prevalence of the syndrome, proposed that "anorexia nervosa is a Western culture-bound syndrome, rooted in Western cultural values and conflicts." (p. 300) A model for culture-bound syndromes was developed by Ritenbaugh (1982) and Cassidy (1982) and applied to obesity and protein-energy malnutrition respectively. Leslie Swartz (1985), using their model, has applied it to anorexia nervosa. This model essentially maintains that a syndrome is culture-bound in the event that any of its characteristics, symptoms, aetiology, diagnosis or treatment are determined by the cultural context in which it occurs. Swartz (1985) takes each of the four characteristics of a culture-bound syndrome and shows how anorexia nervosa fulfills each of the following criteria:

Firstly, it cannot be understood apart from its specific cultural or subcultural context. For Swartz, this refers to the cultural "emphasis on thinness and consumerism" and the subcultural contexts of "image-related careers", empirically shown to manifest an unusually high amount of anorectic attitudes and behaviours (1985, p. 8). This point is important in its implications that the same symptoms found in different historical times and places, may mean different things, thus challenging universalist claims that anorexia nervosa and bulimia have always

existed. It is easy to imagine that symptoms relating to such a central thing as eating may have existed universally, but the importance of recognizing that these may mean different things, depending on the culture in which they appear, is significant. This becomes clear when looking at historical accounts of case studies of eating disorders. Pope, Hudson and Miale (1985) have presented four case studies of Pierre Janet, treated in the early 1900's, which they claim are bulimics according to DSM-III criteria. This kind of historical review appears to prove that the syndrome is universal, ahistorical and not bound to culture. A close study of these cases reveals that, though the symptoms may be the same, their subjective meaning for the patient was very different to the meaning that bulimia appears to have today. Not one of these cases appeared to have been involved in weight control in the way that bulimics are today. For example, Nadia, one of the cases attempted to stop eating so as not to grow bigger. She was not involved in the search for a slim body or the obsession to control her weight. It is not surprising that problems with eating are universal given the universal nature of eating itself. In fact most psychiatric problems appear to involve some dysfunction of eating. But it is quite clear that the eating problems of Paris a century ago meant something different to the individuals and in relation to the social from the eating/body problems found today.

Secondly, the aetiology summarizes and symbolizes core meanings and behavioural norms of that culture. Swartz (1985) takes this to mean that the syndrome of anorexia nervosa serves to express

preoccupations present in Western culture, presumably meaning the preoccupation with food, dieting, fitness and weight control. Thus anorexia nervosa is on one level a caricature of "normal" behaviours in Western culture. This notion is not absent in the literature and is central to one feminist account of anorexia nervosa which will be dealt with later (Boskind-Lodahl, 1976, 1977, 1978; refer to Section 2.5.1). In another paper, Swartz (1985b) takes this notion even further, proposing that anorexia, by medicalizing the "normal" so that it appears as an "abnormal", in fact serves to hide the "normality" of the widespread cultural preoccupations expressed by the anorexic:

"It (anorexia) allows us to ignore the fact that obsessive concern with size and the body's imperfections, far from being "pathological", are actually marketed as desirable qualities for women. By being so clearly a medical problem, anorexia nervosa may be channelling into a well-defined medical area concerns about a society which requires of women to attribute great importance to height, weight and the size of body parts." (p. 436)

Thirdly, the culture-bound position maintains that diagnosis relies on culture-specific technology and is ideologically informed. For Swartz (1985a) this refers primarily to the process of negotiation between the therapist/doctor/psychiatrist and the anorexic. His central points in this respect are that the clinician and patient negotiate the meaning of the patient's illness; this is a process in which both modify their behaviour according to what they see as the expectations of each other; and there is not necessarily a distinction between popular

conceptions of anorexia nervosa (held presumably by the patient) and academic/professional views of the syndrome (held by the clinician). These are important insights in that they allow for the analysis of the role of the therapeutic relationship in the development and maintenance of the symptoms of anorexia nervosa. Any theory which claims to confront cultural issues within the eating disorders, particularly those that present clinically, must take these issues into account. Swartz (1985a) shows how it is not merely the therapeutic relationship in which eating disorders are negotiated, but that the very production of scientific theory and discourse in this area also has an effect upon the creation of these problems.

The fourth criteria for anorexia nervosa as a culture-bound syndrome is that successful treatment is accomplished only by participants in the culture, meaning that the treatment of anorexia nervosa will only make gains within the types of therapeutic systems set up by Western culture (presumably psychiatry and psychology). *end.*

To sum-up: The culture-bound model goes further than both the multi-determined theorists and the symptom-formation theorists in their assertion that the effect of culture needs to be viewed at all levels, not merely the aetiological or the symptomatological. Despite its contributions, a number of similar problems to those of the other theories reviewed, have not been overcome fully:

(1) Implicit in the notion of a culture-bound syndrome is the social/psychological-split. For inherent in the proclamation that

anorexia nervosa is culture-bound is the assumption that some illnesses are not culture-bound. Cassidy and Ritenbaugh (1982) deal with this problem by maintaining that all diseases in all cultures are culture-bound to some extent and use a continuum notion, whereby some illnesses are more culture-bound than others (Swartz, 1985). Implicit in this, is the notion that culture is something external to illnesses/problems, but may intrude to a large degree with certain problems, like eating disorders. The usage of the word "culture" and its treatment as something which acts upon the psyche perpetuates the social/psychological dualism. The usage of the word "culture" forces the reader to recognize culture at all levels of the eating disorder, that is aetiology, symptomatology, diagnosis, treatment. And yet in this very movement of directing the reader towards the social is the idea that it is something external to the "personal".

(2) Like the other theorists above, this theory is largely descriptive, not elaborating the process whereby the cultural assumes such importance for the anorexic. This stems from the lack of an adequate theory of the subject as discussed previously. In effect, this model serves only to emphasize the role of culture in certain syndromes which it believes are more connected to culture than others, as Kirmayer (1985) asks "...is calling all illness culture-bound anything more than a rhetorical point aimed at emphasizing the importance of culture?"

(p. 206) Using a term like culture-bound is important only insofar as it steers one directly towards a level of understanding greatly neglected within the literature on eating

disorders. Given the assumption that no "disorder" can be understood in any way outside of its cultural context, the culture-bound model serves little more than providing a skeletal structure that directs one towards the focus on cultural issues, such as the negotiation between doctor and client. It describes and prescribes what a critical theorist of eating disorders should be looking at, but does not provide the theoretical tools to do so, let alone an entry point. A theory of anorexia nervosa which is serious about cultural issues "must go beyond the label 'culture-bound' to look at the detailed relationships between biology, culture and problematical behaviour" (Kirmayer, 1985, p. 207).

(3) The abnormal/normal split is evident. By adhering to a medical model of eating disorders, culture-bound theorists are attempting to infuse culture into a model of theorizing which is inherently ignorant of culture. They are attempting to add a radical perspective to a conservative medical model of mental illness which is, not surprisingly, highly resistant to this addition. By maintaining the categories of symptomatology, aetiology, diagnosis, treatment and prognosis, it becomes difficult, if not impossible, to transcend the normal/abnormal divisions. The very act of "naming" anorexia an illness isolates it from any "normal" attitudes and behaviours in the culture. An illness is inherently an abnormal occurrence which cannot be viewed within a continuum of normality. Thus while stating that the symptoms of the anorexic reflect prescribed ways of being in the world for women, the medical model terminology at the same time precludes the development of the understanding of the

"normal" within anorexia nervosa. Despite the strong implications that the "normal" is operating at the level of symptomatology and aetiology, the reader is not directed to the "normal", for it still emerges as that which is external to a problem which is described as involving symptoms and aetiology.

(4) The issue of femininity is largely ignored. While recognizing that women are more pressurized than men by the cultural forces prevailing, little attempt is made to articulate how this is related to women's "normal" ideological position.

To conclude: It is clear that a large body of theorists within mainstream psychology and psychiatry have not ignored the issue of culture but have made serious attempts to acknowledge it. These theorists have been important in pointing towards the cultural issues of the pressures on all women to diet and strive for slimness. They have highlighted important cultural forces which have been shown by different theorists to be operating at all levels of the problem, that is, in symptomatology, aetiology, diagnosis and treatment. As such they have opened up the closed world of the psychiatric problems of anorexia nervosa and bulimia to expose the realm of the social, the realm of the "normal" within this assumed "abnormality". There have been important theoretical grounds made for understanding the symptoms within cultural context (Selvini-Palazzoli, 1985; Schwartz, Thompson and Johnson, 1982; Swartz, 1985, 1985a). In this respect it has been proposed that the symptom is a "normal" mode of being in the world for women, but becomes a way of articulating other conflicts for those who take these symptoms to the extreme. The

symptoms are to be understood in a cultural context in three central ways: (1) they are bound to the socio-economic context in so far as they require a plentiful source of food (Selvini-Palazzoli, 1985); (2) they are bound to history in so far as the same symptoms may take on a different meaning within different cultures through history (Swartz, 1985); (3) they are specific to women at present, in so far as they are encouraged for "normal" women (Schwartz, Thompson and Johnson, 1982; Swartz, 1985b; Selvini-Palazzoli, 1985). The multiple-determination position has understood the cultural pressures to diet and maintain a slim body for women as part of the aetiology of the problem, for it interacts with other causes in the determination of an extreme eating disorder (Garfinkel and Garner, 1982). The culture-bound position has also made a place for culture within the aetiology but has not developed this. One of the most important and original insights of the culture-bound model has been the acknowledgment of the role of culture on the levels of diagnosis and treatment. (Swartz, 1985, 1985a). In this respect it has highlighted the role that theorists and clinicians may play in the creation of the disorder (Swartz, 1985, 1985a, 1985b).

All of these theorists have paved the way for the recognition of the role of the social in the understanding of eating disorders. This recognition has implications for the acknowledgement of the role of the "normal" in the sphere of eating disorders and therefore a continuum of eating/body problems, from "normal" concerns of women with their body and eating to the extreme clinical disorders. This continuum in terms of symptomatology,

ranges from mild to extreme forms of the behaviours and attitudes; and in terms of "normality", in so far as socially prescribed "normal" female attitudes and behaviours take on different meanings for women, ranges from mild to extreme forms of obsession/concern with them. However, such a continuum does not clearly emerge in the literature due to a number of inadequacies evident in these theories. The process of opening up this closeted medicalized realm to expose the social within it, has been hindered by the following:

(1) The social/psychological split. This inadequacy arises precisely because there is no adequate theory of the subject within the social which does not in some way conceive of these as two separate entities. Recognizing the cultural context is an important progression however the dualism will continue until such time as a theory exists which can adequately account for the dialectic between what has been created in collective Western academic consciousness as two distinct realms - the cultural and the individual. Thus some of the theorists allow for the role of culture at the level of aetiology, while some allow for it at the level of symptomatology. Others allow for it at all levels, but merely describe its action rather than analyzing the process. It is clear that even by referring to a social the assumption of an asocial is evoked. Until such time as the notion of subjectivity assumes culture as indistinguishable from it, which by default implies a social being that also has a symbolic life of its own, then a dualism remains.

(2) The abnormal/normal split. It is clear that differences in extremes are evident in terms of presentation of eating disorder symptomatology. But a theory which can adequately address the relationship between "normal" eating/body concerns and "abnormal" concerns is required. Although recognizing the "normal" within the sphere of eating disorders, the dichotomy between clinical and non-clinical versions of eating/body problems was consistently present, hindering an adequate way of recognizing the continuum of eating/body problems present in the community.

(3) The issue of femininity is lacking in all of the theories presented. The role played by being a women in the context of eating/body problems (ranging from the extremes of anorexia nervosa and bulimia to "normal" dieting) requires more attention than has been granted it.

In many ways these theorists have implicated culture and femininity, in particular the role of "normal femininity" within the understanding of eating disorders, yet little attempt has been made to seriously deal with these issues. This inadequacy arises precisely from the aforementioned problem, that is, the pervasiveness of the social/psychological dualism and the abnormal/normal dualism within these theories. This is not to say that distinctions between the clinical problems and the more moderate community ones must not be made. It has been pointed out that the reason why they are made, may be the physical danger accompanying the symptoms in their severe form (Swartz, 1985). In this respect, it cannot be argued that all forms of eating/body problems need to be treated in the same way. Nor

will it be argued that they need to be understood in the same way. Differences in symptomatological extremity must in some way reflect differences in the meaning that these symptoms have for the woman involved. But it has also been pointed out that another reason why the abnormal/normal distinction is made, is the difficulty an essentially "positivist model of biomedicine" may have with social theorizing (Swartz, 1985). The inability of the theorists reviewed, despite their acknowledgement of the social realm, to fully articulate the realm of the "normal" within their theories of eating disorders stems precisely from problems within their broad theoretical paradigm. A theory of eating disorders which does not assume a clear cut distinction between clinical and non-clinical problems would direct attention to the "normal" women and the "normal" problems that she has with her body and eating. The continuum between the extremes and the more moderate eating/body problems cannot be properly acknowledged within a model which categorizes problems as either normal or abnormal with no recognition of what lies between the two. A theory of the subject which does not articulate the social as part of the psychological, cannot properly acknowledge the role that "normal" femininity plays within all forms of eating/body problems. For ultimately the assumption that there is an asocial realm which is present within the extreme disorders will prevail. It is only within the context of deconstructing the normal/abnormal and the social/psychological dualisms that the differences between anorexics and more moderate eating/body problems will be understood as resulting from differences in the meaning that eating/body issues have in the lives of women,

rather than from asocial psychodynamic and familial abnormalities. It is nonetheless evident that there will be psychodynamic and familial differences between the extreme and moderate manifestations of the problem, with more conflict experienced in these realms for the former. It is these differences which may determine the development of a severe eating disorder, but these are not asocial nor do they necessarily imply abnormality, statistically or otherwise. The role of the "normal" which is obfuscated by the assumption of anorexia nervosa and bulimia as determined by asocial abnormal determinations must be relocated within these problems. It is towards this aim that the insights of feminists are reviewed. Feminists have focussed on the body and more recently on women's relationship to eating/food as well. In this respect they have developed understandings of "normal" women's relationship to their body and eating which may fill some of the lacunae found within the theories of these eating disorder theorists. Their insights concerning "normal" women's attitudes and behaviours in relation to their body and eating may facilitate the understanding of the continuum between the latter and those found among anorexics and bulimics.

### 2.3 Feminist theories relevant to an understanding of eating/body problems

Feminist theorists have recognized the body as an important site of women's oppression at an early stage in the development of Feminism. Their initial focus on the body was that of pointing to the social emphasis on women's bodily appearance which conflated women's value in the world with their attractiveness and desirability to men (Simone de Beauvoir, 1949; Berger, 1972; Greer, 1970; Orbach, 1978; to cite a few examples). More recently there has been a growing body of work analyzing visual representations of women in the media (Betterton, 1985). This work has focussed on understanding these images as reflecting and reproducing power relations between men and women. Work on the media has also centred on deconstructing the ideologies in which women's attitudes to their bodies and eating are believed to be created (for example, Coward, 1984; Root, 1984; Diamond, 1985). Much of the work concerning the issue of the body as part of women's oppression has focussed on the media and in particular advertising. Although feminists do not believe this is the only site where women are constructed as subjects and power relations between men and women are reproduced, it has been found to be a central area of the reproduction of femininity and masculinity and one in which these ideologies are obvious. Visual imagery of women are of central importance in the reproduction of femininity, both in so far as they reflect and reproduce dominant ideologies about femininity and masculinity and in so far as they perpetuate the emphasis on women's bodies, setting up ideal images for her to conform to. It is not surprising then that

much of the work in this area is directly focussed on images of women or refers to the media imagery in order to reinforce the various arguments. For example, although Rosalind Coward (1984) focusses on language and visual imagery in her analysis of the construction of women's attitudes to their bodies and eating, she utilizes adverts in particular to illustrate the power of the language and imagery in this area.

It must be pointed out that Feminism does not comprise a homogenous group of theories. As mentioned earlier, there are various different theoretical perspectives in feminist literature, such as humanism and gynocentrism. The author is biased towards feminist theories which do not assume either inherent humanity or femininity. In this respect, the insights of other feminists are not considered without value, but need to be reinterpreted in such a way that social/psychological dualisms are overcome. The work of authors like Rosalind Coward (1984) and Nicky Diamond (1985) are particularly useful in this respect. With their focus on language and representations, they illustrate how femininity is constructed within ideology. Femininity is not merely false consciousness which distorts true humanity or true femininity, as it is for humanist and gynocentric feminists respectively, rather it is a socially constructed non-unitary subjectivity which involves unconscious elements.

In feminist theory the following areas of work are of relevance to the development of a theory of eating/body problems. These are interlinked areas but will be reviewed separately for the purposes of clarity:

(1) Feminists have politicized issues of the body by understanding the emphasis on women's bodies as an integral part of women's general oppression within a male-dominated society. In this context it has been claimed that the images of women both reflect and reproduce male control over female sexuality and women in general, as well as male violence towards women (Dworkin, 1981; Coward, 1984; Root, 1984; Brownmiller, 1984). The phenomenon of women's body serving as an object of vision controlled by the male spectator, it is believed, helps to create and maintain female sexuality as a passive powerless position in relation to male domination (Betterton, 1985). This work is important in its acknowledgement of how the focus on women's body, specifically in terms of visual imagery, is a part of and serves to perpetuate power relations between men and women.

(2) Feminist analysis of the value of the body for women. Analysis has focussed on the conflation of women's self-esteem and value of herself as a person with her physical appearance. This work has illustrated how women are valued for their ability to "look good" and attract men, while men are valued for their success in the material world (Adams and Laurickiens, 1976; Brownmiller, 1984; Orbach, 1978; Berger, 1972; de Beauvoir, 1949; Fischer, 1973). It is the ideological equation between attractiveness and self-esteem for women which perpetuates their striving toward perfection, towards the ideal images in the media.

(3) Feminist analysis of the construction of women's attitudes towards their bodies and eating within the ideological realms of

language and visual imagery (Coward, 1984; Root, 1984; Diamond, 1985). These feminists show how women's desires are constructed within ideological representations and language in such a way that their relationship to their bodies and eating is one of similar concern and preoccupation to that found among anorexics and bulimics.

### 2.3.1 Images of women: Reflection and reproduction of power relations between men and women

I am alone in the underground waiting for a train. All around me are huge images of female parts: giant rubber peach-tone breasts, wet lips, denim bums, damp-looking stomachs, long legs in high heels ("Hundreds of women take them off for us every day"). I don't know where to look that does not make me feel angry or vulnerable. A man comes into the tunnel and looks me up and down. All these ads are like his gang - telling him I'm a cunt-thing, a leg-thing, a breast-thing and that I am waiting for him. He is psyched up to think that he has a right to me. (The Lovable bra ad, his hand resting lightly but oh so firmly on her naked waist - his territory.) (Jill Nicholls and Pat Moan, 1982, p. 65)

In Paris, Paulus took me to a street that had what looked at first like the window displays in one of the big Fifth Avenue department stores. But the dummies in different outfits were human beings. I was intrigued. This was the dream street of male desire and female submission. Here was the simply dressed girl looking like a neighbor or the sleeping beauty in pink veils; here was the girl begging for punishment. It was a window into hidden truth. (Hannah Tillich, 1974, p. 176, quoted in Dworkin, 1981, p. 109)

The above quotes are illustrative of the way in which feminists have understood the images of women, both in terms of the process of objectification of women within Western culture and the meanings inherent in the images. Women's bodies are fetishized in Western culture, ostensibly for their aesthetic value (Betterton, 1985; Dworkin, 1981). Feminists have deconstructed this focus on women's bodies in the media, in paintings, in films

and in advertising, revealing that the images both reflect and reproduce dominant ideologies of femininity and masculinity, perpetuating power relations between the two in this way.

Feminists have concentrated on the objectification of the female body and the scrutiny of women's appearance that it encourages. This objectification process has been understood as part of the power relations between men and women. John Berger's (1972) famous words exemplify this notion:

One might simplify this by saying: men act and women appear. Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women but also the relation of women to themselves. The surveyor of woman in herself is male: the surveyed female. Thus she turns herself into an object, and most particularly an object of vision: a sight (p. 47).

In this objectification process, women are the "defined" sex, and a defined sex is a sex controlled (Coward, 1984, p. 30). This control is maintained by the creation of images of women in the media that connote passivity and powerlessness in opposition to male activity and power. The slim media image for women is understood within this context. As Coward (1984) states:

The most striking aspect of this body is that it is reminiscent of adolescence; the shape is a version of an immature body...It is no coincidence that this sexual ideal is an image which connotes powerlessness.\* (p. 41)

The images of women and men which pervade advertising, the media and art reproduce power relations by presenting femininity and masculinity in particular ways. Within the images, women's sexuality is constructed as passive, ever-available and waiting for male attention. Within this passive sexuality, it appears that women are not allowed to be active or desire, but must wait

for men's attentions (Coward, 1984). There is one desire allowed woman - the desire for the desire of the man, that is she desires that he will desire her. This is blatantly clear within pornography as Jane Root (1984) shows:

She will stare directly at the purchaser of her image, often with lips a little parted, always with a face which seems to be communicating 'come-on'. The look says she 'wants it' from him, the individual man looking at the picture...In some images, the power of the spectator is increased by the passivity of the woman, who is often shown sprawled naked on a bed with eyes closed. She is apparently lost in her thoughts, but in the voyeur's eyes, this means that she is waiting for him. (p. 44).

For Root (1984) pornography is not something unique and separate from other images of women in the media, but is perceived as "abnormal" because it is extreme.

Root (1984), in this way, has also pointed to the inequality between the man who looks and the woman who is looked at.

Feminists have focussed on this "looked-at-ness" which is bound up with being a woman and the power it creates for men (Mulvey, 1975). Thus "looking" in Western male-dominated culture is not a neutral activity, rather an expression and reproduction of power relations between men and women. Coward (1984) disputes the claim that men's looking at women is a natural impulse, the "hunter impulse" in man. She maintains rather that it is a way in which men maintain their control over women and thus their sense of security and power within the social system. She sees the obsession in our culture with visual images of women's bodies as being a form of voyeurism in which women are actually distanced and kept in control and powerless in this way:

"Voyeurism is a way of taking sexual pleasure by looking at rather than being close to a particular object of desire, like a Peeping Tom. And Peeping Toms can always stay in control." (1984, p. 77). Men's scrutiny of women's bodies is not a "natural" impulse, but nor is it an idolization of their physical beauty as is commonly believed. Rather these ideals are used as ways of disguising the relations of domination and subordination inherent in the objectification of women's bodies (Dworkin, 1981).

Insights concerning male control over femininity in the aspect of "look-at-ness" are informed by a broader feminist understanding of male control over women which is inherent in patriarchal culture. In this theorizing, men are considered to control and possess women, their sexuality and body, on many levels, especially through marriage and in the family. Violence against women, like rape and battering has been understood in this context as well, that is, as an extension of the control that men are allowed over women. Control over images of women in the media and the setting up of female ideals, is another form of the maintenance of this control. Coward (1984) points out that "where women's behaviour was previously controlled directly by state, family or church, control of women is now also effected through the scrutiny of women by visual ideals." (p. 81) Thus the objectification process, whereby women's bodies are objects of vision is commensurate with their general objectification within a male-dominated culture. Dworkin (1981) maintains that male supremacy depends on the ability of men to view women as

sexual objects. She shows how women have always been perceived as "chattel" of males and therefore objects to be used and controlled in order to enhance male power: "Man,..., uses objects - women, children, animals, ..., sensate beings called objects as a matter of course - to feel his own power and presence." (p. 104)

For some feminists, the images of women set up as the ideal do not only reflect male control over women but also male violence towards women and in this way are a more subtle form of rape and battery. Thus Brownmiller (1984) looking at foot-binding in China as analogous to bra-wearing or dieting in western culture, maintains: "To envision a Chinese nobleman's wife or courtesan with daintily slippared three-inch stubs in place of normal feet is to understand much about man's violent subjugation of women..." (p. 33). And Dworkin (1981) acknowledging that the ideal body has often meant the deformation of the "natural" body, asserts that "the mystification of female beauty in male culture knows no limit but one: somehow the beauty herself ends up dead or mutilated." (p. 117)

Feminists have focussed on the advertisements and the media in general, investigating their role in reproducing dominant ideologies concerning masculinity and femininity. It is believed that they not only reflect, but also reproduce passive femininity and male control and violence towards women's sexuality and women generally. Deconstructing the frequent use of the female body to sell material goods which appear unconnected to femininity (cars, alcohol, etc.), Root (1984)

shows how the female body is present to represent potential power and status for the male consumer. And in order for this to happen "he must think of the woman in the advertisement as a thing over which he has control." (1984, p. 62) Thus the association between women and material goods is made - both a car and a woman are male possessions. This advert reflects and also reproduces in each new generation male control over women, their sexuality and their bodies.

In summary, feminists in deconstructing images of women have attempted to show that the objectification of women cannot be understood outside of male control over female sexuality and women generally. The objectification process is believed to reflect and reproduce passive femininity which is controlled and possessed by male activity. It is also maintained that the process of setting up ideal standards of beauty for women is bound up with male violence towards women and their sexuality which arises from and serves to maintain the power that men have over women generally.

These insights have the following important contributions to make to an understanding of eating/body problems:

(1) The understanding that the emphasis on women's bodies reflects and reproduces power relations between men and women. In this way eating/body problems are politicized. Striving towards the ideal image for women and being preoccupied with the body and its appearance, is no longer understood as a reflection of women's inherent vanity. Rather the centrality of bodily

appearance for women is placed within a political context, as arising out of and in turn reproducing power relations between men and women. There is a tendency within this feminist theorizing towards conspiracy theory, in so far as conscious male hatred is implicated within the creation of the images and the process of objectifying the body. This tendency does not undermine insights if they are reinterpreted within a materialist theory of subjectivity (refer to Section 2.1.2).

(2) The social preoccupation with the image of women has been shown to create woman as the surveyor of herself. The constant presentation of ideal images for women in the media and elsewhere sets up an ever present mirror for women to scrutinize themselves in. Thus being a woman becomes bound up with self scrutiny and self-judgement in relation to others and the ideal. This relationship of scrutiny between women and their bodies is analyzed further by feminists who look closely at the ways in which the body is socially constructed within language and representations to create this relationship (refer to Section 2.3.3).

(3) These feminists have allowed for the understanding of how "looked-at-ness" for women and therefore body consciousness, is part of the construction of female sexuality itself. Women's sexuality is constructed as a passive position which waits on male activity. Part of this passivity is "looking good" in order to be desirable to men.

### 2.3.2 The value of the body for women

A woman...is expected to depend on tricks and suffering to prove her feminine nature, for beauty, as men have defined it for women, is an end in itself. (Brownmiller, 1984, p. 35)

Scarcely any woman dares to ignore male ideas of ideal female beauty altogether because these ideas will significantly determine the quality and limits of any woman's life. (Dworkin, 1981, p. 116) ✓

Another focus for feminists has been that of the psychological value which the body and its appearance assumes for women. A central theoretical notion in feminist thought is that, for women, feelings about self-image are intermeshed with feelings about security, self-worth and self-esteem (de Beauvoir, 1949; Berger, 1972; Orbach, 1978; Brownmiller, 1984). Given that woman is set up as an object on display, her value as a human being becomes centred around the success that she has in conforming to the social ideals concerning female physical beauty. Women's sense of self-worth, value and success in life is seen as dependent on her success as an object on display. As John Berger (1972) shows: "She has to survey everything she is and everything she does because how she appears to others, and ultimately how she appears to men, is of crucial importance for what is normally thought of as the success of her life." (p. 47)

Thus, while men may achieve a sense of value and self-worth within other social realms of activity, it is believed that women are taught from an early age that the "look" is central: ✓

A man's clothes, like his body should indicate his transcendence and not attract attention; for him neither elegance nor good looks call for his setting himself up as object: moreover, he does not normally consider his appearance as a reflection of his ego. (de Beauvoir, 1949, p. 54)

The association between self-worth and appearance for women is shown to be reflected and reproduced within the media.

Advertising perpetuates the idea that for women "achievement is primarily visual achievement, and perfection is the attainment of physical beauty." (Root, 1984, p. 66) ✓

Simone de Beauvoir (1949) maintained that the concern with appearance may take on positive value for women, as one area of their lives in which they have control over within an otherwise powerless life:

To care for her beauty, to dress up, is a kind of work that enables her to take possession of her person as she takes possession of her home through housework; her ego then seems chosen and recreated by herself. (p. 543)

Thus for the woman who feels powerless, controlling the body and its appearance may become a way of gaining a sense of power. ✓

An inadequacy with much of the feminist work which posits an association between bodily appearance and self-esteem for women is that it fails to go further than a description of this ideology. This inadequacy stems from a lack of a theory of the construction of the female subject within ideology, which would elaborate how women take on the aforementioned equations.

Feminists with a materialist theory of the subject take these insights further, showing how the equations are socially constructed within ideology and are internalized by women as part of their construction as subjects within language and representations. Thus Diamond (1985) goes further than de Beauvoir who maintains that women gain a sense of control by beautifying their body. Diamond (1985) shows how the equation

that being in control of one's body equals being in control of one's life is socially constructed within the media, language and representations of femininity. Looking at books on health and fitness, like "Jane Fonda's Workout", she shows how these "texts all promise freedom in a new body and healthy sexuality" (p. 56). The implication is that by gaining control over one's body one gains a sense of autonomy and freedom in the world. Coward (1984) shows how ideological equations between "looking good" and "feeling good" are set up for women in advertisements and the media. Psychological well-being for women is in this way strongly associated with physical attractiveness, which in contemporary Western society is equated with slimness (For example, see Figure 2.1).

In the same vein, Coward (1984) shows how women's appearance becomes associated with their sense of security because it is set up as their "ticket" to being loved and appreciated as worthwhile human beings. Women must conform to the ideal images of what is desirable to men, for "it sometimes appears to women that the whole possibility of being loved and comforted hangs on how their appearance will be received" (p. 78). An example of an advertisement in which this ideological message is crudely stated, is the following:

People have said that my products are too expensive, but they're the people who do not understand that real security is only achieved by feeling beautiful.

\* (Estee Lauder, quoted in Adams and Laurickiens, 1986, p. 76)



Look better,  
feel better!  
You can have

## THIN THIGHS IN 30 DAYS

The first, fast and fun  
program that features:

- The Work-Off
  - The Walk-Off
  - The Weight-Off
- for Calorie Burning,  
Thigh Firming...  
and Total Health.

ISBN 0-553-01443-9



U.K. .... £1.50

0-553-01443-9-295

Figure 2.1: This cover of a booklet for women on how to achieve "thin thighs in 30 days" illustrates how psychological well-being is equated with physical attractiveness within the ideological prescriptions for women in the media: If you look better, you are told that you will feel better.

In summary, feminists have shown how femininity, that is being a woman, implies being a visual image to be looked at and the success of her "look", that is, how attractive she can make herself, is bound up with her sense of self-worth as a person. The relationship between body image and self-esteem which feminists have pointed to theoretically, has been illustrated empirically (Refer to Chapter 1, section 1.3). Feminists have pointed to a number of socially constructed equations concerning the body and its value for women, including the following: (1) attractive body = desirable to men = being loved = security; (2) attractive body = control over one's life = autonomy = freedom; (3) attractive body = successful femininity = feeling confident = high self esteem; (4) attractive body = happiness = mental health. These ideological equations are shown to be present in the media, advertising and language. Femininity is constructed within these ideologies and in this way assumes reality for women. This is a central insight for an understanding of eating/body problems, in that it proclaims the centrality of the body and its appearance within the lives of "normal" women. It is not only the anorexic who values her body as that which is central in her sense of self-worth, rather this attitude is prescribed for "normal" women.

### 2.3.3 The construction of women's attitudes towards their body and eating

Recent writings within a structural-linguistic vein, have concentrated on illuminating the way in which language and visual imagery determine women's attitudes towards their bodies and

food. These feminists have looked in detail at the linguistic and representational elements which create the type of relationship which women have developed towards their bodies and eating. In this respect they have focussed on the media and particularly advertising, and their work pertains strongly to present day ideal images of women, with its emphasis on slimness, health and fitness (Diamond, 1985; Coward, 1984). With their concentration on the media and advertising, these feminist authors have also facilitated the understanding of the prescriptions concerning femininity within capitalist consumer culture. For the latter requires the creation of a constant market for its goods which strongly determines the types of prescriptions women receive for their bodies in the media (Root, 1984; Williamson, 1978).

Women's preoccupation with modifying the body has been shown to be constructed within language and the visual images and messages of the popular media. Coward (1984) maintains that the language pertaining to the female body has constructed representations which can only result in women having a punishing and self-hating relationship to their bodies. The narcissism which the obsession with female appearance creates, she believes, is not a constructive narcissism or a love of the body. Speaking about the images of women in advertising and in the media, she maintains that:

...these images do not give back a glow of self-love as the image in the pool did for Narcissus. The faces that look back imply a criticism. Women's relation to these cultural ideals, and therefore to their own images, is more accurately described as a relation of narcissistic damage. (1984, p. 80).

Within language and visual imagery, the female body is shown to be objectified as a project to be worked on. Adverts in particular create the notion that the female body is something imperfect that has to constantly acted upon in the striving for improvement in relation to the ideal image. It is fragmented, talked about in terms of different parts, "problem areas", and often referred to in the third person, as something external to the woman involved (Coward, 1984, p. 43). An obsessive concern with perfection of each fragment of the body is encouraged in the media - "the message is that each small section of the body needs care and attention so that eventually it can become as perfect as the carefully lit and heavily made-up arm, lip, eyelid, thigh or foot in the photograph." (Root, 1984, p. 66) The emphasis on the need for improvement together with the "perfect" images presented in the media serve to add to the self-punishing attitude women develop towards their bodies:

*too much?*  
For women, the barrage of beautiful and sexualised bodies and parts of bodies almost inevitably produces a feeling that there is much work to be done before the body matches up to the standard shown in the advertisements. A sense of physical self-disgust and hopelessness can easily develop from all the exhortations to 'lose weight faster', 'take positive action on skin', 'create a new face' and 'make fabulous eyes'... (Root, 1984, p. 66).

The ideal body for women, at present a slim one, is shown to be socially constructed in such a way that it becomes associated with all that is positive, in terms of happiness, health and well-being. Language creates negative emotions towards the body which does not conform to the slim ideal image (majority of women), for "it is difficult to find a non-perjorative word to describe what after all is the average female shape in a rather

sedentary culture." (Coward, 1984, p. 43). Diamond (1985) shows how within the social production of the ideal female shape, "fat, thin" appear as pregiven oppositions in nature, "thin" as a natural state and goal, "fat" as pathological and a problem." (p. 54). Neither "fat" nor "thin" have inherent value, rather each gain their meaning in opposition to each other, thus "a positive chain of equivalences: "thin" as "desirable = female sexuality = healthy = ideal/end goal" can only be posed as such by defining a negative relational opposity - "fat" etc." (p. 54) In this way an equation is set up in which fat equals all that is negative and slim all that is positive. Within advertising, the message is sometimes put in its crudest form:

I LOST 38lbs in 6 SHORT WEEKS  
I was a sad, fat figure....then EASYSLIM transformed not only my figure, but my whole life. I am now slim, attractive, happy and contented. (Kate Turner, quoted in Adams and Laurikiens, 1976, p. 87).

Diamond perceives this equation as a power relationship in which "thin" has been set up as privileged, as the dominant image, thus making it hard to envisage "fat" as a desirable goal or as an ideal shape to be. Thus losing weight and being thin are equated with happiness and well-being (for example, see Figure 2.2).

In this way, there is extreme negativity associated with images of "fat" women, for they are seen as weak, out of control, unable to suppress their bodily desires: "Being fat is tantamount to walking around with a sandwich board saying, 'I can't control my appetite'" (Coward, 1984, p. 84).



# WEIGHT LOSS!

Total Image is where the good life begins!

Total Image is completely natural. South Africans are becoming increasingly health-conscious and over weight is under siege. That's why the Total Image range of healthcare products has appeared at exactly the right time. Total image is fast, effective and, *best of all, completely natural.* Vince van der Bijl is just one among thousands who have already benefited from the Total Image protein-sparing modified

fast weight-reduction programme. Built around a nutritious food and vitamin supplement called Ultra Diet, it involves no physical exercise or self-denial. Total Image is completely natural weight reduction.



Make your new image fit and healthy. Excess fat is not only unattractive, it is also totally unnecessary now that Total Image is here. So shed those excess kilos now—send off the coupon today. But remember, as with all weight-reduction programmes, we recommend that you consult your doctor before starting.



**TOTAL IMAGE**  
"Where the good life begins!"

**TOTAL IMAGE**

I'm ready for the good life. Show me how to become a Total Image person.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Phone No. \_\_\_\_\_

Yes, I have a weight problem. I'd like to buy your Ultra Diet products.

I'd like to see your Total Image product range only, please.

I'd like to become a full-time Total Image person.

P.O. BOX 785747,  
SANDTON 2146.  
TEL: (011) 802-8710

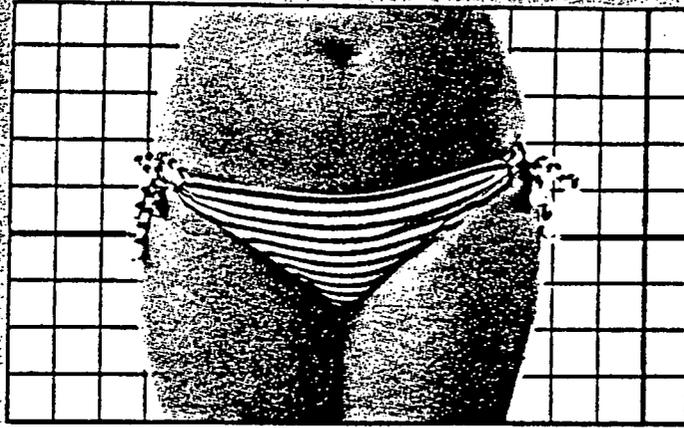
Turner Peachette & Associates  
Advertising and Design

Figure 2.2: This advert illustrates the equations set up for women, of slim = health = happiness. It becomes assumed that attaining the ideal of slimness will bring with it success and well-being in all other areas of one's life as well: Total image is where the good life begins.

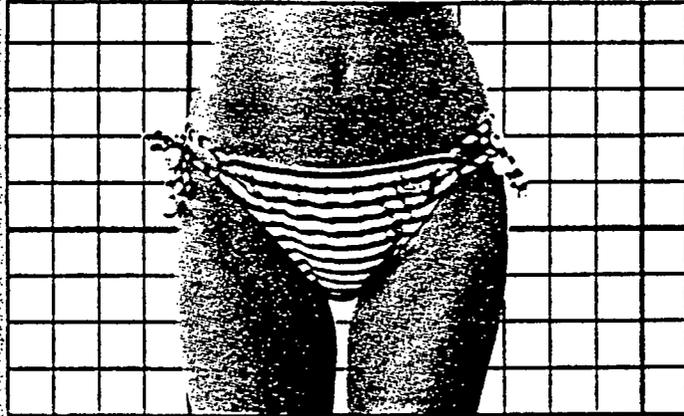
The language also expresses disgust with the fat on the body. It is treated as something external to the body, which mars the body in some way. It is constructed as analogous to a disease -✓ one "suffers" from cellulite (Coward, 1984, p. 44). Adverts create the notion that there is a "real you" being hidden by fat which will emerge if you get rid of the "excess fat" (for example, see Figure 2.3). In this way "thin" is "set up as a privileged image as it becomes equated with the woman's true self and body" (Diamond, 1985, p. 54). Women are lead to believe that their fat is what is ugly about them and once they have removed it they will achieve beauty, as this advert maintains: "FAT CAN MASK BEAUTY" (Advert for a Gym, Argus, August 13, 1985).

Diamond (1985) deconstructs popular notions of the associations between thinness and health, maintaining that "thin" is not *Kosloski's work* necessarily healthier. Conceptions of what is healthy are not constant and "'fat' (and 'thin') do not have fixed referents, as the construction of images and meanings vary in different productive social contexts" (p. 49). Coward (1984) supports the above by showing that despite the media claim that thinness is fitter and healthier, the emphasis on health/fitness is ultimately informed by the same pressures which made women break ribs with their corsets. The new obsession with health is still tied to the preoccupation with appearance, for "as they affect women, these ideas about health always end up around the question of appearance." (p. 23)

# LOST:



# FOUND:



## NU-FIGURE MEANS A DESIRABLE NEW YOU

The Nutrent Nu-Figure diet course is a natural! Our Nu-Figure tablets are scientifically formulated to help your metabolism burn away excess fat. And our Meal In A Glass is nutritionally balanced to provide your body with all the necessary vitamins and minerals it needs, plus a harmless bulking agent to keep hunger at bay between meals.

By taking Nu-Figure tablets together with our new technique diet guide and Nu-Figure's delicious chocolate or strawberry Meal In A Glass, you'll soon be showing off the figure you thought you'd lost forever!

Available at Health Shops and Chemists



**NATURAL INGREDIENTS THAT REALLY WORK.**

Nutritional Enterprises, P.O. Box 396, Rivonia 2128

Figure 2.3: This advert illustrates how fat is constructed within the media as something external to the body which marrs it. Fat hides the "true" thin self. There is a thin body waiting to be "found", for it is "lost" under the fat.

The deconstruction of cultural notions of health are reinforced by Ritenbaugh's (1982) claim that obesity is culture-bound, in which she shows how ideal weight/height standards have been lowered over time, thus defining more people as obese than previously. She presents proof that in fact "heavier is healthier (or at least no less healthy)" (p. 356).

The construction of women's attitudes towards food has also received attention. Many of the attitudes associated with the eating disorders, like guilt about eating and the preoccupation with restricting intake can be traced to the language about food. The media creates guilt and anxiety associated with eating "bad foods", those which are "fattening" and "unhealthy"<sup>1</sup> (for example, see Figure 2.4 and Figure 2.5). Coward (1984) speaks about food pornography, for amid the diets and health prescriptions in the media is the constant presentation of food for women. Women are encouraged to be involved with the production of these delectable foods and yet made to feel guilty about indulging in them:

The presentation of food sets up a particular trap for women. The glossy, sensual photography legitimates oral desires and pleasures for women in a way that sexual interest is never legitimated. At the same time, however, much of the food photography constructs a direct equation between food and fat, an equation which can only generate guilt about oral pleasures. (p. 105)

She shows how at the same time as food is presented as something that women can enjoy, so they are told not to indulge, for it will make them fat (for example, see Figure 2.6).

1. Throughout this thesis, "unhealthy" and "fattening" food refer to social beliefs concerning nutrition.

Where do you spend the majority of your slimming hours? If you've got a job, you'll probably find your biggest struggles against temptation come while you're at your desk, at your check-out, behind a counter, or at your factory bench. CLAIRE CROWTHER found that the business-like approach can pay dividends.

# Just the job for losing weight



Figure 2.4: This picture is an example of the way in which the media encourages women to feel guilty about eating foods which have been prescribed as "unhealthy" or "fattening". In the very act of indulging in food of this nature, a woman is reminded that she should not be eating this food, for she should be watching her weight.

# Catch Your Wife Cheating.



**Sankyo makes it easy.**

Alice insisted she wasn't cheating on her diet. Then late one night I heard noises in the kitchen. Figured it was a good time to try my new Sankyo sound movie camera.

**Figure 2.5:** This advert is another example of the media encouragement of attitudes of guilt towards food for women. Implicit in the advert is the idea that eating cake is "bad" for women as they should be dieting. In this advert the role of men in policing women's eating behaviour is clearly illustrated - for it is the man who may "catch" his wife "cheating" on her diet.

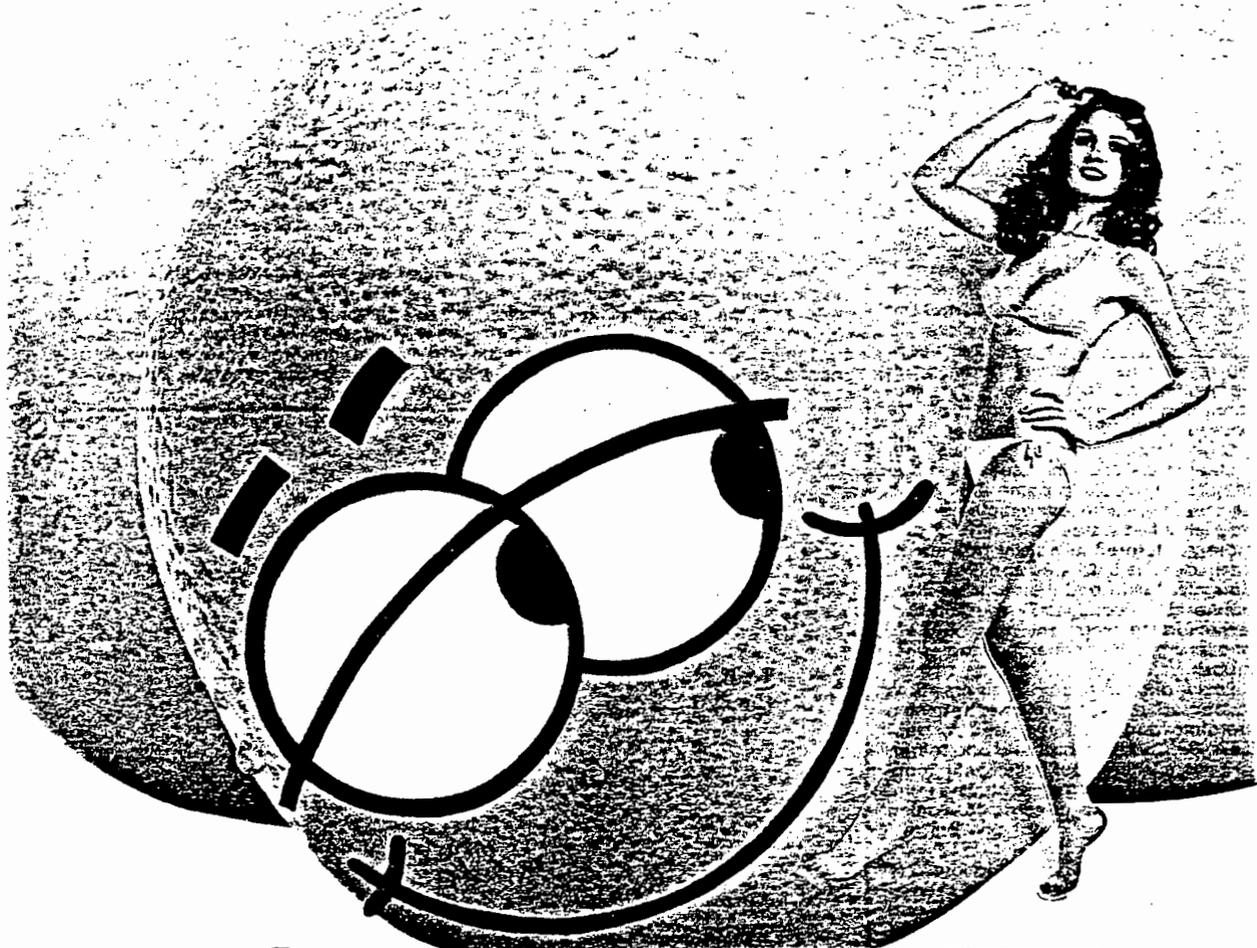
The act of eating is strongly associated with getting fat, as if the food turns immediately to fat (for example, see Figure 2.7). Hence fatness is immediately associated with overeating (Coward, 1984).

Coward (1984) shows how the mouth becomes a symbolic place of taboo a prohibition for women. Women are not allowed to indulge in any of the sensualities associated with the mouth, especially eating. She maintains that the mouth appears to be the organ where the tightest controls are placed on women's behaviour. Thus all oral behaviours, eating, kissing, verbal foreplay, become problematic ones for women. She argues that the mouth occupies this complicated place in women's lives because of its associations with speaking which is a way of asserting one's presence in the world. In the same way as women are not supposed to assert their presence in the world by speaking, so they should not assert their desires to eat which will make them fat, thereby also publicizing the fact that they have overstepped their role. In this way, the guilt and shame that women feel when speaking in public is similar to the guilt they feel about eating which leads to a body that will publicize this. Guilt about eating is also believed to be related to women's socially prescribed nurturing role (Coward, 1984). Women are supposed to give and not take, to nurture and not indulge their own desires, to see to others' needs and not assert their own needs.



Figure 2.6: This advert is an example of how women are encouraged to indulge in food while at the same time being reminded of the "danger" in doing so. It is "naughty" to eat "fattening" cake, but it is also "nice". This is a good example of what Coward (1984) calls "food pornography".

# GRAPEFRUIT



# SHAPEFRUIT

Start your day the superslim way - with a Grapefruit for breakfast!

Being overweight isn't much fun - but then, dieting isn't either! Always hungry, run down, irritable . . .

So here's a diet you **will** enjoy! The South African Official Grapefruit Diet comprises three nutritious meals a day, each starting with a delicious grapefruit 'filler' - which also acts as a vitamin boost.

You'll lose weight slowly but steadily, so your body can adjust to lasting trim looks, and become used to eating less.

So, if you're overweight, mail this coupon today, for your copy of the South African Official Grapefruit Diet. It really works!

What have you got to lose?



*Issued by the Citrus Exchange in the interest of a healthy nation.*



TO: The Citrus Exchange, Box 1158, Pretoria 0001.  
Please send me my free copy of  
the South African "Official Grapefruit Diet"

R. 4/5/83

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Figure 2.7:** This is an example of how adverts equate eating with body size and shape. By eating grapefruit, women are promised a slim body, as if the very act of eating it will cause a weight reduction.

In summary, these feminists have illustrated the construction of women's attitudes to their bodies and eating within language and visual imagery. Attitudes towards the body which are shown to be prescribed for women include the following: self-criticism and self-disgust towards her body; fragmentation of her body into its parts; viewing her body as a project to be worked on; the constant search for perfection; a constant need to modify her body; and comparing her body to the ideal images for women. The ideal images for women by way of which these attitudes are encouraged, are shown to be socially constructed and not inherently beautiful or healthy. In this way the present slim ideal is constructed through the setting up of equations of slim = happy = healthy and fat = unhappy = unhealthy. Attitudes associated with these prescriptions include the following: negativity towards fat on one's body; perceiving fat as something external to and disfiguring the beauty of the body; associating fat women with unhappiness, lack of control around food and hence their lives; and positivity towards slimness as the state that signifies the true self. Attitudes towards eating which are shown to be prescribed for women include the following: guilt about eating, especially indulging in "unhealthy" "fattening" foods; a direct equation between eating and fatness such that food turns immediately into fat; and eating as an indulgence for women who should be nurturing others rather than themselves.

Looking closely at the attitudes towards the body and eating/food prevalent in "normal" and popular ideas about eating and body concern, it becomes clear that they are also those attitudes

which are central within extreme eating disorders. Thus the "normative" nature of these attitudes becomes evident. Obsessive attitudes towards the body and eating/dieting are "normal" prescribed modes of being for women. These insights facilitate an understanding of eating/body problems as a part of ideologically constructed femininity. It becomes clear that the attitudes towards the body/eating which occur in an extreme form in anorexics/bulimics are not outside the realm of the normal, but have taken on an extreme centrality within their lives. The focus on food and the body is thus part of socially constructed femininity, whilst the realm of "normal" femininity is visible within extreme eating disorders, as is the realization that these attitudes must be widespread in more moderate forms among the communities of women exposed to the ideological prescriptions discussed. The continuum which exists between "normal" femininity and the anorexic becomes difficult to ignore.

To conclude: Feminists have broadened the area of understanding of eating/body problems among women in many ways, politicizing these problems in such a way that they cannot be understood outside of power relations between men and women, consumer capitalism and the construction of femininity within ideologies reflecting and reproducing both of these. Insights which are most relevant to a theory of eating/body problems within culture are the following:

(1) Concern with the body cannot be understood outside of the general realm of women's oppression within male-dominated society. The emphasis on women's bodies has been shown to be an

integral part of the control that men have over women, their bodies and their sexuality.

(2) A critical-surveying relationship with her body is created for a woman through the social obsession with her body. The pervasive visual display of the female body sets up a constant mirror in which she must view herself and how she appears to others.

(3) Acceptance of oneself as an object on display, is bound up with the ideological construction of passive femininity which is connoted with an ever-availability and a waiting for male attentions. Female sexuality is constructed in such a way that women's desires becomes primarily that of the desire to be desired by a man.

(4) Within social constructions of femininity, the body is set up as the key object upon which woman's value rests.

Associations between being valuable and successful as a human being and being attractive physically are pervasive within the dominant ideologies of femininity. Ideological equations are prevalent in which being attractive = being desirable to men = being loved = being secure = high self-esteem = confidence = happy = psychological well-being. Thus being in control of the body, in so far as one has shaped it in line with the social ideal, becomes equated with control over one's general well-being.

(5) Ideological prescriptions for women within the media encourage attitudes of concern and obsession towards the body and

eating. In relation to their body, women are encouraged to be self-critical, viewing it as a fragmented project upon which they must constantly work to change and shape it according to the ideals set up. In relation to their eating, women are encouraged to control their intake and to feel guilt at indulging their appetites. Prescriptions about how to look, what and how to eat are therefore inherent in the ideological construction of femininity.

(6) The present ideal image for women is not inherently beautiful or healthy, but is socially constructed in such a way that slimness becomes associated with health, happiness and all that is positive.

(7) The normal/abnormal split prevalent in the eating disorder literature has been challenged throughout the illustration of the pervasiveness of ideologies of slimness, weight control and dieting according to the prescriptions set up for femininity. That "normal" women are encouraged to develop attitudes associated with eating disorders is clear. The obsessive attitudes towards the body and eating/food that manifest as extremes among anorexics and bulimics, are part of "normal" femininity.

The inadequacy highlighted in the review of eating disorder theorists, that of the neglect of the issue of femininity, has been redressed by feminists. Feminists have developed major insights into the way in which women relate to their bodies and to eating/food and how these are socially constructed as part of

female subjectivity itself. In this way, they have shown that eating/body problems cannot be understood without an analysis of "normal" femininity. This theoretical discourse cannot be neglected by any theorist who is serious about understanding eating/body problems, ranging from anorexia nervosa and bulimia to "normal" dieting, within a socio-cultural context.

#### 2.4 Feminist theories of eating disorders

Why are 90 percent of anorexics female ? Why don't most writers about anorexia nervosa explain why 90 percent of anorexics are female ? Why has anorexia nervosa suddenly surfaced as the subject of so much popular speculation ? ...Although a number of books and articles I've read on this subject are useful and interesting, none makes the slightest attempt to answer any of these questions...It is surprising, even puzzling, that none of these scientists attempts seriously to explore the evidently crucial relationship between anorexia nervosa and femaleness. (Sandra Gilbert, 1979; quoted in Chernin, 1983)

The important insights that feminist authors have to offer to a theory of eating/body problems among women has been illustrated. These insights have not been ignored by feminist authors working within the field of clinical eating disorders. Three theorists in particular, informed by feminist insights have produced substantial work in the area of eating/body problems: Kim Chernin (1983); Marlene Boskind-Lodahl (1976); and Susie Orbach (1978). Although very different in their conclusions, what all these theories have in common is the assumption that the issue of femininity is central within the eating disorders of anorexia nervosa and bulimia. This section critically reviews these theorists in order to illustrate how they have applied their feminist insights, with the aim of evaluating their contributions to a theory of eating/body problems among women.

It will become evident that much of the controversy in feminist literature revolves around whether eating disorders can be considered a rejection of femininity or a rigid acceptance or parody of the latter. Following classical psychoanalytic conceptions, anorexia has been viewed as a rejection of femininity, as a defence against underlying fears of oral

impregnation (Thoma, 1967). Even the more recent theory of Crisp (1980) which maintains that anorexia nervosa is rooted in fear of normal adult weight implies a fear of the mature female body in the female anorexic. However, the feminist insights in the previous discussion demonstrate the proximity between the symptomatology of eating disorders and the prescribed patterns of behaviour for women in Western society, hence implying the possibility of eating disorders as an acceptance or an exaggeration of "normal" femininity. The debate concerning rejection or acceptance of femininity highlights key issues involved in the relationship between women's cultural role and eating/body problems. The three theorists mentioned above will be dealt with separately.

#### 2.4.1 Boskind-Lodahl: "Bulimarexia" as a caricature of femininity

Boskind-Lodahl was one of the first clinicians in the area of eating disorders to concentrate on the issue of femininity within her understanding and treatment of eating disorders. Boskind-Lodahl's recognition of widespread binge eating and vomiting among her female clients led her to adopt the term "bulimarexia" referring to a binge-purge syndrome, similar to what is now accepted as bulimia (DSM-111, 1980) (Boskind-Lodahl, 1976; Boskind-Lodahl and Sirlin, 1977; Boskind-Lodahl and White, 1978). Boskind-Lodahl and her co-authors' (White and Sirlin) major thrust is that the pressure for women to maintain a particular female image, which is externally defined by men, is what causes women's obsessions about dieting and weight control and leads to

the diet-binge behaviour. The striving for male attention is therefore central to this syndrome: "The young woman is brought up trying as hard as she can to be acceptable to a man, and she hears constantly that her acceptance depends largely on her appearance." (1978, p. 52) It is evident that this theory is informed by the feminist insights that self-esteem and self-worth for women are conflated with her bodily attractiveness (refer to Section 2.3.2). The psychoanalytic theories that anorexics starve themselves out of fear of oral impregnation or out of rejection of the female role are rejected by these theorists. Rather they believe that the "bulimarexic" over-identifies with what she perceives as the proper female role. The eating disorder is therefore an excessive adherence to the socially prescribed female role.

Boskind-Lodahl's work is important in that it was the first attempt within mainstream eating disorder literature to take femininity and the social demands on women into account. By so doing, it brought the extreme disorders of anorexia nervosa and bulimia into the realm of the social and the "normal" thus illustrating the cultural issues which have to be dealt with in the understanding and treatment of these problems. This work strongly emphasises the role of female subjectivity in understanding and overcoming these problems, whilst the notion of the "bulimarexic" as a caricature of "normal" femininity is vital in illuminating the continuum between "normal" attitudes and behaviours for women and the extremes of anorexia nervosa and bulimia. By bringing into focus the socially constructed

associations between bodily attractiveness and self-esteem, Boskind-Lodahl facilitates the understanding that "normal" femininity may take on a central meaning in the lives of some women, as in anorexics and bulimics.

Despite these important contributions, a number of inadequacies are present in this theory:

(1) It tends to reduce the role of femininity within eating problems to that of women's socialized desires to attract male attentions. The complexity of the acquisition of femininity and what socially prescribed femininity involves is undermined in this way. This stems from the lack of an adequate theory of the construction of the female subject. Being a woman involves more than merely the acceptance or rejection of the social demands for a woman to attract a man. Femininity goes far deeper than the socialized acceptance that one is defined by one's attractiveness to men. Boskind-Lodahl's theories do not provide for lesbians who are not concerned with male attention yet may be preoccupied with their bodies and weight control or develop an eating/body problem. By proposing that "bulimarexics" "have never questioned their assumptions that wifeness, motherhood, and intimacy with men are fundamental components of femininity" (1976, p. 345-346), she can not account for women who have a feminist consciousness and have rejected their socialization or lesbians who are not interested in male attentions, yet still find themselves trapped in obsessions about their weight and body. A theory of the construction of the female subject which takes into account the unconscious is needed. For femininity is not simply a

consequence of socialization which can be challenged by raising one's consciousness of one's oppression as a woman. It is an ideological realm which plays itself out not only in the language, institutions and visual imageries of male-dominated culture, but within the unconscious of every human subject.

(2) Boskind-Lodahl's work is further problematic in that it is informed by humanist Feminism in which an inherent human potential is assumed. This potential is believed to be repressed for women as a consequence of their female socialization (Young, 1985). It is assumed therefore that there is a sense of self and self-worth which exists independently of one's female identity, but has not been allowed to surface following woman's oppressive socialization. The implication is that anorexic or bulimic women are too involved in fulfilling their feminine role to develop their own individualism and sense of self worth. For an adequate understanding of eating/body problems, a theory which can articulate the association between self-esteem and femininity is needed, which does not assume a "true" nature underneath one's social role. Humanist theories assume a preformed human subject which is unitary and rational, underneath the oppressive social roles he/she has taken on. Femininity is not merely a mask underneath which one's real self lies. Thus being preoccupied with one's body is not something that can be overcome by merely developing one's sense of self-worth in ways other than in relation to the body. Within a materialist theory of the subject, there is no "true" humanity which can be reclaimed for women. For as structural-linguistic feminists have shown the

prescriptions concerning femininity, in which the equations of being attractive = self-esteem are evident, are present in the language and representations in which the female subject is constructed (refer to Section 2.3.3). The equations which regulate female identity are not merely a false consciousness which can be undone through self-awareness that spontaneously releases the autonomous human being underneath. The process of undoing the equations of attractiveness = desirability to men = self-worth involves more than a challenge to socialized roles. It involves a confrontation with the ideological representations and language in which femininity is produced and reproduced. It involves a confrontation with female subjectivity which acknowledges the presence of an unconscious level of subjectivity.

These inadequacies in the work of Boskind-Lodahl apply to the understanding of all forms of eating/body problems, that is from "normal" women's relationship with her body/eating to the extremes of anorexia nervosa and bulimia. They further highlight the importance of a materialist theory of the female subject, which has a notion of the unconscious at its basis.

Reinterpreted within the latter vein, her work makes important contributions to filling some of the lacunae within the mainstream eating disorder literature. For although feminists had pointed to these equations in the lives of "normal" women, eating disorder theorists, even those who focussed on socio-cultural issues, had largely neglected the role of femininity. By taking feminist issues into the realm of psychiatric and

psychological wisdom, her work serves to challenge traditional asocial ways of viewing eating disorders. Her work has radical implications for the treatment of eating disorders in its claim that socially constructed femininity needs to be challenged within the "bulimarexic". It is maintained however that the understanding of socially constructed femininity needs to go further than the socialization theory offered by Boskind-Lodahl, both theoretically and practically. This is not to undermine the process of consciousness-raising which is believed to have important benefits for all eating/body problems. These issues are however, beyond the scope of this thesis.

#### 2.4.2 Orbach: Eating disorders as a rejection of femininity

Susie Orbach (1978), strongly informed by a feminist consciousness together with a training in psychology, has written for the lay-woman with eating problems, in particular compulsive eating problems. While accepting that the anorexic may be a caricature of femininity, Orbach's main thrust is that both the anorexic and the compulsive eater represent a rejection of prescribed femininity. As she points out:

\* Anorexia reflects an ambivalence about femininity, a rebellion against feminization that in its particular form expresses both a rejection and an exaggeration of the image. The refusal of food which makes her extremely thin straightens out the girl's curves in a denial of her essential femaleness. At the same time, this thinness parodies feminine petiteness. (1978, p. 165)

"Fat"<sup>1</sup> women who eat compulsively are rebelling against femininity in a similar way: "For some women who eat compulsively

1. Throughout this thesis "fat" and "thin" are used to refer to social ideas of what constitute fat and thin.

the excess weight is also an attempt to defeat the curviness of the female body which brings in its wake dreaded social consequences." (p. 165)

Thus, both the thinness of the anorexic and the fatness of the compulsive eater, by avoiding "natural" female curves, are rejecting their socially prescribed femininity. By ridding themselves of female curves, they challenge the demand on woman to be attractive to men and therefore to fulfill all that which goes with this role. For the compulsive eater, Orbach believes there is an intense fear of being thin, which prevents her from losing weight. For being thin is equivalent to being the ideal female image which means being powerless. She sees a paradox in the position of the "fat" woman who strives to be thin but maintains her "fatness" for as she states : "Women fear being thin; fat has its purposes and advantages." (1978, p. 75) She presents countless reasons as to why women desire to remain fat, all of them related to a basic rejection of prescribed femininity and its meanings for women in a male-dominated culture. If femininity equals powerlessness and being thin equals being feminine, then being fat is understood as a challenge to this position.

Anorexia nervosa and compulsive eating are also understood as a rejection of socially prescribed femininity in that they are rebellions against the invisibility and debilities of being female in a male-dominated world. Thus, for Orbach, the anorexic's intense energy and activity is understood as an attempt to define her social role more broadly, to make an impact

on a male-dominated world in which women are excluded from activity. The compulsive eater's largeness is seen as a protest against women's invisibility in a male dominated world. This notion of psychological rebellion is not absent in eating disorder literature. It has been pointed out by a number of theorists that fasting is traditionally associated with rebellion and the link between anorexia nervosa and rebellion has been forged on this level (Crisp, 1980). Orbach's work however makes an important theoretical leap in its conceptualization of eating disorders as a rebellion against the powerlessness associated with femininity.

The notion of rebellion adds another angle to the understanding of femininity and its role within eating/body problems. Whilst it turns Boskind-Lodahl's over-socialization theory on its head, Orbach shows that developing an eating problem may not be as simple as an exaggerated adherence to one's socialization, but may in fact be a rejection of this at the same time. Her understanding of the construction of femininity is therefore more complex than that of Boskind-Lodahl's in that it creates a space for conflict. Thus anorexics/bulimics/compulsive eaters may not be merely conforming to their socially prescribed roles but may be rejecting them at the same time. That there may be positive rewards in being fat was not contemplated within Boskind-Lodahl's theory, while the security of being fat and the power inherent in its blatant contradiction of the ideal female image is central to Orbach's work.

For Orbach, it is also important that food be understood as something which symbolically fulfills a psychological nurturing role for women. In this way, eating problems, in particular the more bulimic/binge eating/compulsive eating types of problems, are psychologized as an expression of emotional hunger. Her theory thus serves to counteract popular understandings of overeating and compulsive eating.

Orbach's work has been significant in its "normalization" of eating/body problems. By recognizing that many women within the community have problems with eating, particularly compulsive eating, she has allowed for the recognition of the continuum of symptomatology. Furthermore, she has linked all types of eating/body problems, from anorexia nervosa to compulsive eating, from extreme problems to more moderate ones, around the issue of femininity. Her theory is important in its insight that the symptoms of an eating disorder may be indicative of a rejection of prescriptions concerning femininity, rather than an acceptance of them. That femininity may take on both positive and negative meaning in the lives of women is important for a theory which seeks to understand eating/body problems among women. Orbach has thus created an understanding of multiple and contradictory meanings within the symptoms of eating disorders.

A number of problems are evident within Orbach's work:

- (1) Fat is set up as the problem for women, as she maintains: "Fat is a social disease, and fat is a feminist issue" (1978, p. 18). In this way she implies that losing weight is part of the

solution (Diamond, 1985). She accepts the social prescriptions that fat is unhealthy and not a "correct" body shape/size, and idealizes thinness as the "natural" state to be. Her pictures, of a thin women trapped in a fat body, in which fat is seen as something external to the body, are reminiscent of advertisements in the media (Diamond, 1985). By failing to extricate her own theorizing from that of the realm of ideology and its prescriptions concerning health and beauty for women, Orbach ultimately advocates slimness as loudly as the media. To be thin is the goal for women, one in which all her problems will be solved:

To help in the very difficult task of self-acceptance and the preparation for a new slim body and new self-image we employ the following strategies. Bear in mind that you first have to own something before you can lose it. You must first accept your body in its largeness before you can give it up. (1978, p. 91)

Diamond (1985) claims that a feminist intervention, which appears to be Orbach's major goal, should work at constructing alternatives rather than perpetuating ways of viewing women's bodies which are in fact similar to those of popular culture.

(2) Another ideological construction concerning the body and eating, which is left unchallenged by Orbach is the relation between food and fat. Like the media, she assumes a linear relationship between eating and putting on weight, which is not necessarily a physiological truth. The reader is led to believe, through Orbach's conflation of fat with compulsive eating, that all women who are "fat" (by social standards) have an eating problem and that their "fat" fulfills a particular function/s for them. Furthermore, while appearing to challenge stereotypes

of "fat" women, Orbach actually sets up new ones. Little has changed: "fat" women are no longer to be perceived as greedy, out of control or uncaring of their appearance and sloppy, rather their "fatness" is to be understood as a socio-psychological problem, that is, as a response to sexual inequality and/or an expression of emotional needs.

(3) Orbach views food as something nurturant for women, which is important in its challenge to the stereotypes of compulsive eaters as being greedy. This view however, tends to underplay the ambivalent attitudes to food and eating, set up for women within language and the media. As Coward (1984) has shown, women are provided with extremely contradictory messages concerning food. Food is not merely nurturant for women but something "bad" and dangerous as well, in that it makes one fat (refer to Section 2.3.3).

(4) Inherent in Orbach's theorizing is a nature/culture split (Swartz, 1985b). She assumes a "natural" appetite and "natural" weight which will return once women overcome the cultural distortions inherent in prescribed femininity. For example, she states: "We believe that our bodies can tell us what to eat, how to have a nutritionally balanced food intake and how to lose weight" (1978, p. 122). Diamond (1985) questions the notion of a "natural" appetite, maintaining that appetites are structured by the culture in which one lives - "Physical hunger and social habit are not separable as FIFI<sup>1</sup> presumes." (p. 58)

1. FIFI refers to "Fat is a feminist issue", Orbach's (1978) book.

These essentialist notions are retrogressive, especially for feminists who have been struggling against notions of an inborn feminine "nature". The assumptions of "natural" appetites and "natural" body shapes must be critically evaluated lest new prescriptions as to how women should eat and look be set up.

(5) Orbach's understanding of eating disorders as a rejection of femininity is important in so far as it challenges simplistic notions of over-socialization. But this position is potentially dangerous in that within a feminist context, the anorexic, bulimic or compulsive eater may be set up as a heroine. For in her theory, they are women who have not accepted their socialization, but are challenging it in some way.

#### 2.4.3 Chernin: Ambivalence towards the feminine

Kim Chernin (1983) is a radical feminist thinker who is peripheral to mainstream psychology academia and practice. For this author, women's relationships to their bodies and to food cannot be viewed apart from patriarchal culture's attitudes towards the female body. In this respect, she is intent on illustrating that it is not only within the eating disorders of anorexia nervosa and bulimia, that problematic relationships with the body and eating exist, but that these are present among all women.

Chernin's argument centres around women's cultural obsession with body size and dieting which she maintains stems from a fear and hatred of femininity in a male-dominated culture. Her argument begins with a description of these obsessions and the pre-

adolescent body shape which women today are supposed to strive towards. She questions the child-like nature of this body and attributes it to a psychological and social hatred of the female body and what it means to both men and women. This cultural fear and hatred has led to the body obsession:

A woman obsessed with the size of her body, wishing to make her breasts and thighs and hips and belly smaller and less apparent, may be expressing the fact that she feels uncomfortable being female in this culture.  
(1983, p. 2)

Her sensual hungers are also feared and therefore prohibited in a male-dominated culture. This has led to the diet obsession, as Chernin maintains:

A woman obsessed with the size of her appetite, wishing to control her hungers and urges, may be expressing the fact that she has been taught to regard her emotional life, her passions and 'appetites' as dangerous, requiring control and careful monitoring.  
(1983, p. 2)

Chernin presents a psychoanalytic analysis of what she believes are the roots of the cultural fear and hatred of the female body and its "appetites". For Chernin, both men and women harbour an original ambivalence towards the female body. Utilizing an object-relations type of psychoanalytic analysis of the mother/child relationship, she maintains that the mother was once everything to the child, and is therefore "the heartland of our obsession with the female body." (1983, p. 136) Very briefly, the crux of her theory is that the mother is omnipotent for the child, for at times she fulfills all the desires of the child, while at times she may not. An ambivalence arising from early distresses with the mother results, which continues in the psyches of both boy and girl. Both develop solutions for this

ambivalence upon becoming adults. But their solutions differ as a result of their differing roles and access to power in a male-dominated culture. Boys come into their cultural role as men and fathers, a position of control over women. When reminded of his infantile helplessness, when feeling powerless and out of control, the boy now has the means to take control of a woman, like his mother:

It is called a reversal; for now, in his relations with women, he has been able to return to his first experience of being out of control and needing a woman's body. But now he is in a position of power (1983, p. 147).

In this position of power, he has the ability to create "ideal" images of women which act as controls over their bodies. These images in our culture are of slim powerless adolescents which cannot remind him of the power his mother had when he was an infant - "It is an image purged of the power to conjure up memories of the past, of all that could remind us of women's mysterious power" (1983, p. 148).

For the girl who reaches adolescence and begins to look like the omnipotent mother, her body has now become the "female body" about which she feels so much ambivalence. The ambivalence towards her mother becomes for the maturing woman an ambivalence towards her own body. It is this original ambivalence towards the female body which Chernin believes is the motivating force guiding the woman's attempts to gain control over her body by dieting and weight control. The image she is striving for is created by male's ambivalence towards her body. Thus both the ideal image and the way in which women attempt to achieve it,

through manipulation of their bodies, are related to the original ambivalence towards the female body for men and women. For Chernin, it is patriarchal culture and the unequal power relations between men and women, that cause women to suffer for the ambivalence that both men and women experience towards the body of woman.

Chernin's psychoanalytic notion of ambivalence towards the body of the mother and hence the female body, has been present in the mainstream literature on eating disorders. Many theorists have viewed the early mother-child relationship as central. Selvini-Palazzoli (1974) working within object-relations theory shows how the anorexic experiences her body as the "bad" mother, which like the original love object is all-powerful and threatening, resulting in feelings of helplessness on the part of the anorexic. This sense of helplessness, lack of control and powerlessness is akin to the paralyzing sense of ineffectiveness that drives the anorexic to gain control over her body, according to the theorizing of Hilde Bruch (1974). Thus Chernin's work is not unrelated to more classic works on the subject. But for Chernin, the ambivalence toward the mother is present in all men and women, not merely anorexics. She also places the ambivalence within the cultural context of power relations between men and women.

Once of the most important contributions that Chernin makes to a theory of eating/body problems among women, is to challenge the abnormal/normal split present in eating disorder literature. Her work is important in that it does not address the extreme cases

of anorexia nervosa primarily, thus alienating these as "illnesses" separate from the rest of womankind. Rather Chernin addresses the "normal" woman. Her book is "about woman's obsession; in particular the suffering we experience in our obsession with weight, the size of our body, and our longing for food" (1983, p. 1). She only addresses anorexics in so far as they are "extreme examples of this quest" (for smaller bodies) (1983, p. 45). In this respect she goes further than both Orbach and Boskind-Lodahl who address themselves to "problems", rather than to the plight of all those in the community in which these "problems" prevail. All women are expected to be ambivalent to some extent about their bodies in the way anorexics are. Anorexia is thus not simply an extreme form of dieting, but rather an extreme form of a psychological attitude to femininity inherent in all women.

As regards the concept of femininity, Chernin is theorizing at a different level to both Orbach and Boskind-Lodahl. Rather than studying the effect of the social prescriptions of femininity, she analyzes what she believes is a psychodynamically determined relationship of ambivalence towards the female body for women and for men. She also provides a psychical determination for the socially constructed images of femininity, i.e. it is infantile ambivalence to the female body which informs the male production of restricting images of women. This level of analysis is an original one and one that cannot be ignored by a theory of eating/body problems which is concerned with issues of femininity. Chernin's recognition that inherent in socially

constructed femininity there is an ambivalence concerning the female body is particularly important. She allows for the understanding that an eating disorder may not necessarily reflect a rejection or acceptance of femininity. Rather femininity itself may involve an ambivalence towards one's female body. According to Chernin, the present media image of women, a pre-adolescent shape, which appears to deny female maturity, highlights the contradictory attitude of both men and women to the mature female body. Her central insight to a theory of eating/body problems is therefore the proposal of a psychodynamic ambivalence towards the female body as determining the images of femininity in the media, as well as women's attitudes towards their bodies.

Chernin's work is problematic in the following ways:

(1) She tends towards conspiracy theory at many points in her analysis. For example, her analysis of the relationship between male ambivalence towards the female body and media images of women is steeped in conspiracy allegations :

And so he, multiplied by billions, creates an ideal image of woman in which she is not yet woman ... The anorexic girl steps forth. It is an image purged of the power to conjure up memories of the past, of all that remind us of woman's mysterious power...If he can persuade her to abandon the natural inclination of her own flesh, to reduce its size, starve it of its natural power, ... (1983, p. 148).

In this way the ideal images of women in the media are reduced to the determination of male ambivalence alone. This is a simplistic and psychologistic theory of ideology in general and there is no attempt to understand how subjects themselves are

created within these ideologies. The mother-child relationship is universal, however the ideal image for women has not always been so thin, nor have all cultures had such an extreme concern with body size (Swartz, 1985b). Thus the prescriptions about body size for women must go further than the mother/child relationship. These ideologies must be understood in the context of socio-economic forces, for example the demands of capitalism for the creation of consumerist needs in women. They must further be understood as self-reproducing within patriarchal ideologies and capitalist ideologies, rather than as solely determined by the mother-child relationship. Once one begins to speak of a mother-child relationship as all-determining of a problematic relationship between women and their bodies, then the latter is universalized. A theory which psychologizes women's relationships to their bodies cannot account for the cultural and historical differences in this respect. At the same time, the role that the mother/child relationship plays within the creation of an eating/body problem can not be ignored and is an important consideration within a theory of eating/body problems among women.

Chernin does recognize the need to account for the fact that the slimness of the ideal image for women is historically and culturally bound. But in her explanation, a conspiracy is again implied. The image has become slimmer as a result of the development of Feminism in Western culture and the threat it has created for men:

In this age of feminist assertion men are drawn to women of childish body and mind because there is something less disturbing about the vulnerability and helplessness of a small child - and something truly disturbing about the body and mind of a mature woman. (1983, p. 110)

Despite the conspiratorial nature of this answer, it is further problematized by the recent ideal image for women, of an energetic, muscular, fit and trim image (Coward, 1984). This image, predominant in woman's magazines appears to be spurred on by a bourgeois type Feminism which encourages women to develop their bodies and be physically active (something denied them in the past) as well as the new trend towards fitness prevalent in Western culture. Thus this active, energetic image albeit as restricting and potentially dangerous as the anorexic image is a far-cry from the frail, thin, passive image which Chernin speaks about. The everchanging image of women, although constant in its focus on her body size and shape in Western culture, cannot be seen only within the determination of male ambivalence towards the female body, but must be looked at within in the realm of the socio-economic system and changing fashions, such as the new fitness fad which has had effects on the ideal image prescribed for women. ✓

(2) Like Boskind-Lodahl and Orbach, Chernin can be criticized for making use of the notion of the "natural", hence reinforcing the nature/culture dualism which ascribes natural, inherent characteristics to biological females (Swartz, 1985b). Informed by gynocentric Feminism, Chernin tends to idolize traditional femininity and ascribes to a belief in inherent female power. Culture is a negative force which attempts to undermine women's

natural power. Theoretical notions of inherent femininity are retrogressive for Feminism, or any progressive theory of human beings.

(3) As a consequence of the above, she tends to idolize the "fat" woman as exemplifying all that is powerful and "natural" about women. "Fat" women are understood as rejecting the ideal image which is created by a fear of female power, in this way maintaining their "natural" power. She maintains that, historically, large women were powerful and that this image lives on in women's unconscious -

... a wisp, a memory, speaks to us still in the body of a fat woman and calls us back to the body, back to our sensuality, back to our appetite, back to our power... this knowledge of the power of woman must once have been the very essence of goddess worship. (1983, p. 80).

Thus she agrees with Orbach that "fat" women may have become so through a rejection of their powerless female position, but a "primordial meaning of fatness" which "arises spontaneously from an archetypal source" is also believed to be operating (1983, p. 81).

While Chernin's work is important in that it questions the accepted cultural standards of female beauty, her idolization of "fat" women tends to set up yet another image of prescribed femininity. Although she maintains that all female body shapes are beautiful, her counter-bias towards "fatness" is evident - "A fat woman carries in her body the evocative power of the matriarch" (1983, p. 81). It is clear that merely changing the ideal image for women is not the appropriate way to overcome the pressures upon her to conform to an ideal. Chernin's idolization of "fatness" can however be seen as the first move towards

overcoming the strong cultural negativity associated with it. She provides a counter-ideology for women involved in self-hatred of their bodies, as is clear in this quote:

We are in search of vision that will help us to live comfortably within our own bodies, an imagery that is part of our effort to reclaim our bodies from a culture that has alienated them, along with so many other sources of our power and pleasure. Images of large women that can make us proud. (1983, p. 76).

To conclude: These three feminist works are significant in that they bring feminist understandings of the role of the body and eating in women's lives and as a part of their oppression into the realm of eating disorders. In this way the road to understanding women's obsessions with their bodies and eating/dieting in the context of the prescriptions concerning femininity paved. These feminists have also developed the relationship between body concern and eating concern. Eating disorders and "normal" dieting cannot be understood outside of the social pressures on women to conform to a slim ideal. Feminists have allowed for a breaking-down of the normal/abnormal split, showing how "normal" women's relationships to their bodies and eating are evident within the "pathological" relationships that anorexics and bulimics have towards theirs.

The central insights drawn from these theories towards a theory of eating/body problems concerned with the role of femininity are the following:

(1) Eating disorders cannot be understood outside of socially-constructed femininity in which self-esteem, self-worth and one's value as a woman are bound up with physical appearance (Boskind-

Lodahl, 1976). This insight allows for the understanding that the extreme eating disorders are in part determined by "normal" prescriptions of femininity taking on an obsessive meaning in the lives of these women. Their femininity as it is socially constructed may be viewed as a caricature of "normal" femininity.

(2) Eating disorders may be a reflection of a rejection of socially prescribed femininity. By rejecting the rules concerning eating and the body, both anorexics and compulsive eaters are believed to be expressing a challenge to the powerlessness associated with femininity (Orbach, 1978). In this way a more complex understanding of eating disorder symptomatology is created - the symptom may be expressing a rejection of femininity while at the same time ostensibly following the prescriptions of femininity. Chernin (1983) takes this idea further by illustrating that the social ideals for women are themselves bound up with a rejection of femininity ("natural" femininity in terms of size and shape and appetites). Thus even in striving towards the ideal shape women are expressing a rejection of their "natural" bodies and appetites, stemming from an infantile ambivalence towards the female body.

(3) Eating is understood as fulfilling psychological needs for women, rather than a mere reflection of their inability to control their appetites or a show of greediness (Orbach, 1978).

(4) Both the ideal image of women, at present a slim powerless one, and the attitudes that women have towards their bodies and eating are psychodynamically determined following the original

ambivalence the child develops with the mother (Chernin, 1983). Given the social power relations between men and women, men solve their ambivalence by creating powerless images of women and prescribing rigid rules concerning their bodies and eating. While women manipulate their own bodies and control their appetites in order to deal with their ambivalence and to fulfil the dominant male image of femininity.

All of these insights are important considerations for a theory of eating/body problems among women, but the problems inherent in this body of work must be acknowledged. These theorists have a number of problems in common:

(1) The culture/nature dualism is evident in their works. A notion of inherent femininity is assumed in terms of "natural" female power, "natural" female appetites and a "natural" female body shape and size. It has been pointed out with regularity that essentialist theories of femininity are inherently conservative. As has been pointed out by Brown and Adams (1979), the very notion of "natural" is culturally determined. The notion of a reality outside of the social is criticized as "in effect it never exists, since it is always constructed as the other of an already existing social." (p. 41)

(2) Social/psychological splits are also evident within these works. There is a tendency either to psychologize or to sociologize eating/body problems, which arises from an inadequate theory of the human subject in society. Thus for Boskind-Lodahl (1976), the problem is female socialization. Women are

understood as simply moulded by social forces. For Chernin (1983) there is a tendency to psychologize both the social messages concerning women's bodies and eating as well as women's attitudes towards themselves. She traces these back to the mother/child relationship and sees this **psychological** ambivalence as being manipulated by the **social** forces of male-domination in creating eating/body problems for women. A materialist theory of the subject which can articulate the construction of femininity within the cultural context and that does not undermine ideological forces, but simultaneously, does not remove all human agency either, is needed.

(3) There is a strong tendency to idolize women with eating problems or women who are "fat". By idolizing women with eating problems, the latter become legitimized as appropriate ways of rejecting one's oppression as a woman. This glamorization of eating disorders results in the glossing over of the extreme negative experience of developing the full-blown syndromes of anorexia nervosa or bulimia (Swartz, 1985b).

(4) "Fat" is either set up as the problem or the solution. Orbach (1978) endorses the ideology that fat is a problem and must be overcome, thus accepting that thin is the "correct", "natural" way to be. Chernin (1983), on the other hand, idolizes "fat" women. In so doing, an alternative "correct" shape is set up for women. These theorists either endorse the ideal image or by challenging it set up new ones. An adequate challenge to the prescribed ideal images for women would necessarily challenge the notion of setting up ideals itself.

## 2.5 Conclusions

In this chapter, a critical evaluation of theories which explore the issues of femininity and culture in relation to eating/body problems among women was carried out. Following a critical review of the literature of three different bodies of work, important insights concerning the understanding of eating/body problems within a cultural context have been highlighted. In this respect, the theoretical framework presented at the beginning of this chapter has been developed. The central theoretical conclusions concerning the understanding of eating/body problems among women are presented below. These conclusions deal with the issue of "normality" in eating/body problems; the role of the social context within the understanding of these problems, which includes issues of culture and femininity; and the relation between the social and psychological realms pertaining to these problems.

### 2.5.1 The issue of "normality"

Anorexia nervosa and bulimia are not "abnormal" illnesses. It has been shown theoretically that the attitudes and behaviours associated with these syndromes are ones which are legitimized and encouraged by ideologies prescribing ideal images and modes of being for women, present in language, in the media and in advertising. The medicalization of these problems, i.e. the "naming" of the extreme manifestations of these attitudes and behaviours, serves to disguise their social roots. While the woman, who develops such extreme eating problems that she becomes

physiologically ill, will need more psychological and medical attention than the "normal" dieter, her problems must not be seen theoretically as distinct from those of the "normal" dieting concerns of women.

A continuum ranging from mild dieting concerns and behaviours to more severe eating disorders has been proposed. This continuum is also in terms of the meaning that "normal" prescriptions for women take on for different women. Thus the types of relationships "normal" women have towards their body is taken to an obsessive point by anorexics and bulimics. This continuum also implies a level of different meanings that prescribed femininity may take on in the lives of individual women, ranging from rejection to obsessive adherence.

#### 2.5.2 The realm of the social

If one removes the abnormal/normal split, it becomes evident that eating/body problems, like any other problems which manifest as psychiatric, psychological or medical problems, cannot be understood outside of the socio-cultural context in which they are found. The following social forces are central to this understanding:

(1) The material realm of consumer capitalism. The most obvious socio-economic issue of relevance is that it is only in a culture where there is surplus food that slimness can become fashionable and an indicator of success. The capitalist system, which provides surplus for some, facilitates this fashion and allows for the use of food as a manipulative device within

interpersonal relationships (Selvini-Palazzoli, 1985).  
Furthermore, there are industries within the capitalist world which rely on the emphasis on women's bodies and dieting behaviour to make their profits. Desires for products which will aid in women's beautification process, must be created by these industries in order to ensure a constant market for their goods. In this way advertisements, which are integral to capitalism, reproduce in powerful ways ideologies concerning femininity. For example, the association between self-esteem and bodily attractiveness for women is reproduced, as are attitudes of extreme self-criticism and desires to modify the body. Even adverts which do not sell products directly related to the body and dieting for women, serve to reproduce notions concerning femininity. The constant use of women's bodies to sell any product reflects and reproduces the objectification and scrutiny that women's bodies are subjected to, in a culture generally obsessed with surveying the female. The obsession with the body's appearance, central to eating/body problems cannot therefore be understood outside of capitalist consumerism and advertising, which is central to the maintenance of this status quo.

(2) The realm of women's oppression. This is not a realm separate to that of the system discussed above. Although oppressed historically in all economic systems, women's oppression must be understood to take on different forms within different socio-economic realms. The messages in the media, particularly in selling products, themselves rely upon the

ideological construction of a particular form of femininity in order to be effective. Thus, the advert which manipulates women's bodies to sell a motor car is dependent upon relations of control and possession between men and women for its message to work. Although this message itself will recreate these power relations it is also a reflection of already existing ones. Likewise, the industries which are founded on women's needs to beautify themselves, depend upon the construction of a female subject which derives its value from attracting men. The ideological realm of capitalism therefore both reflects and reproduces ideologies which support male-domination and set up femininity as a powerless position. The realm of women's oppression is central to an understanding of women's "normal" preoccupation with food/dieting and body as well as the extremes of anorexia nervosa and bulimia. Feminist theorists have made the following contributions to an understanding of the centrality of femininity in the realm of eating/body problems:

(a) The emphasis on women's bodies reflects and reproduces a system of male control over women and in particular, their sexuality. The ideologies in which women develop concern with bodily appearance serve to maintain a male-dominated status quo. In order to challenge this, the entire system of male-domination, of unequal power relations between men and women needs to be confronted. For as long as men are granted powers of control over women's bodies, their bodies will be objectified as objects of vision. As long as women accept their bodies as objects which must be beautified in order to attract a man, women will remain preoccupied with them. As long as women's sexuality is

constructed as a passive position waiting for male attentions, their concern with modifying their bodies will continue.

Feminists have politicized the body obsession by showing how it is part and parcel of a system of male control over femininity.

(b) Self-esteem and self value are bound up with the body for women. Within ideologies of femininity, equations are set up between their value and self worth and their bodily attractiveness, such that being attractive = being able to attract a man = being happy = being confident.

(c) As part of the objectification of women's bodies, serving both the capitalist and male-dominated status quo, women's attitudes and emotions towards their bodies and eating are constructed within language and visual imagery, particularly within the media. The attitudes associated with anorexia nervosa and bulimia are not only "normal" and encouraged, but they are particularly encouraged for women. The creation of these attitudes is part of the social prescriptions for women in relation to their bodies and their eating. The following attitudes are socially constructed as a part of femininity itself:

- guilt about eating, particularly indulging in socially constructed "bad" foods, those that are "fattening" and "unhealthy"
- equations between fat and food contribute to maintaining this guilt
- preoccupation with "working on" to improve the body and its fragmented parts towards the socially constructed ideal image

- a judgemental, critical attitude towards the body and its fragmented parts
- preoccupation with the struggle to attain the ideal female body
- negativity with fatness on the body and "fat" people
- the social construction of the ideal body in such a way that fat is set up as all that is negative and thin all that is positive.

These attitudes become an extreme preoccupation for some women, which the medical profession have called anorexic or bulimic. They are also present for "normal" women. They are part and parcel of femininity and not merely social forces which one can reject or accept.

(3) The realm of professionals and the creation of popular wisdom about eating/body problems. Illnesses are negotiated between doctor and client, therapist and client. Academic ideas on eating problems are informed by and serve to inform and mystify popular understandings and attitudes concerning these problems. Culture-bound theorists have drawn attention to the importance of both the therapist relationship as well as academic literature (and its popularized forms) in determining eating/body problems (Swartz, 1985). Anorexia nervosa has become idolized in Western culture, as a problem which is believed to reflect a whole range of things, like an over-dominating mother or a rejection of femininity. It is believed that anorexia nervosa and bulimia (although to a less extent) is invested with positivity and treated with respect and awe, despite the devastating reality of these problems. Susan Sontag (1978) shows

how TB in the nineteenth century was romanticized, becoming a metaphor for higher consciousness, psychological complexity or literary/artistic talent. Similarly, in present Western culture, eating disorders have been romanticized, becoming metaphors for a wide-range of positive characteristics, like intelligence, perfection, the desire for autonomy, the rejection of female socialization. The glorification of such self-destructive syndromes must be challenged. It is further believed that the increasing attention given to these problems may encourage and stimulate their growth by "normalizing" the attitudes and behaviours associated with these problems amongst women.

### 2.5.3 Social/psychological issues

In an understanding of eating/body problems, which does not subscribe to abnormal/normal splits, and is aware of the social, economic and ideological context in which these problems occur, an adequate theory of the human subject is necessary. If one understands the social forces which arise from capitalist, male-dominated culture as being central in determining eating/body problems, then it is essential to articulate how these forces operate on a subjective level. As has been shown constantly in this section, there is a pressing need for a theory of the subject which does not subscribe to social/psychological splits. The eating/body problems among "normal" women and anorexics/bulimics are not merely caused by women's socialization or media pressure to lose weight. In the understanding of how women accept the equations of self-worth = attractiveness to men, develop attitudes of scrutiny towards their body or become

obsessed with dieting, a simple socialization theory is inadequate. For women are not simply socialized to accept these equations. Rather, the acquisition of femininity must be conceived as a complex process in which ideology is transmitted on a largely unconscious level. The female subject is formed within the ideologies which prescribe femininity. Being a female subject means being concerned about one's body and eating. Part of the rules and prescriptions for femininity which are played out on unconscious levels as well as conscious, concern the body and eating, the rewards of dieting and being slim, and the importance of being preoccupied with these objectives.

## CHAPTER 3: METHODS OF RESEARCH

### 3.1 Aims and objectives

This study addresses the area of problems with eating and the body for women, both on a quantitative and qualitative level. It researches the prevalence of attitudes and behaviours associated with anorexia nervosa and bulimia among a sample of South African women students. It is also concerned with exploring the nature of eating/body problems among this sample in a more in-depth manner.

Within these broad aims, three main objectives may be stated as follows:

(1) To collect data concerning the prevalence of attitudes and behaviours associated with anorexia nervosa and bulimia among a South African sample of women. Prevalence statistics among this sample are collected with the goal to compare results with those of studies of a similar nature carried out in Britain and the United States of America. Within this aim no attempts are made to establish the prevalence of the syndromes of bulimia or anorexia nervosa, for it is believed that these diagnoses can not adequately be made from a self-report inventory. Within this objective, prevalence data concerning the following areas were elicited:

(a) Prevalence and frequency of binge eating and methods of weight control, including laxative use, self-induced vomiting, diet pill use, exercise, diuretic use and fasting;

(b) Prevalence of combinations of these behaviours, for example, binge eating together with laxative use;

(c) Prevalence of attitudes associated with eating disorders, including attitudes to weight, the body, eating, dieting and food;

(d) An analysis of the nature of attitudes and behaviours, associated with eating disorders, most prevalent in the community under research;

(e) A methodological investigation of the relevance of the problems arising from different definitions of eating behaviours within the elicitation of their prevalence.

(2) To investigate attitudes towards body shape and size. This aim includes the collection of the following data:

(a) Prevalence of dissatisfaction with the body, its various parts and weight;

(b) Exploration of attitudes to respondent's own body as it is now, if it was thinner and if it was fatter, according to personality, health and attractiveness criteria;

(c) Exploration of respondent's attitudes to the social ideal images for women, according to personality, health and attractiveness criteria.

(3) To investigate the relationships between eating problems and attitudes to the body. This relationship will be investigated quantitatively, through the analysis of the questionnaire data 2

and qualitatively, through the interviews. It is hypothesized that eating problems, as gauged by the respondent's own report and by objective measures, will be associated with dissatisfaction with body and weight. It is further hypothesized that eating problems will be associated with negative attitudes to fatness and positive attitudes to slimness.

(4) To explore the nature of eating/body problems among this sample of women. This will be carried out both quantitatively and qualitatively as follows:

(a) A comparison of those who report an eating problem with the rest of the sample;

(b) A qualitative analysis of depth interviews held with a subsample of those who report an eating problem, with the aims to explore: the nature of these problems; the effect of social pressures in relation to these problems; and the nature of interviewees' attitudes towards eating and the body.

### 3.2 Sampling

The community being researched is that of women students at the University of Cape Town. Participants for the survey study were drawn from four large classes: Psychology I, Zoology I, Economics I and Psychology II/III (the two academic years met together in that lecture course). A stratified sample was achieved in this way: 28% (90 students) from Psychology I; 28% (90 students) from Zoology I; 21% (68 students) from Psychology II/III; and 23% (73 students) from Economics I. The sample spanned a broad range of students, the majority being Arts,

Social Science and Science students - 22% B.A., 21% B.SocSci., 26% B.Sc., 15% B.Comm., 9% M.B.Chb., 5% B.BusSci. and 4% B.A.Llb. The total sample comprised 321 respondents out of 350 questionnaires administered, indicating a 91.7% response rate. A subsample for depth interviews was drawn from this sample and other female university students who considered themselves to have an eating problem. Those who were drawn from the questionnaire sample had volunteered their names in a section on the questionnaire for this purpose (Appendix I, page 337). The others were voluntary candidates who had heard of the research and wished to take part. The only criterion for this sample was the belief that they had an eating problem or had experienced one in the past. This sample comprised 16 women.

### 3.3 Participants

The mean age of the questionnaire respondents was 19.5 years (S.D. = 2.4). Ages ranged from 17 to 35 years, but only ten students were above the age of 25 years. The majority of the women in the sample, 97%, were single (unmarried, never divorced). The majority were classified "white", 88%, while 9%, 2% and 1% were classified "coloured", "indian" and "african" respectively. The sample is representative of the general trend in the "racial" breakdown of students at U.C.T.

The sample had a mean weight of 57.5 kilograms (S.D. = 7.9). 81.8% weighed within 85 - 115% of their mean population matched weight (MPMW) (Geigy, 1962), while 12.6% weighed more than 115% and 5.6% weigh less than 85% of their MPMW.

Participants of the subsample had a mean age of 24.6 years, with five of them above the age of 25 (one-third of the sample) and 5 below the age of 21. All interviewees were classified "white". Two of them had been married and divorced with one remarried, while the rest were single unmarried women. The majority of them were Social Science and Art students. All but one of them weighed between 85 - 115% of the MPMW (Geigy, 1962), the one participant weighing less than 85%.

### 3.4 Apparatus

#### 3.4.1. The questionnaire

The self-report questionnaire was made up of five different sections, including two standardized inventories, the Eating Attitudes Test and the Body Cathexis Scale; self-report items on eating/dieting behaviour; self-rating and social ideal rating scales; and demographic items (refer to Appendix I).

##### 3.4.1 (i) The Eating Attitudes Test (EAT)

The 40-item version of the Eating Attitudes Test (EAT) (Appendix I, page 326-327) developed by Garner and Garfinkel in 1979, has been used most widely to elicit the prevalence of anorexia nervosa, bulimia and associated problems. The EAT was originally developed as a screening device for anorexia nervosa and proposed as an objective, self-report measure of the symptoms of the latter. It consisted of 40 items eliciting the presence of both attitudes and behaviour associated with the disorders of anorexia nervosa and bulimia. Each item is answered on a six-point Likert

scale, ranging from experiencing the item under question from always, very often, often, to sometimes, rarely, never. Using two groups of female anorexia nervosa patients (N = 32 and 33) and female control subjects (N = 34 and 59), a high level of concurrent validity was found ( $r = 0.87$ ,  $p < 0.001$ ) (Garner and Garfinkel, 1979). There has been skepticism concerning the EAT's use as a screening device for anorexia nervosa by those using it among samples of students (Garner and Garfinkel, 1980; Button and Whitehouse, 1981). It is maintained that positive predictive values are low (Williams, Hand and Tarnopolsky, 1982). These authors claim that out of 100 high EAT scorers only 19 are diagnosable as anorexics. For the purposes of this research this criticism is of no importance, given that it is not the stated intention to report on the prevalence of diagnosable anorexics but to investigate the prevalence of the attitudes and behaviours which are elicited by the EAT.

The EAT has been factor analyzed, resulting in the creation of a shorter inventory, the EAT-26, consisting of 26 items rather than 40 (Garner et al., 1982). Through this analysis and another factor analysis on the EAT (Wells et al., 1985) what the EAT was actually measuring became clearer (refer to Chapter 1, Section 1.3.2). Both these analyses yielded similar factors, despite the fact that the one was carried out with anorexics (Garner et al., 1982) while the other was carried out with a "normal" population of school girls (Wells et al., 1985). Both of these yielded a major dieting factor; a food preoccupation factor; and a social pressure to eat/oral control factor. In both studies the dieting

factor dominated EAT-40 and EAT-26 scores and was most highly correlated with the total EAT scores.

The EAT has been used widely within prevalence studies among university and college students, school girls, female family planning clinic attenders (Garner and Garfinkel, 1980; Button and Whitehouse, 1981; Mann et al., 1983; Cooper, Waterman and Fairburn, 1984; Cooper and Fairburn, 1983; Clarke and Palmer, 1983; Meadows et al., 1986) (Refer to Chapter 1, Section 1.3.2 for a review of their results).

The EAT is scored using Garner and Garfinkel's (1979) method of collapsing the three categories at the non-anorexic end of the six-point Likert scale for each item. In this study total EAT scores were calculated as well as subscale scores using the four factors arising from Garner et al.'s (1982) factor analysis. An EAT score greater than 30 was considered to be in the "anorexic range", following Garner and Garfinkel's (1979) suggested cut-off point. A factor analysis on the EAT is carried out with the view to establishing what the EAT is measuring within this particular sample of women.

#### 3.4.1 (ii) Measure of eating behaviours

The presence of eating/dieting behaviour, associated with the anorexia nervosa and bulimia, is elicited with the aid of self-report items drawn from those used by a number of prevalence studies in the area, in particular from Pyle et al. (1983) but, also from Halmi et al. (1981) and Cooper and Fairburn (1983) (Appendix I, page 328-330). These items elicit data on the

following: methods of weight control, presence of experiences of binge eating, frequency of binge eating (both in the month previous to the questionnaire and in the month when it occurred most frequently), frequency of self-induced vomiting, laxative use, diet pill use, water pill use, fasting, chewing/spitting out food (both within last month and within month when it occurred most frequently). Respondents were also asked whether they considered themselves to be binge-eaters, compulsive eaters or as having an eating problem. Within this section, two definitions of binge eating were used in eliciting the presence of the behaviour: Cooper and Fairburn's (1983) "episode of uncontrollable excessive eating; and Pyle et al.'s (1983) "experience of rapidly eating a large amount in a short period of time in such a way that you would be embarrassed if others saw you" (refer to Chapter 4, Section 4.1.1).

#### 3.4.1 (iii) Body cathexis scale

A combination of Secord and Jourard's (1953) body cathexis scale and Berscheid, Walster and Bohrnstedt's (1973) body satisfaction inventory, was utilized to measure the respondent's satisfaction with her body and its parts (Appendix I, page 330-333). Secord and Jourard (1953) reported the corrected split-half reliability for this scale as 0.78 for males and 0.83 for females (Robinson and Shaver, 1973). Tucker (1981) established test-retest reliability at 0.87 suggesting that the body cathexis scale is stable over time. The original scale comprised of forty-six items, although most studies have employed a modified 40-item version. A five-point Likert scale, ranging from very positive

to very negative was used originally. The present study employs only fifteen body parts, drawn from those suggested by Jourard and Secord (1955) to be most salient for women. Three items were added to their original items, overall body, buttocks and stomach, utilized by Berscheid et al. (1973). Following Berscheid et al. (1973) a six-point Likert scale was utilized, ranging from extremely satisfied, quite satisfied, only just satisfied, to only just dissatisfied, quite dissatisfied, extremely dissatisfied.

#### 3.4.1 (iv) Self-rating and social ideal rating-scales

These were drawn up by the author and follow a repertory grid format, with three self elements ("self with body as it is now", "self much thinner", "self much fatter") and three social ideal elements ("typical photographic model", "slim teenager", "athletic woman") (Appendix I, page 333-336). A seven-point rating scale was used to rate the elements in terms of eight bipolar constructs, comprising personality constructs (assertive, well-liked, in control), physical appearance/attractiveness constructs (glamorous, attractive body, sexually attractive) and physical well-being constructs (healthy, energetic). The constructs were drawn from a combination of those used in a cross-cultural study by Furnham and Alibhai (1983) and from the elicitation of constructs using the method of triads (Fransella and Bannister, 1977) carried out with a small sample of female students at the University of Cape Town. Elements received a total score by addition of scores on each construct.

#### 3.4.1 (v) Elicitation of demographic details

A number of demographic details were elicited including data on the following (Appendix I, page 324-326): age; weight; highest weight; lowest weight; ideal weight (what they would like to weigh); the degree to which they consider themselves to be overweight or underweight; weight as a child; height; registered degree; marital status; "race" as classified in South Africa; religion; place of residence; and frequency of exercise .

Respondents were also required to indicate whether they had ever received treatment for an eating disorder, weight problem or drug/alcohol abuse problem and by whom (doctor, psychiatrist, dietician, etc.). Weight fluctuations, differences between ideal weight and actual weight and % of matched population mean weight (MPMW), for each respondent were calculated (Geigy, 1962).

#### 3.4.2 Depth interviews

Depth interviews were held with the subsample. Two interviews between one to two hours were held with each interviewee. Two semi-structured interview schedules were utilized (Appendix II and Appendix III). The first one elicited data regarding the following broad areas: eating/dieting behaviour, including methods of weight control and bingeing; attitudes related to food and eating; the history of the problem; phases the problem has been through; the relationship between eating and emotions/moods; issues of control concerning eating; family and friends' attitudes to the problem; aid sought for the problem; the interviewee's understanding of her problem; and her understanding

of eating disorders in general. The second interview involved the following broad areas relating to the body: satisfaction with the body/weight and body parts; general feelings about the body; consciousness of the body; history of body consciousness; relationship between eating and body image; attitudes towards fatness and slimness; notions of an ideal body image; and impressions concerning why the social ideal image has become so slim. This interview also involved the collection of background material concerning the family and personal history, personality (particularly the presence of "perfectionism" and conscientiousness), habits and social activities. The presence of a feminist consciousness, including ideas concerning women's oppression, was elicited as well. Interviewees were further asked to express their ideas concerning solutions to eating/body problems among women.

A tape-recorder was employed for recording the interview material.

### 3.5 Procedure

#### 3.5.1 The questionnaire survey

The questionnaires were handed out to four large classes 10 - 15 minutes before the end of their lecture. The four samples were informed that the data was being collected for a prevalence study concerning attitudes and behaviours associated with anorexia nervosa and bulimia. They were told that the questionnaires were anonymous, although there was a space provided for those interested in speaking more about the issues to fill in their

name and phone number. Men in the classes were asked to leave before the women were informed as to the purpose of the questionnaire. Respondents voluntarily stayed behind to fill in the questionnaires.

Questionnaires were coded and the data was placed on computer for statistical analysis.

### 3.5.2 The interview study

Respondents from the questionnaire sample were contacted by telephone and asked if they would like to be interviewed. They were informed of the time commitment involved (two interviews) and the nature of the two interviews. As many of these respondents as possible were contacted. Other interviewees who approached the researcher on their own accord were asked if they considered themselves to have an eating problem, and then informed of the practical issues as regards the interviews.

The two interviews were held within a couple of days of each other. The interviews were carried out in an informal manner, with interviewees being encouraged to ask questions or express dissatisfaction or uneasiness with questions. The interview questions were elicited in a semi-structured way with the utilization of counselling techniques when necessary. The interviewee was asked at the beginning if taping was acceptable to her and reassured of the anonymity of the interview material.

The taped interviews were transcribed.

### 3.6 Analysis

#### 3.6.1 Questionnaire analysis

Data analysis was carried out using the BMDP statistical package (Dixon, 1981), including simple descriptive analyses, cross-tabulations, t-tests, chi-square tests, correlations and factor analyses.

#### 3.6.2 Interview analysis

Transcriptions from the interviews were content analyzed. The questions used in the interviews covered four broad areas and provided the predetermined categories for these analyses: (1) the nature of the eating problem; (2) social pressures on the interviewee in relation to eating, the body and her eating problem; (3) attitudes to food and eating; (4) attitudes to the body, its appearance, shape and size. Within each of these predetermined categories, emergent categories were developed. These formed sub-categories and reflected the similarities and trends which emerged from the responses of the interviewees.

## CHAPTER 4: THE RESULTS OF THE SURVEY STUDY

### 4.1 Introduction

In this chapter, the results of the questionnaire survey are reported. These results are presented in four different sections corresponding with the aims of the survey as outlined in Chapter 3:

(1) Prevalence of attitudes and behaviours associated with the disorders of anorexia nervosa and bulimia. In this section, a wide variety of prevalence findings are reported. These include: self-reported prevalence of anorexia nervosa and bulimia; the prevalence and frequency of binge eating and methods of weight control; the scores on the EAT; results of a factor analysis on the EAT; and the prevalence of more than one behaviour associated with anorexia nervosa and bulimia. The prevalence findings concerning the behaviours and attitudes associated with eating disorders are compared with findings of other studies. Finally, methodological problems concerning these findings are reported.

(2) An investigation of attitudes towards the body. In this section, results concerning body affect, including feelings towards respondent's own bodies and other shapes, are reported. These findings are compared with those of other studies.

(3) An investigation of the relationship between eating problems and attitudes to the body. In this section, findings concerning the relationship between EAT scores and the various measures of attitudes to the body, are reported. The relationship between body affect towards respondents' own bodies as well as other shapes and their eating attitudes and behaviour is examined.

(4) An investigation of those who consider themselves to have an eating problem. This group is focussed on both because they comprise almost one-third of the sample and because it is from this group that most of the interviewing subsample was drawn. In this section, this group is viewed in relation to the rest of the sample in order to highlight the way in which this group differs from the rest.

Throughout the presentation of the results the sample is considered as a unitary group. There was no reason to differentiate in terms of the different classes represented (Psychology I, Psychology II/III, Zoology I, Economics I) as no significant differences emerged on most variables (t-tests). The sample was not stratified in terms of "race" either as no significant differences emerged on any of the variables.

## 4.2 Prevalence of behaviours and attitudes associated with anorexia nervosa and bulimia

### 4.2.1 Findings concerning anorexia nervosa and bulimia

No attempt was made to diagnose cases of anorexia nervosa or bulimia from the questionnaire sample. It was believed that the questionnaire data was insufficient for such diagnoses. Rather the attitudes and behaviours associated with and central to these syndromes were investigated. According to the respondents' own reports, four of them had been diagnosed as having anorexia nervosa while the same amount, four, had been diagnosed as having bulimia (1.25%). Two of those reporting anorexia nervosa also reported bulimia. Two of the anorexics reported being treated by doctors (general practitioners), one by a psychologist and one by a psychiatrist. Of the four bulimics, one was treated by a doctor, three by a psychologist, one by a psychiatrist and one by a dietician. None of the anorexic or bulimic women in the sample had been hospitalized for the disorder.

### 4.2.2 Prevalence and frequency of behaviours associated with eating disorders

Two definitions of binge eating were used in eliciting the prevalence of this behaviour:

(1) Cooper and Fairburn (1983) use the definition of "an uncontrollable excessive eating episode". For these authors current bingeing refers to an episode of this nature within the last two months.

(2) Pyle et al. (1983) refer to bingeing as "repeated experiences of rapidly eating a large amount in a short period of time in such a way that you would be embarrassed if others saw you". These authors elicit the prevalence by allowing for four different options: no; no, but I have had infrequent binge eating episodes; yes, but I no longer binge-eat; yes, and I still binge-eat. One would assume that only a positive response to the last option would refer to current binge eating.

Table 4.1: Prevalence of binge eating

	number of subjects	% of sample
Ever had an episode of uncontrollable excessive eating	115	35.9
Experienced an episode in the last two months	70	21.9
Ever had an experience of rapidly eating a large amount in a short period of time in such a way that you would be embarrassed if others saw you (binge-eating, gorging or bulimia):		
- infrequent episodes	91	28.7
- frequent episodes in the past	14	4.4
- frequent episodes at present	23	7.3
- total	128	40.7

As Table 4.1 shows, according to both definitions of binge eating, as many as 35 - 40% of women in this sample have ever had an episode of this nature. By Cooper and Fairburn's definition, as many as 21.9%, one-fifth of the sample, are currently doing so. ✓

By Pyle et al.'s definition, only 7.3% are currently bingeing with some frequency, while 33.1% have done so in the past or are doing so infrequently.

The frequency of binge-eating was elicited without the provision of a definition. Thus respondents were either applying the definitions above, or their own definitions. Respondents were requested to indicate the frequency of this behaviour within the one month period when it occurred most frequently as well as in the period of the previous month.

~~Table 4.2: Frequency of binge eating\*~~

	never	less than once a week	more than once a week	about once daily	more than once daily
during last month	226 71.1%	60 18.9%	25 7.9%	5 1.6%	2 0.6%
during month when most frequent	183 57.5%	85 26.7%	38 11.9%	7 2.2%	5 1.6%

\* Respondents used their own criteria for binge eating

From Table 4.2 it is clear that the prevalence of binge eating on a daily basis is relatively uncommon, constituting 3.8% of the sample in the one month period when the behaviour occurred most commonly.

The prevalence of methods of weight control was elicited in a number ways: Firstly, respondents were asked to indicate their

methods of weight control (Table 4.3); secondly, the frequency of these behaviours within the one month period when they occurred most often (Table 4.4); and thirdly the frequency of these behaviours within the last month period (Table 4.5).

Table 4.3: Prevalence of methods of weight control

	number of subjects	% of sample
exercise	216	67.5
strict diets	50	15.6
fasting	49	15.3
diet pills	39	12.2
laxatives	30	9.4
self-induced vomiting	20	6.3
chewing/spitting out food	5	1.6
diuretics	1	0.3

In Table 4.3 methods of weight control are reported in order of frequency. From Table 4.4 and Table 4.5 it is clear that more subjects report these behaviours as ever occurring than currently occurring. This illustrates that more respondents have a history of these behaviours than are presently practising them. This highlights the phasic character of these behaviours.

Table 4.4: Frequency of vomiting, fasting, laxative and dietpill use within the one month when it occurred most frequentl

	never	less than thanonce a week	more than once a week	about once daily	more than once daily
self-induced vomiting	289 90.9%	11 3.5%	12 3.8%	2 0.6%	4 1.3%
laxatives	273 86.1%	23 7.3%	9 2.8%	11 3.5%	1 0.3%
dietpills	263 83%	18 5.7%	14 4.4%	13 4.1%	9 2.8%
fasting	236 74.7%	54 17.1%	19 6%	5 1.6%	2 0.6%

\* All percentages provided are of the total sample

Table 4.5: Frequency of vomiting, fasting, laxative and dietpill use within the last month

	never	less than once a week	more than once a week	about once daily	more than once daily
self-induced vomiting	300 94%	12 3.8%	3 0.9%	1 0.3%	3 0.9%
laxatives	300 94%	10 3.1%	3 0.9%	2 0.6%	3 0.9%
diet pills	299 94%	5 1.6%	9 2.8%	2 0.6%	3 0.9%
fasting	273 86.1%	33 10.4%	8 2.5%	3 0.9%	- -

\*All percentages provided are of the total sample

Table 4.6: Comparison of findings with other studies: Prevalence of binge-eating, self-induced vomiting and laxative use\*

	Hawkins & Clement (1980)	Halmi, Falk & Schwartz (1981)	Clarke & Palmer (1983)	Cooper & Fairburn (1983)	u s
sample	college students	summer school students <sup>1</sup>	college students	women at family planning clinic	
size	182	355	206	369	
response rate (%)	-	66	76	96	
measure used	self-report	self-report	EAT	EAT plus self-report	s
age (mean $\pm$ SD)	-	25.6 $\pm$ 10.7	19.2 $\pm$ 0.8	24.1 $\pm$ 5.5	19
binge-eating ever (%)	-	68.1	46.2	26.4	
current(%)	79	53.8	30.2	20.9	2
at least weekly(%)	33	-	7.1	7.3	
self-induced vomiting ever (%)	4.9	22.1	5.8	6.5	
current(%)	-	11.9	1.3	2.9	
at least weekly (%)	-	1.7 <sup>3</sup>	0	1.1	2.
laxative use current (%)	-	4.8 <sup>3</sup>	7.0	4.9	5.
exercise as weight control (%)	-	4.5 <sup>3</sup>	-	7.3	67.

\* This table drawn from Fairburn (1984) with own findings added

1 59.8% of this sample were female.

2 The first figure is by Cooper and Fairburn's criteria, the second by Hawkins and Clement's criteria

3 These figures are for the whole sample, remaining for female respondents only.

The prevalence of the behaviours associated with bulimia and anorexia nervosa found in this study are similar to those found overseas, as is indicated in Table 4.6. Only exercise as a means of weight control stands out as considerably higher than both the other studies' findings (Cooper and Fairburn, 1983; Halmi, Falk and Schwartz, 1981). This finding is perhaps related to the current cult of fitness which emphasizes exercise and perhaps had not yet filtered through at the time of the other studies' collection of data.

#### 4.2.3 EAT scores

Table 4.7 is a summary of results from the Eating Attitudes Test (EAT). 11.9% are found to score in the "anorexic range" (score greater than 30), which indicates that more than one-tenth of the sample score as high as those with diagnosed anorexia nervosa do. The mean score for the sample is 15.34.

Table 4.7: Eating attitude scores

	Below 20	Above 20	Above 30	Above 40
full sample (314 - 7 incomplete)	235 74.8%	39 23.2%	21 11.8%	19 6.1%

These findings are similar to those of other studies, but are one of the highest results found as is clear from Table 4.8. This sample also scores higher on individual items in comparison with the other study which reports findings on individual items (Refer to Appendix IV: Table i)

range, weighing between 85 and 115% of matched population mean weight, or MPMW (Geigy, 1962). 12.6% weigh above 115% and 5.6% below 85%. Furthermore, the large majority of the sample, 91.6% desire to weigh less than they do, while only 6.4% desire to weigh what they do at present and 1.9% desire to weigh more. The mean ideal weight of the sample (53.05 kilograms), that is what respondent's reported they would like to weight, is 4.43 kilograms less than their actual weight (57.48 kilograms).

Table 4.9: EAT items: Dieting and weight consciousness

EAT item	Total positive response	often	very often	always
Terrified about being overweight	108 33.6%	47 14.6%	34 10.6%	27 8.4%
Aware of the calorie contents of foods that I eat	99 30.8%	53 16.5%	22 6.9%	24 7.5%
Particularly avoid foods with high carbohydrate content (e.g bread, rice, etc.)	68 21.2%	37 11.5%	25 7.8%	6 1.9%
Think about burning up calories when I exercise	122 38%	64 19.9%	26 8.1%	32 10%
Display self control around food	95 29.6%	63 19.6%	27 8.4%	5 1.6%
Engage in dieting behaviour	87 27.1%	34 10.6%	38 11.8%	15 4.7%

Table 4.8: Comparison of findings with other studies: EAT scores of "normal" women

Study	Sample	Mean EAT score	% in "anorexic range"*
Garner & Garfinkel (1979)	59 students	15.6	13
Button & Whitehouse (1981)	446 students	12	6.3 <sup>1</sup>
Cooper & Fairburn (1983)	369 clinic attenders	11.4	-
Clarke & Palmer (1983)	156 students	-	11.5
Mann et al. (1983)	262 schoolgirls	9.6 <sup>2</sup>	6.9
Meadows et al. (1986)	411 female G.P. clients	12	6.8
Present study (1986)	321 students	15.34	11.8

\* "anorexic range" = score > 30

1 using an EAT score > 32 for "anorexic range"

2 using the EAT-26, >20 = "anorexic range"

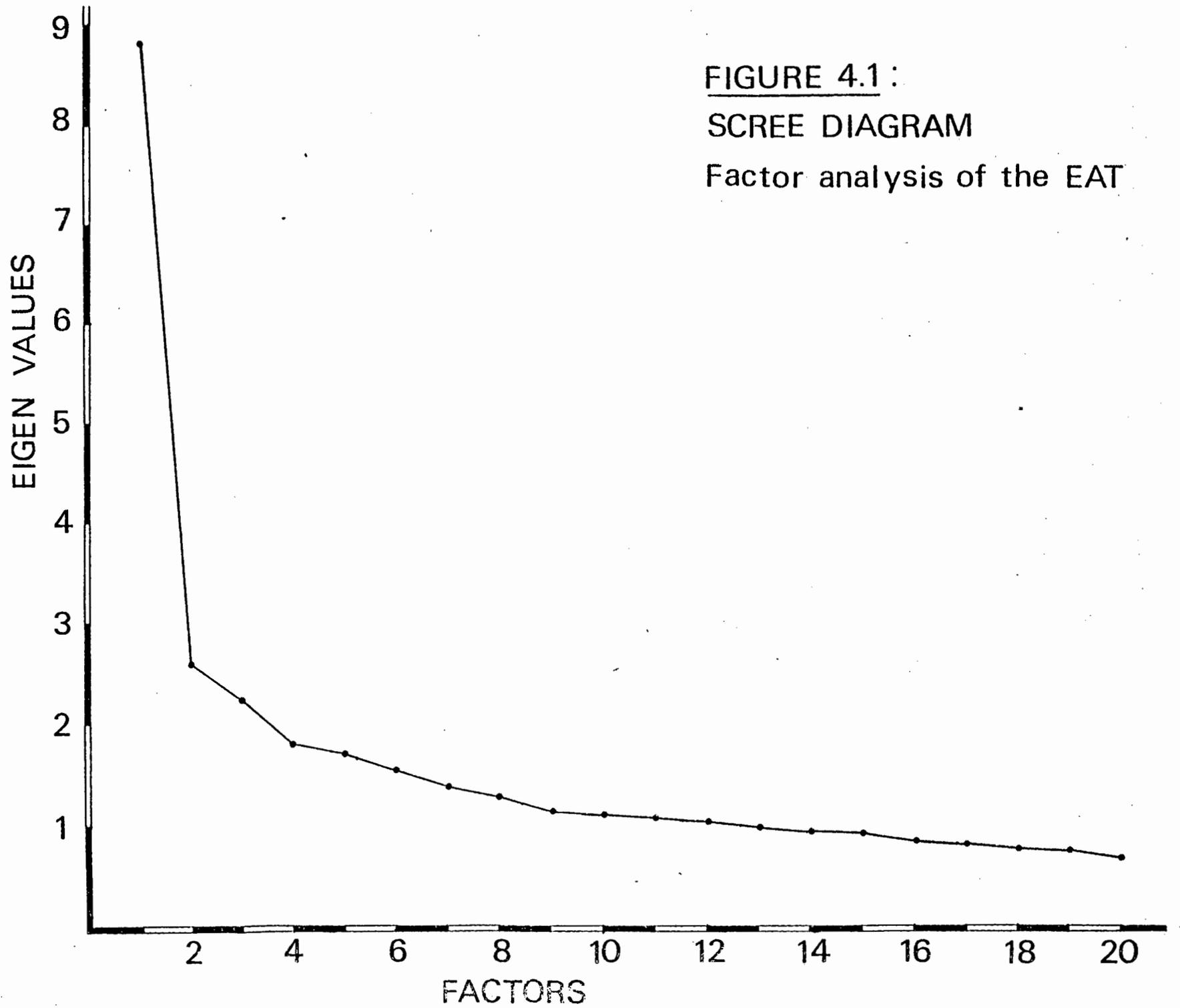
Table 4.9 and Table 4.10 show how the items relating to concern/preoccupation with food/eating/diet and body/weight were the most widely responded to positively. The concern with weight indicated here is supported by the finding that 76.8% of the sample consider themselves to be overweight (5.3% very overweight, 16.6% quite overweight, 54.9% slightly overweight). 19.1% consider themselves to be the correct weight and 4.1% consider themselves to be slightly underweight. This is despite the finding that 81.8% of the sample are within an average weight

Table 4.10: Eat items: Food and body preoccupation

	Total positive response	often	very often	always
Am preoccupied with a desire to be thinner	124 38.7%	48 15%	28 8.7%	48 15%
Am preoccupied with the thought of having fat on my body	104 32.3%	39 12.1%	30 9.3%	35 10.9%
Find myself preoccupied with food	92 28.7%	48 15%	23 7.2%	21 6.5%
Give too much time and thought to food	95 29.6%	39 12.1%	32 10%	24 7.5%

#### 4.2.4 Factor analysis on the EAT

From the individual items reported above, it is clear that attitudes and behaviours relating to body/weight and food/dieting preoccupation are widespread among this sample. The predominance of these attitudes is also borne out by the factor analysis, using principal components extraction with varimax rotation, carried out on the EAT scores from this sample. Inspection in the light of Cattell's (1966) scree test suggested three or six factors, accounting for 34.1% and 46.9% of the variance respectively (See Figure 4.1). The three-factor solution with items loading above 0.40 on each factor is shown in Table 4.11. The major factor to emerge, accounting for 22% of the variance, includes items relating to food and body preoccupation. A second factor relating to dieting and food control accounted for 6.5% of



the variance. A third factor, accounting for 5.6% of the variance, included both vomiting items and social pressure to eat and gain weight items, forming a food control/vomiting factor. Laxative use does not feature in this analysis. Rotation with six-factors yielded the same two major food/body preoccupation and diet/restraint factors. Factor three related to vomiting, factor four to laxative use and factor five to social pressure to eat and gain weight. Factor six emerged as a social eating factor (for example, "like eating with other people", "enjoy eating at restaurants").

The factors emerging for this sample are similar to those found in overseas samples by Wells et al. (1985) and Garner et al. (1982). The dieting factor, factor two, that emerged in this study is similar to both these studies' factor one, called "dieting". Factor one in this study, the food/body preoccupation factor is similar to factor two of the other two studies, which they call "food preoccupation" and "bulimia and food preoccupation" respectively. Like Wells et al.'s (1985) study, vomiting was found as a separate factor while Garner et al. (1982) found it as a part of their factor two. Unlike Wells et al. (1985) laxative use, in the six-factor rotation, also formed a separate factor while it was a part of their factor three, "vomiting/laxatives" factor. Factor five in this study (six-factor rotation) corresponds with Wells et al.'s (1985) factor four, "social pressure to eat" and includes items of Garner et al.'s (1982) factor three, "oral control". Factor six is similar to that found by Wells et al. (1985) when they rotated with six

factors and called it a "social eating" factor.

This study differs from the other two in that the food/body preoccupation accounts for a greater amount of the variance than in the other two analyses. Although dieting does appear to play an important role, food preoccupation together with body/weight concern appear to be of more significance in determining the scores of this sample. Furthermore, in this sample, body and food preoccupation appear together in one factor while in the other two studies the body preoccupation items appeared with the dieting factors, although they did load on the food preoccupation factor for Wells et al. (1985) as well. It is clear therefore that within this sample, preoccupation with the body is related to preoccupation with food and controlling intake. This study also differs from the other two in that with the three-factor rotation, vomiting and social pressure to eat are found in the same factor. Neither of the other two studies found this and Garner et al. (1982) found vomiting in the same factor as bingeing and food preoccupation, therefore associated with lack of control over eating, rather than with control as in this sample.

Table 4.11: EAT factor structure

item number	item content	factor loading
<u>Factor 1: Food/body preoccupation</u>		
34	Give too much time and thought to food	.804
6	Find myself preoccupied with food	.796
31	Feel that food controls my life	.792
15	Am preoccupied with a desire to be thinner	.756
25	Am preoccupied with the thought of having fat on my body	.749
14	Feel extremely guilty after eating	.746
7	Have gone on eating binges where I feel that I may not be able to stop	.645
4	Am terrified about being overweight	.617
11	Feel bloated after meals	.593
3	Become anxious prior to eating	.518
<u>Factor 2: dieting</u>		
29	Avoid foods with sugar in them	.699
30	Eat diet foods	.674
10	Particularly avoid foods with high carbohydrate content (e.g.bread, rice, etc.).	.657
37	Engage in dieting behaviour	.614
9	Aware of the calorie content of foods that I eat	.505
22	Think about burning up calories when I exercise	.473
38	Like my stomach to be empty	.447
32	Display self-control around food	.412
36	Feel uncomfortable after eating sweets	.411
5	Avoid eating when I'm hungry	.402
<u>Factor 3: Vomiting/social pressure to eat</u>		
40	Have the impulse to vomit after meals	.607
17	Weigh myself several times a day	.596
24	Other people think that I am too thin	.573
33	Feel that others pressure me to eat	.552
12	Feel that others would prefer if I ate more	.549
13	Vomit after I have eaten	.530

#### 4.2.5 Prevalence of combinations of symptoms

Although some of the behaviours associated with eating disorders are widespread among this sample, with binge eating having been experienced by more than one-third of the sample, it appears that the occurrence of more than one symptom is not as common. The symptom-formation of bulimia, that is, binge eating with purging (vomiting or laxative abuse) is relatively uncommon (Table 4.12). With both definitions of binge eating used in this study, the occurrence of this behaviour together with either vomiting or laxative use (stipulated as weight control) is infrequent.

Table 4.12: Prevalence of more than one bulimic symptom\*

behaviours	number	% of sample
<u>Binge eat: Pyle et al.'s (1983) criteria</u>		
Binge eat <u>ever</u>	128	40.7
Binge + vomit	12	3.78
Binge + use laxatives	12	3.78
Binge + vomit + laxatives	5	1.57
<u>Binge eat: Cooper and Fairburn's (1983) criteria</u>		
Binge eat <u>current</u>	23	7.3
Binge + vomit	2	0.6
Binge + use laxatives	3	0.94
Binge + vomit + laxatives	2	0.6
<u>Binge eat: Cooper and Fairburn's (1983) criteria</u>		
Binge eat <u>ever</u>	115	35.9
Binge + vomit	9	2.8
Binge + use laxatives	13	4.1
Binge + vomit + laxatives	2	0.6
Binge eat <u>current</u>	70	21.9
Binge + vomit	5	1.6
Binge + use laxatives	10	3.2
Binge + vomit + laxatives	1	0.3

\* All percentages provided are of the total sample

It is quite clear that many of those who binge, by both definitions, are not self-inducing vomiting, using laxatives or practising other behaviours associated with bulimia. Although the prevalence of the weight control methods is higher among those who binge more frequently, there appear to be many who carry out certain weight control measures but do not binge (Appendix IV, Table ii and Table iii). For example, 21.7% of those presently bingeing (Pyle et al.'s definition, 1983) also use laxatives, while 6.9% of those not bingeing do so. The use of more than one form of weight control is not very common either, for less than 5% of the sample practise any combination of two of these weight control methods (Table 4.13).

Table 4.13: Prevalence of more than one weight control method\*

methods of weight control	number	% of sample
Vomiting and laxatives	7	2.2
Vomiting and strict dieting	5	1.6
Vomiting and dietpill	8	2.5
Vomiting and fasting	8	2.5
Laxatives and strict dieting	8	2.5
Laxatives and dietpill	10	3.1
Laxatives and fasting	9	2.8
Strict dieting and dietpill	14	4.4
Strict dieting and fasting	15	4.7
Dietpill and fasting	14	4.4

\* All percentages provided are of the total sample

From the above it is clear that the behaviours associated with bulimia are not uncommon, yet the combination of more than one behaviour with others, as is required for a diagnosis of bulimia is relatively uncommon. Slightly more than one-third (36.7%) of the sample is not practising any of the symptoms associated with bulimia, that is binge eating, self-induced vomiting, laxative use, dietpill use, fasting and strict dieting. That is two thirds of the sample are presently engaged in at least one of these behaviours.

#### 4.2.6 Methodological issues concerning prevalence findings

In reporting the prevalence findings of this survey, an important methodological issue emerges. Different definitions of the behaviours under research are shown to yield different prevalence findings. This is particularly clear with the binge-eating items. Two definitions of binge eating were employed partially for this reason (Pyle et al., 1983; Cooper and Fairburn, 1983). Although appearing to be similar in terms of prevalence rates for ever bingeing, on closer inspection it is clear that a different group of respondents is in fact responding to the two different items. Thus although the items are equally responded to, they do not appear to correlate well with each other as Table 4.14 illustrates.

Table 4.14: A comparison of the prevalence of binge eating using different definitions

		Cooper and Fairburn's criteria (1983)		
		ever binge		
		no	yes	total
Pyle et al.'s criteria (1983)				
no	155	82.5%	17.6%	188
		76.7%	28.9%	
yes	47	36.7%	63.3%	128
		23.3%	71.1%	
total	202		114	316
current bingeing				
no	237	81.7%	18.3%	290
		97.5%	75.7%	
yes	6	26.1%	73.9%	23
		2.4%	24.3%	
total	243		70	313

\* Percentages provided refer to those of row and column totals, with the top figure referring to the former and the bottom to the latter

It is evident that more than a third (36.7%) who answer positively to Pyle et al.'s (1983) definition of ever bingeing answer no to Cooper and Fairburn's (1983) definition. Almost a third (28.9%) of those answering yes to the former answer no to the latter. The discrepancy is even greater when it comes to the definition of current bingeing. As many as 75.7% of those who answer yes to Cooper and Fairburn's (1983) definition of current bingeing answer no to Pyle et al.'s (1983) definition. And 26% of

those who answer yes to the latter answer no to the former. Pyle et al.'s (1983) definition does appear to include the majority of Cooper and Fairburn's (1983) current bingers (74%), but the same does not apply vice-versa.

Summary:

Results of the prevalence of attitudes and behaviours associated with the eating disorders of anorexia nervosa illustrate a number of issues concerning the nature of these problems in the community under research. These results and the conclusions arising from them may be summarized as follows:

(1) Attitudes relating to food/eating and the body/weight are widespread, with more than 30% of the sample being at least often preoccupied with a desire to be thinner and the thought of fat on their body; terrified about being overweight; aware of the calorie contents of foods they eat; and think about burning up calories when they exercise. Almost 30% are also preoccupied with food and feel that they give too much time and thought to food. The vast majority (76.8%) consider themselves to be overweight and over 90% wish to lose weight. ✓

(2) The behaviours associated with the eating disorders are by no means uncommon. Binge eating is particularly widespread, with more than 20% currently doing so according to one definition of current binge eating (Cooper and Fairburn, 1983). Self-induced vomiting and laxative use as a means of weight control are not as common (less than 9%), but more than 12% of the sample use strict diets, fasting and dietpills to control their weight. As many ✓

as 67.5% of the sample use exercise to control their weight.

(3) The prevalence of more than one behaviour is low. Not many respondents (less than 5%) use more than one means of weight control or behaviour associated with bulimia or anorexia nervosa.

(4) The prevalence of behaviours occurring on a daily basis, is low. However, less frequent occurrences of these behaviours is more common.

(5) The behaviours appear to have a "phasic" nature. More respondents report the behaviours under question as occurring ever than at present. This illustrates that a history of phases of practising these behaviours is common among this sample. For example, 6% of the sample report current self-induced vomiting, while 10% report it ever occurring; 6% report laxative use within the last month while 14% report ever using them; 6% report using dietpills within the last month while 17% report ever having used them. It is clear that the least discrepancy is found with self-induced vomiting, perhaps illustrating the long-term pervasiveness of this symptom.

(6) The prevalence of attitudes and behaviours associated with the eating disorders found in this sample are similar to those found in overseas studies. In terms of both attitudes and behaviours the prevalence found in this sample is one of the highest reported.

(7) From a methodological perspective, the results concerning the prevalence of the behaviours illustrates the discrepancies

that can arise between the results of similar studies when utilizing different definitions. This was illustrated with the binge-eating items. Two definitions were used and it was evident that about a third of each group who responded positively to the one definition did not respond positively to the other.

#### 4.3 Attitudes to the body

##### 4.3.1 Results on the body cathexis scale

Results on the EAT indicate widespread concern with body size, fatness/thinness and weight. The body cathexis scale was used as another measurement of attitudes towards the body, i.e. as an indication of the level of satisfaction with different body parts. The mean score on this scale is 3.18 which falls between only just satisfied and only just dissatisfied on the six-point scale from extremely satisfied (1) to extremely dissatisfied (6). Results as provided in Table 4.15 indicate widespread dissatisfaction with the torso area. More than half of the sample show some dissatisfaction with their thighs, buttocks, stomachs and weight, while almost half show some dissatisfaction with their overall body and hips. Thighs are by far the most widespread area of dissatisfaction. The strength that the torso area and weight has in determining the overall satisfaction with the body is also borne out by a varimax rotation factor analysis, extracting principal components, on this scale in which four major factors emerge. The most significant one, accounting for almost a third of the variance (29%) includes weight, overall body shape, hips, stomach, waist, thighs and buttocks. Weight

correlates most highly with this factor. The extreme dissatisfaction with weight has also been illustrated by the widespread desire to lose weight in this sample (refer to Section 4. Shoulders, feet, ankles and neck received relatively high ratings, with 6.9%, 12.9%, 10.1% and 5.6% dissatisfied respectively.

These results are similar to those found by Berscheid et al. (1973) in the U.S.A., except that the present sample are slightly more dissatisfied on all body parts (about 5% on average).

Table 4.15: Satisfaction and dissatisfaction with body parts

	quite or extremely dissatisfied		any <sup>1</sup> dissatisfaction		any <sup>2</sup> satisfaction		quite or extremely satisfied	
thighs	153	47.9%	211	65.9%	109	34.1%	65	24.4%
buttocks	142	44.4%	191	59.7%	129	40.3%	76	23.8%
stomach	102	32.2%	172	54.1%	147	45.9%	116	36.3%
weight	95	29.7%	172	53.8%	148	46.2%	90	28.1%
overall body	80	25.0%	158	49.5%	161	50.5%	103	32.3%
hips	91	29.1%	154	48.6%	164	51.4%	113	35.4%
waists	57	17.8%	110	34.4%	210	65.6%	153	47.8%
breasts	40	12.6%	77	24.1%	243	75.9%	188	58.3%
calves	32	10.0%	63	19.7%	257	80.3%	208	65.0%
height	28	8.7%	54	16.9%	265	83.1%	213	66.7%

1 refers to extremely, quite and only just dissatisfied  
 2 refers to extremely, quite and only just satisfied

#### 4.3.2 Body cathexis and attitudes to weight

Weight appears to play a strong determining role within the overall body cathexis scale as illustrated by the factor analysis (Section 4.3.1). This is also borne out by the relationship between total scores on the body cathexis scale and conceptions of weight as is illustrated in Table 4.16. 100% of those who consider themselves to be very overweight are dissatisfied with their bodies, while only 8.3% of those who consider themselves to be the correct weight are dissatisfied with their bodies. Of those who are dissatisfied with their bodies, as many as 96.21% consider themselves to be overweight to some extent. The salience of weight in determining overall satisfaction with the body, particularly for women, has been found with regularity in other studies (Berscheid et al., 1973; Worsley, 1981; Gray, 1977; Pearlson et al., 1981) (refer to Chapter 1, Section 1.4).

Table 4.16: The relationship between satisfaction with the body and weight concept

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weight concept	dissatisfied <sup>1</sup>		satisfied	
Very overweight	15	100%	0	0%
Quite overweight	40	76.9%	12	23.1%
Slightly overweight	72	41.1%	103	58.9%
Correct weight	5	8.3%	55	91.7%
Slightly underweight	1	7.7%	12	92.3%

---

\* weight concept refers to what respondents consider themselves to be

1 dissatisfied = above a score of 45

#### 4.3.3 Results on the self-rating and social ideal rating-scales

On the rating scales, "myself with my body as it is now", "self much fatter", "self much thinner" and three social ideal bodies, (model, athlete, slim teenager) are rated according to character and appearance constructs (e.g. healthy, assertive, attractive body, sexually attractive, well-liked and so on). "Self much fatter" is most negatively rated. Although "self with my body as it is now" is rated neutrally, it is the second most negatively rated. Table 4.17 illustrates the mean ratings on the seven-point scale with 1 as most positive and 7 as most negative.

Table 4.17: Results on the self-rating and social ideal rating-scales: rank ordered

Element	Mean rating
athletic woman	2.47
typical photographic model	2.58
slim teenager	2.84
self much thinner	2.95
self with body as it is now	3.33
self much fatter	5.56

There is evidence of a relationship between the body cathexis scale and ratings of "self now", "self fatter" and "self thinner". Total scores on the body cathexis scale correlate significantly with ratings of "self now" ( $r = 0.63$   $p < 0.01$ ), "self thinner" ( $r = -0.38$ ,  $p < 0.01$ ) and "self fatter" ( $r = 0.32$ .  $p < 0.01$ ) Those who are dissatisfied with their bodies rate "self now" and

"self fatter" more negatively and "self thinner" more positively than the rest. The correlations between the body cathexis and "self thinner" and "self fatter" are weak, indicating that negativity with fatness and positivity with slimness are not that different for those who dissatisfied with their bodies than for those who are satisfied.

The positive ratings that the social ideals and "self thinner" received from this sample support other studies' findings concerning women's strivings towards an ideal shape that is very thin (Fallon and Rozin, 1985; Secord and Jourard, 1955) (refer to Chapter 1, Section 1.4)

#### Summary:

The following main results concerning attitudes to the body emerge:

(1) There is widespread dissatisfaction with the torso area, thighs and weight in this sample. The results on the body cathexis scale indicate that about half of the sample are dissatisfied with their hips, stomach, weight and overall body while far more than half are dissatisfied with their buttocks and thighs. If desiring to weigh less and considering oneself to be overweight is any indication of satisfaction with current weight than a great deal more than half of the sample are dissatisfied with their weight. Although the torso area and thighs were negatively rated in a widespread fashion, not many respondents rated body parts like shoulders, feet, ankles and neck negatively. This may support Rosalind Coward's (1984) notion that the fragmentation of the body which appears in the media and is common among women, allows them to appreciate some parts of

the body while disliking others.

(2) Attitudes about weight appear to be salient in determining overall satisfaction with the body. Far more of those who considered themselves to be overweight were dissatisfied with their bodies than of those who considered themselves the correct weight or underweight.

(3) There is much negativity associated with fatness and positivity associated with thinness for all respondents.

(4) Although there was a relationship between negativity associated with fatness/positivity associated with thinness and dissatisfaction with one's body, it was not very strong. This indicates that all the respondent's feel negatively towards themselves "fatter" and positively towards themselves "thinner", whether they are satisfied or not with their bodies. This seems to indicate a fear of fatness and concern with remaining slim even for those who are satisfied with their bodies.

(5) The sample conforms to the social ideal images which are prevalent in the media. Model bodies, athletic bodies and young, slim bodies are rated most positively.

(6) These results are similar to those found by other studies. Berscheid et al. (1973) found a similar dissatisfaction with the torso area and weight. The negativity associated with fatness and the positivity associated with slimness found in this sample reflects other studies' findings as well (Fallon and Rozin, 1985; Jourard and Secord, 1955).

#### 4.4 Relationship between body attitudes and eating problems

Attitudes towards the body, like concern about fatness and weight are an integral part of attitudes central to the eating disorders. In this study the relationship between attitudes towards the body and towards eating among a community sample of women was investigated. Correlations between the EAT and body cathexis and self-ratings were computed together with t-tests and cross-tabulations comparing the low scorers with those scoring in the "anorexic range" on the body-related variables. Thus, in looking at the relationship between body cathexis and eating problems, the EAT is used as the main indicator of eating problems while the body cathexis scale, the self-rating scales ("self with body as it is now", "self fatter" and "self thinner") and self-perception of weight as the main indicators of body image (referring to affect).

Table 4.18: Pearson correlation coefficients:  
body attitudes and the EAT\*

	Body cathexis	Total scores		
		"self now"	"self thinner"	"self fatter"
total EAT score	0.4028	0.292	-0.2086	0.2812

\* All the correlation co-efficients are significant at 0.001 level

As illustrated by Table 4.18 significant correlations were found between the EAT and all the indicators of attitudes towards the body, the body cathexis scale and the rating of "self with body as it is now" ( $p < 0.001$ ). Although these correlations are weak,

the relationship is also borne out by t-tests and cross-tabulations. In comparing high EAT scorers (i.e. those who score in the "anorexic range", >30) with low scorers, it is clear that the former are significantly more dissatisfied with their bodies ( $t = -5.07$ ,  $df = 302$ ,  $p < 0.001$ ), scoring ten points higher (more dissatisfaction) on average than the latter (mean 52 vs 42).

Table 4.19 illustrates how a higher percentage of those in the "anorexic range" rate themselves negatively on the self-rating scale, whereas a higher percentage of those scoring low on the EAT rate themselves positively. But the differences between the two groups are not major.

High EAT scorers also rate "self thinner" more positively and "self fatter" more negatively than low scorers. Although the correlation coefficient was weak, t-tests indicate that those scoring in the "anorexic range" on the EAT rate "self thinner" significantly more positively than low scorers ( $t = 3.45$ ,  $df = 306$ ,  $p < 0.001$ , mean 18 vs 24).

There is also evidence of an association between a high EAT score and negativity associated with "self fatter". Those who score in the "anorexic range" also rate "self fatter" significantly more negatively than low scorers ( $t = -5.04$ ,  $df = 309$ ,  $p < 0.001$ , mean 50 vs 43.5).

The associations between a high EAT score and negativity associated with "self now" and "self fatter" and positivity with "self thinner" is also borne out by cross-tabulations of low/high eat scorers and low/high ratings of "self now", "self thinner"

and "self fatter" as indicated in Table 4.19.

Table 4.19: Relationship between EAT scores and self-rating scales

Self-ratings	Low scorer (<30)		"Anorexic range" (>30)	
<u>"self now"</u>				
positive	21	7.7%	1	2.8%
neutral	198	72.3%	22	61.1%
negative	55	20.1%	13	36.1%
<u>"self fatter"</u>				
positive	2	0.8%	0	0%
neutral	19	6.9%	0	0%
negative	175	63.6%	11	30.6%
very negative	79	28.7%	24	69.4%
<u>"self thinner"</u>				
positive	65	23.9%	18	50%
neutral	107	53.3%	15	41.7%
negative	57	22.8%	3	8.3%

Another indication of the relationship between body attitudes and eating is the relationship between weight concept (what subjects perceive their weight to be) and the EAT (Table 4.20). Those who believe themselves to be overweight tend to score higher on the EAT, illustrating a relationship between perceiving oneself as overweight and "abnormal" eating attitudes. Furthermore, given that the perception of oneself as overweight is associated with negative affect towards the body, it can be assumed that the relationship between weight concept and the EAT is another indication of the association between negative body image and eating problems (Section 4.3.2).

Table 4.20: Relationship between weight concept and EAT scores

	Eating attitudes score			
	Normal Eat score (below 30)		"Anorexic range" (above 30)	
Weight concept				
Very overweight	9	3.3%	8	22.2%
Quite overweight	43	15.6%	9	25.0%
Slightly overweight	154	55.8%	17	47.2%
Correct weight	58	21.0%	2	5.6%
Slightly underweight	12	4.3%	0	0%

The relationship between body cathexis and eating problems is also borne out, by comparisons between those who consider themselves to have an eating problem and those who do not (refer to Section 4.5).

Summary:

The main results concerning the relationship between eating disorders and body image are the following:

(1) Those with high EAT scores are more dissatisfied with their bodies, as illustrated by scores on the body cathexis scale and ratings of "self now". Thus a high EAT score is associated with negative affect towards the body. This association is not as strong as might be expected.

(2) High EAT scorers also rate "self thinner" more positively and "self fatter" more negatively than those with lower EAT scores. The negativity associated with fat and the positivity

associated with thin appear to have more salience for those who score high on the EAT. This is not surprising given that abhorrence and fear of being fat or overweight is one of the most central attitudes within the eating disorders. Again, the differences between the two groups were not as large as was expected, illustrating that negativity towards fatness and positivity towards slimness are evident for all respondent's whether they score low or high on the EAT.

(3) Conceptions of weight are associated with eating problems, as more of the high EAT scorers consider themselves to be overweight than low scorers.

(4) The associations between eating problems and body image corroborate those found in other studies (Hawkins and Clement, 1980; White, Hudson and Campbell, 1985) (refer to Chapter 1, Section 1.5)

#### 4.5 An investigation of those who consider themselves to have an eating problem

##### 4.5.1 Symptomatology

Almost one-third of the sample, 31%, consider themselves to have an eating problem. Those who consider themselves to have a problem do appear to manifest more symptomatology than those who do not believe they have a problem. Table 4.21 illustrates how a far greater percentage of those who consider themselves to have a problem, practise those behaviours associated with anorexia nervosa and bulimia.

Table 4.21: A comparison between those who consider themselves to have an eating problem and the rest: Eating/dieting behaviour

	Those who consider themselves to have an eating problem	Rest of sample
Cooper and Fairburn (1983) criteria for bingeing:		
ever binge	62.25%	23.5%
current (last two months)	44.9%	11.22%
Pyle et al. (1983) criteria for bingeing:		
Total positive response	62.25%	27.91%
infrequently	32.65%	24.65%
frequently in the past	10.2%	1.86%
frequently at present	19.39%	1.4%
Vomiting as weight control	13.27%	3.21%
Laxatives as weight control	19.38%	4.59%
Strict diets	30.61%	8.72%
Diet pills	24.49%	6.88%
Spitting out food	4.08%	0.46%

The relationship between symptomatology and the expression of an eating problem is also borne out by the scores on the EAT. Those who consider themselves to have an eating problem have a significantly higher EAT score than the rest ( $t = -9.57$ ,  $df = 308$ ,  $p < 0.001$ , mean 23.66 vs 11.29). One-third of those who consider themselves to have an eating problem (30.2%) score in the "anorexic range", while only 2.8% of those who don't consider themselves to have a problem score in this range.

#### 4.5.2 Factors associated with reporting an eating problem

In order to investigate what factors investigated in this study are most associated with reporting an eating problem, relative risk analyses were conducted (McMahon and Pugh, 1970). It is clear that high EAT scores and binge eating (current and past) are most associated with reporting an eating problem (Table 4.22).

Table 4.22: Factors associated with reporting an eating problem:  
rank ordered in terms of relative risk

factor	relative risk value
1. EAT score > 40	18.32
2. Binge eating (current) (Pyle et al. (1983) criteria)	16.99
3. EAT score > 30	15.23
4. EAT score > 20	7.13
5. Binge eating (current) (Cooper and Fairburn (1983) criteria)	6.45
6. Binge eating (ever) (Cooper and Fairburn (1983) criteria)	5.36
7. Binge eating (ever) (Pyle et al. (1983) criteria)	5.33
8. Laxative use (as a means of weight control)	5.00
9. Self-induced vomiting (as a means of weight control)	4.61
10. Strict dieting	4.60
11. Dietpill use (current)	4.38
12. Fasting	3.38

\* Relative risk =  $ad/bc$ , where a = cases with the factor; b = non-cases with the factor; c = cases without the factor; and d = non-cases without the factor.

These results are similar to those found by Cooper et al. (1984) who found frequent binge eating to be most associated with reporting an eating problem, followed by EAT score > 29 ("anorexic range"). Laxative use was more associated with reporting an eating problem in their sample than in the present sample (6.91 vs 5

#### 4.5.3 Reporting an eating problem and weight variables

As is evident from Table 4.23, those who consider themselves to have an eating problem are also more dissatisfied than the rest of the sample with their weight and desire to weigh less (i.e. there is greater difference between their real weight and their ideal weight than for the rest). The former do in fact weigh significantly more than the latter ( $t = -4.21$ ,  $df = 310$ ,  $p < 0.001$ , mean 60kg vs 54kg) and experience significantly greater weight fluctuations than the latter ( $t = -5.47$ ,  $df = 304$ ,  $p < 0.001$ , mean 10kg vs 7kg). Far more of those who consider themselves to have an eating problem also weigh more than 120% of their MPMW than the rest of the sample (15% versus 4%). It is clear that a larger amount of those who weigh more than 120% of their MPMW consider themselves to have an eating problem (64%). A minority of those who weigh less than 85% of their MPMW consider themselves to have an eating problem (29.4%) About the same amount (29.2%) of those who weigh between 85 - 120% consider themselves to have an eating problem. Being overweight by ideal standards is therefore more associated with reporting an eating problem than being underweight or the correct weight by ideal standards.

Table 4.23: A comparison of those who consider themselves to have an eating problem with the rest: Weight variables

	Those who consider themselves to have an eating problem	Rest of sample
Consider self to be overweight:total	92.78%	69.13%
slightly overweight	46.39%	58.53%
quite overweight	34.02%	9.22%
very overweight	12.37%	1.38%
Mean weight	60kg	56kg <sup>1</sup>
< 120% MPMW	5%	6%
Between 85-120% MPMW	80%	90%
> 85% MPMW	15%	4%
Mean difference between ideal and real weight	-6.47kg	-3.35kg <sup>1</sup>
Mean weight fluctuations	10.04kg	7.34kg <sup>1</sup>

1 p < 0.001

#### 4.5.4 Reporting an eating problem and body cathexis

Table 4.24 illustrates how those who consider themselves to have an eating problem are also considerably more dissatisfied than the rest of the sample with their bodies according to the body cathexis scale. Only those parts of the body which appear to have most salience for the entire sample are compared.

Similarly, with the self-rating scale, "eating problem" respondents rate "self now" and "self fatter" more negatively and "self thinner" more positively than the rest of the sample (Table 4.25). There is however only a very slight difference

between the way in which the two groups rate themselves much fatter, indicating an almost equal aversion to being fatter. Ratings of the slim teenager, model and sportswoman do not differ much either, indicating a similarity in response to these social stereotypes.

Table 4.24: A comparison of those who consider themselves to have an eating problem with the rest: Body cathexis\*

	Those who consider themselves to have an eating problem	Rest of sample
<u>mean scores</u>		
total score on body cathexis scale	50.9	38.9
waist	3.71	2.57
buttocks	4.6	3.56
hips	4.37	3.05
thighs	4.86	3.68
overall body	4.38	3.02
weight	4.67	3.13
stomach	4.52	3.06
breasts	3.04	2.48

\* for all variables:  $p < 0.001$  level

Table 4.25: A comparison of those who consider themselves to have an eating problem with the rest: Body rating-scales

	Those who consider themselves to have an eating problem	Rest of sample
<u>Mean scores</u>		
"self with body now"	30.3	24.8 <sup>1</sup>
"self thinner"	19.95	25.5 <sup>1</sup>
"self much fatter"	45.9	43.7 <sup>2</sup>
model	19.52	21.98 <sup>n.s.</sup>
slim teenager	20.8	23.04 <sup>2</sup>
athletic woman	19.28	19.9 <sup>n.s.</sup>

1 p < 0.001

2 p < 0.05

n.s. = not significant

#### 4.5.5 Other categories of eating problems

Many of those who consider themselves to have an eating problem also classify themselves as compulsive eaters and binge eaters. (Table 4.26). 58.2% of those who consider themselves to have an eating problem consider themselves to be compulsive eaters, while a lesser amount, 23.5%, consider themselves to be binge eaters (Table 4.26). Thus the majority of those reporting an eating problem appear to associate it with compulsive eating. Those who classify themselves as binge-eaters are highly likely to report an eating problem, as 73.9% who consider themselves to be binge eaters also consider themselves to have an eating problem (see Appendix IV: Table iv). On the other hand, almost half of those

who classify themselves as being compulsive eaters do not consider themselves to have an eating problem - 55.6% do consider themselves to have an eating problem (see Appendix IV: Table iv). Thus while compulsive eating is not considered as an eating problem by all, it is still strongly associated with reporting an eating problem. Being a binge eater is however considered an eating problem by the majority who report this, but it is not as commonly associated with reporting an eating problem for it is not as common within the general sample.

Table 4.26: The relationship between reporting an eating problem and considering oneself a binge/compulsive eater

	Those who consider themselves to have an eating problem	Rest of sample
Consider self to be a compulsive eater	58.2%	16.97%
Consider self to be a binge eater	23.5%	3.7%
Consider self to be both a binge eater and a compulsive eater	17.4%	2.3%

Summary:

The main insights concerning those who consider themselves to have an eating problem are summarized as follows:

- (1) This group of women does appear to manifest more symptomatology, that is behaviours associated with anorexia nervosa and bulimia, than the rest of the sample. By "objective" criteria, like the EAT and the self-report behaviour items, this

group does appear to have an eating problem. Significant amounts of this group manifest binge eating, self-induced vomiting, laxative use and score in the "anorexic range" on the EAT. A high EAT score is one of the factors most strongly associated with reporting an eating problem.

(2) A major factor associated with reporting an eating problem is bingeing behaviour. A large amount of those who report an eating problem also describe themselves as compulsive eaters. Overeating or eating compulsively is therefore strongly related to reporting an eating problem.

(3) Reporting an eating problem is also associated with dissatisfaction with one's body and weight. Those who report an eating problem are significantly more dissatisfied with most parts of their body and their weight than the rest of the sample.

(4) Being overweight by ideal standards appears to play a role in reporting an eating problem. Those who report an eating problem weigh on average more than the rest of the sample and a greater amount of them weigh more than 120% MPMW. A greater amount of those who report a problem consider themselves to be overweight and there is a greater difference between what they would like to weigh and what they do weigh, than the rest of the sample.

(5) Considering oneself to have an eating problem is also associated with a stronger dislike of "self fatter" and more positive affect with "self thinner". But the two groups do not differ greatly in their dislike of fatness and like of thinness.

#### 4.6 Conclusions

In this chapter the prevalence of attitudes and behaviours associated with the eating disorders of anorexia nervosa and bulimia have been reported. It was found that certain attitudes, specifically preoccupation with food/diet and body/weight are particularly widespread. Many of the "abnormal" behaviours, particularly bingeing are also common but usually in a more moderate form (that is, occurring less frequently) than they occur with anorexics and bulimics. Furthermore, the behaviours on their own are found to be more common than the combinations required for diagnosis, illustrating the diversity of symptoms which occur in the community. It is clear that the combination of symptoms required for a diagnosis of bulimia is far more uncommon than the presence of these behaviours on their own. That is, many women appear to binge but not as many binge and vomit.

One could not therefore speak of an epidemic of eating disorders in this sample, for the severe disorders of anorexia nervosa and bulimia appear to be relatively rare. At the same time it must not be forgotten that almost one-third of the sample consider themselves to have an eating problem and that by "objective" criteria they do manifest the behaviours and attitudes associated with the eating disorders to a greater degree than the rest of the sample. Furthermore those attitudes concerning preoccupation with weight/body and eating/dieting are extremely common, with some of them experienced at least often by more than a third of the sample.

Attitudes to the body, including affect towards body parts, shape and weight, was investigated. Widespread dissatisfaction was found with the torso area, thighs and weight. Attitudes to the body were also investigated in terms of self-ratings and ratings of social ideals (e.g. model, athletic woman). It was found that fatness is strongly associated with negativity while the social ideal body shapes and slimness are highly valued. The salience of weight in determining overall bodily satisfaction was evident. Dissatisfaction with one's body within this sample appears to be articulated around perceiving oneself to be overweight, negativity about being fat and positive associations with slimness. The associations between a negative body image and negativity associated with being fat and positivity with being thin were not as strong as expected. This may illustrate that dislike of fatness and liking of thinness is common for all respondents, no matter how satisfied or dissatisfied they are with their bodies.

The relationship between attitudes to the body and eating problems was investigated. A relationship was found between dissatisfaction and negativity towards body and weight and eating problems (attitudes and behaviours associated with anorexia nervosa and bulimia as measured by the EAT). An association between negativity towards fatness and positivity toward thinness and high EAT scores was also evident. None of these relationships were as strong as expected, illustrating that no matter what one's EAT score is, there is a similar dislike of fatness and liking of thinness. Having an eating problem,

according to "objective" criteria does not appear to be of salience in determining attitudes towards fatness and thinness.

Finally, those who report an eating problem were researched more closely. It appears that those who report an eating problem practise more of the behaviours, particularly binge-eating, associated with eating disorders than the rest; experience more of the attitudes associated with these disorders than the rest; are more dissatisfied with their bodies and their weight than the rest; weigh more than the rest; and value thinness and dislike fatness more than the rest of the sample do. A high EAT score and binge eating are highly associated with reporting oneself to have an eating problem. Considering oneself to be a compulsive eater is also common among this group. Thus eating too much, according to respondent's own criteria, appears to be a central issue for those reporting an eating problem. It is clear that this group of women do have more of an eating problem than the rest of the sample both by their own criteria and "objective" ones (EAT scores, self-reported behaviours). And yet the majority of them would not qualify for an eating disorder per se (only a third of those reporting an eating problem score in the "anorexic range" on the EAT). What is clear therefore is that there is a fairly large group of women, one-third of this sample, who are experiencing similar problems to anorexics and bulimics yet are not diagnosable for an eating disorder according to psychiatric criteria. It is this group of "normal" women with eating problems who form the sample for the qualitative research study reported in the next chapter.

## CHAPTER 5: ANALYSIS OF INTERVIEWS WITH WOMEN WITH EATING/BODY PROBLEMS

### 5.1 Introduction

This chapter presents an analysis of the depth interviews held with sixteen women who consider themselves to have an eating problem. The main trends that emerge are presented in the following sections:

- (1) An analysis of the nature of the eating problem, including a review of the history of each interviewee, attempts to categorize these problems in relation to the eating disorders of anorexia nervosa and bulimia and the types of symptoms prevailing and aid received for the problem;
- (2) An analysis of direct social pressures experienced by the interviewees in relation to their eating and body;
- (3) An analysis of the attitudes towards eating and food which prevail among the sample;
- (4) An analysis of the attitudes towards the body, weight and physical appearance which prevail.

### 5.2 The problem

#### 5.2.1 Anorexia nervosa and bulimia

All of the sample considered themselves to have an eating problem. While the majority felt it to be under control at the

time of interviewing, two of the interviewees were going through a phase of extreme symptoms. The first was going through an anorexic, restricting phase and had lost almost 20% of her original body weight and was amenorrhoeac. The second was engaging in laxative-abuse, together with binge/starve behaviour. Both were in therapy at the time of the interview, only one of them for an eating disorder, while the other was in therapy for depression, the anorexic symptomatology having developed after the commencement of therapy.

Of the other interviewees, two had been diagnosed as anorexic by their doctors (G.P.s). None had been hospitalized. From interviews, nine interviewees (56%) were identified as having been through at least one "anorexic phase" where they experienced major weight losses (10 - 20% of original weight) and amenorrhoea for a period of two or more months. Five (35%) were identified as having experienced at least one "bulimic phase" where they experienced episodes of excessive eating compensated by purging (laxatives/vomiting) or fasting. For most interviewees the "anorexic phases" had not been experienced as a problem at the time and were only recognized as problematic in retrospect. The "bulimic phases" and overeating generally were quite evidently experienced as problems for them.

An attempt was made to classify interviewees into groups according to their tendencies towards either anorexia nervosa or bulimia (Table 5.1). Their eating problem history was taken into account. Thus some interviewees fitted into all categories at different phases of their lives. This attempt at categorization

illustrates the potential for a wide variety of changes in symptomatology over time. As many as 8 interviewees, 50% of the sample, could be seen to have experienced both tendencies at different stages of the problem.

Table 5.1: Eating disorder tendencies

Eating disorder tendency	no. of interviewees
Anorexic	
-restraining only	5
-with purging	6
Bulimic	
-bingeing/purging	9
-bingeing only	6
Anorexic/bulimic at different times	8

### 5.2.2 Symptomatology

The most widely reported behaviour is binge eating. As many as 14 out of 16 interviewees report binge eating or compulsive eating at some stage of the problem. The definition of a binge was however very relative (refer to Section 5.4.5). For most interviewees, an extreme eating binge, where obviously excessive amounts are eating (according to most social standards), was relatively **uncommon**. What was more common was a form of compulsive eating where little bits were eaten continuously during the day. Interviewees were also more concerned by the eating of "bad" foods, i.e. "unhealthy" or "fattening" ones. For most, bingeing was associated with dieting as most described the behaviour as only occurring following a period of restraint.

Dieting was extremely common. All except one interviewee reported compulsive dieting aimed at weight loss and this interviewee had been engaged in "cleansing diets" like the "grape cure" (eating only grapes for long periods of time). Many interviewees had subsequently rejected dieting for weight loss but were still engaged in attempts to control their eating for "health reasons". Starvation diets and various "health" fasts (e.g. the "grape cure", "fruit fasts") were extremely common.

Self-induced vomiting, was at the time of interview, being practised by only two interviewees. A quarter of the sample, four interviewees, had been involved in the behaviour frequently in the past, some as often as 5 - 7 times a day. Four interviewees had practised the behaviour infrequently. And four interviewees had seriously attempted to induce vomiting but with no success. Laxative abuse in an extreme form, as in every day use of large quantities, was only practised by one interviewee. Most other interviewees had used them for weight loss with about four using them with some frequency during a phase.

Diet pills had been used by 12 interviewees with most of them going through phases of regular use (i.e. every day, at least once a day). At least two interviewees described themselves as having been addicted at certain stages but not in a drug-abuse manner, as neither had taken excessive quantities and both managed to stop.

There were no interviewees free of all these behaviours, but two had never engaged in diet pill use, laxative use or self-induced

vomiting. It is clear that there were a wide range of behaviours associated with eating disorders practised among this sample. The patterns of behaviour were very diverse. Not one interviewee could be said to mirror exactly the behaviours of another. It is clear that some were involved only in bingeing, while some binged and purged, while some starved and purged and so on. This diversity of symptomatology was paralleled in terms of extremity of symptom as well. It is quite clear that some were "worse" than others, some were closer to fitting the diagnostic categories of anorexia nervosa and bulimia than others. Furthermore, there was seen to be a wide range of changes occurring over time. Most interviewees, especially the older ones, saw themselves as having passed through different phases within the eating problem. For some, the phases were in terms of severity, that is, at times the behaviours were less extreme than at other times. For others, the phases were in terms of differences in actual behaviours, moving from more anorexic restraining modes to more eating/bingeing modes and vice-versa.

### 5.2.3 Aid for the problem

Although as many as nine interviewees were seeing or had seen psychologists in the past, only one of these had done so specifically for the eating problem. One interviewee had been hospitalized, but this was for depression whilst her eating problem had only developed subsequent to this time. Three interviewees had been taken by their mothers to doctors for the problem and one to a psychiatrist.

### 5.3 Social pressures experienced by interviewees

It was evident that all interviewees were subjected to direct and more subtle social influences to conform to the ideal body image and to modify their eating behaviour. These pressures came from family, peer groups, boyfriends, health professionals and the media.

Most interviewees were brought up in weight-conscious families with mothers who were concerned with their own weight and physical appearance and that of their daughter. Twelve out of the sixteen interviewees came from families who were weight conscious to some extent. One interviewee's mother had taken her to a doctor to put her on a diet, while a number took their daughters to Weight Watchers or other organizations of a similar nature. One woman's mother gave her diet pills to aid her weight loss. Mothers were generally supportive of dieting behaviour even if they did not actively suggest it. As one woman, speaking of her mother's response to her dieting, said:

"She would get very happy when she saw me rationing out foods. She's very into deprivation and if she could get me into being that she was very happy."

Modelling oneself on mother's way of "looking after herself" also played a role:

"She always kept herself trim, so that's my mother, I learned it from her."

Socialization as a girl child seemed to have a particular influence on the development of attitudes towards food and eating for this sample. Some interviewees traced the roots of their

guilt about eating to the process of modelling their mother's behaviour and attitudes and being taught what was "correct" for girls. One woman spoke of how her mother would always take the smallest portions of food if there was not enough to go around and assume that she should eat less than her brother:

"The two men (brother and father) could eat what they wanted because they don't put on weight. It was never said that I can't eat because I'll get fat, but that is the implication, that the men did not get fat but the women did."

And another interviewee:

"My brothers and father were allowed to eat, but I wasn't...My mother would offer my brothers and father pudding but say to me: 'You don't want any, do you?' and I would say: 'I do', so she would give me a small helping."

Thus assumptions that women should eat less than men and watch their weight were rooted in the family experiences of these women and became deeply rooted attitudes, as one interviewee stated:

"I don't like seeing women (any size) overeat... whereas when men overeat it's so different - I think of things like 'big appetite', 'muscles', 'strength' - strong and positive images. Whereas with women, images of 'slob', 'messy', 'uncontrolled', 'uncontrollable' come into my head."

The pressure for some interviewees came from siblings and other family members as well:

"My brothers always teased me about how fat I was...they made me feel guilty about eating. And when I started losing weight they said 'good, good...'"

"My grandmother would say 'when you lose x amount of weight I'll give you this dress...'" (she owned a clothes boutique)

Pressure to diet and be conscious of bodily appearance came from the peer group as well, particularly during the stage of adolescence, as one interviewee stated:

"There was pressure at school to go on diet, to have a good figure, especially for the boys. One was 'written off' if you weren't thin..."

The reality of this was borne out for one interviewee who was, according to her, fat when younger:

"I was ostracized because I was fat and ugly and revolting."

Peer pressure to diet was so strong and so much a part of the norm that those who were not involved in it felt excluded :

"That's all they talked about at school - food and dieting. And everyone's mother used to put them on these diets. I remember being relieved that my mother was unconcerned but I felt a bit excluded. I could not participate in those conversations. Also there was a kind of jealousy that I was thin.

This experience, although she was not a part of it then, provided this interviewee with the "materials" for an eating problem later on:

"That's where I saw for the first time what bingeing was and what feeling so guilty about food was ... and how to get rid of it ..."

For most interviewees the beginnings of the eating problem can be traced back to a weight consciousness and a diet. For most, but not all, this was an adolescent phase which often was articulated through a growing awareness of one's physical appearance as a woman and directed towards male attentions:

"I started dieting at the stage when we started going out. Girls get guys phase. We were fashion conscious and figure conscious. The image was very important."

The peer pressure to diet and be slim was strongly associated with the importance of being desirable to boys/men. It will be shown later the role that men played in terms of body attitudes for women (refer to Section 5.5.6). For some of the women however, male attitudes appeared to play a role in the formation of the eating problem in more direct ways than the striving to be attractive for men. For example, as mentioned, one interviewee's brothers made her feel guilty about eating, while another's boyfriend placed pressure on her to watch what she was eating even though she was thin by social standards.

This interviewee found that her mother began colluding with her boyfriend in this respect:

"If there was something nice in the house, say cake, we would all have tea together. He would watch closely how much I had. She would agree with him and say 'you can only have a small piece'. So they were all against me eating too much ... I would look for ways of getting him out of the house. The minute he would leave the house I would run and cut a huge piece of cake !"

And another interviewee's boyfriend would comment on her eating saying things like: "you don't need that."

Peer influence was also important in the development of "abnormal" means of weight control. A number of those interviewed had learned their behaviours from friends:

"I went to University and decided now I am going to make a success of myself and get thin. It was there that the bulimia started ... I had heard about vomiting from someone who did it."

A kind of camaraderie develops and women teach each other new "tricks

"My friend also vomited. We shouted at each other for doing it, but we both knew that we would go and do it again. I learnt from her that if you swallowed more water you could bring it up easier ..."

The media, its image of the ideal woman and its emphasis on dieting, seemed to play a significant role in the development of their eating/body problems, for many of the women. Most of them appeared to have gone through a stage, or are still involved in this, of reading women's magazines and being very conscious of women's fashions, clothes and appearances. As one woman stated:

"I used to read Fair Lady from cover to cover and was aware of all the diets."

The strength of these magazines in influencing attitudes is illustrated by the following quotes:

"I started reading women's magazines and became aware of the media image and I saw that if I was thin, everyone would love me."

"I would buy magazines religiously and always read the 'beauty' articles first. I only bought them for those things. I was always comparing myself to the models..."

An important aspect of the social context, which has been highlighted theoretically, is that of the negotiation between the therapist and client and the role of professionals in general (Swartz, 1985, 1985a). It is clear from this sample that professional judgements and professional literature, particularly following its entry into the popular media, has played a role in the interviewee's perceptions of the problem as well as the actual development of the problem. One interviewee who was restraining her eating to an extreme point, only called it a problem once she had been taken to a doctor who scolded her and threatened her with hospital. She thought "he was stupid as he could not see how beautiful I was when I was thin". In this instance, negotiation and the naming of the problem was harmless,

but in others it appears that eating disorder symptomatology may have developed in response to views of a therapist. One interviewee, who was being treated for depression, was told by her therapist that a body image picture that she had drawn reflected an anorexic tendency. This was when she first thought that she might have a problem in the area of eating. It was unclear if she had at this point begun dieting but from then on her eating became more and more restrained.

Attitudes of doctors (G.P.s) appear to have had a negative effect on the eating/body problem for some interviewees:

"I felt very conscious of my body whenever I went to the doctor. He would weigh me and always tell me to lose weight. He did not even ask me anything about the rest of my life, whether I exercise or not."

It appears that accepted theories about eating disorders have affected the interviewees' and their families' responses to the problem. Two interviewees spoke of their mothers' guilt about their problem as they had read or heard that eating disorders are caused by domineering mothers. One interviewee spoke about her mother's reaction to her self-induced vomiting:

"When she expressed the whole problem of it and took it so personally I was shattered. To me it was not psychological thing. I'd never seen it as a result of having a domineering mother or anything like that. I just saw it as a way out of fat and a very easy one."

In this case it appears as if the family doctor had reinforced the mother's guilt by implicating her as a dominating mother.

An example of an interviewee being affected by the academic theories in the way she understands her problem is the following:

"I only noticed it as being an emotional problem when I started to study psychology. Then I realized that all those phases of overeating were also very stressful for me."

Other interviewees were not as accepting of the theories they heard:

"I have read that vomiting is a response to anger but I don't think it was for me. It was actually just plain overindulgence or to control the effects of eating."

A more serious effect of the media coverage and professional literature on these interviewees, is its role in the development of eating/body problems. It may be argued that anorexia nervosa has been idealized for women in the media. This is internalized by women, as one interviewee illustrates:

"At school I wished I could get anorexia. But I saw it as a disease, something far away from me." (at this time she was going through what was identified as an anorexic phase).

One interviewee illustrates her understanding of how literature may effect the development of eating disorder symptomatology. She used self-induced vomiting as a form of weight control and when asked if she ever used laxatives, she replied:

"You hear that`s how you're supposed to be ... this is what a bulimic or an anorexic does, so you think maybe you should do that. A lot of the time it was those ideas that started me on the process."

## 5.4 Attitudes to eating and food

### 5.4.1 Guilt

Complicated taboos and prohibitions surround the sensual pleasures of the mouth. In fact, the mouth appears to be the organ where the tightest controls are placed on women's behaviour, where women's sensual life is most closely policed. No one is in any doubt about the strengths of women's oral appetites. Food, kissing, verbal foreplay - these are some of the great delights of female erotic life. But all the evidence suggests that these pursuits can quickly become problematic. When oral pleasures are indulged, there's often a whole train of guilty and anxious consequences to deal with. (Rosalind Coward, 1984, p. 118).

Extreme guilt about eating, particularly the "bad" foods (those that are "fattening" or "unhealthy") is experienced by all interviewees. These quotes, from different interviewees, illustrate this:

"If I had one chocolate I would suffer guilt pangs..."

"At work I would buy chocolates and eat them in the toilet because I felt so ashamed."

"I have extreme guilt about eating bad foods but also a constant obsession with them."

For some, this guilt even extends to healthy, diet foods (by social belief) as well:

"I feel a tremendous amount of guilt about eating...even if I eat cottage cheese and salad, like I did today, I still feel guilty because I feel full and I have trained my stomach not to be used to food."

Food, especially "bad" food, is perceived as something threatening, because it is constantly there tempting one to indulge in it, as these two quotes from different women illustrate:

"I actually just wish I did not have to eat - I wish there was no such thing as food. It's a threat to me. Even when I eat healthy food. Even if I just drink coffee - I feel full and if I feel full I feel guilty."

"I was very scared of it in a way (fattening food) ... I felt a need to get rid of it before I could eat it ... but the only way to get rid of it was to eat it" (So she would binge-eat to get rid of it as quickly as possible).

The guilt about eating leads to extreme self-consciousness about eating in front of others. Many of the women interviewed were involved in secret eating, particularly during a binge or when eating "bad" foods. As a number of interviewees expressed it:

"A lot of people think I don't eat, as I never eat with others ... I usually plan my eating around people's visits - if I know someone is coming, I eat before they arrive."

"I don't like eating with others - I feel too self-conscious that they'll be thinking 'why is she eating?'"

"I feel watched ... I feel convinced that everyone knows how much I'm eating, how many helpings I've had ..."

"I still feel, when sitting in the (students') union eating, that I shouldn't be, that others are looking and thinking that I should not be eating."

"I went through a time when I did not eat in front of others at all. I felt incredible anxiety, I would choke on the food ..."

One interviewee whose male lover would pressure her to watch her diet, found herself eating "bad" foods in secret:

"I would hide chocolate papers or throw them in the bin outside ... I could not start a chocolate and leave it, I had to eat the whole thing else he would notice. Then I would go and buy another one to replace it. It took me many years to admit that. I was so ashamed about it."

The guilt and self-consciousness appears to be experienced more in the company of particularly judgemental others, for example:

"I feel guilty eating in front of my granny as she's so image conscious, and so thin and nice herself. And she's always commenting on my body."

For many of the interviewees, the guilt was experienced more intensely in the company of restrained eaters:

"I feel uncomfortable eating with those who are controlling themselves. I feel uncomfortable eating a lot in front of them - it makes me feel more guilty ..."

This self-consciousness also reflects these interviewee's own attitudes about seeing "fat" people eat:

"I feel conscious of eating in front of other people because when I see fat people eating I think 'how can they eat?', and I don't want people to think that about me".

For most women, guilt feelings about eating are informed by an irrational belief that they do not deserve to eat, either because they consider themselves to be overweight or because of guilt for "overeating" at times. As some interviewees expressed it:

"I don't deserve to eat. I must be punished for eating such a lot."

"When I was overweight I felt I did not deserve to eat. I felt I should be starving as there was so much fat on me."

"I see myself as having a body where I can't afford to eat. I feel I don't deserve to eat, I have no right to eat ... I am not allowed to eat. Every single time I eat, I feel like it's a treat - it's not a necessity ... I'm spoiling myself."

The feeling of not deserving to eat is also evident in the widespread feeling that one must earn the right to eat. Most interviewees expressed feeling better about eating once they had exercised, using exercise as a way of legitimizing eating, as illustrated by the following examples:

"If I've done strenuous exercise then I feel like I deserve to eat ... "

"Exercising burns up calories and I would not feel so guilty about eating ... "

"I don't purge or vomit or anything like that. But I use exercise in a similar way. I'll exercise rigorously and then feel happy that I can go and eat."

"I feel good when I go to gym - I allow myself to eat just that extra little bit ..."

The guilt about eating leads to an extreme anxiety associated with food and eating, particularly in anticipating overeating or eating "bad" foods. As one woman expressed it:

"I'm very anxious before I eat ... I'm anxious when I wake up in the morning, thinking about food ... I'm anxious before meals, I'm anxious when I know I'm going out for supper..."

#### 5.4.2 Preoccupation with food/eating/dieting

Obsessive thoughts about food in terms of controlling/restricting intake and eating the "forbidden" foods were widespread.

Thoughts about eating and thoughts about dieting are linked with each other. For attempts to control food intake are experienced ✓ as resulting in a greater awareness and consciousness of food. For, according to one interviewee, "when you decide to go on diet then you get preoccupied with food." Many interviewees felt that their lives were centred around food, that they were "obsessed" ✓ or "possessed" or "ruled" by it, as a number of interviewees expressed it:

"I feel like food rules my life ... I hate it, because it just rules me. Everything that I do, my whole life is centred around food."

"Eating has become the centre of my life and I don't think that's normal ..."

"...it's (food) always in the back of my mind, so many things revolve around it."

"I still have a food consciousness, it's so imprinted on my brain ... but it's not as conscious as it used to be ... at one time it was **my whole life**, it was my little personal thing, my little world."

Much of the thought about food centres around **control** over intake. Much time and energy is spent planning eating, planning dieting and planning getting rid of food following eating. These quotes from different interviewees illustrate this:

"I am obsessed with food, I plan my whole life around food. Everything is food. This total obsession has been with me for so long. Every single day I wake up and I think of food and plan what I am going to eat and how I am going to get rid of it."

"I am constantly planning meals and cutting out as much as possible ."

"I know when I am going to eat a lot and I will know when I'm going to take laxatives ... my whole life is planned around food and getting rid of it."

"I was constantly preoccupied with food and planning eating. If I eat now then I can't eat later ... and so on."

"I would decide at the table that I was going to vomit ... Sometimes it would make me eat more."

For most interviewees preoccupation with food is experienced as a waste of time and energy and an interference in daily life:

"Thinking about food took up so much time ... Continually reading diet books, being preoccupied with food wastes so much time ... "

For some interviewees the preoccupation is experienced as something which occurs as a result of having too much free time:

"Because my life is not full, food becomes a focus."

"If I'm extremely happy or busy I don't think about food, it's alien from my thoughts."

### 5.4.3 Control over eating

A woman obsessed with the size of her appetite, wishing to control her hungers and urges may be expressing the fact that she has been taught to regard her emotional life, her passions and 'appetites' as dangerous, requiring control and careful monitoring. (Kim Chernin, 1983, p. 2)

Among this sample, the desire to maintain extreme control over food intake is common. Rigid eating "rules" are set up as part of this:

"I would count every calorie. At the end of the day I would count all the calories I had consumed that day."

"I've set rules and now I must stick to them." (she was feeling weak during the day and knew that she needed to eat, but her "rule" is not to eat during the day).

"You start to look at food like a person. Either you're going to control it completely or it's going to control you completely. That's starving and bingeing. Either I've just lost control or I am in control."

As a consequence of the strict controls set up around food, there is a fear of loss of control around food and of "breaking the rules", which manifests as anxiety:

"I'm too scared to lose control of the dieting. I feel that if I did let go I would go back to bingeing."

"I stop myself from eating when I want to because I'm afraid of losing control if I start ..."

"I'm just so scared of getting out of control. Like last night I went out for supper, and an hour before I was saying to myself: 'Temptation, just don't be tempted'. I'm so scared of being tempted ... if you put a whole lot of food in front of me, I'm terrified ..."

If the rules are broken, even in a dream, the anxiety is extreme:

"I dream about eating a lot, and then I wake up feeling very anxious that I might have eaten all of that in reality ..."

This is another factor leading to secret eating or difficulties eating with others:

"I am afraid to eat with others as I might get out of control."

Control over eating appears to be very strongly associated with a sense of overall control over their lives. Most interviewees expressed very strongly the feeling that if they felt in control of their eating then they would feel in control of their lives in other spheres as well. An equation of "control over eating equals control over one's life equals happiness" is evident in the following quotes:

"I felt most in control when I was starving and out of control when I was bingeing ..."

"The minute I get out of control with my food, I feel like I'm losing control with myself, with my moods ... Everything becomes blurred, I don't know what's going on, I become jittery and tense and depressed."

"I feel in control of all the areas of my life when I'm in control of my eating - like my boyfriend at the moment, I want to end the relationship. When I was not eating I felt much stronger to do this. But now that I'm eating, I don't feel secure enough to do it."

"When I am dieting I normally feel very good about myself. I feel like I'm in control of my body and my life. I just feel really controlled and sussed."

As a consequence, restrained eating is experienced as an enjoyable time, while periods of eating are experienced negatively:

"The more I eat the worse I'm going to feel. The less I eat, even if I feel weaker, I feel better. I feel like going out or working. It's like a schizophrenic feeling when I'm fasting - I'm starving but I'm still happier."

"It's very free for me not to eat - I actually feel much better in myself."

"If I've starved and haven't eaten I feel good, very good. If I'm eating I feel terrible, depressed ... that's why I mainly eat a lot at **night** so that I can just go to sleep and forget about it and start again the next day ..."

"When I'm eating **healthily** and losing weight I know I will be happy."

"If I haven't eaten I just feel on top of the world."

Being able to control one's eating is experienced as an achievement, as something to be proud of. ✓

"When the anorexia began, I did not think I had a problem. I was actually proud of losing all the weight. It was nice to have that control."

Another interviewee, speaking with pride about being able to control her eating, stated:

"Now I know I don't need diet pills, I can do it alone."

When asked why she thought she had an eating problem, another interviewee replied:

"I wish I knew ... it started with depression, with a loss of appetite, but it's not that anymore. When I lost weight it immediately changed to a desire to achieve something. It felt great - it was the only thing I got pleasure out of. I was feeling very down before that, and when I began losing weight I felt quite exhilarated."

No matter how much pain the control involves it is experienced as preferable to losing control. The pain involved becomes a positive experience as it is a reflection of the control: ✓

"My whole life is like a control. Sometimes I feel like a masochist - it's weird - I enjoy these feelings. I enjoy waking up feeling hungry, I enjoy getting hunger pangs, I enjoy waking up in the middle of the night with stomach cramps from the laxatives."

Because of the positive feelings associated with restrained eating, some interviewees would manipulate their eating to create their moods or to prepare for a difficult time ahead:

"If there are negative things approaching on the horizon or things irritating me, I just want to get control. So I start dieting."

"I know if I'm going to a party or I'm going to meet someone nice, then for that day I won't eat because then I'll feel good"

#### 5.4.4 Ambivalence towards food: nurturer and destroyer

It is clear from the above that food is viewed as something   
threatening and anxiety provoking. Food is something which must  
be rigidly controlled in order to maintain control over one's  
life generally. Control over food equals control over self  
equals happiness and well-being. It also means controlling one's  
size, as fatness is directly equated with eating (refer to  
Section 5.4.8 and 5.5.3). If you control your eating you also keep  
yourself thin. Thus control over food means a sense of well-  
being both in terms of the positivity associated with restrained,  
controlled eating and in terms of the idealized image of  
slimness. And yet for most interviewees food is also experienced  
as something nurturant. They believe that it is something that   
brings comfort and warmth, and is used during times of emotional  
upset, as is expressed by a number of interviewees:

"Food is symbolic of motherliness and nurturance, love and   
fulfilment of your needs."

"Food means nurturance. I eat a lot when I'm feeling  
powerless and weak."

"When I'm under stress or have emotional upsets I  
immediately go up a couple of kilograms. I'm not the sort  
of person who goes around feeling terribly depressed and  
moping or showing it. So the only way I can release my  
emotions is by eating ..."

Behaviour around food is thus understood as associated with their  
emotions by many interviewees:

"My eating habits are **completely** related to my emotional  
well-being or not well-being."

One interviewee understands her laxative use as an emotional  
catharsis:

"Laxatives get rid of the emotions and the food."

Another expression of the relationship between eating and emotions, is illustrated by the fact that some interviewees experience their eating behaviour as as an expression of negative feelings towards themselves. They believe that they use their eating controls to inflict hurt upon themselves or to intensify negative emotions already present:

"When I'm really feeling deprived and rejected I deprive myself even more ... I live out the rejection by feeling empty, by depriving myself of food."

"When I know there's going to be a bad time ahead, then I punish myself more, I set more limits. Eating is part of a regime I set up for myself. For example if I am writing exams or someone close is going away, I will set up a diet for myself."

Overeating, according to the interviewees' standards, or eating "bad" foods is also experienced by some, as a way of inflicting hurt on oneself:

"I see bingeing as a self-destructive thing - it means I am angry with myself. Because when I don't eat I'm feeling kind to myself. I might not be being nice to myself by starving, but that's the way it feels. It feels like I'm not showing respect to my body when I binge."

"I see the bingeing as part of a self-destructive theme in my life ... I pull myself down ... So bingeing is a way of undermining myself. I'm constantly doing that. Things will go well and then I'll suddenly binge."

Some interviewees recognized that they displaced anger towards others onto themselves through the medium of what they perceived as self-destructive eating:

"If I was feeling very angry at someone else and I could not tell them, then I might binge. Then I would feel really shit at myself and it's easier to feel shit at myself."

The ambivalence involved in interviewees' relationship to food is clear in this quote:

"Food is part of a need for nurturance, a need for love. But I also manipulate control over it to punish myself. "

#### 5.4.5 The "good" and the "bad"

From the regular use of the term "bad" food above, it is clear that a distinction between "good" and "bad" food exists in the minds of the interviewees. There are foods that are "forbidden" because of their social stigma as being fattening or unhealthy. These are the foods which are most frequently eaten during a binge. And there are the "good" foods which are associated with health and diet. The good/bad dualism in terms of food is evident in these quotes:

"To me there are diet foods and there are other foods. In a binge phase I never eat diet foods, that's why I can't eat small quantities of these foods, because they are divided in my mind."

"As long as I can remember I have been dieting, conscious of the good and bad foods."

It is quite clear that along with this dualism goes a thorough and sophisticated knowledge of nutrition. Most interviewees know a great deal about calories and what foods are slimming and healthy or fattening and unhealthy, as one interviewee expresses it:

"I know everything there is to know about diets and the right type of food to eat."

The split in types of food is paralleled by a split in eating behaviour for most interviewees. They tend to view themselves as passing through "good" and "bad" phases of eating, "dieting" or "bingeing" phases. What they eat will be greatly determined by what they have "named" their eating phase to be. If they have defined themselves as being in a binge phase then "bad" foods will be consumed and usually in "excessive" quantities according to interviewees.

The following quotes illustrate these split worlds of eating:

"If I was on a binge I would eat four pieces of cake. If on a diet I would eat none."

"In phases of restraint anything unhealthy or sweet becomes forbidden. But unhealthy things will become part of a binge. In a binge I eat things that I don't usually eat."

The perception of the appropriate amount to eat is also determined by the definition of the phase:

"In starving phases anything I put into my mouth is a lot. On the other hand when I'm bingeing anything is okay ... the more the better, because officially I am bingeing, so under that heading I can do what I want ...

Bingeing behaviour is also relative to the definition of the eating phase and is relative to the interviewees "normal" eating, as these quotes illustrate:

"My bingeing is not like you see on the TV. I call it my diet mind - when I'm conscious of my weight bingeing is two slices of bread."

"I know for most people what I consider a binge is normal eating - if I have a pizza at night I'll consider it a binge."

For many interviewees there is a consistency involved in the definition of the phases. Thus if one starts the day in a particular eating mode it will usually be continued in that way as the following quotes from different interviewees indicate:

"If I have breakfast I'll feel bad, I'll feel like I've already binged and then I might as well just carry on bingeing for the rest of the day ... I might as well just carry on eating all day once the day is spoilt."

"I wake up in the morning thinking today I'm not going to eat or I'm going to eat well. I start feeling hungry and I think 'I'll just have one thing'. So I have one slice of toast and then I think 'I've fucked it up already so I might as well carry on ...'"

For most interviewees the split of "good" and "bad" food and dieting and binge phases is reflected in their own responses to themselves. Many of them speak of a split self, a "good" and a "bad" self. For some interviewees, the "good" self is the one who controls food intake appropriately and eats "good" not "bad" food. The "bad" self is the one who binges and eats "bad" food. For some interviewees the "bad" self is also the one who takes laxatives or vomits, for these behaviours are rationally considered by those concerned to be bad for them. The following quotes illustrate this dualism experienced within the self concept:

"I feel there are two people in me, one of them wants to eat, and another does not. When I manage to be the person who doesn't want to eat then I feel much happier."

"Although I can talk about it now, it's almost like a totally different person who does it. I could walk out of this room and take a laxative or a dietpill. It's almost like another thing comes out of me and of its own will takes these things."

"When I'm going through a fine phase, it does not enter my thoughts and it seems almost strange and disgusting that I make myself sick."

"When I take laxatives it is like the evil part of me doing it ... I realize it's wrong but theres that bad part of me that comes out and I do it so quickly ... it's not me, it's the evil part of me."

#### 5.4.6 An abnormal/normal problem

For many interviewees there was a feeling that they were acting "abnormally" in terms of their thoughts and behaviour around food, that there was something "ill" about them. These quotes illustrate this:

"Eating has become the centre of my life and I don't think that's normal. "

"I made myself become pathological. My attachment to food is pathological."

Despite this feeling, it was difficult for interviewees to relate to what they understood as "normal" eating behaviour. Thus while recognizing that their attitudes to eating were not "normal" by others' standards the "normal" was something foreign:

"Seeing people eat just three meals a day is hard to understand - it's become abnormal for me ... Normal people to me are abnormal."

"I feel like I'll never be able to eat like a normal person."

In spite of the interviewees' recognition that behaviours like self-induced vomiting and laxative abuse, were "pathological", they also had definite positive meanings for them. In spite of their awareness of the physiological dangers of these behaviours and the fact that they are associated with anorexia nervosa and bulimia, all those who practised them felt a sense of pride about it and did not find them disgusting. Rather these behaviours were described as an "achievement", a clever way of keeping slim if one could not be restrained enough about eating.

The following quotes are illustrative:

"It was amazing that I could eat as much as I did and then just vomit - I felt so in control of my body."

"I was quite proud of it, I thought it was very clever because I could eat and it just would not go anywhere ..."

"I saw myself as being better than others because I could vomit ... My friend and I discussed it and she said she could not do it and I said I could and it was like I had one up on her."

"It was such an easy way out. I discovered it one day and said 'that was quick and easy'. I remember thinking that it was rather revolting, but it does not seem revolting. It would seem disgusting to an onlooker, but it's actually very clinically done. Once it's done, you wash your hands and face, make sure the toilets clean so there's no mark of me having been there. I'm feeling better within myself, I'm not feeling so bloated and I know it's not going to show on my body ... I know it's crazy as it messes up your insides and it's not how you're supposed to work. But I had found an outlet for undisciplined eating."

For one interviewee it was a clever way of keeping everyone who was concerned about her eating happy, while at the same time maintaining her weight loss. For she appeared to be eating to the eyes of the world:

"I thought I'd keep everyone happy so I stuck my finger down my throat."

That self-induced vomiting is not considered "abnormal" by those practising it is borne out by one interviewee who did not consider herself to have a problem until her mother "labelled" it:

"My mum said to me 'it is a real problem - you are a bulimic'. I had never even thought of it as label, I found out from her, before that I had not really thought of it as a problem."

For many of the restrained eaters too, the self-starvation was only viewed as a problem when identified as such (refer to Section 5.2.2). That self-induced vomiting is perceived in a positive light is also borne out by the widespread feeling of other interviewees that they would have liked to have done so if they could, despite their "better judgement". For example:

"I've tried to vomit, but I can't. I love it when I get nauseous and vomit spontaneously. I always wished I could vomit. "

"If it had been easy for me theres no doubt in my mind that I would still be vomiting today. I admire, well not admire, but I just think people who can vomit are so lucky."

"I've got a friend who is bulimic and she was talking to me about it and I was actually jealous. It's very strange - I was actually jealous of someone who is sick." ✓

And for those who could not vomit and were looking for ways of ridding themselves of food already consumed, there were laxatives:

"I was trying to find an easy way out ... the easiest diet ... laxatives are wonderful, I can eat and still get rid of the food."

"If you really go too far then just get it out with laxatives - I find it very difficult to vomit."

#### 5.4.7 Resisting the eating/body problem

Most interviewees view their concerns and problems with eating as an undermining aspect of themselves. They experience resentment towards themselves for having the problem. The reasons for this resentment are different for different interviewees.

For those with a feminist consciousness, about half of the sample, anger and frustration is experienced as a consequence of not having internalized theoretical insights on an emotional level:

"I'm working through feminism, reading feminist literature. And I really understand the theory behind it but I can't seem to do it now, I can't be happy the way I am."

Having a feminist consciousness and not being able to put it into practice invokes guilt:

"I go and look at myself in the mirror and I just don't like what I am seeing and so I start a diet. And then I feel guilty - I should be conscientized enough not to do it."

For others there is anger at themselves for conforming to society's demands:

"I get angry with myself for conforming to the world's standards but at the same time you can't help it."

The eating problem is not accepted easily by most interviewees and there are feelings of self-disgust and lack of respect for themselves as a consequence.

"I've got no respect for someone like me."

"I get very irritated with myself that this takes up so much of my time."

"I feel it's a very trite thing to be obsessed about and not very interesting either."

#### 5.4.8 Relationships between attitudes to eating and the body

An equation is set up ... between what goes into your mouth and the shape your body will be. It is as if we swallow a mouthful and it goes immediately, without digestion, to join the 'cellulite'. (Rosalind Coward, 1984, p. 105).

Eating behaviour and feelings about the body are closely associated with each other for most interviewees. For many the eating problem is understood as having developed from a concern about body size, as one interviewee who had been through an "anorexic phase" expresses it:

"If I did not care about my body I would never have become anorexic."

And another interviewee illustrates the effect of body consciousness on her eating behaviour:

"As soon as I became conscious of my appearance I would start purging and starving."

For many interviewees feelings towards their bodies are integrally related to their eating behaviour:

"My revulsion for my body is related to revulsion I feel for lack of control over eating. I don't think that I would feel so bad about my body if I did not feel bad about having no control over eating."

"When I'm eating a lot I won't look at myself in the mirror."

"If I'm not eating a lot I feel much more acceptable ... attractive bodily ... When I don't eat a lot I feel good about my body ..."

Thus the body is seen as a reflection of the eating behaviour and feelings about it hinge on what and how one has been eating:

"I feel my fat gives away my undisciplined eating habits - my body reflects my eating."

"I've always been very conscious of my imperfections. I feel very exposed by my body, like it's saying to everybody 'I am weak, I don't have enough self pride to motivate myself'."

Most interviewees express the feeling that as soon as they have eaten they feel different about their bodies, as if there is a direct relationship between food and fat, which often defies common knowledge nutritional facts:

"After a binge I feel different ... I feel bigger, feel bloated, feel like I've put on two kilo's."

"When I have an extra piece of bread, I know tomorrow I'm going to be feel horrible and uncomfortable in those pants again ..."

"While I'm eating I'm thinking of fat ... I can almost feel where it's going to go ... You immediately become aware of the fatter parts of your body."

"When I eat I instantly feel like I've put on weight. I think about how much the food on the plate weight and think that's how much weight I've put on."

The feelings about the body after eating are also determined for most by the type of food eaten - "bad" food makes one feel "bad" about one's body:

"My body feels corrupted if I eat something bad and I feel awful about it ... If I eat a little chocolate I will feel like I've put on a whole lot of weight whereas if I eat a tuna salad I will feel different ..."

And if one has been eating in a restrained way or has rid oneself of food eaten, feelings about the body appear to improve:

"The only time I feel good about my body is when I have not eaten ... I feel more confident about how I carry myself..."

"When I vomit my body shrinks in my mind. I feel tremendous relief ... it's gone .. it won't go to all those places on my body."

The strong association between food and fat leads many interviewees to desire extreme thinness of body so as to legitimize eating. While recognizing the negativity associated with anorexia, this interviewee still admires it for its slimness:

"I used to think at least she (the anorexic) does not have my problem, she has a different problem which I would enjoy more. It's easier to work from that side of body size than from the fat side ..."

Other interviewees express similar sentiments:

"I often have these feelings that I would like to be so thin that I could just eat, thin enough to afford to eat."  
"I envy those people who can just be thin and eat ..."

## 5.5 Attitudes to the body

### 5.5.1 The value of the body

This is her look  
This is his style  
This is her shape  
And this is his performance. (Opel Kadett Advert, 1986)

The body and its appearance appear to be of great value in the lives of the interviewees. The body is experienced as a vehicle by which many personal goals, especially a sense of self-esteem, may be attained: As one interviewee expressed it, being attractive and slim is important for women "because it gives you power, confidence, ..." Many women expressed the importance of appearance in their lives, illustrating how the ideology that if one is attractive by social standards one will be socially accepted, has been internalized.

"I am very aware of appearance. It is the first thing people see. You constantly want to make an impression on people you meet so you must look good. People put a lot of emphasis on looks."

"I'm just so aware of the difference when you meet someone attractive or unattractive."

"That's the first image people get of you. You don't get your personaliy rushing out like beauty does with someone who is attractive."

For some women extreme dislike and dissatisfaction with the body is experienced, for example this woman speaking of her body states:

"It's revolting. I hate it - I hate my legs, my thighs are the absolute worst. I can always feel them. I'm always conscious of them ... I hate looking at myself in mirrors, I despise my body."

For others the body is not as extremely rejected, but it is fragmented with certain parts causing offence:

"It feels alright overall but if I look at parts, like when I'm in the bath I can see it better, I see all that useless stuff on my stomach and round my back."

Most of the interviewees are involved with a constant critical appraisal of varying intensity of their bodily appearance in which there is never satisfaction, particularly in terms of thin/fat and weight issues. Within this criticism there is a constant desire to change the body which is viewed as an object to be acted upon:

"I am constantly aware of my body - I always want to change it."

"I was never perfectly happy with the way it was ... always wanted to be thinner."

"I know with my head it's (her body) not fat, but my first thought is I could lose some weight. I always resent it in a strange kind of way. Because I know I have an attractive face and I think 'damn that bum'. I see my body as a downfall."

"I will never be satisfied. Even if I had the most perfect body ... I would find something else, my nose probably !"

The self-criticism is evident in many interviewees inability to accept compliments about their bodies, as one woman expresses it:

"I don't believe anything positive which people tell me about my body ... I believe the negative things."

It is clear that even the goal of slimness is not enough to bring satisfaction:

"Even when I was thin I was not satisfied with my body. I was thin enough but not the right shape."

For most interviewees, their relationship to their bodies is an ambivalent and fragmented one:

"I love some parts and I hate some .. sometimes I feel very positive towards it and sometimes very negative."

And another interviewee speaks of what she likes about her body:

"The parts of my body I like are those that are controllable, that don't hang out. The ones that are out of control are the tummy, breasts - they're untidy. I like my back and the lower parts of my arms."

The self-criticism and rejection of the body in which these women are involved is revealed in some interviewees' fantasies of dispensing with it altogether:

"It would be nice to have just a head, cruise around on wheels."

"I used to fantasize about hiring someone else's body for 24 hours every day."

Feelings about the body play a role in determining feelings about the self in general as well as determining life-style as is illustrated by these quotes:

"The way I feel about my body affects everything, it affects the way I feel about people, the way I feel about myself..."

"When I was fat I hated my body. I did not want to go swimming or go out. Even if I had something smart on I did not feel smart which reflects back on how I felt about myself - I did not feel smart as a person."

### 5.5.2 Preoccupation with body size, shape and weight

The central aspects of the obsession with bodily appearance are the control of weight and the acquisition or maintenance of slimness, as is evident in these quotes:

"I was obsessed with getting thin. I would never wear clothes that might make me get fat ... I used to enjoy it when people said 'look how thin she is' ..."

"Losing weight occupied me a lot ... it was part of a more general obsession with my image. I would buy a lot of baggy clothes thinking I was slim underneath them."

The goal of thinness was for many women the central one in their lives at some stage and a goal that they would pay any price (both financial or other) to achieve:

"You know if I could have spent my whole salary every month to be thin, I would happily have worked **just** for that reason. I was prepared to work for nothing else but to keep my weight down."

"I wanted to get thin at any cost. It did not bother me at all what I was doing to my body by not eating."

The intense emotions associated with the goal is illustrated by this quote:

"If someone could look into the future and say that I'll stay the same weight for ever and not lose it I would throw myself over the balcony."

Even for those who were or are not "fat" by social standards, the fear of becoming "fat" appeared to be a constant one, threatening their sense of well-being. Often this fear is one induced by threats from others, for example this interviewee's boyfriend:

"He made me very aware of what I ate. He would say 'do you think you should be eating that?' And I would say 'but I'm not fat' and he would agree but reply 'you'll get fat' He constantly hung this threat on me, that I would get fat"

Another interviewee's mother would comment: "You better be careful or you will end up like your father ..." (who was overweight).

For many interviewees it is the fear of becoming "fat" and the tenuous grasp that they feel they have on being slim that perpetuates the compulsive dieting:

"I feel I could easily get like that ... it's a horrible image. If I was fat I would not like myself, nobody would like me ..."

"I am afraid of getting fat, that's why I diet."

"I have a terrible fear of being overweight - it's absolutely paralyzing."

The fear of being overweight is particularly intense for those who have felt themselves to be overweight and experienced it negatively, as this quote illustrates:

"I can't stop dieting because I have this intense fear that if I stop monitoring my weight I am going to get fat again ... That's why I can't get out of it because I'm so scared that it's going to happen again, that I am going to revert to that miserable fat 13 year old ... As unhappy as I am now, as much as I hate this syndrome and it controls my whole life, it's still infinitely preferable to being fat."

The fear of being overweight leads to a need to control the body and its weight which is manifested as a preoccupation with monitoring and measuring the body size and shape. This control pattern appeared to be one necessary to the overall sense of security of some interviewees. All interviewees had been through phases or were still experiencing an intense awareness of their weight as is illustrated by the following:

"I'm constantly aware of whether I am putting on weight - if I do then I will diet."

"I feel insecure without a scale. I need to monitor what's going on."

"I need to keep my membership with Weight Watchers. I just feel secure knowing that I've got it, I'm going to be weighed ... Whether I'm sticking to it or not, I feel better having it."

"I weighed myself very often and was very conscious of my stomach size. If I ate a bit over I would feel it was large and uncomfortable."

"I weigh myself every morning. I think it's a good habit. If I'm a kilo more then I'm a little more careful that day."

"It was an absolute total obsession - for about 10 years I can remember my weight at every important point."

"I can trace the stages of my life through what weight I was and my attitude to eating."

"If I'm deprived of a scale I'll resort to tape measures or start monitoring using clothes."

For some interviewees life was experienced as suspended until the goal of weight loss had been achieved. This focus on the future and the belief that being slim will change one's life is clear in the following quotes:

"I would say to myself when you've lost x amount of weight then you're allowed to buy clothes ... or I don't want to go out yet - when I've lost weight I can ..."

"I used to think if I was slim and beautiful I could do this..."

### 5.5.3 Negativity associated with fatness

Save the whales, harpoon a fat chick. (car sticker)

It is already clear from the above that fatness is associated with negativity on many levels. An equation has been set up in which thin is equated with all that is physically attractive and healthy as well as with psychological well-being and happiness. Fat, by contrast, is associated with ill-health, unattractiveness, unhappiness and psychological problems. For many interviewees the equations of "thin equals all that is positive" and "fat equals all that is negative" are deeply internalized and have also been their real experience. When they were "thin" most interviewees did indeed feel better and did receive more social rewards for being so:

"The time I lost all that weight, I don't remember ever being as happy as I was then. I know everyone always says if you lose weight it does not mean you'll necessarily be happy. But for me it was, it really was. When I was losing weight, coming close to my ideal, I was a happy, happy person. I was in a secure relationship, there were lots of nice men after me, I felt amazing about myself, I looked good in clothes ... everything started coming right..."

"When I'm thin I get more extrovert. When I'm fat I feel unconfident and so conscious of what I look like."

Some examples of the equations set up about fat and thin in these interviewees' consciousnesses include the following:

Being thin = being loved: Being fat = being unloved: ✓

"Everybody's attitudes changed towards me. It was then that I realized that if I was beautiful than people would love me, be more attracted to me. When I was fat and ugly nobody wanted to be near me"

Being thin = healthy: Being fat = unhealthy:

"I do think it's important to try to keep yourself as healthy as possible. Slimness and healthiness go together. I still think that slim as opposed to fat is important."

"I always put fat and unhealthy together."

Being thin = social acceptance/confidence: Being fat = rejection

"I had a very thin sister. I was amazed at the ease in which she slipped into adolescence - she was so confident. I thought it was because of her body ... A socially nice body would have made me more acceptable. It was one way of getting acceptance and popularity and confidence."

Being thin = femininity: Being fat = lack of femininity

"I feel like a big strong macho next to frail feminine woman. Thin women make me feel unfeminine."

Being thin = being happy: Being fat = unhappy, depressed

"People who are fat can't be too happy. I just know for myself if I'm fit and slim then I feel good. And I always think that people who are fat can't feel good. But it can't be true, all fat people can't be suicidal."

"... ugly, unattractive to others - for me it's unhappiness within myself."

"I immediately assume that they (fat people) are feeling as shit as I did. I tend to associate overweight with unhappiness, misery, rejection of your own body. To me putting on weight is a form of self-hatred. I punish myself when I put on weight."

Being thin = more me: Being fat = not me

"When I'm thin I find that I am far more outgoing. I can be more myself than I usually am."

"Being fat means I can't work properly. I can't be myself."

For some interviewees the desirability of being thin entailed a contradiction. Although they felt better on some levels they also associated thin with smallness and vulnerability, particularly in terms of sexuality, as one interviewee expressed her feelings following a large weight loss:

"I felt much more secure about myself but I also felt as if I was not wearing any clothes, I just felt completely naked and in view ... So obviously you have to put on layers of covering, in term of flesh, to cover up... I was surprised that I felt vulnerable as somewhere embedded in my head that's the right thing to be (thin) - the woman you've always wanted to be emerges - having lost the weight I felt exposed around the issue of sexuality."

For most interviewees, the thought of having fat on their bodies is experienced very negatively:

"It sickens me, repulses me to have fat on my body."

Some of the words used to describe fat include:

"...useless, not desirable, yellow, mushy and blubbery."

"really disgusting, white, blubbery, really ugly."

The fat on their body is experienced as something useless and external to them:

"I see my fat as something external to me ... I feel it as an addition to me as I walk around ... that's not me. I'm not prepared to accept myself as a fat woman."

"I'd do anything to get rid of it (fat) ... I grab a whole handful and I think 'how disgusting, how will I ever get rid of this ?' - it's like something you have to carry with you all the time"

"It's this thing hanging on to my body. It's not a part of it. It's something that is totally alien - it should not be there - it should go away."

There are many negative associations with fatness. Some of the central associations include the following:

Fatness and overeating:

For most interviewees fatness is strongly associated with eating too much or eating the "wrong" things. Fatness is understood as being caused by uncontrolled and excessive eating for most interviewees, even if they feel this to be untrue on a rational level:

"I associate fatness with eating even though knowing large people I know it is not linked with that - it's a myth to say it is."

"Fat" people are viewed with disgust if they eat a lot:

"When I see fat women eating I think "you're crazy, where's your self-respect ?"

And yet they are not believed when they eat a little:

"You know she will go and eat after the meal."

"I know that fat people don't eat normally,. They might be eating normally at the table, but before that they might have gone mad eating, and after that they might go mad eating. But I know that in front of other people they especially try to eat normally."

Most interviewees, on an emotional level, felt that "fat" people do not deserve to eat, especially large quantities and "bad" foods, and feel disgust if they see them eating a lot:

"I get very repulsed when I see obese characters stuffing their faces."

Yet "thin" people "stuffing their faces" are considered to be fortunate:

"For a thin person that is her blessing in life, that she can eat and not get fat. But I can't understand a fat person eating fattening food."

"Fat" people are perceived as being out of control around food. They eat either because they have an "eating problem" or because they lack respect and care for themselves ("thin" people "look after" themselves, "fat" people don't), as the following quotes illustrate:

"When I see fat people, I think why don't you do something about it? It's good to be slim and eat healthily. Anyone can lose weight. It's easy to do. I still think it's good to look after yourself."

"When I see someone overweight, my immediate thought is that person has some sort of problem."

It is clear that, as one interviewee stated: "People never think you've got a problem (with eating) unless you're overweight or grossly underweight."

Fatness is a trap: ✓

Fatness is perceived as something outside of one which is preventing one from being a full human being.

"I feel totally trapped, like this thin person trapped in this fat person."

For those who idealize muscles fat is inhibiting:

"Muscles are marred by fat."

For those who idealize beauty by social standards, fat hides this too:

"She'd be much more attractive if she lost weight ...especially if she has a beautiful face, I think what a pity"

Fatness connotes lack of sexuality: ✓

The media stereotype that only slim women are sexually attractive is internalized:

"You cannot be perceived as sexual when you're fat."

Fatness and old age ✓

For some interviewees fatness is associated with the ageing process. This is negative following the privileged place that youth assumes in Western culture and the popular media in particular:

"I can see my mother's body when I look at myself. I can see exactly what I'm going to look like. For me, fat means ageing, getting old ... I can see my body turning into hers."

Fatness equals passivity and lack of energy: ✓

Fatness is associated with a "heaviness" both emotionally, in terms of depressed mood, and physically. Being fat means lacking energy and being inactive. For this interviewee, fatness is associated with being...

"...out of control, passive, depressed, lying in bed all day, uncomfortable, it drags you down. There is nothing empowering or enlivening, nothing useful, comfortable or energetic about it."

Fatness is "abnormal" ✓

Fatness is perceived as "abnormal" in so far as it is so different to the social ideal:

"Being fat means that I am different from what **society expects of you** and different from what I want to be. You feel totally left out of society, a total misfit."

The ideology that fatness is an abnormality in our culture is borne out by the pity for "fat" people expressed by most women interviewed, together with patronizing attitudes:

"I really feel sad for her (fat woman), but in another way I think why don't you pull yourself together and do something?"

"I feel sorry for fat people."

"I feel I must be careful not to mention anything about fatness or about diet ... I feel I have to protect them as I imagine they're sensitive to it."

#### 5.5.4 Body consciousness

Because she is forced to concentrate on the minutiae of her bodily parts, a woman is never free of self-consciousness. She is never quite satisfied, and never secure, for desperate, unending absorption in the drive for a perfect appearance - call it feminine vanity - is the ultimate restriction on freedom of mind. (Susan Brownmiller, 1984, p. 51

It is clear from the above that the preoccupation with bodily appearance, weight, size and shape and fear of fatness leads to an extreme self-consciousness. This is reinforced by the social realm in which, as John Berger (1972) has shown, woman is constantly under surveyance. Most interviewees felt more self-conscious of their bodies in contexts in which they perceived more judgement:

"I feel that people are looking at me and thinking 'how fat, how ugly, how awful' !"

"Like walking through the student's union I felt very big and heavy and felt that people were looking at me as something abnormal."

"I feel very aware of it (her body ... uncomfortable about it, especially in the streets ... And I just feel eyes on me. It creates a lot of anger and humiliation and hurt to. I refuse to wear bathing costumes. I always felt strange when swimming with people looking at you."

"I often feel conscious of being weighed up according to my body. For example comments about weight. My cousin always says things like 'you haven't put on weight'. They usually say positive things but the very fact that they are noticing positive things means that they notice negative ones as well."

"You know the types, some girls who just look at you and you can feel their eyes going up and down your body."

"I feel uncomfortable in a setting where people expect women to be thin or that women should not eat too much."

The majority of interviewees felt more conscious of their bodies in the context of the beach or swimming pools where more of their bodies are exposed. Body consciousness was also heightened in discos or at parties where they felt on display. For example:

"I feel very conscious on the beach. I never stand up without a towel around me. I'll take it with me right until the edge of the water."

#### 5.5.5 Woman as comparison

Hippy or scrawny, busty or flat, the general principal governing the feminine body is not subject to change. How one looks is the chief physical weapon in female-against-female competition. Appearance, not accomplishment, is the feminine demonstration of desirability and worth. In striving to approach a physical ideal, by corsetry in the old days or by a cottage-cheese-and-celery diet that begins tomorrow, one arms oneself to fight the competitive wars. (Susan Brownmiller, 1984, p. 51.)

Awareness of the bodies and physical appearance of other women was a common experience among this sample. Many of the women used body size, fat or thin, as a category when viewing other women:

"I try not to, but unconsciously, I do judge people by weight. I think things like 'she should lose a bit' or 'she's put on weight'."

"When somebody comes into the room, the first thing I notice is their body shape and size."

They tend to compare themselves to others with weight being an important dimension. Here are some examples of the process of comparison:

"I put people on a plane and see where I fit in."

"I usually make a snap comparison and then judgement rests. Women tend to do that a lot. We are brought up to see ourselves as rivals. So I do tend to compare a lot."

"When I'm feeling threatened by other women I find myself comparing a lot and saying things to myself like 'I may be fatter but I've got a better shape'".

The comparison is also carried out for many of the interviewees in terms of actual body parts, like comparing leg size or stomach size. Those body parts which are felt to be most problematic will be the most compared. For example one interviewee thought she had the "smallest breasts in the world" and would be very aware of other women's breasts. Another interviewee had a similar problem, feeling her breasts were too large:

"When I was at high school I was very aware of my breasts being big and I remember thinking how much bigger they were than anyone else's."

Competitiveness between women in terms of being slim and attractive (by social standards) was a common experience for the interviewees, especially during their adolescence. The following quotes are illustrative in terms of attractiveness and slimness:

"Girls can be incredibly judgemental. Especially if you are attractive and there's another attractive girl in the group. She will tend to suss you out and pick out your flaws and think 'I've got one up on you'."

"When I'm in the company of someone really attractive it makes me feel uneasy. One can't really feel attractive with their beauty around."

"Sometimes I have this nasty suspicion that I don't want anyone else to get thin - like it's a competition."

"There was a lot of competitiveness at boarding school. My friends did not want me to lose weight and get too thin."

Within the competition there is a tendency to covet that which is perceived as attractive in the other:

"If I see really nice legs I will think 'how come I did not get that?' or 'I wish I had her discipline'."

"If there's some feature another woman has that I really admire, like long legs, then I will wish that I had them."

The competition between women is experienced in terms of eating behaviour as well, with success as a dieter being a key concern:

"Theres always a bitchy thought when I watch a woman eat, I think let her eat, let her get fat."

The competitiveness and process of comparing between women is also illustrated by interviewees feelings about being in the company of "fat" or "thin" women, attractive or unattractive women:

"I feel more comfortable with fatter women, it makes me feel thinner while with thin people I feel fatter. I tend to lounge around more with my fatter friends. With my thin ones I pull my stomach in and try to look my best."

Most interviewees echoed these feelings. Being in the company of "thin" women elicited the following:

"I feel inferior and very fat even if I've been starving."

"I feel really self-conscious. I'd rather expose myself to somebody the same size as me."

"I feel envious, feel less confident."

Being in the company of "fatter" women was a more comfortable experience:

"I feel better. I feel slimmer."

"I would feel quite chaffed. I would feel thinner, happier and good about myself."

"I feel more superior. I feel thinner, prettier and happier."

"Anything worse than me I sort of look down on."

### 5.5.6 Men and body consciousness

In our obsession with our own flesh, in our repeated efforts to strip it of the abundance that arouses male envy, we have unwittingly enrolled ourselves in this troubled tradition of repugnance for the body. And we have allowed the men of our culture to persuade us that this fleshly miracle granted to us through our membership in the female sex is really a cause for shame and disgust.  
(Kim Chernin, 1983, p. 120)

Men appear to have played a role in the development of these women's attitudes to their bodies on many levels. Many of the interviewees could trace the start of their consciousness about weight and dieting to their adolescence with these issues articulated around a desire to attract men (refer to Section 5.3). Although this was not the only factor playing a role in creating the consciousness, as it was very much a norm in its own right, it was an important aspect of the diet/weight consciousness:

"I remember as I started becoming interested in guys I became more aware of myself and my body."

Consciousness about the body is felt most intensely in the company of men and many interviewees felt that men scrutinize their bodies, which is experienced negatively:

"I'm more aware of my body with men, they look harder."

"I am more frightened that I am being judged according to my body in the company of men. I feel ashamed. I want to talk through something so that my body is not a part of what I'm saying. I prefer to talk over the phone ..."

"I cannot work in male wards at all. If I walk in there it freaks me out - all those men sitting in bed with nothing else to do but to look at me ... they're trying to see whats underneath the dress."

Being in the company of men also increases the competitiveness between women, discussed above:

"If there is competition around I feel more conscious about my body. But if I'm in the company of males only then I know they can't compare me to anybody else."

A number of interviewees experienced difficulties in terms of intimate relationships with men, as a result of their self-consciousness about their bodies. One interviewee felt comfortable being physically intimate with her boyfriend but did not like "being looked at":

"I'd even be shy to stand in front of him with a costume." Two interviewees did not like being touched by their lovers in the areas of their bodies that were perceived as fat to them. Some interviewees felt that their boyfriend/husband's love was contingent on their appearance, on the maintenance of their slimness, as one woman expressed it:

"He would not have loved me if I'd got fat ... He was very aware of image, not just body size but clothes and everything ... it was like a reflection on him what kind of body his lover had ... his love was very conditional."

For some women their male partner's responses had an extreme effect on their attitudes to their body as well as their eating behaviour (refer to Section 5.3). Thus one interviewee speaks about how her husband continually undermined her in terms of her body. Before meeting him she had felt attractive and confident about herself. Through the duration of the relationship these feelings were broken down. She said:

"He kept on and on about me being fat - it was a continual issue for him ... He had a very rigid idea of what the ideal woman should be and one of the criteria was thin."

Even before their marriage, he had urged her to diet, took her to exercise classes and later brought her a hip vibrator.

Throughout the relationship he used the issue of her weight as a way of undermining her. For example, once when she expressed a desire to put more energy into the relationship, he replied: "but you can't even get thin ..."

For most interviewees being involved with a man as a lover intensified the awareness of their bodies and their desire to lose weight, even if the pressure did not come from them:

"When ever I got involved with men I always lost weight. It was self-pressure not really from them."

"When I got involved with X I lost a lot of weight. I was very consciously aware of being thin for him."

"I see the problem as stemming from stereotypical things, like women wanting to be thin for men. It was for men when I was at school, and the attachment to food and dieting is from there."

"I suddenly started to have men in my life more and then I started thinking that they're not going to want me or desire me if I'm fat and so then I started dieting."

"Strangely enough whenever I got involved with a guy then I became aware of my weight again."

One interviewee found that when she went through a phase of being disinterested in men and only seeing woman friends, she found her self unconcerned about her weight:

"All this time I was eating a lot and not caring - I did not need to impress the boys. At this stage I was only involved with girls ... And what I found a tremendous relief was that girls did not make that demand on me - I could be accepted as I was ... But perhaps boys don't even make that demand on me, that's probably in my brain."

It is clear however that the concern with the body goes further than the demands of men, as a number of women interviewed were lesbians and still concerned about their weight and bodies, despite their lack of interest in male attentions. One interviewee stated:

"I have to consciously work against "lookism". It's still there, even in feminist and lesbian communities - women are still tuned into the physical."

For some women their physical largeness in relation to men was a factor contributing to the obsession with slimness. For being larger than men is experienced as stepping out of the feminine role:

"I was seeing a guy who was thin as a stick and I suppose I felt quite fat and butch comparatively."

Another woman interviewed also expressed a similar feeling. She felt that her husband may have been criticizing her fatness so vigorously because of his own inadequacies as a man - he was very thin and weak looking. He also undermined her strength in other areas, like not allowing her to laugh and be frivolous in public, which led her to this conclusion.

### 5.5.7 The ideal image

The ideal promoted by our culture is pretty scarce in nature; there aren't all that many mature women who can achieve this shape without extreme effort. Only the mass of advertising images, glamour photographs and so on makes us believe that just about all women have this figure. Yet the ideal is constructed artificially. There are only a very limited number of models who make it to the billboards, and the techniques of photography are all geared towards creating the illusion of the perfect body.

(Rosalind Coward, 1984, p. 45)

It has been shown that the ideal image for women at present is one which connotes powerlessness, a pre-adolescent body size and shape (Coward, 1984; Chernin, 1983). More recently the media image has become more concerned with images of fitness and musculature at the same time as being slim. For most women in this sample the ideal body size and shape correlated very highly with that presented in the media, for example:

"I would like a taller, slimmer body. I feel short and bulky. I would change nearly everything if I could - longer legs, bottom smaller, larger bust ... I feel it more elegant to be longer, you can wear tight skirts and show off your legs - you have a much wider scope."

Despite the fact that some of the more feminist-conscious interviewees associated the model images with ill-health and negativity generally, in describing their ideal shape and what they find attractive, they did not stray far from this image:

"I don't feel an affinity to magazine women - they don't come into my ideal at all and yet I do want to be thin ..."

Most interviewees had accepted the fact that their actual shape could not fit the ideal no matter how thin they became. Yet their ideal was still one which, within their own "limitations", fitted the social ideal.

Most interviewees felt they had been affected by the media image to some extent:

"I think that's how I picked up the desire to be thinner, I conformed ..."

For some interviewees their ideal was at times even slimmer than that of the media, an anorexic image, as this interviewee shows, speaking about her feelings during her anorexic phase:

" I thought I was too fat, mainly my stomach. I wanted a concave one. I love bones to stick out."

This is reflected by another interviewees desire to be as thin as possible - "it would not bother me if I did not have a shape - I hate curves, people think it's feminine but I hate it." But clearly this extreme thinness was not the ideal for the majority. The present media image which emphasizes muscle definition and is boyish and trim predominated:

"I want an up and down boyish body - slim body, small boobs, small bum."

"Now I buy into the muscular number and it's supposedly tied up with fitness - also as a feminist you should have muscles." (with a tongue-in-cheek tone)

"I used to be quite unrealistic about my body, wanting to be boyish ... I hated having big breasts."

## 5.6 Conclusions

In this chapter, the main trends that emerge from the depth interviews are reported. The central insights from this study are organized in the following categories: (1) the nature of eating/body problems among this community of women; (2) the attitudes relating to eating and food which prevail; and (3) the attitudes relating to the body.

### 5.6.1 The eating/body problem

An understanding of the types of problems associated with the eating disorders of anorexia nervosa and bulimia which prevail in this community was illuminated. The following main insights emerged in this respect:

(1) All of the interviewees considered themselves to have an eating problem, although none of them had been hospitalized and only two of them had been diagnosed by a general practitioner as having an eating disorder. Despite the non-clinical nature of their problems, many of them had experienced phases of the problem which appeared as extreme as those found with clinical cases of anorexia nervosa and bulimia. It is clear therefore that more problems of this nature are present in the community than have been recognized and diagnosed by professional clinicians.

(2) The problems described were very diverse. A range of symptomatology was evident. Thus some interviewees only binged while others binged and purged, thus fitting the diagnostic category of bulimia more closely.

(3) The phasic nature of symptoms was evident, i.e. symptoms changed over time. These changes occurred both in terms of the severity of symptoms and in terms of changes in behaviour. For all interviewees there was an experience of different phases of the problem in both ways described. Some interviewees appear to have fitted the criteria for anorexia nervosa and bulimia at one time or another, while others never reached those extremes. Some interviewees were primarily restrained eaters at some point in their history and later changed to a more bulimic position and vice-versa. This aspect is consistent with past studies, where phases, in terms of changes from an anorexic position to a bulimic one, have been recognized in extreme eating disorders (Sours, 1980; Vandereycken and Pierloot, 1985).

(4) The eating problem is perceived as a problem for the interviewees only under particular circumstances, which include the following:

(a) When they are overeating, eating "bad" food, not dieting and not eating "healthily".

(b) When identified as such by others. Most of the interviewees with anorexic tendencies only accepted or identified themselves as having a problem in retrospect or through being "named" anorexic or bulimic by parents or doctors. At the time they did not experience themselves as having a problem. The failure of anorexics to recognize that they have a problem has been acknowledged in the literature and has even become a part of the criteria for diagnosis (DSM-III, 1980). Bulimics generally recognize that they have a problem, which is also a part of the

diagnostic criteria for bulimia (DSM-III, 1980).

(5) In terms of binge eating and overeating, which were considered the most problematic behaviours, the definition of these behaviours varied from one interviewee to another. For some interviewees the definition depended on whether they were dieting or not. For others, they were aware that their binges were "snacks" or "normal" eating for other people.

(6) Dieting was considered to be at the root of the problem for most interviewees. Bingeing behaviour was usually preceded by dieting behaviour. A dieting and weight consciousness was perceived as determining the "abnormal" behaviours like laxative abuse, vomiting and bingeing. This supports findings of studies of women manifesting extreme bulimic symptomatology (Boskind-Lodahl and Sirlin, 1977).

(7) Social forces were considered by most interviewees to have played a major role in the creation of the dieting and weight consciousness. Social pressures to diet and be body conscious appeared to arise from peer groups, parents (especially mothers), socialization in the family and the media (particularly women's magazines). As emerged clearly within the section on attitudes to eating and body, men in particular were seen to have played an important role in the development of the problem - both as individuals and in terms of the general social pressure for women to be desirable to men. Other social forces which emerged as playing a role in the development and understanding of the problem were the influence of the media and professional

attention given to the eating disorders. The idealization of anorexia nervosa and bulimia both in terms of the body shape and the eating behaviour was evident. Professional understandings of the problem were seen to play a role in the interviewees' own understanding of the problem. Professional wisdom concerning these problems was shown at times to play a negative role for members of the family, as in the case of mothers who blamed themselves for causing the problem. The role of the peer group in educating "abnormal" means of weight control, like self-induced vomiting, was evident in this study as it has been in others (Schwartz, Thompson and Johnson, 1982).

(8) Attitudes associated with the disorders of anorexia nervosa and bulimia were very widespread among this group of women. It is clear that the attitudes, especially the preoccupation with eating, are themselves experienced as a problem. The constant need to think about what one is eating and how one is looking is experienced as a hindrance in these women's lives. It is clear that these attitudes are experienced for some of the group, as extremely as they are for anorexics and bulimics. The attitudes also change over time and obviously are experienced more intensely during times when the symptomatic behaviours are practised more frequently.

### 5.6.2 Attitudes concerning food and eating

The most prevalent attitudes associated with food and eating among these women are the following:

(1) Guilt about eating. Extreme guilt is experienced about eating "bad" foods, overeating (according to social and individual standards) and for some, even "normal" or healthy eating. This guilt is experienced particularly within the company of judgemental others and restrained eaters. The guilt appears to arise from a feeling that they don't deserve to eat - either because their body cannot "afford" it or because of feelings about overindulging. For some, the guilt causes self-consciousness about eating in front of others, leading to secret eating.

(2) Preoccupation with food and diet. Thoughts about eating, planning dieting and planning purging are prevalent. For some interviewees these obsessive thoughts are a result of having too much free time. The obsessive thoughts about eating, particularly "bad" foods is strongly associated with being on diet.

(3) Concern about control over food intake. Part of the preoccupation with food is that of planning the control over what is consumed and how it is purged. Control over food is strongly associated with control over one's life and a sense of well-being. In this way, the self-concept is seen as determined by eating behaviour. Eating "well" (restrained) determines positive feelings about oneself.

(4) "Good" and "bad" splits. Food is split into "good" and "bad" food. It is the "bad" food which is consumed during a binge. These rigid splits in food are reflected by a behavioural split as well. Many interviewees experience themselves as being divided between the "good" self who is restrained and diets, and the "bad" self who binges and then has to purge to get rid of the effects of this. The "labelling" of diet or binge is seen as determinant of the behaviour of the individual. For under the "label" of a binge, "bad" food will be eaten in excess quantities, while a "diet label" automatically precludes the consumption of these foods.

(5) Ambivalence towards food. Food is experienced as "good" and "bad". For many interviewees the popular psychological understanding of "food equals nurturance" is internalized. They believe that they eat for emotional reasons and use both bingeing and purging as emotional releases. On the other hand, food is experienced as something threatening - it is a temptation which will lead to overindulgence or fatness. Most interviewees felt that their bingeing was self-destructive behaviour. Restrained eating was also understood as a punishment and self-destructive behaviour for some interviewees. Thus, eating behaviour not only determines how you feel about yourself (that is, if you restrain your eating you will feel better) but it also determines what you are feeling: if you eat a lot you are depressed or feeling self-destructive. This ambivalence towards food has been well-documented by feminist writers on the subject of compulsive eating (Orbach, 1978; Roth, 1983).

(6) Eating behaviour determines body shape. A strong association between what one eats and what one's body will look like is experienced. Eating is experienced as an immediate modification of the body. "Bad" foods, especially, transform the body into a "fat" one. Restrained eating and fasting leads to sensations of slimness even if actual weight has not been lost.

### 5.6.3 Attitudes concerning the body

Attitudes and emotions about the body, its size and shape, which prevail, include the following:

(1) Preoccupation with body size and shape. Extreme fear about being overweight manifests as constant monitoring of body size and shape. Much time is spent thinking about the body and how it looks. There is much critical appraisal directed at the body. For some interviewees the body was strongly rejected and disliked. For most there was an appreciation of certain parts of it. In this way the body is fragmented with certain parts accepted and liked while others are rejected and disliked.

(2) Extreme self-consciousness about bodily appearance, size and shape. Body self-consciousness is experienced more intensely among judgemental others, when felt to be under surveyance or in certain situations, (e.g. at the beach), where more of the body is exposed. Being in the company of men increases this awareness for some interviewees.

(3) Association between bodily attractiveness, femininity and self-esteem. The interviewees felt their bodily attractiveness

to be a strong determining force of their overall value as human beings and women. As slim is the ideal of bodily attractiveness for women at present it is imbued with extreme positivity, with equations being set up with "slim equals attractive equals happy".

(4) Negativity associated with fat. Fat on one's body is experienced extremely negatively, as a useless and extra part of the body. Being fat is associated with all that is undesirable. Fatness is associated with unhappiness, physical inactivity, an inhibiting force, an eating problem, overeating, an emotional problem and old age. For some, notably interviewees with a feminist consciousness, their fat is understood as a protection against being attractive and therefore vulnerable to men.

(5) Competition between women. For many interviewees the body is experienced as a tool with which to compete against other women. Other women are weighed up according to their physical attractiveness, with fat/thin being an important category. Most interviewees feel better about their bodies and therefore themselves in the company of women fatter than them and vice-versa in the company of slimmer women. Individual body parts are often compared. Other women's bodies are coveted if viewed as more attractive than their own. The competition is experienced on the level of eating as well with restrained eating being admired and envied.

(6) Men and body consciousness. Most interviewees felt more conscious of their bodies in the company of men. When attracted to a man or at the start of a new relationship body consciousness will be intensified and dieting behaviour increased. Individual men have played a more direct role in determining attitudes to the body and to eating for some of the women. This role included negative comments about the body and eating, using the body issue as a way to undermine the women and making their affections contingent on the bodily attractiveness of the women involved.

(7) Acceptance of the social ideal body. For most interviewees, their ideal body size and shape correlated with the social ideal. Even those who rejected the models in the media or believed they had come to terms with their body and its "limitations", described an ideal which was slim and very similar to present media images. There was a tendency towards a preference for fit, muscular and boyish body shapes which is the media ideal at present (Coward, 1984).

In conclusion: This interview study has focussed on problems with eating and the body among "normal" women in the community under research. Many of the attitudes and behaviours concerning eating and the body which are central to the clinical disorders of anorexia nervosa and bulimia were prevalent among these women. The relationship between these clinical disorders and the problems discussed here is therefore an important issue, which will be discussed in the final chapter. Many of the attitudes prevalent among this sample are ones which directly reflect social ideologies and prescriptions concerning femininity. The

role of the social within these problems is thus highlighted, as will be discussed in the final chapter. The interview analysis has been important in two respects: (1) In its deeper empirical exploration of the attitudes, behaviours and eating/body problems found to be widespread among the survey sample; (2) and in its implications for a theory of eating/body problems which focusses on issues of culture and femininity. The theoretical implications arising from both the quantitative survey and this qualitative interview study, will be discussed in the next and final chapter.

## CHAPTER 6: CONCLUSIONS

### 6.1 Introduction

The aim of this chapter is to summarize the two sets of results, the quantitative and qualitative findings of this research, and to present conclusions from these combined findings. It also aims to discuss the theoretical implications emerging from both the empirical findings and the critical theoretical review. Implications for the treatment of eating/body problems are tentatively suggested. Finally, issues requiring further research and theoretical attention are discussed.

### 6.2 Summary of findings

In this section, the main results emerging from both the survey study and the depth interviews are summarized. The findings will be presented in terms of three central areas: prevalence findings; findings concerning the nature of eating/body problems among this community; and findings concerning those who consider themselves to have an eating problem.

#### 6.2.1 Prevalence findings

The central findings concerning the prevalence of eating/body problems among this sample may be summarized as follows:

(1) The prevalence of severe eating disorders, anorexia nervosa and bulimia, is relatively low. By respondents' own reports the prevalence of a history for each of the eating disorders is less than 1% of the sample. Through the questionnaire analysis, severe disorders were found to be relatively rare. For any combination of two bulimic symptoms as is required for a diagnosis of bulimia (like self-induced vomiting and bingeing) was less than 5%. Furthermore the occurrence of symptoms in an extremely frequent form were relatively uncommon, with less than 4% ever bingeing, using laxatives or self-inducing vomiting as often as once a day. Thus while no attempt was made to establish the prevalence of bulimia and anorexia nervosa from the questionnaire data, it appears that the extreme frequency of behaviours associated with these disorders and the particular clustering of symptoms required for a diagnosis are not widespread. The self-reported prevalence of anorexia nervosa is similar to findings overseas (Nylander, 1971; Crisp et al., 1976; Pope et al., 1984). The self-reported prevalence of bulimia and the prevalence for clusters of symptoms required for a diagnosis extracted from questionnaire data, corroborates findings of those studies using stricter criteria for bulimia (Cooper and Fairburn, 1983; Hart and Ollendick, 1985; Pyle et al., 1983).

(2) The prevalence of behaviours associated with the disorders of anorexia nervosa and bulimia is far more common. Binge eating, in particular, is widespread. As many as 40% have ever binged. 22% have binged in the last two months, constituting current bingeing by one definition (Cooper and Fairburn, 1983).

7% are currently bingeing with frequency by another definition (Pyle et al., 1983). Purging behaviour, represented by self-induced vomiting and laxative use, are not as widespread, with less than 6% using either method currently. In terms of weight control methods, exercise is extremely common, with almost two-thirds of the sample using it to control their weight.

Diet pills, strict diets and fasting are also common forms of weight control, with between 12 - 15% of the sample reporting their use. Prevalence of these behaviours in extreme forms or frequency are rare. These results are consistent with other studies, appearing to be one of the highest reported prevalence rates for these behaviours. The prevalence figure for exercise is by far the highest reported prevalence rate for this behaviour. It is believed that this is related to the recent popularization of exercise within the current fitness cult.

(3) Certain attitudes associated with anorexia nervosa and bulimia are widespread. As many as 11.8% of this sample score in the "anorexic range" on the EAT which is considered primarily an attitudinal measure. This result is consistent with those found overseas, being one of the highest results found (Garner and Garfinkel, 1979; Button and Whitehouse, 1981; Clarke and Palmer, 1983; Mann et al., 1983; Meadows et al., 1986). For many of the attitudes concerning the body/weight and food/eating as many as one-third of the sample responded positively.

(4) By far the most widespread attitudes are those relating to preoccupation with the body/weight and eating/dieting. As many as 33% are often terrified about being overweight, 77% consider

themselves to be overweight and 92% desire to weigh less than they do. A factor analysis on the EAT also illustrated the strength of preoccupations with food/eating and the body/weight in determining the overall score on the test. This finding was similar to those of other factor analytic studies of the EAT, except that the preoccupations with food and the body were more relevant in this sample while dieting attitudes and behaviour were more relevant in the other two (Wells et al., 1985; Garner et al., 1982).

(5) Prevalence findings concerning body affect illustrate that dissatisfaction with certain parts of the body was widespread, in particular the torso area, that is hips, buttocks, waist and stomach, and the thighs. Between one third and a half of the sample experienced some dissatisfaction with these parts of the body. Much dissatisfaction was also experienced with weight.

(6) Methodological problems with the reporting of behaviours associated with the eating disorders were evident, which necessarily has implications for the prevalence of these. This was particularly clear in the reporting of binge eating. It was found that many respondents were responding positively to the one definition of binge eating that was used, while responding negatively to the other definition. The methodological problems that can arise in terms of definitions of binge eating was illustrated in the interview sample as well. It was clear that the definition of bingeing or excessive eating is subject to personal and therefore differing interpretations (e.g. some interviewees were quite aware that what for them constituted a

binge or excessive eating was a "snack" for "normal" eaters). The problems of ambiguity in the definition of bingeing has been pointed out in the literature (Meadows et al., 1986).

#### 6.2.2 Findings concerning the nature of eating/body problems

The main findings concerning the nature of attitudes and behaviours associated with clinical eating disorders among this sample may be summarized as follows:

(1) There is a wide range of behaviours associated with clinical eating disorders found among the community. The range of symptom clusters in this sample is evident in the survey sample, but is also borne out by the depth interviews. There was not one interviewee whose behaviours were replicated by another. Some only binged. While others had practised bingeing, laxative use and self-induced vomiting.

(2) The behaviours associated with anorexia nervosa and bulimia are not static but change over time. In the survey study it was evident that a history of all behaviours was more common than present prevalence. This illustrates that phases of experiencing these behaviours is widespread. The phasic, non-static nature of behaviours was evident in the interview analysis. Most interviewees had fluctuated either in terms of frequency of behaviours, that is practising the behaviours far more frequently at certain stages than others, or in terms of actual changes in behaviour, that is moving from primarily anorexic symptomatology to primarily bulimic symptomatology. Similar fluctuations in terms of the attitudes and emotions associated with these

problems occurred for the interviewees. During "bad" phases of their eating problem, the preoccupations with the body and eating/food were more intense than at other times.

(3) A continuum of behaviours and attitudes associated with eating disorders is evident, both among the survey sample and the interviewees. More extreme behaviours and the manifestation of combinations of these are relatively rare, while more moderate behaviours are more frequent. This was evident in the sample interviewed. While all of them considered themselves to have an eating problem, some had experienced extreme phases where they might have been diagnosable as anorexic or bulimic, while others had never experienced phases as extreme.

(4) A deeper exploration of the attitudes associated with severe eating disorders, but found widespread among the survey sample, was achieved through the interviews. The attitudes concerning food/eating were made up of the following central concerns: preoccupation with food in terms of thinking about it, (especially "bad" foods) and in terms of thinking about controlling food intake, that is planning diets, binges and purges; guilt about eating, especially "bad" foods, and feeling that one does not deserve to eat; self-consciousness about eating in public, particularly with judgemental others; feeling that controlling one's food intake results in overall control over one's life; eating behaviour is experienced as determined by and determining of how one feels emotionally; a good/bad split exists in terms of foods, eating behaviour and oneself; ambivalence towards food as nurturer or destroyer. The central concerns with

the body/weight include the following: preoccupation with body size, shape and weight in terms of time spent thinking about it, critically appraising it and monitoring it; self-consciousness about the body in public or when felt to be under surveyance; bodily attractiveness is central in determining one's value and therefore happiness; slim equals all that is positive; fat equals all that is negative resulting in fear about being overweight; and eating and body size are strongly associated with each other (a belief that what you eat determines your body size).

(5) It is clear that certain parts of the body cause more distress than others. Within both the survey sample and the interviewee subsample, aspects of the body that caused most distress and concern were those of the torso area, thighs and weight.

(6) In both the survey study and the interviews, slimness was imbued with much positivity while fatness was experienced very negatively. In the rating scales, "self fatter" was rated very negatively while "self thinner" was rated far more positively. In the interviews, as has been pointed out, there were strong positive associations with slimness and negative association with fatness, both for interviewees themselves and for others. These associations were common for all the women in the survey sample and no major differences were found between those who were dissatisfied with their bodies and those who were satisfied, and between those who scored high on the EAT and those who scored low.

(7) The ideal body for both the survey sample and the interviewees is consistent with the media images of the ideal body for women. The highest rated image was that of an athletic woman, illustrating the high value attached to fitness at present. This was followed by a typical photographic model shape and a slim teenager. Within the interview sample, even those who ideologically rejected the media image, subscribed to an ideal body shape similar to that idealized by the media. There appears to be a preference for a shape that is both slim and strong as illustrated by the highly rated athletic shape and the "boyish", muscular shape described by interviewees.

(8) A relationship between eating problems and body image was evident within both the survey and interview studies. From the questionnaire data analysis significant correlations emerged between the EAT and all indicators of body affect (body cathexis scale, self-rating scale). Significant correlations between high EAT scores and negativity associated with "self fatter"/positivity associated with "self thinner" also emerged. Those who considered themselves to have an eating problem were also significantly more dissatisfied with their bodies, rated "self with my body as it is now" more negatively, rated "self thinner" more positively and "self fatter" more negatively than the rest of the sample. The relationship between negative body image and eating problems was borne out by the interview sample, who were all dissatisfied or had been dissatisfied with their bodies to some extent. The association between the body and eating was evident on other levels as well. All interviewees

felt that their eating problem was related to their obsession with their bodily size in some way. There was a strong association between what is consumed and what the body looks like. That is, after eating in excess or eating "bad" foods the body is experienced as immediately fatter for many interviewees. When there is control over eating during phases of restraint, the body is experienced as slimmer and smaller, whether actual weight loss has occurred or not.

### 6.2.3 Findings concerning those who consider themselves to have an eating problem

Central findings concerning this group of women from the survey study as well as the interviews, may be summarized as follows:

(1) Those who consider themselves to have an eating problem, constituting 31% of the sample, were compared to the rest of the sample. This group differed significantly from the rest of the sample on most variables: they appear to manifest more of the behaviours like binge eating, self-induced vomiting and laxative use than the rest; they score significantly higher on the EAT than the rest; are significantly more dissatisfied with their bodies; rate "self thinner" more positively than the rest; rate "self fatter" more negatively than the rest; and considerably more of them consider themselves to be overweight compared to the rest. Reporting an eating problem appears to be most associated with binge eating and a high EAT score, which reflects findings by Cooper et al. (1984). Considering oneself to be a compulsive eater is also highly associated with reporting an eating problem.

These findings are supported by the interview sample. The major behaviour reported as problematic was that of binge eating or compulsive eating.

(2) Following on from the strong association between reporting an eating problem and binge eating, is the finding that it is the desire to eat/overeate/eat "bad" foods which is considered the problem rather than the other behaviours like self-induced vomiting, starving, fasting, dietpill use and laxative abuse. For the interviewees, self-induced vomiting and restrained eating behaviour were experienced as an achievement, something to be proud of, rather than a problem.

(3) The eating problems of the women interviewed cannot be seen out of social context in terms of the following central determining forces: peer influence in terms of dieting and body consciousness and in terms of learning "abnormal" means of weight control (for example, self-induced vomiting); male influence in terms of direct intervention on the part of male lovers or generally in terms of desiring to be attractive for a man/to attract men; family influence in terms of weight consciousness in the home or criticisms from family members; socialization in the home and outside in terms of appropriate eating behaviour for women and concerns about appearance; the role of the mother, both directly and indirectly; the ideological prescriptions for women concerning eating and their bodies which prevail in language and representations of socially constructed femininity; the role of doctors and other professionals' attitudes to weight and eating

problems; and the role of the media in giving attention to eating disorders and popularizing psychological theories about these problems.

### 6.3 Discussion of findings: Theoretical implications

The findings of both the survey study and the depth interviews have implications for the theoretical understanding of eating/body problems among this community of women. In this respect, they add to some of the conclusions arrived at within the critical theoretical review. It is believed that the focus on non-clinical or what has been called subclinical eating/body problems (Button and Whitehouse, 1981) within the interview sample has contributions to make to filling some of the lacunae found within the literature on eating/body problems. The area of "normal femininity" which it was concluded plays a central role within eating/body problems, has been developed. The ideological prescriptions inherent within socially constructed femininity, concerning women's eating and body, which have been theorized about by feminists, were apparent within this community of women. It has been claimed theoretically that attitudes and behaviours associated with the eating disorders are "normal" for women, in that they are socially legitimized and encouraged. Whilst empirical studies have shown that statistically, certain attitudes and behaviours are "normal" in that they are widespread. The present study adds to these claims by supporting the findings of other empirical studies with its prevalence findings. The present study also illustrates, through a more in-

depth exploration of these attitudes and behaviours among non-clinical eating/body problems, the way in which the latter reflect social ideologies concerning femininity. The findings concerning the nature of eating/body problems within the survey study and the interview sample, also have implications for an understanding of clinical eating disorders, that is, the relationship between "normal" femininity and "abnormal" anorexia nervosa and bulimia is necessarily developed following the focus on the more moderate forms of these clinical disorders.

The central conclusions concerning eating/body problems among women will be discussed in four sections: the issue of femininity; the creation of an eating problem; the nature of eating/body problems among the community under research; and the relationship between eating and body problems among the community and the clinical disorders of anorexia nervosa and bulimia.

### 6.3.1 Femininity

Within the theoretical review, eating disorder theorists were criticized for not adequately theorizing the role of femininity in their understanding of eating disorders (refer to Chapter 2). Even those theorists who were concerned with including the role of cultural forces within their understanding of eating disorders did not develop the role that socially constructed femininity plays within these problems. In this respect, the experiences of non-clinical communities of women in relation to their bodies and eating, that is the role of "normal femininity" has been underdeveloped, both theoretically and empirically within the

eating disorder literature. It was shown theoretically that feminist authors have an important contribution to make in this respect, in that they have theorized about "normal" women's relationships to their body and eating. There has been little empirical work, especially of a qualitative nature, both in eating disorder and feminist literature, which explores "normal" women's relationships to their bodies and eating. For although recognizing the presence of less severe eating/body problems among certain communities of women, these problems have not been focussed on by eating disorder researchers. And although theorizing about the construction of femininity within ideology, Feminists have not carried out much empirical work in the area of the construction of attitudes to the body and eating for women.

In this thesis "normal" women's relationships to their bodies and eating were empirically investigated with the view to filling this lacuna. Women within the community being researched who considered themselves to have an eating problem were focussed on. Their problems ranged from moderate concerns and behaviours to more extreme ones. Despite their different behavioural patterns there was a range of attitudes towards eating and their bodies, common to all of them, which reflect the ideological prescriptions concerning femininity within Western culture. It is maintained that the ideologies prescribing femininity are central in creating both the "abnormal" attitudes and behaviours found among anorexics and the "normal" attitudes and behaviours which women in this community develop towards their bodies and eating. Through the interview analysis, the internalization of

"normal" ideological prescriptions concerning femininity was exposed as central within these women's attitudes and behaviours to their bodies. Ideologies of femininity, particularly the prescriptions concerning the body and eating, which are evident in language and representations of women were shown to be of great salience in the emotional worlds of these individual women. Central ideological equations and prescriptions which are evident in the external world and reflected in these women's attitudes and emotions to their eating and their bodies include the following:

(1) Being physically attractive equals being desirable to men equals successful femininity equals being valuable equals being confident and happy. Feminists have shown that within the construction of femininity, bodily value is bound up with self value (de Beauvoir, 1949; Coward, 1984; Berger, 1972; Root, 1984). Women are seen to take on their value through their bodily attractiveness in terms of the social ideals set up for them. The women in the interview sample, who ranged from the "normal" dieters to those experiencing an "anorexic" phase, had all internalized this ideological equation. They believed this psychically and had experienced it in reality. For when they had been more attractive by social standards, for example slimmer, they had experienced more social rewards and appeared in reality to be more desirable to men. Thus the preoccupation with the body and its appearance which manifests in an intense form with anorexics and in a more moderate form with "normal" women cannot be understood outside the of the ideological realm of femininity

in which an equation is set up between the value of the body and self value. Being a woman means being an object of vision, a body which which must be made beautiful in order to attain value in the world.

(2) Bodily appearance must be constantly worked at for improvement. Feminists have shown how women are encouraged to view their bodies as projects to be worked on towards the goal of self-improvement, which is particularly inherent in advertising (Root, 1984; Coward, 1984). This was evident among the interviewees who related to their body as objects which are compared to the social ideals and to others' bodies, with the view to changing and modifying them. Coward's (1984) notion that women are encouraged to view their bodies as fragmented objects was illustrated. The way in which this may lead to positive feelings towards certain parts of the body, while others are disliked, was evident among interviewees and within the survey sample, in which the torso parts of the body were negatively rated while other parts were relatively positively rated. Berger's (1972) notion that women are split into surveyed and surveyor was clear, for these interviewees were preoccupied with constant self-appraisal and self-criticism as if they were outside of their own bodies.

(3) Slim equals all that is positive, while fat equals all that is negative. Although the ideologies which set fat and thin up as opposites and in a relation of inferior/superior pertains for both men and women, they are experienced more intensely for women whose self-value is constructed as contingent on their bodily

attractiveness. Feminists have deconstructed the ideological equations concerning fatness and slimness (Coward, 1984; Diamond, 1985). The equations that they have highlighted were prevalent among the interviewees. It was shown how fat is experienced as something external to the body, useless, inhibiting and marring it, which is a view propagated particularly within advertisements (Diamond, 1985). It was shown how fat was associated with unhappiness, physical inactivity, undesirability and unhealthiness, both physical and psychological which are all socially constructed equations (Diamond, 1985; Coward, 1984). Diamond (1985) pointed out that an equation between thin as the "real me" and fat as "not me" has been socially constructed, which was evident within this sample's perceptions of themselves. The "true" self was the thin self for interviewees. Moreover, being slim, for the interviewees, was associated with being sexual while being fat was connoted with lacking in sexuality. The ideological superior position granted slimness and inferiority granted fatness (Diamond, 1985), was illustrated by the interviewees' different experiences of themselves when in the company of "fat" or "thin" women; that is they felt more self-confident and superior when with "fat" women and vice-versa with "thin" women. It is quite clear then, that the preoccupation with weight and the striving towards slimness, found among these "normal" women is bound up with a socially constructed abhorrence of fatness on the body and a fat body shape.

The idealization of slimness and the abhorrence of fatness was also illustrated through the ideal images for both the survey and

interview samples. That the social ideal of slimness is internalized for women was clear. Even for those women who consciously reject media images of beauty, slimness was desirable.

(4) What you eat is what you will look like and feel like. In Western culture, as is particularly evident in the media, strong associations between eating and the body and emotional well-being exist (Coward, 1984; Diamond, 1985; Adams and Laurikiens, 1976). Equations like "control over eating = control over the body = control over one's life" were internalized by interviewees and were real experiences for them. When controlling their eating, they felt in control of their lives.

Socially constructed equations between food and fat, that is what you eat is how you will look, and associations between being a "fat" woman and overeating were also evident (Coward, 1984). Interviewees experienced their bodies as becoming larger upon intake of food, especially "bad" food ("fattening" and "unhealthy" foods). They also immediately associated "fat" women with overeating, even those who believed this not to be true rationally. Following the internalization of these equations, it was clear that it was expected that women should be concerned with their bodies and their weight. If women are not concerned in this way they were viewed with disgust - thus "fat" women "stuffing their faces" are disgusting, "thin" women doing the same are lucky. "Fat" women are perceived as uncaring of themselves and their appearances. They have broken a rule by being fat. As such they are socially rejected and "abnormal".

If they indulge in food they are doubly trespassing the rules of femininity. It is clear therefore that concerns with eating are bound up with prescriptions concerning women's bodily appearance.

(5) Women must nurture, not indulge. Coward (1984) has shown how guilt about eating is encouraged for women, which she believes is related to women's role as nurturer and as supporter of others. Women should not assert their needs, should not indulge their appetites. Guilt about eating was widespread among the interviewees, leading to self-consciousness about eating in front of others, and strongly tied to the fear that others will feel they are too fat to eat.

(6) Food is prescribed as nurturer and destroyer. On the one hand, food is set up within the media as something threatening, that which can do damage to women by making them fat (Coward, 1984). Thus the interviewees spoke of "bad" food and a "bad" self who indulges in the "bad" food. Many interviewees understood their eating behaviour as a tool to punish themselves emotionally. At the same time, food is associated with emotional nurturance through popular psychological ideas, which have enjoyed much support within feminist understandings of compulsive eating (Orbach, 1978; Roth, 1983). The notion that food was emotionally nurturant was evident in many of the interviewees' understanding of their eating behaviours.

(7) The "anorexic image" is set up as a positive one for women. Both the "anorexic look" and the popular understandings of anorexia nervosa have been idealized for women within Western

culture. Being anorexic is popularized as a reflection of a striving towards perfection and an indication of extreme control over the body and eating. The body of the anorexic has been shown to be admired (Branch and Eurman, 1980). In this way, both anorexia nervosa and bulimia have been idealised for women. In the media, they have received much attention with a focus on famous women who have suffered from these problems (for example, Jane Fonda the bulimic [Janos, 1985], Barbara Barnard the anorexic [Sampson, 1985]). The slimness of anorexics and their ability to control their appetite was strongly admired and envied by the interviewees. Feminist theories may have also played a role in the glorification of severe eating disorders (Swartz, 1985b), especially through the idea that the anorexic/bulimic/compulsive eater is in some way rebelling against her powerlessness as a woman or is an attempt to gain control over her powerless life (Orbach, 1978; Chernin, 1983).

The rules and prescriptions concerning femininity which are evident in the media, advertising, representations of women and language, have been shown to be reflected in the attitudes and emotions experienced by the interviewees towards their bodies and eating. But these cannot be seen as acting externally, influencing women from the outside, rather they appear to be deeply internalized. Thus, all of the women interviewed were critical to a certain extent of the social pressures on them as concerns diet and weight control. Almost half of the sample could be described as feminists and a number of them were lesbians who were unconcerned by male attention. Nonetheless,

despite feminist awareness and despite a disinterest in men, all of the women were trapped in their preoccupations with their bodies and eating. Their concerns went further than a mere conforming to the social pressures. This finding reinforces the theoretical proposal that femininity has to be understood within a more complex theory of the subject, rather than as a process of socialization. In the theoretical section, theorists were criticized for seeing femininity or female socialization as a cloak which could easily be removed. Boskind-Lodahl's (1976) notion that "bulimarexics" are simply over-socialized was criticized. Although their femininity, in terms of the prescriptions about the body and eating, may have taken on an extreme meaning for "bulimarexics" a theory which can more adequately account for the taking on of a female subjectivity, that goes beyond socialization, is needed. For what was evident throughout the interview analysis was the strength of the ideologies of femininity concerning eating and the body, despite a rejection of the social expectations for women. The majority of the women interviewed were not simply over-socialized. Many of them had a feminist consciousness, and even those who did not have a strong feminist consciousness were critical of conformity to ideal images. In their behaviour and attitudes, the majority of them did not fit social stereotypic femininity or manifest traditional female characteristics (for example, passivity, unassertiveness, lack of confidence). Despite counter-ideologies, like a feminist consciousness, these women were trapped in the concerns of their socially prescribed femininity. Despite conscious attempts to overcome these problems, through

deconstructing the social prescriptions, the pervasiveness of eating/body concerns within these women's lives was evident. The finding that conscious attempts to reject ideologies of femininity does not properly overcome the body/eating obsessions, points to the deeply-embedded nature of these attitudes and emotions. The deep-rooted, pervasive nature of these attitudes indicates the need to more adequately theorize how women take on the social prescriptions of femininity. It is clear that women are not simply influenced by the ideologies discussed, but take on their subjectivity as women within them, in a process which involves the unconscious. Furthermore, the ideological equations and prescriptions by which femininity is constructed must be understood as continually reproduced, so that the exposure to these ideologies is always present for women.

This study has thus facilitated the recognition of the power of external ideologies within the inner emotional world of women. The prescriptions concerning femininity, in particular those concerning the body and eating, have been shown to be present in a deep-rooted, pervasive manner within the psyches of individual women. The unconscious nature of these concerns has been highlighted, particularly in that conscious actions to overcome them appear to meet with considerable resistance. Although women may consciously reject the social ideals foisted on them, in practice these continue to pervade their lives. Thus for those women consciously involved in a counter-ideology, like feminism, femininity is experienced in a conflictual way. Those interviewees with a feminist consciousness who were actively

working against their desire to give up their body/diet concerns may be understood as being in conflict with their unconscious female desires. The complexity of the construction of female subjectivity and the presence of contradictions within this subjectivity have been highlighted in this way.

The complexity, pervasiveness and deep-rooted nature of female subjectivity recognized through this study raises important questions concerning feminist struggles. For it highlights the pervasive, unconscious nature of women's concerns with their bodily appearance and their eating. In this way it points towards inadequacies within feminist theorizing and attempts at consciousness raising, which it is suggested, do not go far enough in challenging the roots of femininity. To adequately challenge the concerns with the body and eating a way of taking into account the deep-rooted nature of female subjectivity appears to be necessary.

In speaking of the ideologies of femininity, these were illustrated primarily within the media, advertising and visual representations of women within this study, where they appear in their most blatant forms. This does not mean that this is the only place where the prescriptions concerning the body and eating for women, are produced and reproduced. Also, although this study concentrated on later female development, adolescent and post-adolescent stages, this does not mean that this is the only developmental point at which the social prescriptions concerning the body/eating are significant for women. As was illustrated by the interviews, these prescriptions were evident within many

realms of these women's lives, within the family, within the peer group, between mother and daughter, between patient and doctor, and so on. It is believed that the ideologies of femininity, in terms of the prescriptions concerning women's bodies and eating and the social construction of fat and thin, are reproduced at all places within the social system and at all times through the history of the individual. In this thesis, the early construction of femininity and the early internalization of the prescriptions concerning the body and eating were not concentrated on. The importance of early experiences did however emerge through the interviews. The relationship between mother and daughter appears to be a central one in which the body and eating prescriptions for women are reproduced. The mother for most interviewees played an important role as a model within the transmission of the ideologies of femininity. This is an area of research and theory which is beyond the limitations of this study, and requires more attention.

### 6.3.2 The creation of an eating problem

It has been proposed that the preoccupations with eating and the body which the women interviewed have in common with each other and with anorexics are "normal" for women, in so far as they are socially constructed as part and parcel of femininity itself. The question may then arise: if these concerns and the behaviours are "normal" why are they considered a problem? All the women interviewed considered themselves to have an eating problem. Yet all of them were or had been extremely concerned with fulfilling the "normal" prescriptions of femininity - that

is controlling their weight and body size and controlling their intake. In this case, at what point does an eating/body problem become a subjective problem ?

Objectively the "normal" concerns with eating and body are problematic in so far as they are believed to be disempowering for women. From a feminist perspective, the scrutiny of the body which women internalize but which is also evident in the external social realm, reflects and reproduces power relations between men and women. Internalizing these ideologies does not merely mean that women develop problematic relationships with their bodies and eating, but that the very process by which this relationship is set up perpetuates the power relations between men and women. In the construction of the equation between self value and bodily value for women, for example, the creation of women as an object to be viewed and therefore controlled, is achieved. Socially, therefore, the ideologies of femininity in which eating/body problems are created are problematic. Psychologically and physiologically, they are problematic in that the potential for these developing into severe psychologically and physically injurious forms is set up. It has been shown that dietary restraint is associated with bingeing behaviour (Boskind-Lodahl and Sirlin, 1977; Hawkins and Clement, 1980; Polivy and Herman, 1985; Wardle, 1980; Wardle and Beinhart, 1981) and that diets themselves may encourage eating disorder behaviour, e.g. the Beverley Hill diet which basically prescribes binge-purge behaviour (Wooley and Wooley, 1982). Objectively then the prescriptions concerning dieting and the body for women may be

viewed as a political and personal problem, and particularly as the potential for an eating disorder, but subjectively these concerns are a "normal" part of being female.

When does it become a subjective problem ? It has emerged from both the survey study and the interview study that the attitudes and behaviours associated with the disorders of anorexia nervosa and bulimia become a problem under two conditions: firstly, when the eating behaviours and attitudes and the body size/weight are not perceived to be under control; and secondly when they are "labelled" as a problem by others. Eating behaviour and attitudes are therefore considered a problem when the rules and prescriptions concerning femininity are broken or when somebody else has decided that there is a problem. Anorexics deny having a problem (DSM-III, 1980). They are primarily restraining. They are thin. In this respect they are following the rules of femininity to an extreme. In their eyes it is an achievement. Self-induced vomiting is viewed as an achievement, as one has managed to undo the rule that one broke (of overeating, indulging). Bulimics and binge eaters have never doubted that they have a problem. They are breaking the rules and eating in excess. It is not the periods of fasting which constitutes the problem for the bulimic, but the periods of eating. In the survey sample, preoccupation with eating and food was widespread, and formed the strongest determining factor of their EAT scores. Reporting an eating problem was most associated with binge eating and a high EAT score (which as has been shown through factor analysis strongly reflects food preoccupation). Within the

interview sample, periods of restraint were experienced positively, even in the event of physical weakness or illness, while periods of bingeing were experienced negatively. Within both the survey and interview samples it appears therefore that the problem is not eating too little or being too thin. But eating too much and being too fat. Feeling that one is overeating, eating the wrong foods and is not thin enough becomes the problem for women. Transgressing the laws of femininity is the problem. Following the rules, even to an extreme of physical ill-health, is an achievement.

### 6.3.3 Eating/body problems in the community

It has become clear that a wide range of eating/body problems prevail in the community under study. Some of these are closer to being diagnosed as clinical eating disorders, while others would never fit the criteria. It is clear that a continuum of symptomatology prevails in this community. Two types of continuums of symptoms are evident:

(1) A continuum of symptoms from primarily bulimic to anorexic occurs. Individuals may fluctuate from one position to another over time. This dynamic notion of eating disorder symptomatology has been proposed for the clinical syndromes of bulimia and anorexia nervosa (Vandereycken and Pierloot, 1985; Sours, 1980). It is clear that this dynamic model of symptomatology is relevant to the non-clinical problems as well, as illustrated by the interview sample.

(2) A continuum of extremity of symptoms occurs. It is clear that the symptoms, that is the behaviours and attitudes, constituting anorexia nervosa and bulimia are prevalent among community samples of women as well (as illustrated by this study which supports many other survey studies). There is therefore a continuum from more moderate symptoms in non-clinical women to the extreme symptoms which present in the clinic as anorexics or bulimics. The continuum is both a quantitative and qualitative one. It is quantitative in so far as the symptoms on their own are more widespread than are the symptom clusters required for a diagnosis of bulimia or anorexia nervosa. For example, binge eating, as a behaviour on its own, is more widespread than binge eating together with purging (required for a diagnosis of bulimia). Vomiting may occur on its own more frequently than vomiting and binge eating. It is qualitative in that the symptoms in an extreme form in terms of frequency are more rare than in a more moderate form. For example, binge eating daily is relatively rare, whereas binge eating once a week is more common.

The continuum model is useful in describing the wide range of eating/body problems among the community, but it is also useful in describing the experiences of individual women. The non-static, phasic nature of eating/body problems was evident in the results of both the survey and the interview studies. From the survey study a history of behaviours was more common than the prevalence of behaviours at present. From the interview sample, it was evident that through their history of the problem they had fluctuated from a more anorexic mode to a more bulimic mode and

vice-versa, and had experienced periods of more intense and less intense problems. At times they may have practised only one behaviour, like binge eating, while at other times they may have been bingeing and inducing vomiting. At times they may have been close to the diagnostic category of bulimia, in terms of frequency and quantity of symptoms, at other times they may have been closer to the experience of a "normal" dieter. The notion of "anorexic" or "bulimic" phases is therefore a useful way of describing these problems. This has implications for the traditional way in which these disorders have been viewed, that is as static, long-term problems. They may be long-term in that the attitudes are deeply entrenched, but for many women, the extreme phase in which a clinical disorder is diagnosable may be shorter, as illustrated by the interview sample.

It appears that eating/body problems are recognized as a problem by the professionals only when at the extreme levels of the continuum - when the symptoms are very frequent and when more than one symptom occurs. It is only when eating/body problems present themselves as electrolytically imbalanced bulimics and emaciated anorexics that they are considered a problem by psychiatric, medical and psychological authorities. It appears as if the problem has to reach a point of physical danger to be recognized as an issue. Even those theorists who have recognized these problems on a community level have set physical criteria for considering it a problem, like Well's et al. (1985) who treat a high EAT score as a problem only in women who are thin and not women who are "normal" or overweight. In this way the wide

range of more moderate problems are ignored. The continuum model exposes the arbitrary boundaries that have been laid between clinical disorders and other eating/body problems of a less extreme nature. The overlap between the two is considerable. It is clear that many more women than are clinically diagnosed as anorexic or bulimic may experience phases of the clinical disorders which may pass without the intervention of a professional. It was clear within the interviewing sample, that a majority had experienced these phases, yet only a minority had received professional help. The issue of when to consider eating behaviour and attitudes a problem is one which is necessarily a challenge to medical, psychiatric and psychological professionals.

#### 6.3.4 The relationship between eating/body problems and clinical eating disorders

It has been concluded that the concerns with the body and eating which are a part of the clinical eating disorders are socially legitimized and "normal" for women. It has been concluded that a continuum of symptomatology exists between "normal" dieting, or "normal" concerns with the body and eating, and the severe clinical disorders of anorexia nervosa and bulimia. Does this mean that anorexia nervosa and bulimia are "dieting gone mad" ? This simplistic notion is by no means being implied. From a descriptive point of view these syndromes are reflecting "normal" dieting attitudes and behaviour taken to an extreme degree. In so far as these are "normal" attitudes associated with being a female, they may also be considered "normal" femininity taken to

an extreme. But this is a mere description.

It is assumed that each woman's unique experiences will determine what role her "normal" femininity and her "normal" attitudes towards eating and her body, will assume in her life. It is maintained that there are underlying reasons why these symptoms become so extreme for some women and not for others. The presence of unique psychodynamic realms, interpersonal experiences and familial and social contexts are central in determining these problems. For all women, at all points on the continuum from mild concerns to extreme disorders, it is maintained that unique factors are determining her position on that continuum. Garfinkel and Garner's (1982) multiple-determination model for anorexia nervosa is useful in that it illustrates the possibilities of multiple aetiologies for an eating disorder. But it fails to recognize that for each woman, within the community in which the anorexic is created, there will be unique forces, psychodynamic and familial experiences, determining the path her relationship with eating and her body will take. It is not merely the clinically diagnosed anorexic whose symptoms are informed by unique familial, psychodynamic and other causations. It is also the woman who falls in the middle of the continuum whose problem is informed by unique determinations and the woman who falls at the other end of the continuum, with minimal concerns about her body and eating, whose lack of a problem must be understood in the light of her unique experiences.

It must be pointed out that in speaking of the familial or psychodynamic levels of eating/body problems, these are not considered asocial realms. It was concluded earlier that mothers play a central role in the transmission of the social ideologies of femininity. Thus the mother-child relationship is a social one, but it is equally unique. A mother who is obsessive about her own body will necessarily transmit the ideologies of femininity to her daughter in a different way, with different effects, than a mother who is not.

It is claimed that there are no clear cut normal/abnormal splits within the realm of eating/body problems, both in terms of the symptomatology as well as in terms of the understanding (causation/aetiology) of the problem. The construction of femininity, it is claimed, involves the creation of problematic attitudes for women towards their body and eating. It is a common experience for both the anorexic and the "normal" woman. But the meaning this common experience takes on in the lives of individual women is determined by her unique background. The exact meaning which prescriptions concerning the body and eating take on and the way in which they are manifested symptomatologically will be different for each woman, including anorexics and bulimics. Anorexia nervosa and bulimia are not therefore realms apart from the non-clinical similar problems. There is no clear-cut distinction between the two. As has been shown some of the latter may have passed fleetingly through a phase of the former. Both in terms of a continuum of symptomatology and in terms of a continuum of aetiology, the

abnormal/normal split is a false one.

The realm of the "normal" and the continuum of eating/body problems among certain communities of women, which have formed the subject of this thesis, are therefore of importance in the understanding of the severe problems "named" anorexia nervosa and bulimia. Although it is claimed that these cannot be understood outside of "normal" femininity, the meaning that the "normative" eating/body symptoms take on for an individual woman (and therefore the severity of her symptoms and the understanding of them) will be determined by unique experiences for that woman. It may not be a mere acceptance of the role of femininity, as Boskind-Lodahl (1976) has claimed. It may also reflect a rejection of socially constructed femininity, as Orbach (1978) has claimed. For some women, the symptoms may mean primarily a rejection of socially constructed femininity, while for other women they may mean primarily an acceptance of this. Theories which generalize the experiences of all women in the understanding of their eating/body problems are unacceptable. For in the same way as it has been claimed that there is no single aetiology for anorexia nervosa, so the meaning that eating/body problems take on in women's lives may be extremely diverse. Eating/body problems may involve a central commonality, which is bound up with being constructed as a female subject, but they also involve personal experiences and personal meanings in the lives of women. Theories which generalize the problems are as problematic as those which personalize or individualize them. Although the personal is not an asocial personal, its uniqueness

for each individual women is not being questioned.

In summary, four central conclusions concerning eating/body problems have been presented. Firstly, it has been claimed that "normal" femininity, that is, the ideological prescriptions concerning eating and the body for women, are central in the understanding of "normal" women's relationship to her body/eating and the "pathological" forms of this relationship (anorexia nervosa and bulimia). The material ideologies of femininity have been shown to be reflected in "normal" women's emotional relationships to her body and eating. And the pervasive and deep-rooted nature of these ideologies, despite a conscious rejection of them, has been highlighted within the emotional lives of women. Secondly, it is maintained that these "normal" relationships to the body/eating only become subjective problems for women when the prescriptions are not being followed, or when they are identified as problems by others. Thirdly, it is claimed that a continuum of symptomatology exists in the community. Fourthly, following the understanding of the symptoms of anorexia nervosa/bulimia as bound up with "normal" femininity, and as representing a severe form of "normal" attitudes and behaviours, a continuum of eating/body problems is proposed which acknowledges unique experiences at all points. In this way the meaning that the "normal" relationship women have to their bodies and eating assumes in a woman's life, is seen as determined by each individual's unique psychodynamic, personal and familial experiences. Thus in speaking of a commonality between "normal" women's relationship to her body/eating and the anorexic, the

uniqueness within which the commonality manifests is not being ignored.

#### 6.4 Implications for the treatment of eating/body problems

Implications for those involved with the treatment of eating/body problems and clinicians generally are tentatively proposed as follows:

(1) In so far as a continuum of symptomatology exists between "normal" attitudes and behaviours among women and severe clinical eating disorders, and in so far as "normal" femininity is central within problems at any point on this continuum, the point at which a problem is identified is a central issue. It has been shown that a problem is experienced subjectively when the prescriptions concerning the body and eating are perceived as being broken. Clinicians, in so far as they are members of the community from which these ideological prescriptions arise, make their diagnoses within these ideological realms. They may be responsible for "naming" a problem when it is in fact not one, or for ignoring a problem when there is one. The notion of the continuum of eating/body problems means that far more women than are presently granted attention, may be in need of aid. But at the same time, it has been pointed out that an eating/body problem may have become an easy way of articulating other problems for women (Swartz, 1985a; 1985b). It is proposed then that eating/body problems be acknowledged, but not encouraged. There is a fine line between these two, for as has been suggested the acknowledgement of eating disorders as an important issue in

the media may have added to the problem rather than alleviating it. It appears that the eating disorders have become idealized in similar ways to which life-threatening illnesses have in the past, as Sontag (1978) illustrates with TB.

(2) Culture-bound theorists, like Swartz (1985, 1985a) have begun to show how eating disorders are negotiated between doctor and client and the effect of professional wisdom on the understanding of these problems. It is clear that professionals and their theories may play an important role in the creation and the understanding of these problems. This was clear within the interviews, where three areas of academic/professional influence were evident: firstly, doctors' opinions about weight added to the preoccupations of certain interviewees; the popularization of eating disorders and theories about them played a role in the creation of symptoms for some interviewees; and the popularization of theories of eating disorders and their presentation as the "truth" were shown to have a negative effect on family of interviewees and may have affected interviewees' own understandings of their problem (in this way perhaps serving to prolong the problem). It is strongly suggested that professionals deconstruct their own understandings of health for women, and present their understandings of eating/body problems in a careful way. It is a legacy of psychological theory and practice that it assumes it plays a neutral, value-free role within the social system. The creation of knowledge cannot be understood in a vacuum. It arises from and in turn affects the community from which it arises. Clinicians are themselves

subjects of the ideologies in which eating/body problems are constructed and at the same time constructionists of ideology. Thus eating/body problems can not be understood outside of the professional understanding of eating disorders, them for these very theories have themselves become a part of ideology.

(3) In so far as eating/body problems cannot be understood outside of the ideological realms of femininity, it is believed that the treatment of these problems must serve to deconstruct these ideologies for women. For example, until such time as the ideological equations concerning fatness and thinness are deconstructed, a woman will be obsessed with avoiding fatness and controlling her eating. The treatment of these problems must therefore involve the challenging of women's socially constructed identity, as Boskind-Lodahl (1976), Orbach (1978) and Chernin (1983) have pointed to. Furthermore, in so far as it has been shown that professionals have a role to play in the construction of ideology, professionals may have a role to play in challenging these ideologies on a social level as well. By illustrating the "normal" within the "abnormal" eating disorders, the ideologies in which the "normal" are constructed are necessarily challenged.

#### 6.5 Problems with the present study and suggestions for further research

Before suggesting areas of future research, problems and limitations inherent in this research are briefly discussed. These include the following:

(1) Methodological problems with self-report questionnaires. A major problem in this respect was discussed within the presentation of the quantitative results (Chapter 4). The case of binge eating was most illustrative of the ambiguity concerning definitions in questionnaire surveys, which necessarily have implications for the prevalence findings of these surveys. It must also be stated that there are problems generally with self-report methods of research in that false positives or negatives are easily reported. In the reporting of problematic eating behaviours and attitudes there is more likely to be an even higher prevalence than is reported rather than inflated findings, given the secrecy and shame associated with these problems (Meadows et al., 1986). At any rate, problems with self-report questionnaires must be borne in mind, and ways of overcoming the problems of ambiguity associated with definitions of eating behaviours must be sought for prevalence studies.

(2) The qualitative findings are of limited generalizability in that the interviewing sample was small. Despite the fact that the central trends in terms of attitudes towards eating and the body were extremely uniform within this sample, its size must be borne in mind. They are also limited in so far as they constitute those women who consider themselves to have an eating problem, which constituted one-third of the survey sample. The relationship that the other two-thirds of the sample have with their bodies and eating remains largely unexplored.

(3) The generalizability of the results of both the qualitative and the quantitative study are limited by the homogeneity of the

sample. This was a study conducted among women university students, and as such applies predominantly to middle class educated "white" women.

The following areas of research are believed to be important, arising from the findings of this study and the limitations discussed:

(1) Research which deals with the ideological prescriptions concerning women's body and eating. The interviewees in this study were a particular grouping, in that they all considered themselves to have an eating problem. Although their problems ranged from moderate to more severe forms of eating/body problems, how generalizable these findings are, may be questioned. It is important that more work be carried out on "normal" women's relationships to their bodies and eating, in order to further develop the understanding of the role that "normal" femininity plays within eating/body problems as well as to develop the understanding of how women are constructed within the ideologies of femininity.

(2) More theoretical and empirical work is required within the understanding of severe eating/body problems as involving "normal" femininity. On a theoretical level, there is the need to theorize why and how "normal" femininity assumes centrality within the lives of certain women. On an empirical level, as part of that task, case studies are required which illustrate both the unique and the universal within the understanding of the anorexic and bulimic experience.

(3) It is believed that the lack of cross-cultural work in this area is a lacuna in the literature. It has been pointed out that the results of this study are not generalizable to all women. The sample was predominantly a middle class, "white" group of women within Western culture. It is quite clear that issues of class, "race" and culture cut across the commonalities of femininity. It is suggested that in this respect these differences might be acting as part of the unique realm spoken of above, shaping in some way the meaning that the prescriptions concerning the body and eating take on for different women. But this requires further research. Within the South African situation, the dominant ideologies of femininity are present across class and culture boundaries. Prescriptions about the body and eating are present in the media messages to working class women as well as to middle class women. The meaning that these prescriptions take on in different women's lives requires investigation.

## 6.6 Conclusion

This thesis has explored what it believes to be an important area of woman's oppression today, that of her relationship to her body and eating. Theoretically and empirically it has focussed on the construction of female subjectivity within ideologies, in particular those within which prescriptions about eating and the body prevail. It has attempted to show empirically and theoretically how the realm of "normal" femininity is central to the understanding of eating/body problems which it has shown range from the "normal" to severe eating disorders. It has

theoretically discussed the material realm of ideologies of femininity within which woman's attitudes and emotions to her body and eating are constructed. It has illustrated empirically the powerful, pervasive and deep-rooted nature of these internalized ideologies. In so far as a continuum of eating/body problems is acknowledged, the dichotomized normal/abnormal divisions in the area of eating disorders has been challenged. In so far as unique experiences determine the meaning that this "normal" femininity takes on for individual women at all points of the continuum, the strict division between anorexia nervosa/bulimia and non-clinical/subclinical problems becomes blurred. Acknowledging the commonalities, that is acknowledging socially constructed ideologies of femininity, becomes a necessity. Theorizing about the complex process of the construction of female subjectivity within these ideologies becomes central to the understanding of "normal" women's relationships to their body and eating and to the understanding of the realm of the social within severe eating/body problems. A challenge to all eating/body problems, from mild to severe forms, is realized as involving a challenge to both the material realm of ideological femininity and the psychical realm of female subjectivity.

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APPENDIX I: THE QUESTIONNAIRE

I am a psychology masters student investigating eating disorders and body image problems amongst women on a community level. The following self-report questionnaires are therefore mainly about eating and the way you feel about your body. You are not required to give your name and therefore remain unknown to me. Please fill in the questionnaires as carefully and honestly as possible. Your co-operation is greatly appreciated.

Thank you.

Tammy Shefer

PLEASE FILL IN THE FOLLOWING DETAILS ABOUT YOURSELF (where applicable place a tick in the correct box):

1. Please state your age  YEARS
2. Please state your present weight (estimate if you are not sure:)  kilograms

Note: Use the table at the back of this questionnaire to convert from pounds to kilograms.

- 3a. What is the most you have ever weighed?  kilograms
- 3b. What is the least you have ever weighed?\*  kilograms  
\* (as an adult)
4. What is your ideal weight, i.e. what would you like to weigh?  kilograms
5. Please state your height  Centimetres

Note: Use the table at the back to convert from feet and inches or metres to centimetres.

PLEASE ANSWER THE FOLLOWING BY PLACING A TICK IN THE CORRECT BOX:

6. Degree registered for:

- BA                       BSocSc                       BA LLE
- BCom.                       BSc.                       MBCHB

7. What is your marital status?

- Never married                       Married
- Divorced                       Widowed

8. Please specify your "race" as classified in this country:

- Indian                       Coloured
- African                       White

9. Please state the religion you were brought up in:

- Muslim                       Jewish
- Catholic                       Protestant

Other, please specify .....

1	
4	1
6	
8	

10	
12	
14	
16	

19

20

21

22

10. Please state your place of residence:

Parental Home	<input type="checkbox"/>	Own home/rented accommodation	<input type="checkbox"/>	<input type="checkbox"/>	23
University residence	<input type="checkbox"/>	Communal House	<input type="checkbox"/>		

11. Do you consider yourself

Very overweight	<input type="checkbox"/>
Quite overweight	<input type="checkbox"/>
Slightly overweight	<input type="checkbox"/>
The correct weight	<input type="checkbox"/>
Slightly underweight	<input type="checkbox"/>
Quite underweight	<input type="checkbox"/>
Very underweight	<input type="checkbox"/>

24

12. As a child, before puberty, were you

Overweight	<input type="checkbox"/>	correct weight	<input type="checkbox"/>	underweight	<input type="checkbox"/>	<input type="checkbox"/>	25
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13. How often do you exercise at present?

Every day	<input type="checkbox"/>
Two to four times a week	<input type="checkbox"/>
Once a week	<input type="checkbox"/>
A couple of times a month	<input type="checkbox"/>
Very seldom or never	<input type="checkbox"/>

26

14. Have you ever been treated for any of the following? (You may tick more than one)

Anorexia nervosa	<input type="checkbox"/>	bulimia nervosa	<input type="checkbox"/>	obesity	<input type="checkbox"/>	<input type="checkbox"/>	27
Compulsive eating	<input type="checkbox"/>	being overweight	<input type="checkbox"/>	loss of weight/underweight	<input type="checkbox"/>		
Alcohol abuse	<input type="checkbox"/>	drug abuse	<input type="checkbox"/>			<input type="checkbox"/>	28
						<input type="checkbox"/>	29
						<input type="checkbox"/>	30
						<input type="checkbox"/>	31
						<input type="checkbox"/>	32
						<input type="checkbox"/>	33
						<input type="checkbox"/>	34

Other, please specify .....

14a. If so, what forms of treatment did you receive? (You may tick more than one).

hospitalization	<input type="checkbox"/>	doctor (G.P.)	<input type="checkbox"/>
psychologist	<input type="checkbox"/>	psychiatrist	<input type="checkbox"/>
dietician	<input type="checkbox"/>		
other, please specify .....			
.....			

The following questions mostly relate to food and eating. Please place a cross in the bracket which best applies for you to each of the numbered statements.

	Always	Very often	Often	Sometimes	Rarely	Never
1. Like eating with other people	( )	( )	( )	( )	( )	( )
2. Prepare food for others but do not eat what I cook	( )	( )	( )	( )	( )	( )
3. Become anxious prior to eating	( )	( )	( )	( )	( )	( )
4. Am terrified about being overweight	( )	( )	( )	( )	( )	( )
5. Avoid eating when I am hungry	( )	( )	( )	( )	( )	( )
6. Find myself preoccupied with food	( )	( )	( )	( )	( )	( )
7. Have gone on eating binges where I feel that I may not be able to stop	( )	( )	( )	( )	( )	( )
8. Cut my food into small pieces	( )	( )	( )	( )	( )	( )
9. Aware of the calorie content of foods that I eat	( )	( )	( )	( )	( )	( )
10. Particularly avoid foods with high carbohydrate content (e.g. bread, rice, etc.)	( )	( )	( )	( )	( )	( )
11. Feel bloated after meals	( )	( )	( )	( )	( )	( )
12. Feel that others would prefer if I ate more	( )	( )	( )	( )	( )	( )
13. Vomit after I have eaten	( )	( )	( )	( )	( )	( )
14. Feel extremely guilty after eating	( )	( )	( )	( )	( )	( )
15. Am preoccupied with a desire to be thinner	( )	( )	( )	( )	( )	( )

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54	

	Always	Very often	Often	Sometimes	Rarely	Never	
16. Exercise strenuously to burn off calories	( )	( )	( )	( )	( )	( )	55
17. Weigh myself several times a day	( )	( )	( )	( )	( )	( )	56
18. Like my clothes to fit tightly	( )	( )	( )	( )	( )	( )	57
19. Enjoy eating meat	( )	( )	( )	( )	( )	( )	58
20. Wake up early in the morning	( )	( )	( )	( )	( )	( )	59
21. Eat the same foods day after day	( )	( )	( )	( )	( )	( )	60
22. Think about burning up calories when I exercise	( )	( )	( )	( )	( )	( )	61
23. Have regular menstrual periods	( )	( )	( )	( )	( )	( )	62
24. Other people think that I am too thin	( )	( )	( )	( )	( )	( )	63
25. Am preoccupied with the thought of having fat on my body	( )	( )	( )	( )	( )	( )	64
26. Take longer than others to eat my meals	( )	( )	( )	( )	( )	( )	65
27. Enjoy eating at restaurants	( )	( )	( )	( )	( )	( )	66
28. Take laxatives	( )	( )	( )	( )	( )	( )	67
29. Avoid foods with sugar in them	( )	( )	( )	( )	( )	( )	68
30. Eat diet foods	( )	( )	( )	( )	( )	( )	69
31. Feel that food controls my life	( )	( )	( )	( )	( )	( )	70
32. Display self control around food	( )	( )	( )	( )	( )	( )	71
33. Feel that others pressure me to eat	( )	( )	( )	( )	( )	( )	72
34. Give too much time and thought to food	( )	( )	( )	( )	( )	( )	73
35. Suffer from constipation	( )	( )	( )	( )	( )	( )	74
36. Feel uncomfortable after eating sweets	( )	( )	( )	( )	( )	( )	75
37. Engage in dieting behaviour	( )	( )	( )	( )	( )	( )	76
38. Like my stomach to be empty	( )	( )	( )	( )	( )	( )	77
39. Enjoy trying new rich foods	( )	( )	( )	( )	( )	( )	78
40. Have the impulse to vomit after meals	( )	( )	( )	( )	( )	( )	79

PLEASE COMPLETE THE FOLLOWING BY PLACING A TICK IN THE CORRECT BOX:

1. Have you ever had an episode of uncontrollable excessive eating?

yes  no

10

2. In the past two months have you experienced an episode of uncontrollable excessive eating?

yes  no

2

5

3. In order to control your weight, do you use any of the following methods? (Check all those that apply)

Self induced vomiting

6

Laxatives

7

Diuretics

8

Strict diets

9

Diet pills

10

Chewing or spitting out food

11

Exercise

12

Fasting

13

Other .....

4. Have you had repeated experiences of rapidly eating a large amount in a short period of time in such a way that you would be embarrassed if others saw you? (Binge-eating, gorging, or bulimia?)

No

No, but I have had infrequent binge-eating episodes

14

Yes, but I no longer binge-eat

Yes, and I still binge-eat

5. For each of the behaviours listed below, select the one month period in your life when that behaviour occurred most often and check the appropriate column.

	Never	Less than once a week	More than once a week	About once daily	More than once daily	
"Binge-eating"						15
Vomiting (Self-induced)						16
Laxative use (for weight control)						17
Diet Pill use						18
Water Pill/Diuretic use (for wt. control)						19
Chewing Food and spitting it out						20
Fasting						21

Explain if necessary: \_\_\_\_\_

6. How often have you engaged in each of the behaviours listed below in the last month?

	Never	Less than once a week	More than once a week	About once daily	More than once daily	
"Binge-eating"						21
Vomiting (Self-induced)						22
Laxative use (for weight control)						23
Diet pill use						24
Water Pill/Diuretic use (for wt. control)						25
Chewing food and spitting it out						26
Fasting						27

Explain if necessary: \_\_\_\_\_

7. Do you consider yourself a binge-eater?

yes

no

29

8. Do you consider yourself a compulsive eater?

yes

no

30

9. Do you consider yourself to have an eating problem?

yes

no

31

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER NEXT TO YOUR CHOSEN RESPONSE.

1. How satisfied are you with the way your body looks?

A Extremely satisfied

B Quite satisfied

C Only just satisfied

D Only just dissatisfied

E Quite dissatisfied

F Extremely dissatisfied

32

2. How satisfied are you with your height?

A Extremely satisfied

B Quite satisfied

C Only just satisfied

D Only just dissatisfied

E Quite dissatisfied

F Extremely dissatisfied

33

3. How satisfied are you with your weight?

A Extremely satisfied

B Quite satisfied

C Only just satisfied

D Only just dissatisfied

E Quite dissatisfied

F Extremely dissatisfied

34

4. How satisfied are you with the size of your stomach?

A Extremely satisfied

B Quite satisfied

C Only just satisfied

D Only just dissatisfied

E Quite dissatisfied

F Extremely dissatisfied

35

5. How satisfied are you with your waist?
- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied
6. How satisfied are you with your buttocks (seat)?
- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied
7. How satisfied are you with your breasts?
- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied
8. How satisfied are you with your hips?
- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied
9. How satisfied are you with your thighs?
- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied

10. How satisfied are you with the width of your shoulders?

- A Extremely satisfied
- B Quite satisfied
- C Only just satisfied
- D Only just dissatisfied
- E Quite dissatisfied
- F Extremely dissatisfied

41

11. How satisfied are you with your feet?

- A Extremely satisfied
- B Quite satisfied
- C Only just satisfied
- D Only just dissatisfied
- E Quite dissatisfied
- F Extremely dissatisfied

42

12. How satisfied are you with your ankles?

- A Extremely satisfied
- B Quite satisfied
- C Only just satisfied
- D Only just dissatisfied
- E Quite dissatisfied
- F Extremely dissatisfied

43

13. How satisfied are you with the length of your nose?

- A Extremely satisfied
- B Quite satisfied
- C Only just satisfied
- D Only just dissatisfied
- E Quite dissatisfied
- F Extremely dissatisfied

44

14. How satisfied are you with your neck?

- A Extremely satisfied
- B Quite satisfied
- C Only just satisfied
- D Only just dissatisfied
- E Quite dissatisfied
- F Extremely dissatisfied

45

15. How satisfied are you with your calves?

- A Extremely satisfied
  - B Quite satisfied
  - C Only just satisfied
  - D Only just dissatisfied
  - E Quite dissatisfied
  - F Extremely dissatisfied
- 

IN THE FOLLOWING EXERCISE YOU WILL BE PRESENTED WITH A LIST OF OPPOSITE WORDS. ON EACH PAGE YOU WILL BE ASKED TO RATE DIFFERENT PEOPLE IN TERMS OF EACH PAIR OF OPPOSITE WORDS. FOR EXAMPLE, IF YOU ARE PRESENTED WITH LOYAL-DISLOYAL AND ASKED TO RATE YOURSELF AND YOU FEEL THAT YOU ARE COMPLETELY LOYAL, THEN CIRCLE 1 AS IT IS CLOSEST TO LOYAL AND FURTEST FROM DISLOYAL, LIKE THIS:

LOYAL    ①    2    3    4    5    6    7    DISLOYAL

IF YOU FEEL YOU ARE MODERATELY LOYAL THEN CIRCLE 4, IN THE MIDDLE:

LOYAL    1    2    3    ④    5    6    7    DISLOYAL

IF YOU FEEL YOU ARE EXTREMELY DISLOYAL THEN CIRCLE 7 CLOSEST TO THE OTHER SIDE:

LOYAL    1    2    3    4    5    6    ⑦    DISLOYAL

TRY AND REGARD EACH PERSON SEPARATELY BUT DO NOT BE TOO CONCERNED TO RESPOND SIMILARLY TO SOME OF THEM.

\*

Please rate a typical photographic model, the sort of woman who appears on the cover of women's magazines, on the following

healthy	1	2	3	4	5	6	7	ill/unhealthy	47	<input type="checkbox"/>
assertive	1	2	3	4	5	6	7	unassertive	48	<input type="checkbox"/>
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	49	<input type="checkbox"/>
in control	1	2	3	4	5	6	7	out of control	50	<input type="checkbox"/>
attractive body	1	2	3	4	5	6	7	unattractive body	51	<input type="checkbox"/>
energetic	1	2	3	4	5	6	7	lacking energy	52	<input type="checkbox"/>
well-liked	1	2	3	4	5	6	7	unpopular	53	<input type="checkbox"/>
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	54	<input type="checkbox"/>

Imagine yourself as much fatter/heavier than you are now and then rate yourself on the following:

healthy	1	2	3	4	5	6	7	ill/unhealthy	55	<input type="checkbox"/>
assertive	1	2	3	4	5	6	7	unassertive	56	<input type="checkbox"/>
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	57	<input type="checkbox"/>
in control	1	2	3	4	5	6	7	out of control	58	<input type="checkbox"/>
attractive body	1	2	3	4	5	6	7	unattractive body	59	<input type="checkbox"/>
energetic	1	2	3	4	5	6	7	lacking energy	60	<input type="checkbox"/>
well-liked	1	2	3	4	5	6	7	unpopular	61	<input type="checkbox"/>
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	62	<input type="checkbox"/>

Rate a slim teenager on the following:

healthy	1	2	3	4	5	6	7	ill/unhealthy	63	<input type="text"/>
assertive	1	2	3	4	5	6	7	unassertive	64	<input type="text"/>
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	65	<input type="text"/>
in control	1	2	3	4	5	6	7	out of control	66	<input type="text"/>
attractive body	1	2	3	4	5	6	7	unattractive body	67	<input type="text"/>
energetic	1	2	3	4	5	6	7	lacking energy	68	<input type="text"/>
well-liked	1	2	3	4	5	6	7	unpopular	69	<input type="text"/>
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	70	<input type="text"/>

Please rate yourself with your body as it is now on the following:

healthy	1	2	3	4	5	6	7	ill/unhealthy	71	<input type="text"/>
assertive	1	2	3	4	5	6	7	unassertive	72	<input type="text"/>
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	73	<input type="text"/>
in control	1	2	3	4	5	6	7	out of control	74	<input type="text"/>
attractive body	1	2	3	4	5	6	7	unattractive body	75	<input type="text"/>
energetic	1	2	3	4	5	6	7	lacking energy	76	<input type="text"/>
well-liked	1	2	3	4	5	6	7	unpopular	77	<input type="text"/>
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	78	<input type="text"/>

Please rate an athletic woman (like a runner or aerobic gymnast) on the following:

healthy	1	2	3	4	5	6	7	ill/unhealthy	79	
assertive	1	2	3	4	5	6	7	unassertive	80	
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	3	
in control	1	2	3	4	5	6	7	out of control	5	
attractive body	1	2	3	4	5	6	7	unattractive body	6	
energetic	1	2	3	4	5	6	7	lacking energy	7	
well-liked	1	2	3	4	5	6	7	unpopular	8	
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	9	
									10	

Please imagine yourself as much thinner and then rate yourself on the following:

healthy	1	2	3	4	5	6	7	ill/unhealthy	11	
assertive	1	2	3	4	5	6	7	unassertive	12	
glamorous	1	2	3	4	5	6	7	dowdy/unattractive	13	
in control	1	2	3	4	5	6	7	out of control	14	
attractive body	1	2	3	4	5	6	7	unattractive body	15	
energetic	1	2	3	4	5	6	7	lacking energy	16	
well-liked	1	2	3	4	5	6	7	unpopular	17	
sexually attractive	1	2	3	4	5	6	7	sexually repulsive	18	

COMMENTS:

1. How did you find this questionnaire (i.e. boring, stimulating)?

.....  
.....

2. Did you encounter any difficulties or problems in answering it?

.....  
.....

3. Did it arouse any emotions in you about yourself, friends or society?

.....  
.....

If you would like to chat some more about these issues, I am looking for interested people who have been through personal experiences or can identify with this issue in any way. You may write down your name and phone number in the space provided.

NAME: .....

TELEPHONE NO: .....

or you can contact me personally at the Psychology Department, Room 2.27.

**PLEASE USE THE FOLLOWING TABLES TO TRANSFORM POUNDS TO KILOGRAMS AND FEET/INCHES OR METRES TO CENTIMETRES**

POUNDS	KILOGRAMS	POUNDS	KILOGRAMS	POUNDS	KILOGRAMS
80	36.4	121	55	161	73.2
81	36.8	122	55.5	162	73.6
82	37.3	123	55.9	163	74.1
83	37.7	124	56.3	164	74.5
84	38.2	125	56.8	165	75
85	38.6	126	57.3	166	75.5
86	39.1	127	57.7	167	75.9
87	39.5	128	58.2	168	76.4
88	40	129	58.6	169	76.8
89	40.1	130	59	170	77.3
90	40.9	131	59.5	171	77.7
91	41.4	132	60	172	78.2
92	41.8	133	60.5	173	78.6
93	42.3	134	60.9	174	79
94	42.7	135	61.4	175	79.5
95	43.2	136	61.8	176	80
96	43.6	137	62.3	177	80.5
97	44.1	138	62.7	178	80.9
98	44.5	139	63.2	179	81.4
99	45	140	63.6	180	81.8
100	45.5	141	64.1	181	82.3
101	45.9	142	64.5	182	82.7
102	46.4	143	65	183	83.2
103	46.8	144	65.5	184	83.6
104	47.3	145	65.9	185	84.1
105	47.7	146	66.4	186	84.5
106	48.2	147	66.8	187	85
107	48.6	148	67.3	188	85.5
108	49.1	149	67.7	189	85.9
109	49.5	150	68.2	190	86.4
110	50	151	68.6	191	86.8
111	50.5	152	69.1	192	87.3
112	50.9	153	69.5	193	87.7
113	51.4	154	70	194	88.2
114	51.8	155	70.5	195	88.6
115	52.3	156	70.9	196	89.1
116	52.7	157	71.4	197	89.5
117	53.2	158	71.8	198	90
118	53.6	159	72.3	199	90.5
119	54.1	160	72.7	200	90.9
120	54.5				

feet	inches	meters	centimetres	feet	inches	meters	centimetres
4	5	1.34	134	5	5	1.65	165
4	6	1.37	137	5	6	1.67	167
4	7	1.39	139	5	7	1.7	170
4	8	1.42	142	5	8	1.72	172
4	9	1.44	144	5	9	1.75	175
4	10	1.47	147	5	10	1.77	177
4	11	1.49	149	5	11	1.8	180
5	0	1.52	152	6	0	1.82	182
5	1	1.54	154	6	1	1.85	185
5	2	1.57	157	6	2	1.87	187
5	3	1.6	160	6	3	1.9	190
5	4	1.62	162	6	4	1.93	193

## APPENDIX II: FIRST INTERVIEW SCHEDULE: THE EATING PROBLEM

This is a broad outline of the questions covered in the interview. The interview was semi-structured and as such the questions did not follow this format exactly, as attempts were made to let the interviewee set the pace and to probe her replies in more detail.

### The eating problem: history and present symptomatology

- (1) You answered on your questionnaire that you considered yourself to have an eating problem. Can you elaborate what you mean by that ?
  - (2) Do you remember the first time food or eating became a problem for you ?
  - (3) Have you ever been on a voluntary diet ? Do you remember the first time you did so ? Why did you do so ?
  - (4) Have you ever been for long periods of time when you have not eaten (fasted) ?
  - (5) Have you ever lost extreme amounts of weight (10kg or more) ?
  - (6) Did your periods stop ? How regular are they generally ?
  - (7) Can you describe how your eating problem has developed/changed over the years ? Have there been different phases ?
  - (8) Which of these methods of weight control have used in the past and which do you presently use:
    - self-induced vomiting
    - laxatives
    - diet pills
    - fasting
    - diuretics
    - exercise
    - others ?
- Why did you start using them ? How frequently did you do so - during the most extreme times and generally ?
- (9) Do you ever "binge" or eat excessive amounts of food ?
  - (10) What do you consider a "binge" to be ? Can you give me an example of a "bad binge" ?
  - (11) When did the "bingeing" begin ?

### Attitudes towards food/eating

There would often be no need to ask these questions as they would come up on their own accord. In fact, attempts were made not to ask these directly and the direct questions would only be asked if no mention was made of it.

(12) How do you feel about eating/food ? Do you ever feel anxious around food ? Do you ever feel guilty about eating ? Do you feel that you deserve to eat ?

(13) Are you afraid of losing control over your eating ? How do you feel when you have been in control over your eating ? Is your control over your eating related to your sense of control over your life ?

(14) Do you prefer to eat alone or with others ? Do you eat in secret ? Do you eat differently in the company of different people ?

(15) Do you think women should eat less than men ?

### Responses and attitudes of others to the problem

(16) How did your family handle your eating problem ?

(17) How did your peers and boyfriend/lover handle your problem ?

(18) Does anyone else in your family have an eating problem ?

(19) Is your family weight conscious ?

(20) Have you received any aid/help for your eating problem ?

### Understanding of the eating problem

(21) Why do you think you developed an eating problem ? How do you understand your problem ? What do you think is at the root of it ?

(22) How are your emotions related to your eating behaviour ?

(23) Does your eating problem interfere in your life ? In what ways ?

### Understanding of eating disorders

(24) How do you understand anorexia nervosa and bulimia ?

(25) How do you understand the relationship between your problem and these problems ?

APPENDIX III: SECOND INTERVIEW SCHEDULE: ATTITUDES TO THE BODY

At the beginning of the second interview, the interviewee was asked how she has felt since the last interview, particularly whether there have been any changes in relation to her eating problem. Again, the interview was semi-structured with this outline not followed closely.

Attitudes to the body

- (1) Think about your body. What is the first thing that comes into your mind ?
- (2) What sorts of feelings do you have towards your body ? Do you like/dislike it ? Which parts do you like/dislike ?
- (3) What do you think of/feel when you hear the word "fat" ? How do you feel about having fat on your body ? How do you feel about fat people ? Why do you think people get fat ?
- (4) Are you conscious of your body ? Are there particular places where you feel more conscious of it than others ?
- (5) Why do you think you are conscious of your body ? Can you remember when you first became conscious of it ?
- (6) Are you afraid of putting on weight or becoming fat ? What does it mean for you to be fat ?
- (7) How important is your body in your life ? Why do you think it has taken on this value ?
- (8) Do you feel judged/weighed up in terms of your body ?
- (9) Do you judge/weigh other women up in terms of their bodies ? What is the first thing you notice when a strange woman walks into the room ? Is thin/fat a category you use to judge people by ?
- (10) Do you ever find yourself comparing your body or parts of it to other women's bodies ? Do you ever wish you could have somebody else's body or parts of it ?
- (11) How do you feel when you are in the company of women slimmer than you ? And women fatter than you ?
- (12) Do you feel more aware of your body in the company of men or women ?
- (13) Can you describe your ideal body size and shape ?
- (14) How do you think it correlates with the media ideal for women ?

(15) Why do you think the social ideal for women has become so thin ?

(16) How does your body feel after you have eaten ? Do you feel slimmer when you have been restraining your eating ?

(17) How do you think the way you feel about your body is related to your problem with eating ?

Background questions: family, peer group and schooling

(18) If nothing spoken about the family, a brief description is asked for.

(19) What sort of school did you attend ?

(20) How did you achieve at school - academically and otherwise ?

(21) Were you conscientious, then and now ? Were/are you placed in positions of responsibility ?

(22) Were you sporty ?

(23) Were you involved in performing activities - dancing, drama, etc. ?

(24) Would you describe yourself as fashion conscious at school ? And now ? Did/do you read women's magazines ?

(25) Were there any particular role models that had a strong effect on you as a child/adolescent ?

(26) Can you remember when you got your periods and started developing breasts ? What sort of experience was it ?

Personality and social characteristics

(27) How would you describe yourself as a personality ? Are you introvert or extrovert ? Confident or unconfident ? shy or outgoing ?

(28) Are you sociable ? Do you find it easy to get on with other people ?

(29) Are you a supportive person ? Do others tend to confide in you ? Are you independent/self-sufficient ?

(30) Would you describe yourself as a perfectionist ?

(31) Are you presently involved in an intimate relationship ? Man or woman ? How do you find they relate to your body ?

(32) Are you involved in community organizations ?

(33) How do you feel about the South African situation ? Would you describe yourself as a politically concerned person ?

(34) Do you think women are oppressed ? How ? Would you call yourself a feminist ?

Activities/habits

(35) Do you smoke cigarettes or cannabis ?

(36) Do you take any drugs ?

(37) Do you drink alcohol ?

(38) Have you ever had a problem with alcohol or drug abuse ?

Solutions to eating/body problems

(39) Do you think that eating problems are widespread among women ? Do you know any other women who have similar problems to you ?

(40) Why do you think these problems exist ? What do you think a solution would be ?

(41) What would have helped you deal with your problem when it was most severe/or now ? What sort of therapy/support would most suit you ?

APPENDIX IV: TABLES

Table i: Comparison of results of individual EAT items with Meadows et al's (1986) findings

<u>EAT item</u>	<u>% scoring at least "often"</u>	
	<u>Meadows et al (1986)</u>	<u>present study (1986)</u>
4 terrified about being overweight	26.8	33.6
15 preoccupied with a desire to be thinner	22.5	38.7
25 preoccupied with the thought of having fat on my body	17.8	32.3
3 feel that food controls my life	8.1	17.1
14 feel extremely guilty after eating	7.7	17.2
38 like my stomach to be empty	5.7	19.2
16 exercise strenuously to burn off calories	9.7	15.6
37 engage in dieting behaviour	9.0	27.1
10 particularly avoid foods with a high carbohydrate content	5.4	21.2
30 eat diet foods	4.9	15.6
5 avoid eating when I am hungry	3.9	6.2
7 have gone on eating binges where I feel that I may not be able to stop	6.9	11.2
28 take laxatives	0.7	3.4
13 vomit after I have eaten	0.5	1.8

Table ii: Relationship between binge eating and methods of weight control

<u>Cooper and Fairburn's (1983) criteria</u>						
method of weight control	never binge	ever binge	current bingeing			
vomiting	9	4.3%	11	9.6%	6	8.6%
not vomiting	196	95.7%	103	90.4%	64	91.6%
laxative	15	7.3%	15	13.2%	11	15.7%
no laxatives	190	92.7%	99	86.8%	59	84.3%
strict diets	22	10.8%	28	24.6%	14	20%
no strict diets	183	89.2%	86	85.4%	56	80%
dietpill	19	9.3%	20	17.5%	15	21.4%
no dietpill	186	90.7%	94	82.5%	55	80.6%
fasting	17	8.3%	32	28.1%	20	28.6%
no fasting	188	91.7%	82	71.9%	50	71.4%

Table iii: Relationship between binge eating and methods of weight control

method of weight control	Pyle et al (1983) criteria								
	never binge		present frequent bingeing		past frequent bingeing		infrequent bingeing		total
laxatives	13	6.88%	5	21.73%	3	21.43%	9	9.89%	
no laxatives	176	93.22%	18	78.27%	11	78.57%	82	90.1%	287
total	189		23		14		91		
strict dieting	20	10.6%	6	26.1%	4	28.6%	19	20.9%	49
no strict diet	169	89.4%	17	74.9%	10	71.4%	72	79.1%	268
total	189		23		14		91		
fasting	14	7.4%	8	34.8%	3	21.4%	24	26.4%	49
no fasting	175	92.6%	15	65.2%	11	78.6%	67	73.6%	268
total	189		23		14		91		
dietpill	13	6.9%	4	17.4%	4	28.6%	18	19.8%	39
no dietpill	176	92.1%	19	82.6%	10	71.4%	73	80.2%	278
total	189		23		14		91		
vomiting	3	1.6%	4	17.9%	5	35.7%	8	8.8%	20
no vomiting	186	98.4%	19	82.1%	9	64.3%	83	91.2%	297
total	189		23		14		91		

Table iv: Relationships between considering oneself to have an eating problem, a binge eater and a compulsive eater

		Eating Problem			
		no		yes	
Binge eater	no	178	32	35	40
		56.3%	10.1%	11.1%	12.7%
	yes	3	5	6	17
		1.6%	0.9%	1.9%	5.4%
		no	yes	no	yes
		Compulsive eater		Compulsive eater	

All percentages provided are of the total sample.