

The Fashion Industry and Eating Disorders

The Fashion Industry and Eating Disorders:

The Dangers of the Catwalk

By

Nikolett Bogár and Ferenc Túry

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To Lőrinc, who taught me the real meaning of love, support,
and acceptance.

—Nikolett

To my family.

—Ferenc

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PREFACE

Modern civilization has a great impact on our lives and this includes our health. While the development of medical sciences has been spectacular, especially if we consider the advances in technology, the rate of civilization's illnesses is higher. If the main indicator of a society's health status is life expectancy at birth, then we will live to an increasingly greater age. At the same time, health risks have escalated in many respects; therefore, we cannot be satisfied with improvements on a global scale.

Both lifestyles and our relationships with our bodies are fundamental in determining our quality of life. Eating and physical activity constitute the key areas of our lifestyles. Their cultural background is most important. The food, fitness, and beauty industries, along with help from marketing, serve the purpose of adjusting the human body to cultural norms. Consumption oriented societies convey multiple messages related to eating: eat as much as possible, consume a diverse range of food, healthier nutrients, and be as slim as possible. This paradox has permeated life today. The same is true for physical exercise: sports achievements are extraordinary. However, the majority of the general population does not carry out activities that promote or develop health. Instead, they have sedentary lifestyles and too much nourishment. Therefore, it is understandable that the rate of obesity is increasing throughout the world.

As far as cultural ideals are concerned, we can observe a similar duality within the acceptable body shape. The slim ideal is fundamental, yet the general population is increasingly obese. Cultural aims have become unreachable but we still strive to reach these goals: it is like holding up a carrot beyond the reach of a donkey. Cultural ideals related to body shape are conveyed by role models such as movie stars and models. Interestingly enough, the appearance and body shape of athletes are not so prominent, despite the fact that one would think that athletes should represent the ideal body shape (obviously this does not include extreme sports performers, such as professional boxers or long-distance runners). Photographs of fashion models are readily available: on the internet, in fashion magazines, and advertisements. They are exhibited and many people try to follow them. Young people often dream of similar careers and all their trappings:

international fashion model careers, luxurious lifestyles, dreamlike dresses, exotic travels, fame, and so on.

This book guides the reader through the world of fashion models; this is all based on personal experience and research conducted via interviews with models. The everyday life of fashion models is not nearly as attractive as one might think. In many cases the difficult task of controlling one's body shape entails daily suffering. This results in eating disorders that often affect fashion models. Anorexia nervosa and bulimia nervosa, which is accompanied by overeating and self-induced vomiting, are psychiatric disorders. It is a well-known fact that the thin ideal in the modern age is a specific risk factor for the development of eating disorders. This ideal is sustained by the people who shape fashion and it is conveyed by fashion models. Naturally, this formative process is not a conscious one and, instead, it conforms to the current cultural medium. It is, therefore, a complex phenomenon with many agents and responsibility for this condition is shared among multiple actors.

This book also attempts to cast light on the sociocultural background of the fashion phenomenon. The human body also comes into view where the thin ideal is concerned: how important is it to maintain a healthy body, and how much abuse can our body take? Furthermore, to what extent can others misuse our body in the name of certain cultural ideals? What is the task of health policy and what regulations are necessary in order to secure health promotion as a fundamental value? These questions seem simple enough but they are not: we are part of a game that includes multiple actors, and the rules are often far from clear. These are, in fact, bioethical issues.

The pressure of the fashion industry does not only involve issues related to culture but it also greatly influences the general population who aspire to emulate models, which affects their health. Therefore, regulating the employment of fashion models will also positively impact the public's health. If this book contributes to reinforce the intentions of health policy decision-makers, then it was worth writing.

The Authors

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I am specifically grateful to my beloved parents, Zoltán Bogár and Irén Bogárné Váradi, for their endless patience and support in whatever difficulty I had to face throughout my life and for letting me seize the opportunities that I came across. They are the ones who established understanding and loving foundations, so that I could focus on my goals and work towards them. They put an incredible amount of energy into raising me to their best ability and they provided me with the best childhood I could ever wish for.

Nikolett Bogár

CHAPTER ONE

EATING DISORDERS: CULTURAL BACKGROUND

1.1. Eating disorders as “diseases of civilization”

Modern civilization has raised social and psychological questions that we could not have imagined earlier. If we consider the innovations of information technology, we will realize how these have fundamentally changed human communication. The illusion of permanent accessibility endows us with power. Virtual communities and social networks play an ever-increasing role in our lives, which means that face-to-face communication often takes a back seat. Another important area is the world of food and eating. In previous centuries eating disorders were not remarkable. The situation was plain and clear: if you do not eat, then you will perish. Since food became abundant—following periods of famine in a non-linear development—manipulation of food started: rejection of food, throwing up/vomiting consumed food, and so on. Eating disorders can be regarded as modern civilization’s disease (Miller and Pumariega, 2001).

Why has eating changed so much in modern times? One of the background factors may be the various emotional meanings of eating: who prepares the meal, whose dish is being rejected, how a meal strengthens family cohesion, and so on. There are several reasons that provide explanations for the prominence of eating disorders.

1. **High prevalence:** The obesity rate is high in both the adult population and among children in the Western countries (see below). The average prevalence of anorexia nervosa (AN) in Western civilization is 0.3% among women (Hoek and Hoeken, 2003; Machado et al, 2007). The prevalence of life expectancy among women is 0.9–2.2% (Keski-Rahkonen et al, 2007; Wade et al, 2006). Morbidity rates among women are ten times higher than among men but this difference has decreased in the past decade.

2. **Increased morbidity:** This is mainly related to milder disorders. After an initial increase, the prevalence of bulimia nervosa (BN) is now in decline; however, it has been replaced by other types of disorders.
3. **The metamorphosis of eating disorders:** Pathomorphosis takes place with rapidity. A growing number of new types of disorders are being recorded.
4. **The severity of the syndrome:** This is shown by the fact that the mortality rate of anorexic patients has one of the highest death rates in psychiatric disorders. According to a meta-analysis, the standardized rate in AN is 5.86, in BN 1.93 and in other uncategorized eating disorders it is 1.92. One fifth of AN mortality results from death by suicide (Arcelus et al, 2011).
5. **Learning through modeling, imitation, and the thin ideal:** These all play a significant role in the background of eating disorders. Due to the importance of their sociocultural background, these disorders receive much public interest. Practically every day we read news related to eating disorders or hear about well-known public figures who suffer from the disease.
6. **Eating disorders also represent/reflect social phenomena:** This disease may be considered as an outgrowth of civilization and it can also be seen as a distortion of consumer culture.

1.2. The main types of eating and body image disorders

1.2.1. *The classic forms of eating disorders*

The conditions of being *overweight* or *obese* frequently occur, and their prevalence is increasing all over the world. It is a complex phenomenon with many somatic factors in the background. It is the most prevalent risk factor in type-2 diabetes, hypertension, and cardiovascular diseases. However, the psychosocial background often plays a crucial role.

The nutritional state is shown by the body mass index (BMI: body weight in kg/height [in meters] squared). The normal BMI range is 18.5–25 for women and 20–25 for men. The World Health Organization defines being overweight as having a BMI greater than or equal to 25, and obesity as a BMI greater than 30. Research data indicates that the percentage of overweight people in the US (including obesity) is 66.3%, and obesity stands at 32.2%. Morbid obesity, (a BMI greater than 40) is 4.8% (Hu, 2008). The increase in morbid obesity is dramatic as it has quadrupled between 1986 and 2000. In this period of time, the mean BMI increased

worldwide by 0.4 percent per decade (Finucane et al, 2011). There are ethnic differences as well. Obesity in the US is prevalent among non-Hispanic black women (53.9%), and less frequent among Asian women (7.8%). Similar trends can be found in Western Europe. The prevalence of obesity among children is also increasing. According to one study, it has doubled between 1961 and 2001 (Styne, 2001).

Beside obesity there are two classic types of eating disorders: *Anorexia Nervosa* (AN) and *Bulimia Nervosa* (BN). These disorders primarily affect women, as only 2–10% of men are affected by various forms of eating disorders. In the past two decades new disorders have emerged and we will briefly review the most important of these based on the most recent psychiatric classification system: the DSM-5 (APA, 2013).

The basic symptoms of AN are significant abnormally low body weight, pathological fear of becoming fat, and distorted body image. Menstruation frequently stops. The disease has two subtypes: fasting (restrictive) type and bulimic (purging). The latter includes bulimic symptoms but if the sufferer is abnormally thin, then an AN diagnosis will be given (thus the symptoms of AN overwrite the symptoms of BN). The dominance of the slim ideal is found in the history of AN.

BN is characterized by binge eating, weight loss manipulation (self-induced vomiting, misuse of laxatives, etc.), and loss of control. It has two subtypes: purging and the non-purging. The latter does not include purging and weight loss is achieved by intense physical exercise or fasting.

In the past two decades the impulse control disorders accompanying AN and BN multiplied. These occur in cases where emotionally unstable personality disorders are involved, and are manifested in the following behaviors: alcohol abuse, drug abuse, self-mutilation, suicide attempts, kleptomania, and promiscuity. This subtype has a poor prognosis and traumatic recollection of past experiences often plays an important role in the development of impulse control disorders.

1.2.2. Other types of eating disorders

Binge eating disorder (BED) is considered a relatively new disease (Spitzer et al, 1991). It is characterized by binge eating but there are no compensatory behaviors; this means that patients may become overweight. One third of obese people who seek treatment suffer from BED. Therefore, this disorder is in a category between obesity and BN.

It is characteristic of male body builders to suffer from a disorder which was initially described as reverse AN (Pope et al, 1993). The symptoms are opposite to those found in AN. These men are extremely muscular but they perceive themselves as slim and so they often use anabolic steroids in order to increase their muscle mass. This syndrome was later named muscle dysmorphia because the focus of the disorder is body image rather than eating (Phillips et al, 1997). The denotation of the syndrome “*machismo nervosa*” as a form of AN is an interesting one (Whitehead, 1994; Connan, 1998). The athletic ideal (so-called Schwarzenegger ideal) is found in the cultural background of this disorder. The cult of physical training and the fashion of fitness in today’s society increases the risk of suffering from this disorder.

Eating disorder body builder type, or body fat phobia, may be considered a close relative of muscle dysmorphia. This was described as a disorder that affects female body builders (Gruber and Pope, 2000). The central feature of the disorder is body fat phobia (i.e., a refusal to maintain body fat at a healthy level) and this is the drive for bodybuilding. There is an intense fear of being fat or losing muscle. These subjects have obsessional eating habits and follow a very rigid diet with high-calorie and low-fat foods. In this case, the target of the obsessional behavior is the quality of the muscles. Muscle size or sports achievements are less important and reducing body fat is what really counts.

There is a high potential of significant psychological distress and food preoccupation among competitive female bodybuilders (Andersen et al, 1998). Gruber and Pope (2000) have also discussed the concept of “*non-traditional gender roles*”. The non-traditional gender role is characterized by a strong preference for male characteristics and activities: e.g., wearing masculine clothing and a preference for masculine jobs. These subjects do not want to be male and are satisfied with their sex. Although their lifestyle is special, this condition causes only minimal distress.

Orthorexia nervosa was first described by Steve Bratman (1997), who analyzed his own symptoms. The syndrome can be described as a dependence on healthy food. These people consume only very healthy food or, at least, what is considered to be very healthy. The focus of this eating disorder is not the quantity but the quality of food. Obsessive thoughts and behaviors related to healthy foods emerge and may become pathological. As a consequence, strict dietary restrictions develop that can lead to serious nutrient deficiency.

Purging disorder is the counterpart of the binge eating disorder described above (Keel et al, 2005). This is when a dissociation has occurred in the basic symptoms of BN; therefore, binge eating episodes and compensatory behaviors do not always depend on each other. It is characteristic of the purging disorder that there is no binge eating involved; however, it includes purging behaviors. The patients do not eat a spectacular amount of food but self-induced vomiting and the misuse of laxatives and diuretics occur on a regular basis.

Excessive exercise (or *exercise dependence/exercise addiction*) focuses on the control of the body as well. It is a behavioral addiction, where physical training is the core symptom (Coverley Veale, 1987). In its primary form, dependence on physical activity has an end in itself. In its secondary form, physical activity is motivated by the control of the body. This is known as hyperactivity and can be observed in the majority of patients with AN. In order to diagnose excessive exercise at least three of the following symptoms must occur (Hausenblas and Downs (2002):

1. Tolerance: the desired effect can only be achieved by constantly increasing the amount of exercise
2. Withdrawal: such as anxiety or fatigue
3. Intention: exercising more and longer than intended
4. Lack of control: a constant desire to control the duration and intensity of exercise, but this is unsuccessful
5. Time spent organizing all other activities (e.g., holidays) around fitness
6. Reduction of other activities: cancelling or limiting important social engagements, work plans, or leisure opportunities in order to exercise for longer
7. Continuing despite injury, which can take the form of physical injuries or emerging mental disorders

1.2.3. The prototype of body image disorders: body dysmorphic disorder

One of the classic types of body image disorders is *body dysmorphic disorder (BDD)*, which was previously known as dysmorphophobia. This syndrome is more prevalent today and is partially responsible for the rapid growth in plastic surgery procedures (Sarwer et al, 2004). 1–2% of the general population suffer from this condition. The essence of the syndrome is that sufferers are dissatisfied with their appearance. They perceive it as a flaw and will do everything in their power to hide it or alter it. This is a

specific body image disorder. It is accompanied by great suffering and a decrease in quality of life. Thoughts of suicide and suicide attempts frequently occur. The onset of the disorder is in adolescence and it may become chronic if it is not treated properly (Phillips et al, 2005).

76% of patients suffering from body image disorders opt for plastic surgery and two thirds of these patients undergo surgical interventions (Phillips et al, 2001). The most popular surgical intervention is rhinoplasty. It is not surprising that body dysmorphic disorder is prevalent in 7–15% of plastic surgery patients (Dufresne et al, 2001). The majority of patients who undergo cosmetic surgery do not experience improvement in BDD symptoms; therefore, BDD is a contraindication for cosmetic treatment (Sarwer and Crerand, 2004).

1.2.4. The Adonis complex: men's obsession with their appearance

A preoccupation with appearance has been women's privilege for a long time. However, in the past few decades, men have caught up with women and aesthetic considerations started affect them as well. The Adonis complex is the name given to men's anxieties and worries related to their bodies: a desire to attain a muscular, athletic body; a struggle with weight; excessive use of the fitness and beauty industries (Pope et al, 2000). This is supported by the rapid growth of cosmetic surgery interventions, especially hair transplants, and the development of the bodybuilding and fitness industries. The drive behind excessive physical activities is not sports performance but a desire to modify the body. It is cultural values, rather than health concerns that motivate activities that target the ideal body: control, self-discipline, competence, and sexual appeal. The media plays an important role in deciding the "ideal" body shape. The predominant ideal among men is still the athletic body type but the thin ideal is also growing rapidly.

1.2.5. Body image disorders and plastic surgery

Plastic, cosmetic, and aesthetic surgery interventions aim to change the appearance for aesthetic purposes (Sarwer et al, 2004; Phillips, 2005). Dissatisfaction with appearance plays a key role in stimulating demand for plastic surgery (Sarwer and Crerand, 2004). Plastic surgery has become a thriving branch of industry. Half a century ago body modification was considered a taboo. Nowadays the surface of the human body has become

an aesthetic area: e.g., tattoos and piercings. According to data from the American Society of Plastic Surgeons (2010), more than 12 million surgical operations and small intervention procedures had been performed in the US by the end of 2009. The number of interventions among men was 1.5 million and the demand for these procedures is increasing. Plastic and cosmetic surgeries are popular and there are a growing number of interventions every year. For example, the number of the two most popular body contouring procedures (breast augmentation and liposuction) sextupled over the past decade. It is not only surgeons who carry out cosmetic surgery interventions but other professionals as well: e.g., dermatologists.

Diseases related to body image disorders are prevalent among cosmetic surgery patients: the prevalence of body dysmorphic disorder is 7–16% among plastic surgery patients. Since surgery yields no improvement in two thirds of these patients, body dysmorphic disorder is a contraindication to cosmetic procedures (Sarwer et al, 2004; Phillips, 2005).

The purpose of undergoing plastic or aesthetic surgery is to achieve a more attractive appearance. Interestingly, from an evolutionary perspective, facial characteristics are not the sole determinants of an attractive appearance. The waist to hip ratio plays a role as well. Women are considered to be more attractive if their waist size is 80% of their hip size (Singh, 1993). It is worth mentioning here that two very popular plastic surgery interventions, liposuction and abdominoplasty, influence the waist to hip ratio.

These types of body modifications have also permeated games for children. Today one can find surgery videogames for children: if their doll is too fat, they can perform liposuction surgery to remove it. This means that children learn how to modify the body in a playful way. This could be regarded as a good example of the current cultural distortions.

1.3. The medicalization of eating disorders seen through a historical lens

In order to better understand the relationship between fashion and eating disorders, it is worth reviewing the history of eating disorders. When does a common behavior become a medical issue?

The word “anorexia” (an + orexis [Greek: desire]) denotes an absence of desire and a lack of appetite. It was first mentioned in the 1st century, where it was used to mean lack of desire. Not long after, the Roman physician Galenus used this term to indicate a loss of appetite. Various forms of self-

starvation are closely linked to the history of AN. They do not meet the requirements of today's AN criteria but there is great resemblance in many respects. There are three main phases in the history of descriptive accounts that relate to self-starvation: religious explanations were predominant at first, then it became a spectacle, and finally it was considered as a medical condition (Vandereycken and van Deth, 1994; Vandereycken et al, 2003; we have mainly used their work for this historical review).

Religious explanations were prevalent in the 13th century but there are still references to religious miracles related to weight loss even in the 20th century. Fasting is the practice of ritual self-starvation found in various religions and it has many meanings and purposes. One way to become demonically possessed was through food intake; therefore, fasting was considered a method of overcoming demonic possession. Later, self-starvation became a form of penance, whether the sin was committed by the fasting person or others. It was in the Christian tradition that abstinence from food became an elevated form of asceticism. The Greek word "askesis" (meaning exercise or training) was originally used to mean physical exercise and an athletes' diet. Fasting was often accompanied by hyperactivity and sleep deprivation. An example of some fasting saints are Saint Hedwig of Silesia (1174–1243); Saint Margaret of Hungary, who was a princess (1242–1270) in the 13th century; and Saint Catherine of Siena (1347–1380) in the 14th century.

In the 15th and 16th centuries self-starvation was generally explained by witchcraft and demonic possession. Towards the end of Middle Ages some of the fasting saints were brought in front of the Inquisition and were charged with witchcraft. The presumption that demonic powers exist was widespread. Before providing any treatment, the nature of the problem and whether it was a case of illness, demonic possession, or witchcraft had to be established. In the latter two cases, the main treatment was exorcism. The difficult task of deciding whether the underlying causes of self-starvation were natural or supernatural weighed heavily on the shoulders of physicians.

From the 16th century self-starvation gradually became a spectacle. Starting from the 19th century self-starvation became a source of income for hunger artists (and this will be of interest when we later consider the fashion world). Medical explanations emerging from the 17th century questioned the connection between demonic possession and fasting. However, even in the 20th century there were instances when AN was explained by demonic possession, especially in an orthodox religious environment. As the ties

between fasting and religion weakened, self-starvation gradually became a medical issue. The starving saints and those possessed by demons became patients in need of medical care. This slow process of medicalization was completed in the 19th century. However, it is important to note that ritual fasting (such as Ramadan in Islam) has a significant social and political role. In such cases, the strict rules around eating provide a safe frame for purification and ensure that the fasting will have no detrimental effects on health. Similar rituals are found in Buddhism and Brahmanism.

Before self-starvation was considered as a disorder, it took other specific forms: e.g., “fasting girls”, “miraculous maids”, “hunger artists”, or “living skeletons”. These reveal the transition between the religious explanations and the disease model. Self-starvation became a spectacle. “Fasting girls” abstained from food, sometimes for many years. Unlike the fasting saints, self-mortification was not characteristic for them. They were strictly watched and checked upon for many weeks in a row in order to detect any form of cheating. This phenomenon reoccurred in the 19th century, even after AN was first diagnosed; however, it was heavily criticized and was irreconcilable with several medical facts.

Although the “miraculous maids” disappeared, the spectacle of self-starvation did not altogether cease to exist. Hunger strikes emerged at the end of the 19th century. Hunger strikers deliberately and consciously destroy their own health and take full responsibility for it. Hunger strikes became widespread in the 20th century and this form of fasting had sharp political undertones. Despite this, rejection of food as a means of protest has previously been recorded.

“Living skeletons” and “hunger artists” as spectacles became widespread at the end of the 19th century. They could be seen at fairs and circuses for an entrance fee and so self-starvation was a source of income. Hunger artists were mainly men and it is interesting to compare them with the “miraculous maids” who preceded them. Hunger artists disappeared after 1930. Extreme self-starvation was seen as a medical condition and was no longer considered worthy of exhibition; this may have contributed to the disappearance of hunger artists. Living skeletons did not abstain from food, while hunger artists did. The former became widespread along with other performers in the 19th century. One of the most famous living skeletons was Claude Ambroise Seurat (1798–1826; Figure 1). He was so slim that one could see his heart beating. He was 170cm tall and weighed 32kg (BMI 11.1).

In literature Franz Kafka gave artistic expression to this human condition in his short-story entitled “A hunger artist”, which was published in 1922. Incidentally, Kafka presumably suffered from atypical AN. He was ascetic, vegetarian, and achievement-oriented with an obsessive-compulsive and depressive personality (Fichter, 1988).

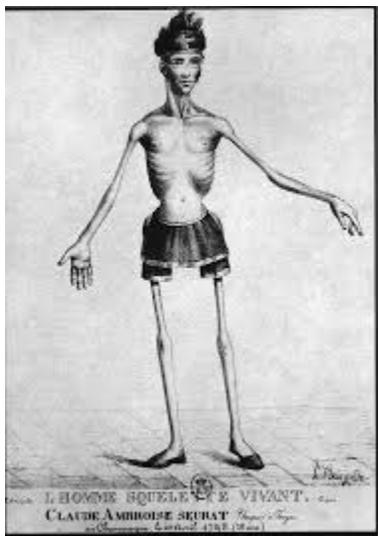


Figure 1: Claude Ambroise Seurat, a French hunger artist (1798-1826)

An essential issue in the history of AN is how the various forms of starvation resemble each other and to what extent they correspond to AN as it is understood today. Many have described the ascetic features of AN, which reminds us of the fasting saints. The patients affected were mainly women, who experienced amenorrhea, sleep deprivation, and an aversion towards sex. These all indicate psychological causes. Despite the anorexic features found in the behavior of the fasting saints, they cannot be considered undiagnosed anorexic patients. The symptoms listed above (strange eating patterns/behaviors, hyperactivity, sleep deprivation, asexuality, etc.) may be seen as consequences of fasting. The saints were not afraid of being fat. Indeed, they did not obsessively pursue thinness and were not preoccupied with their appearance. Instead, they were motivated by spiritual communion with Christ. Their practice of fasting was dominated by the cult of religion and mysticism rather than a culture of thinness (Vandereycken and van Deth, 1994; Vandereycken et al, 2003).

Medical explanations related to severe weight loss have occurred since the 13th century. The first description that may correspond to AN as we understand it today is credited to Richard Morton, the English physician, who, in 1689, published a textbook in Latin entitled “Phthisiologia”, which dealt with severe weight loss (five years later it was translated into English, with the subtitle “Treatise of Consumptions”). He presented two case studies: an 18-year old young woman who died, and a 16-year old boy who recovered. In both cases weight loss was attributed to psychological causes and both of them rejected food. Morton referred to this clinical condition as nervous consumption.

In the 19th century several case studies on chronic thinness were presented. It is interesting to note that tuberculosis was a public health disease at the time, and people attempted to explain the slimness of unknown origins with this medical condition. As the diagnosis of AN became acknowledged in the field of medicine, the tuberculosis diagnosis no longer provided an explanation for thinness resulting from unknown origins.

In 1873 the British physician William Gull and the French physician Ernest-Charles Lasègue, independently of each other, described the clinical conditions of AN and referred to the illness as “anorexia hysterica”. They both emphasized that it was not a stomach disease and that the remedies administered to increase appetite had not been proved effective. They drew attention to the importance of regular feeding.

Several explanations related to AN emerged in the 20th century. At the beginning of the century pituitary insufficiency was thought to be the cause of AN; this meant that AN was included in the internal medicine textbooks as an endocrine disorder. From the 1940s, as psychoanalysis spread, growing emphasis was placed on the psychological factors of AN. Sexual immaturity was highlighted. The significance of the body image disorder, as mentioned in the seminal work of Hilde Bruch, was acknowledged after 1960. Bruch (1966) distinguished three basic symptoms: body image disorder, unrecognized body sensations, and helplessness associated with low self-efficacy.

From the 1970s, the appearance of family therapy opened up new possibilities in the treatment of AN and this can be perceived as a new chapter in terms of treating AN. The systemic approach started to become widespread as a result of the two major schools of family therapy: the structural family therapy model of Salvador Minuchin in Philadelphia and

the Milan strategic school of family therapy associated with Mara Selvini Palazzoli.

The widely recognized pathogenic concept of today—the multidimensional model of eating disorders—started to gain ground from the 1980s. This is known as the *biopsychosocial* age as it drew the attention to the complex regulatory mechanisms. This is when the use of integrative therapy in the treatment of eating disorders started to emerge.

The concept of bulimia was developed a long time ago. The term comes from the compound of *bous* (=ox) and *limos* (=hunger). In the 4–5th century B.C., Hippocrates distinguished between “boulimos” (sick hunger) and a normal appetite. It is worth mentioning the hedonistic feasts of ancient Rome that significantly differed from the common eating habits of people suffering from BN, which are characterized by compulsive overeating in secret accompanied by feelings of guilt. Until the 1960s binge eating was seen more as a sign of various physical and mental disturbances than the main symptom of a separate syndrome. Later bulimia was distinguished as an independent category among psychiatric disorders (Vandereycken and van Deth, 1994; Vandereycken et al, 2003). The description of BN as an independent clinical condition (not only a symptom) is associated with Gerald Russell (1978); although even he described it as an ominous variant of AN. As we can see, BN was only included among the officially recognized psychiatric disorders after a considerable period of time.

1.4. The sociocultural background of eating and body image disorders

It is evident from the history of eating disorders how abstinence from food depended on sociocultural influences: e.g., religion, changes in the value of the human body, and so on. It had already been noticed in the 19th century that AN was a disease of the upper social classes. However, sociocultural models that explain eating disorders have only been in use since the 1990s (DiNicola, 1990; Gordon, 1990; Szmukler and Patton, 1995; Wilfley and Rodin, 1995).

Eating disorders are considered to be a culturally determined (“culture-bound”) syndrome that can only be understood in the context of culture. DiNicola (1990) refers to AN as a “culture-reactive” syndrome that can be divided into a culture-bound syndrome and a culture-change syndrome.

Sociocultural factors (cultural values, economic resources, social institutions, etc.) have an immediate effect on the regulation of body weight. They can manifest on many levels. Families provide food and structured activities but they also convey social values. Weight patterns within families are constant and are not genetically determined because these patterns also affect non-biological relatives. The family's emotional system plays a significant role as well. The role of social organizations (such as the workplace or school) is also important; these places have different requirements for eating and activities. Values and norms associated with eating, activities, and appropriate appearance are conveyed by both the media and by word of mouth and are, therefore, reinforced in everyday social interactions (Sobal, 1995). Culture exerts a strong influence on body weight and assigns both moral and social meanings to weight. In traditional societies obesity is a sign of well-being because food provisions are often uncertain. In industrialized societies thinness and an attractive appearance are more valued, while obesity is an object of contempt and is often stigmatized. Physical characteristics are considered to be more changeable than genetics. So, it is understandable that various body contouring methods have become widespread. Public opinion generally accepts that individuals should take responsibility for their appearance. Therefore, obesity is seen as a sign of moral weakness and those who do nothing to lose weight are rightfully criticized (Puhl and Brownell, 2001).

Body shape related *prejudice* has been assigned an important role in accordance with the norm-shaping power of culture. Prejudice against obesity is a very frequent occurrence. Even children are prejudiced against obese people; this is true for both boys and girls. Therefore, obesity is seen as a stigma (Puhl and Heuer, 2009). Richardson et al (1961) conducted a survey on prejudice among children. The children's task was to rank six drawings of children. The drawings depicted a healthy child, a child on crutches, a child in a wheelchair, a child with a missing hand, a child with facial disfigurement, and an obese child. The obese child was ranked last by the children. Latner and Stunkard (2003) replicated this study. According to their results, the obese child was disliked significantly more than in the 1961 study and the girls' negative attitude to obesity significantly outweighed that of the boys.

Obesity has negative connotations and there is prejudice towards those that suffer from it. This is conveyed by several forms of cultural transmission: parents, peers, and the media (Stanford and McCabe, 2005). Parents, other relatives, and peers are very often a source of criticism and stigmatization. Moreover, obese people frequently suffer from disadvantages in employment

settings, health care, and educational institutions (Puhl and Latner, 2007; Puhl and Heuer, 2009). Employers consider obese employees to be lazier, less self-disciplined, and less competent than non-obese employees. As a result, they are paid less, have lower level jobs, and are rarely promoted (Roehling et al, 2008; Rudolph et al, 2009). Prejudice can also be found in health care and because obese people are often criticized they feel less inclined to seek help in this area (Puhl and Heuer, 2009). Similarly, in education, obese children are considered less clever or skillful by their teachers (Puhl and Brownell, 2001). Peers are equally prejudiced: teenagers consider their obese peers unhealthy, lazy, and socially inept. This may explain why they refrain from attending educational, social, or recreational activities with them (Greenleaf et al, 2006). Obese children often become targets of bullying and abuse.

1.4.1. Observations supporting the role of sociocultural influences

First, we will analyze the results in relation to obesity. Body weight is influenced by the following social variables (Sobal, 1995; Szmukler and Patton, 1995; Wilfley and Rodin, 1995):

- Women are more likely to be overweight than men.
- The prevalence of obesity increases with age and decreases in old age.
- Ethnicity may have a role in the development of obesity (for example, in the US the prevalence of obesity is higher in blacks than whites).
- Women with lower socioeconomic status are more likely to be obese than women with a higher socioeconomic status.
- Married men are more likely to be obese than the unmarried ones.
- Women with more children are more likely to be obese than childless women.
- People living in the countryside are more likely to be obese than people living in cities.

This data can only be understood from a sociocultural perspective and cannot be explained by biomedicine.

The following arguments support sociocultural explanations for the prevalence of AN and BN:

1. The prevalence of eating disorders varies among cultures but the highest prevalence is in developed Western countries. The prevalence of eating disorders is higher among immigrants than in the immigrants' country of origin. It is also higher in countries undergoing social change. Abnormal eating attitudes and symptoms are associated with the effects of "*Westernization*" and cultural assimilation.
2. In the past few decades an increasing number of new eating disorders have emerged.
3. Eating disorders are rare among men and these gendered differences cannot be explained by clear biological causes.
4. Eating disorders mostly emerge in puberty and adolescence and this cannot be explained on biological grounds.
5. There are ethnic differences: eating disorders mainly affect white people.
6. Eating disorders are an upper and middle-class disease.
7. Certain subcultures and occupations (models; dancers; certain sports people, such as gymnasts, long-distance runners, and jockeys) are under increasing sociocultural pressure to be thin. Those involved in fields where the thin ideal is both predominant and promoted are at high risk of developing an eating disorder. This leads us to question whether people at high risk for developing AN gravitate towards such professions, or does participating in these professions mean that individuals are more likely to develop AN?
8. No clear biological factors have been identified as being the primary cause of eating disorders; however, these are of great importance when we consider certain aspects, such as predisposition and maintenance.

1.4.2. Eating disorders and female roles: conceptions of femininity

Gender identity encompasses not only biological differences but also cultural aspects that vary across societies. Based on the gender-bias in the prevalence of eating disorders, feminist theories of eating disorders emerged. These attempt to explain what the eating disorders reflect about the condition of women. Feminism particularly criticizes male dominance and social inequalities (Wilfley and Rodin, 1995; Szmukler and Patton, 1995).

A well-known and general symptom of AN is the patient's fear of growing up and accepting the traditional female role. Yet from a feminist approach it is not so much the rejection of femininity but the desperate attempt to conform to gender stereotypes and roles. These, however, are determined by a "sexist" society. The trap frequently mentioned by feminists is the fact that, on the one hand, women have a deep desire to be accepted and appreciated by men and, on the other hand, also have an intense fear of men.

Feminist aspects, which relate to a change in culture are also important. Women have experienced changes in their roles, which have resulted in role conflicts; in addition, achievement orientation has now also been added to the roles expected of women. In the Middle Ages women who were too independent or determined were considered to be witches. Women were less likely to be rebellious or independent.

Gender roles are shaped by societal expectations. As far as the assessment of men and women is concerned, physical appearance is rated as more important for women than men. Female roles in Western societies have changed a lot in the past century. Women's uncertainty has increased, while their perfectionism has been reinforced and their body control has become a core element of their self-esteem. Intellectual self-actualization became essential. The self-conscious woman became a fashionable identity; this was characterized by imitating men and by pushing motherhood into the background. Women paid a high price for these efforts. Illnesses specific to women started to emerge: such as, hysteria and neurasthenia. The "discovery" of sexuality was one of the characteristics of this period.

Prepubescent girls and teenage girls who have low self-esteem are at risk of developing eating disorders. Gender inequality in education is one of the factors that may increase their vulnerability. In the school system girls are conditioned to be less clever than boys because schools set lower educational expectations for them. Confidence is pushed into the background. In a traditionally organized society girls learn that their passivity is more valued than their actions. Thinness is one component of this ideal female figure. These ideals are practically unattainable for the average woman.

In Western culture, thinness symbolizes competence, success, control, and sexual attractiveness, while obesity represents laziness, disinterest, and lack of willpower. This has an impact on women in Westernized countries as well. When food is abundant, the average weight of the population increases. Women spend money, time, and energy to become thin. Social