THE ROLE OF CULTURE IN THE DEVELOPMENT OF EATING DISORDERS WITH SPECIAL ATTENTION TO ANOREXIA NERVOSA AND BULIMIA NERVOSA

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Supervisor: Dr. Petro Esterhuyse

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To study the world of eating disorders is to encounter a universe of pain. Navigating this sad and troubled turf would have been impossible without the help of a great many people.

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Iris Maria Bauchinger

DECLARATION

I declare that the dissertation hereby submitted by me for the Master of Social Sciences degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the dissertation in favour of the University of the Free State.

Signed on the ..... day of ..... 2002.

Iris Maria Bauchinger

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SUMMARY

THE ROLE OF CULTURE IN THE DEVELOPMENT OF EATING DISORDERS WITH SPECIAL ATTENTION TO ANOREXIA NERVOSA AND BULIMIA NERVOSA

by

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This study is an exploratory, empirically based investigation into the connection between culture and anorexia nervosa and bulimia nervosa as found in three selected female groups. The specific objectives of the research were to obtain perceptual-conceptual information concerning the individual's experience of her self and the body image; to investigate the influence of familial factors such as the family environment, parent-child relationship, parental styles, discourses on weight, food consumption, and lifestyle present in the family; and to examine popular cultural influences, like the pressure for thinness expressed by peer groups and the visual as well as printed media.

The literature study included subjects such as the relationship between food and culture; the history, characteristics of and approaches to anorexia nervosa and bulimia nervosa; beauty standards and the fear of obesity in the Western culture; and the nature and influence of socialisation agents. The empirical research was carried out among 24 Caucasian females between the ages of 14 and 28. Three different groups were formed with Group 1 consisting of females already diagnosed with an eating disorder; Group 2 comprising young females working part-time or full-time for a model agency; and Group 3 comprising young females who are members of a dance school.

Quantitative research information was obtained through the use of three standardised questionnaires, namely the Body Shape Questionnaire (BSQ), the Socio-cultural Attitudes Towards Appearance Questionnaire (SATAQ), and Eating Attitudes Test (EAT 40). However, the main emphasis in data gathering was qualitative in nature. For this purpose, a structured questionnaire was drawn up to obtain information on cultural influences. This was followed by semi-structured, in-depth interviews with all the research participants. Results of the analysed data revealed that the participants have a thorough knowledge on calorie intake, dieting and various methods of controlling weight. All the participants are preoccupied and dissatisfied with their body size and shape. They have an almost irrational fear of obesity and go to extreme lengths to maintain a slim and slender physique. Consciously or unconsciously, they all acknowledge the ideological influence of the Western ideal of thinness, which is transmitted, in equal intensity by family, peers and the media. Assumptions that women should eat less than men and watch their weight are rooted in the family experiences of most participants. This deep-seated belief in restraining women consequently influences the participants to model weight conscious behaviours practised in the family home. In order to conform to the societal pressure to be thin and to attract male counterparts, the participating girls also encourage each other to lose weight by suggesting dieting behaviour. Competitions are held between peers regarding the most attractive female physique and teasing behaviour is said to occur in the event of girls not achieving the ideal. In addition to family and peer influences, the media also enhances behavioural modelling by presenting a largely unattainable ideal of the thin, beautiful, successful superwoman. Participants idealise and glorify the slender ideal and stars' and fashion models' bodies presented on television and in magazines are the ultimate in preferred physiques. In addition, dietary products advertised by the media are often bought and seen as the last solution in the ongoing struggle to be slim.

The essential conclusion is that eating/body problems among Western women cannot be understood outside the cultural settings in which they occur and will not be solved unless cultural agents like the family, peers and the media undergo a paradigm shift regarding the dangerous side of the slender female body ideal.

Key words: *Food as culture; socialisation; multi-media; body image; weight control; dieting; eating disorders; anorexia nervosa; bulimia nervosa; culture-bound syndrome*

SAMEVATTING

DIE ROL VAN KULTUUR IN DIE ONTWIKKELING VAN EETVERSTEURINGS MET SPESIALE AANDAG AAN ANOREXIA NERVOSA EN BULIMIA NERVOSA

deur

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Die studie is 'n verkennende, empiriese ondersoek na die verband tussen kultuur en anorexia nervosa en bulimia nervosa soos bevind in drie geselekteerde groepe vroue. Die spesifieke doelwitte van die navorsing was om perseptueel-konseptuele inligting te bekom aangaande die indiwidu se ervaring van haar self- en liggaamsbeeld; om ondersoek in te stel na die invloed van gesinsfaktore soos die gesinsomgewing, ouer-kind-verhouding, ouerskapstyle, gesprekke oor liggaamsmassa, eetgewoontes en die lewenstyl van die gesin, asook om algemene kultuurinvloede, by voorbeeld die druk om 'n skraal liggaamsbou te hê, soos voorgehou deur portuurgroepe en die visuele en gedrukte media, te ondersoek.

Die literatuurstudie dek onderwerpe soos die verhouding tussen voedsel en kultuur; die geskiedenis, kenmerke van en benaderings tot anorexia nervosa en bulimia nervosa; skoonheidstandaarde en die vrees wat betref vetsug in die Westerse kultuur; en die aard en invloed van sosialisieringsagente. Die empiriese ondersoek is onderneem met 24 Kaukasiese meisies met ouderdomme wat wissel tussen 14 en 28 jaar. Drie afsonderlike groepe is gevorm, met Groep 1 bestaande uit persone wat reeds gediagnoseeer is met 'n eetversteuring; Groep 2, bestaande uit jong meisies wat voltyds of deeltyds vir 'n

modelagentskap werk; en Groep 3, bestaande uit jong meisies wat lede van 'n dansskool is.

Kwantitatiewe navorsingsinligting is verkry deur drie gestandaardiseerde vraelyste te gebruik, naamlik die *Body Shape Questionnaire (BSQ)*, die *Socio-cultural Attitudes Towards Appearance Questionnaire (SATAQ)* en die *Eating Attitudes Test (EAT 40)*. Die hoofdoel was egter om kwalitatiewe inligting te bekom, en vir die doel is 'n gestruktueerde vraelys opgestel om inligting te bekom aangaande kultuurinvloede. Hierna is semi-gestruktureerde in-diepte onderhoude met al die deelnemers aan die navorsingsprojek gevoer. Resultate van die geanaliseerde data het getoon dat die deelnemers 'n deeglike kennis het van kalorie-inname, diëte en verskeie metodes om liggaamsmassa te beheer. Al die deelnemers was oormatig bekommerd oor en ontevrede met die grootte en vorm van hul liggame. Hulle het 'n byna irrasionele vrees vir vetsug en gaan tot uiterste handelinge oor om 'n tenger en slanke liggaamsbou te handhaaf. Bewustelik of onbewustelik gee hulle almal erkenning aan die ideologiese invloed van die Westerse ideaal van skraalheid, wat in gelyke mate oorgedra word deur familielede, portuurgroepe en die media. Aannames dat vroue minder as mans behoort te eet en hul massa moet beheer het hul ontstaan in die gesinservaringe van die meeste deelnemers. Hierdie diepgesetelde opvattinge rakende die inperking van vroue beïnvloed gevolglik die deelnemers om die massabewustheidsgedrag van hul gesinsgenote net so as die norm te aanvaar. Om te konformeer aan die gemeenskapsdruk om skraal te wees en om manlike aanhangers aan te trek, moedig die deelnemende meisies mekaar aan om gewig te verloor deur diëte te volg. Kompetisies word gehou tussen portuurgroepe om te bepaal wie die aantreklikste liggaam het, en meisies wat nie die ideale liggaamsbou bereik nie, word geterg. Tesame met die invloed van die gesin en portuurgroep, dra die media ook by tot die navolgingsgedrag deur 'n feitlik onbereikbare ideale supervrou met 'n pragtige skraal lyf uit te beeld. Deelnemers idealiseer en verheerlik die slanke uiterlike voorkoms en die liggame van filmsterre en mannekyne wat in tydskrifte of op televisie voorgehou word. Daarby word vele verslankingsmiddels en dieetprodukte wat deur die media geadverteer word, gekoop as 'n laaste uitweg in die ewigdurende stryd om skraal te wees.

Die kern gevolgtrekking wat gemaak word is dat eet- en liggaamsprobleme onder Westerse vroue nie buite hulle kulturele agtergrond verstaan kan word nie, en dat

probleme ook nie opgelos kan word, tensy kulturele agente soos die gesin, portuurgroep en die media 'n paradigmaskuif ondergaan rakende die gevaarlike kant van die skraal vroulike liggaamsideaal nie.

Sleutelwoorde: *Voedsel as kultuur; sosialisering; multimedia; liggaamsbeeld; gewigsbeheer; dieet; eetkversteurings; anorexia nervosa; bulimia nervosa; kultuurgebonde sindroom*

CHAPTER 1: INTRODUCTION

1.1 PROBLEM STATEMENT

Eating disorders and their consequences for a healthy lifestyle were first described in medical literature in the 1870s by Sir William Withey Gull in the UK[1] (Lee 1998 : 128). Gull's account of anorexia nervosa highlights: its occurrence in adolescent girls and young women (15 to 23 years); the absence of any medical lesion; its central (brain) rather than peripheral (stomach) origin; lack of appetite due to a morbid mental state; the patients' uncomplaining attitude; restlessness and constant motion-associated psychological disturbance, and family dysfunction. He was also the first to champion careful feeding with supervision, as it could not be entrusted to patients (DiNicola 1990a : 168 – 169). Gull's general description holds up remarkably well in its clinical details and more than a hundred years later all experts could add to his description was a differentiation of subtypes. In 1979, Gerald Russell, another London physician, established the distinction between anorexia nervosa and bulimia nervosa. Although there is no doubt that both disorders can be closely associated with each other, the sufferers of bulimia nervosa would be unlikely to stand out in a crowd. Bulimics are mostly average in weight, and generally do not look unwell. Feelings of guilt and disgust at their behaviour lead them to be secretive and possibly this may explain why bulimia nervosa was not formally identified until the 1970s (Button 1993 : 8). Russell's diagnostic criteria consist of powerful and intractable urges to overeat; the avoidance of the fattening effects of food by inducing vomiting and/or abusing purgatives, and a morbid fear of becoming fat (Button 1993 : 9).

The current clinical and research criteria for anorexia nervosa and bulimia nervosa, as indicated in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) (American Psychiatric Association 1994 : 544 – 545), include the following: anorexia nervosa involves a refusal to maintain a normal body weight, leading to a weight at least 15 percent below a minimum normal body weight; an intense fear of gaining weight; a disturbed perception of the body, such as a denial of the seriousness of the

[1] In France, at the same time, the neuropsychiatrist Ernest Charles Lasègne was working independently on the same subject (Lee 1998 : 128).

problem or an insistence that one is fat; and the absence of menstruation where it would normally be expected. DSM-IV defines bulimia nervosa by two linked habitual activities: recurrent episodes of binge eating, characterized by eating a very large amount of easily digested food in a discrete period of time, while experiencing a sense of lack of control over that behaviour; and purging, involving any or all of self-induced vomiting, inappropriate use of laxatives or diuretics, prolonged fasts, or excessive exercise, in order to counteract the effects of the bingeing (American Psychiatric Association 1994 : 549 – 550).

Today, eating disorders can be regarded as an epidemic in the Western world. Even though there exists an increasing number of eating disorder sufferers (Barlow and Durand 1995; Gordon 1990; Heesacker *et al.* 2000; Van t'Hof 1994) most of these people, 95 percent of anorexics and 90 percent of bulimics, are adolescent women (Killian 1994 : 312). The American Anorexia and Bulimia Association states that anorexia and bulimia strike a million American females every year – almost 150 000 deaths are reported to be due to anorexia (Wolf 1990 : 148). Barber (1996 : 296) estimates that approximately one percent of young women in Western countries suffer from anorexia, while the incidence of bulimia may be as much as ten times higher. In an extensive overview on the prevalence of eating disorders, Killian (1994 : 312) suggests that estimates for anorexia range from less than 1 percent to 3 percent of adolescent Western females. Even though the prevalence of bulimia is more difficult to determine – as mentioned above, bulimics typically do not exhibit weight loss – estimates range from 5 to 23 percent. Stein and Brinza (1989 : 206) found an average prevalence rate of 2 percent for junior high school girls and 4 percent for high school girls. Furthermore, researchers (Kaminski and McNamara 1996; Kirk *et al.* 2001; Raudenbush and Zellner 1997; Tsai *et al.* 1998) found that female college students comprise the greatest number of bulimics in the Western world, with the disorder sometimes even being the rule rather than the exception. Some surveys suggest a prevalence of bulimia for this at-risk population of between 10 to 20 percent (Gordon 1990 : 42), while others indicate that about 40 percent of college women intentionally vomit to control their weight (Raudenbush and Zellner 1997; Tsai *et al.* 1998).

In the Republic of South Africa, little research has been conducted concerning eating disorders. One of the prevalence studies on anorexia nervosa was carried out among

Johannesburg schoolgirls by Ballot *et al.* (1981 : 993). Their findings indicate that 2.9 percent of the girls were more than 20 percent underweight. According to the researchers, this suggests a prevalence rate of anorexia nervosa in South Africa of nearly 3 in every batch of 100 schoolgirls studied. Yet another South African study by Sheward (1994) focused on the prevalence of eating disorders in three different universities in the Western Cape. An overall prevalence rate for bulimia nervosa of 6.8 percent for Caucasian females, 5.2 percent for Coloured females and 5 percent for African female university students was found. Additionally, the researcher seemed surprised that African university students were as likely to develop eating disorders as their Caucasian fellow students and she concluded that: "It may be that urbanised, achievement-orientated African women in South Africa are increasingly adopting Western ideas of acceptable body weight and shape, and thus becoming subject to the same pressures to be thin as their White and Coloured counterparts" (Sheward 1994 : 47).

It is important to state that, based on cross-cultural research (Akan and Grilo 1995; DiNicola 1990b; Furnham and Alibhai 1983; Gray *et al.* 1987; Parker *et al.* 1995), eating disorders are not found universally. Historically, for the majority of human societies, fatness has been valued over thinness, particularly in women. A very common explanation for this preference is one that invokes economic determinism; in societies where resources and health are limited, the larger body is admired because it is a sign of wealth and prosperity (Garfinkel and Garner 1982 : 106; Gordon 1990 : 76). However, Western societies currently find themselves in a relatively new state of plenty, which has changed the perceptions concerning health and disease as well as the body. Consequently, there seems to be a shift regarding the idealised female shape from the voluptuous, curved figure to the more angular, lean look (Garfinkel and Garner 1982 : 106). Furnham and Alibhai (1983 : 829) suggest that awareness of the dangers of being overweight, as well as the fashion and diet industries, have been primarily responsible for this shift. Dally and Gomez (1980 : 64) explain that slimness in Britain is often equated with self-control, elegance, social attractiveness and youth and that this culturally preferred body shape affects women especially. They appear to be greatly influenced by men's preferences as well as their negative evaluation of particular forms. As a result, in Western societies specific stereotypes exist among both men and women concerning an ideal female physique. Obesity is widely

stigmatised as well as devalued, therefore pressurising women to conform to a relatively narrow range of body sizes and shapes. Today, the idealised bony thin body form leaves millions of women trying to loose weight, some of them literally dying in the pursuit of thinness.

Furthermore, within Western cultures the above-mentioned societal pressure to remain slim is often coupled with a person's socio-economic status. South African researchers Ballot *et al.* (1981 : 993) confirmed this assumption by indicating that the highest incidence of anorexia nervosa is found among middle- and upper-class schoolgirls rather than in girls coming from the so-called "working-class". According to Barlow and Durand (1995 : 300): "Over 90 percent of severe eating disorders are found in young, white females of upper socio-economic status who are living in a competitive environment". It is therefore understandable that some writers refer to anorexia and bulimia as "rich-girl" syndromes – disorders of the affluent. Thus, it is clear that not everyone in the Western world is at risk. One can conclude that the disorders seem to be localized in a relatively small segment of the population.

This very specificity of anorexia nervosa and bulimia nervosa, as well as the sudden increase in eating disorders over the last couple of decades, suggest that the strongest contribution to aetiology seems to come from socio-cultural rather than psychological or biological factors (Barlow and Durand 1995; Counihan 1999; DiNicola 1990a; Garfinkel and Garner 1982; Gordon 1990; Lelwica 1999; Stice 1994). In South Africa however, most attention in psychiatric, psychological and nutritional research was directed at the prevalence of eating disorders (Ballot *et al.* 1981; Robinson 1987; Sheward 1994), as well as at body satisfaction/dissatisfaction and body image disturbances amongst adolescent girls (Bothma 1999; Caradas *et al.* 2001; Davies 1995; Phipps 1995; Shefer 1986; Wenhold and Joubert 2000; Williams 2000). This does not imply that the importance of culture relative to eating disorders was always totally ignored. For example, the psychiatrist and head of the Eating Disorder Unit of TARA Hospital, Prof. Szabo (1997; 1998), has especially acknowledged the cultural dimension to eating disorders by stating that Western values appear to be instrumental in promoting the emergence of these conditions. However, in this research process, the emic perspective of the proposed problem was mostly ignored. An example thereof is the research that was conducted by the Department of Nutrition and Dietetics Unit and

Sports Science Institute of South Africa, University of Cape Town. Caradas *et al.* (2001 : 111) undertook "an ethnic comparison of eating attitudes and associated body image concerns in adolescent South African schoolgirls". The study consisted of three self-report questionnaires, namely the Eating Attitudes Test (EAT), the Body Shape Questionnaire (BSQ) and the Body Silhouette Chart, which were given to 228 South African schoolgirls. The researchers (Caradas *et al.* 2001 : 111) conclude that abnormal eating attitudes are equally common in South African schoolgirls from different ethnic backgrounds, but that Caucasian girls exhibit greater body image concerns and body image dissatisfaction than mixed-race or Black individuals. According to Caradas *et al.* (2001 : 111), the notion that eating disorders are culture-reactive rather than culture-bound phenomena was reinforced by their findings and therefore "provide insight into the extent of eating-related problems and body image issues in developing societies". This is a rather typical way of conducting quantitative research within the field of psychology. However, when conducting research on attitudes and images with a preferred qualitative outcome, it seems that an in-depth investigation is appropriate in order to get a validated picture of the apparent problem. In the research of Caradas *et al.* (2001) the Western (un)conscious "fear of fatness" was taken for granted and perceptions concerning body, food, and eating among all research participants from the many different backgrounds were never investigated.

Within the field of medical anthropology, the researcher could not get hold of any South African anthropological research focusing exclusively on the connection between eating disorders and culture. Therefore, a holistic and in-depth investigation of the connection between culture and eating disorders was considered to be very important. Anthropology is regarded as the discipline being most specialised in terms of people, their lives, and their ways of acting in certain situations. It achieves integration through the concept of "culture" and it is this very concept which is the essence of this research project. Even though a great many definitions exist, the one best fitting the purpose of this study is formulated by the well-known medical anthropologist, Helman (1994 : 3), who views culture as a "set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to *view* the world, how to *experience* it emotionally, and how to *behave* in it in relation to other people, to supernatural forces or gods, and to the natural environment".

In applying this definition to the question of the development of eating disorders, the shift in emphasis becomes apparent through the following questions: "Does growing up in the Western world, acquiring the Western standards or values, influence the production of eating problems?" If so, "which agents of socialisation (e.g. family, peers, media) are the main contributors to anorexia nervosa and bulimia nervosa?" Further, as one could have seen with the above-mentioned example of Caradas *et al.* (2001), contemporary Western medicine often approaches diseases in a "mind-body dualism". This medical way of thinking focuses on identifying physical and psychological abnormalities but often ignores the patient and his attributes as a person. Within the field of anthropology, one essential way of conducting research is through trying to understand the persons own subjective way of viewing and experiencing the world. Therefore, the questions: "How do young women perceive and experience their bodies as well as their role as a female" "What is their personal connection to food and eating" and, "What relation do they have to eating disorders, and why they think this connection exists" need to be addressed in depth as well.

The contribution of this study lies in its holistic socio-cultural approach which emphasises (in contrast to the clinical approach often preferred by dieticians, psychiatrists and psychologists) that the patient is a cultural being who lives in a specific cultural context and has culture-bounded ideas and perceptions regarding his/her illness aetiology and experience. Therefore, the anthropological approach demands cognition of the broader cultural context, assuming that ideas and perceptions are especially influenced by three agents: The *nuclear family* is considered the major socializing agent. It operates as a crucial influence on the formation of the self-image of a child and it conveys messages about body-image, health, food, relationships and lifestyle (Garfinkel and Garner 1980 : 654; Haworth-Hoeppner 2000 : 212; Stice 1994 : 645). The prominence of *peers* in the process of socialisation varies among cultures. In industrialized cultures, however, peers are a very important source of socialisation. Especially in childhood and adolescence, children spend a great deal of time with same-age peers both in school and in leisure time out of school (Arnett 1995 : 621). This raises the strength of peers as a socialization influence and this may correspondingly diminish the role of the family, given that the time spent in school and day-care centres with peers is time which otherwise, historically in the West – and now still in many pre-industrialised cultures – is spent with the family. For girls, family

background, physical appearance and the interest in more mature social concerns – such as the ability to attract popular boys – is often found to be highly important (Henslin 1996 : 65 – 66). Additionally, the research will also take cognisance of yet another agent influencing perceptions concerning beauty, body and eating. The increasing influence of the broader (even global) domain of popular culture, which is mainly embodied in the Western aesthetic preference for thinness, presented by the *media, the world of fashion, and cosmetics* is also closely investigated.

In the last couple of decades, many girls and women from Western cultures spend incalculable time, money, and energy worrying about their weight and its appearance on their bodies. It is assumed that due to eating practices and body shapes recommended by cultural authorities, the clinically identified eating disorders, anorexia nervosa and bulimia nervosa, are on the rise. However, in order to get a more holistic picture on the production of eating disorders, perceptions and experiences of individuals suffering from anorexia and/or bulimia as well as at-risk populations have to be studied in-depth.

Furthermore, this research seeks to contribute to the body of literature on whether culture plays a significant role in the production of eating disorders and if so, which cultural components are the most influential. During the research, eating disorder specialists (medical practitioners, psychologists, psychiatrists, dieticians, etc.) were consulted concerning their perceptions regarding the influence of culture on anorexia nervosa and bulimia nervosa. It was found that most of them were extremely inconsistent and unsure when answering the question concerning which cultural component, in their opinion, might be most influential in the aetiology of eating disorders. Therefore, it is often found that the prescribed treatments – from psychoanalysis to force-feeding – are, according to these specialists, relatively ineffective. In coming to terms with possible cultural triggers of anorexia and bulimia, more successful treatment strategies could be implemented. Therefore, the data gained from this research project will help medical personnel, psychiatrists, psychologists, nutritionists, family members of anorexics and/or bulimics and all people being concerned with eating disorders, to get a broader picture of the aetiology and influence that culture has on these often deadly diseases.

1.2 OBJECTIVES

1.2.1 General objective

Against the background of the foregoing problem statement, the overall objective of this research project is to conduct an exploratory, empirically based investigation into the connection between culture, eating disorders and eating patterns among three selected female groups in Bloemfontein.

1.2.2 Specific objectives

The specific objectives are to:

a) scrutinize the relevant literature on anorexia nervosa and bulimia nervosa;
b) obtain perceptual-conceptual information concerning the individual's experience of the self and body image;
c) investigate the influence of familial factors such as the family environment, parent-child relationship, parental styles, discourse on weight, food consumption, and lifestyle present in the household; and
d) examine popular cultural influences, like the pressure for thinness expressed by peer groups and the visual as well as printed media.

1.3 RESEARCH UNIT

1.3.1 Identification of research participants

Through the literature study it became clear that any study on anorexia nervosa and bulimia nervosa should be aware of the role of gender, age, as well as the Western lifestyle regarding the prevalence of the illness. In the identification of suitable research participants, these criteria were crucial to the decision process. According to consulted literature it seemed clear that there is an extremely skewed gender incidence rate of anorexia nervosa and bulimia nervosa. Contemporary studies indicate with almost near uniformity that the ratio of female to male anorexics (and bulimics) is at least 9.1 to 1 (Szmukler *et al.* 1995 : 181), and some suggest that it is far higher than

this (Bruch 1973 : 287; Button 1993 : 13; Crosscope-Happel *et al.* 2000 : 365; Dally and Gomez 1980 : 98; Gordon 1990 : 32). Furthermore, nearly universal agreement exists concerning the age of onset of both disorders. Banks (1992 : 872) notes that the demands of an aesthetic ideal stresses youth and androgyny more often than the mature female body, leaving eating disorders to occur mostly in adolescence. In addition, most research conducted within the field of eating disorders left scientists with the impression of anorexia and bulimia occurring in the Western world and within the more westernised section of the population in non-industrialised countries (Bordo 1993; Bruch 1973; Brumberg 1988; DiNicola 1990a; Garfinkel and Garner 1982; Gordon 1990; Lelwica 1999; Stice 1994; Wolf 1990). In addition, Western women who follow a lifestyle that requires conformation to this cultural standard of thinness are said to be more at risk of developing an eating disorder. It stands to reason that models represent the current beauty standard of a society and are therefore the ultimate transmitters of bony thinness. Furthermore, eating disorder specialists (Montanari and Zietkiewicz 2000 : 38) often argue that particularly intense pressures to attain a thin body shape exist in the case of ballet dancers. Ballet dancers should trace out a sharp, moving contour and slight body bulges are seen as a drastic impairment (Gordon 1990 : 72). Furthermore, the aspirant dancer is punitively socialised into the belief that the only way to succeed in the highly competitive environment is to develop the wiry and extremely thin body that represents the world-class dancer. Yet another characteristic of anorexia nervosa and bulimia nervosa seems to be the increasing occurrence from lower to higher socio-economic classes of individuals. Even though the association with anorexia and bulimia being illnesses of the affluent is sometimes debated, most eating disorder specialists support this view (Gard and Freeman 1996 : 1; Szmukler *et al.* 1995 : 181 –182).

Therefore, in considering the worldwide research (Bruch 1973; Brumberg 1988; Chernin 1981; Dally and Gomez 1980; DiNicola 1990a; Furnham and Alibhai 1983; Garfinkel and Garner 1982; Gordon 1990; Haworth-Hoeppner 2000; Lelwica 1999; Wolf 1990) which highlights the clearly defined areas of occurrence of anorexia nervosa as well as bulimia, it seemed unavoidable to select participants with the following characteristics: South African Caucasian females between the ages of 15 – 25 who have already been diagnosed with either one (or both) of the eating disorders anorexia nervosa or bulimia. In addition, due to fact that models and dancers are

considered to be under particularly intense pressure to attain a thin body shape, individuals belonging to these professions were selected and included in the research process.

1.3.2 Selection of research participants

With this in mind, three groups of young Bloemfontein females were identified for selection.

- Group 1 was to be a group consisting of females already diagnosed with an eating disorder.
- Group 2 would include young females working part-time or full-time for a model agency.
- Group 3 would include young females who are members of a dance school.

In order to limit the scope of the study, it was decided to select 10 individuals per group. However, "decided to select" might not be the right expression if one considers the unwillingness of especially the eating disordered girls to participate in the research project. Being under the impression that it would be best to start out by telephoning each and every psychiatrist as well as psychologist listed in the yellow pages of the Bloemfontein telephone directory, attempts were made to arrange appointments to get more detailed information on their perception of the topic. However, it was a shock to learn that most of them seemed somewhat unwilling to support research conducted within a field where successful treatment is practically non-existent. With the knowledge that the ethical code between therapist and patient must be upheld at all times, only a small number of psychologists were willing to sacrifice their time and give permission for pamphlets containing the researcher's details, telephone number and the purpose of the research to be left in their office. This method of selecting research participants was rather unsuccessful.

Yet another way to get hold of diagnosed individuals was to contact three of South Africa's best-known eating disorder units. However, the reaction of personnel in charge of these clinics was not very different from that of the private practitioners. With weeks of searching for participants having passed unsuccessfully, it was decided

that the following advertisement would be placed in the local newspaper: *"For a study being done at the University of the Free State, girls between the ages of 15 – 25 who have been diagnosed with anorexia and/or bulimia are kindly requested to participate"*. Originally this had been regarded as a futile way of searching for informants because anorexia and bulimia are known to be extremely secretive disorders. However, to the surprise of the researcher, three weeks after regularly placing the advertisement in the newspaper, 8 girls, either suffering from anorexia, bulimia, or both, came forward to participate.

Finding participants who were either models or danced in their leisure time was by far less difficult. The owner of the consulted dance school saw the research as an opportunity to familiarise the students with a well-known disease, especially to international dancers. Nine dance school girls agreed to participate. However, 2 of the 9 selected students had in the past suffered from anorexia and bulimia, which meant Group 1 – the group comprised of eating disordered girls – finally totalled 10 individuals. However, that meant that Group 3 only involved 7 participants. With Group 1 (the eating disordered girls) being intact and Group 3 (the dance school girls) consisting of a rather unsatisfactory number of 7 participants, there were 'only' 10 models (Group 2) to be obtained. The first model agency contacted had long been interested in the topic of eating disorders and offered to help out. In exchange for an in-depth presentation on both eating disorders to their students, the researcher's name and telephone number were given to the girls with a friendly request to participate. Even though 10 modelling students contacted the researcher, and definite appointments were made, it was a great struggle to really meet with them. Because of their being in competitions and on courses all over the country, only 7 of them were finally able to participate.

At this stage it has to be mentioned that in the course of the data collection process, 1 of the dance girls and 1 of the models decided against participating due to personal problems and disinterest in the study respectively. Therefore, only the first phase – the completion of the structured questionnaires EAT, BSQ, and SATAQ – could be completed with all 24 participants. The Cultural Background Questionnaire (CBQ) as well as the semi-structured, in-depth interviews were conducted with 22 informants, 10 anorexic and bulimic girls, 6 models and 6 dancers.

1.3.3 Establishing rapport

It is a common practice among anthropologists to establish rapport between researcher and research participants. Especially with a secretive and "not easy to talk about" topic like eating disorders it was found necessary to meet and build a more relaxed, trusting relationship between the two parties. The Group 2 and 3 participants together received a detailed description of the aims of the research, but for the members of Group 1, individual appointments were made. The reason therefor was that in 6 out of 10 cases, the mothers of girls suffering from anorexia and bulimia contacted the researcher after reading the notice in the newspaper. Most eating disordered individuals do not perceive themselves as having a problem and for those who do, talking about it to a stranger is not perceived as desirable. Therefore, it was essential to meet beforehand and remove the tension by explaining the necessity and aim of the whole research project as well as to ensure that the autonomy and privacy of the participants would be respected at all times. Through this process, informed consent for, and confidentiality of obtained data were assured.

1.3.4 Characteristics of research unit

This section will give descriptions of the age, language, religious affiliation, and socio-economic status of the research participants. However, because of the problems mentioned in paragraph 1.3.2 concerning the number of participants, only the age and language of all 24 of the girls could be obtained. The religious affiliations as well as the socio-economic status of the 2 girls who quit was not determined before their leaving.

a) Age of research participants

Due to eating disorder specialists being of the opinion that anorexia and bulimia are disorders occurring mostly in late adolescence and early adulthood (Garfinkel and Garner 1982; Lelwica 1999), the age group regarded as appropriate for the purpose of this study was between 15 – 25. However, because of difficulties to canvass participants, a rather broad age category of informants was permitted. As a result, the category expanded to 14 – 28, with most of the participants being

between 16 and 20 years old. Furthermore, it has to be mentioned that even though the girls in the group "anorexics and bulimics" made up the oldest members of the participants, the onset of their illness was in their late adolescence, mostly between 17 and 20 years of age.

Table 1: Age of research participants

Age	Results		
	Group 1	Group 2	Group 3
14 – 15	1	1	-
16 – 17	-	4	3
18 – 19	4	2	2
20 – 21	1	-	-
22 – 23	1	-	1
24 – 25	1	-	-
26 – 27	1	-	-
28	1	-	1
Total	**10**	**7**	**7**

b) Language

Concerning the cultural background of the research participants, it has to be mentioned that out of 24 participants, 23 of the girls came from Afrikaans-speaking families, with only one girl being an exception. Even though this participant was raised with English as her mother tongue, the family is actually of Greek origin. Therefore, not one of the participants belonged to the English speaking community. The predominance of Afrikaans-speaking girls was no surprise in Bloemfontein, where Afrikaans is the second principal language after SeSotho. However, language was not a criterion in the selection of participants. In fact, the assumption was made that there was a fair chance for both Afrikaans- and English-speaking girls to be included in the research group. The fact that 23 out of 24 participants were Afrikaans-speaking limited the possibility for comparison between the participants. However, the positive side was that a foundation was provided for a higher level of sharing culture – more specifically a common upbringing and worldview. Furthermore, in a study of such limited numbers of

total participants, it is accepted to be of greater value when ensuring as much homogeneity as possible.

Table 2: Languages spoken by all 24 participants

Language	
Language	**Results**
Afrikaans	23
English	1
Total	**24**

a) Religious affiliation

Some researchers (Lelwica 1999) argue that girls in contemporary Western societies starve, binge, and purge their bodies due to a feeling of being trapped in a society that ignores and denies their spiritual needs. As a result, these girls construct a network of symbols, beliefs, and rituals around food and their bodies. Whether there really is a parallel between the patriarchal legacies of Christianity, which associates women with sin and bodily cravings, and the cultural preference for a thin female body, is not clear. However, it seemed appropriate to include religious affiliation as one of the characteristics of the participants because of a possible connection with eating disorders.

Most of the girls belonged to the Dutch Reformed Church, which is the biggest religious denomination amongst Afrikaans-speaking citizens of Bloemfontein. Two belonged to the long-established Apostolic Faith Mission of South Africa, one each to the Christian Revival Church, the spiritual group of Love Incorporated, and the Greek Orthodox Church. Three girls did not belong to any formal church at all.

Table 3: Religious affiliations of research participants

Denomination	Results		
	Group 1	Group 2	Group 3
Dutch Reformed	6	3	5
Apostolic Faith Mission of South Africa	1	1	-
Christian Revival Church	-	1	-
Love Incorporated	-	-	1
Greek Orthodox	1	-	-
No religious affiliation	2	1	-
Total	**10**	**6**	**6**

d) Socio-economic status

As already mentioned in paragraph 1.1, Ballot *et al.* (1981) and Barlow and Durand (1995) indicated that socio-economic status plays a role in the development of eating disorders. It was therefore necessary to establish the occupations of the girls as well as their parents. However, it was not possible to determine whether the parents' occupations could be classified as a high or low-income occupation in all cases. Nonetheless, it seems that most of the girls came from the middle and upper classes rather than from the lower socio-economic classes. Especially the parents of Group 1 were described by their daughters as being in relatively high-income positions. Further, most of the Group 1 participants' parents lived in either upper-middle or middle class areas in Bloemfontein. In the case of the dance school and modelling participants, most families were perceived to belong to the middle class. However, even though the Group 2 and 3 interviewees indicated that their families live predominately in middle class areas of Bloemfontein and have middle class incomes, the fact that the participants' parents could afford the extra fees for a recreational program like a modelling school or a dance school, seemed a positive indicator of a upper-middle socio-economic class.

Table 4: The socio-economic status of Group 2 and Group 3 participants

Career category	Results		
	Father	Mother	Total
Professional; Semi-professional; Technical	3	1	4
Managerial; Executive; Administrative	2	-	2
Clerical and Salesperson	-	4	4
Transport and Communication	1	-	1
Service Providers	5	7	12
Farming; Fishing; Agriculture	1	-	1
Mining; Factory worker	-	-	-
Unemployed	-	-	-
Total	**12**	**12**	**24**

Table 5: The socio-economic status of Group 1

Career category	Results		
	Father	Mother	Total
Professional; Semi-professional; Technical	6	2	8
Managerial; Executive; Administrative	2	1	3
Clerical and Salesperson	1	4	5
Transport and Communication	-	-	-
Service Providers	1	3	4
Farming; Fishing; Agriculture	-	-	-
Mining; Factory worker	-	-	-
Unemployed	-	-	-
Total	**10**	**10**	**20**

1.4 RESEARCH METHODS AND TECHNIQUES

1.4.1 Introduction

The process of data collection was divided into three broad phases. The first phase consisted of gathering and reading relevant literature. The second phase was devoted to the gathering of quantitative research data. In this phase, attention was paid to the broad issues and tendencies, as well as specific cultural information regarding the family context and behaviour of participants. In other words, the aim was to reveal

apparent problems young girls experience in regard to eating, food, and the body in a more structured way. The third phase was qualitative in nature and attempted to explore in-depth the perceptions and experiences young females have concerning the eating disorders anorexia and bulimia, as well as related to aspects like family, peers, and the influence of the media.

1.4.2 Literature study

The literature selected, consulted and processed for the purpose of this study was derived mainly from books and articles obtained from different printed and online journals. Some Internet websites, especially the ones on eating disorders, were consulted, and some of the relevant information was used.

- Because this study is an in-depth investigation into the concept of culture in relation to eating disorders, the first part of the literature review was aimed at comprehension of the content of the concept of culture, and how it can be defined, as well as the study of some of the key characteristics of culture. For this purpose, mainly introductory texts within the field of anthropology (Ember and Ember 1996; Haviland 1994) as well as prominent medical anthropological publications (Foster and Anderson 1978; Hardon *et al.* 1994; Helman 1994; Sargent and Johnson 1996) were consulted. In addition, this part of the literature review consisted of an investigation into the process of socialisation. A mixture of sociological and anthropological material (Arnett 1995; Benson 1991; Corsaro 1997; Haviland 1994; Popenoe 1995a) was studied. Information concerning the agents of socialisation (family, peers and the media) was gathered from the writings of especially Henslin (1996), Neubeck and Glasberg (1996) and Popenoe *et al.* (1998).

- The second group of publications largely entailed theoretical and empirical aspects on the subjects of culture, food and nutrition. The works of Fox and Cameron (1989) as well as Lamb and Harden (1973) were used concerning the discussion on what food is. Because food and eating are always closely intermingled with interpersonal and emotional experiences, discussions in Eckstein's *Food, People and Nutrition* (1980), Helman's *Culture, Health and*

Illness (1994) and Rosman and Rubel's *The Tapestry of Culture* (1981), amongst others were consulted and reviewed. The connection between culture and nutrition was established via writings by authors like Gordon (1990), Lelwica (1999) and Wolf (1990), the latter also discussing the role of women in our society and their apparent fear of obesity. An apparent diet and fitness boom existing in the Western cultures was discussed based on the work of Sardar and Saunders (2001) and articles from magazines like *Health, News and Review* (1993), the *Women's Health Weekly* (Marble 1997) and *Women's Sport and Fitness* (Manocchia 1999), which were drawn from the Internet, were used in an effort to integrate everyday news concerning the topics of dieting and fitness.

- Eating disorder classics as well as writings of specialists on anorexia nervosa and bulimia nervosa were consulted and integrated as part of a third group of publications. The study entailed an extensive investigation into the nature of eating disorders, with definitions on anorexia and bulimia being taken from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV 1994). Direct information on the illnesses of anorexia nervosa and bulimia nervosa, i.e. the history of eating disorders as well as the explanatory models, was selected from Barlow and Durand (1995), Button (1993), Dally *et al.* (1979), DiNicola (1990a), Furnham and Alibhai (1983), Garfinkel and Garner (1982), Giannini and Slaby (1993), Gordon (1990), Szmukler *et al.* (1995), Thöma (1967), Welbourne and Purgold (1984), Wolf (1990), amongst others. Further, information on the factors directly influencing anorexia nervosa and bulimia nervosa – family life, socialisation, influence of parents, peers and the media – was gathered from Garfinkel and Garner (1982), Haworth-Hoeppner (2000), Lelwica (1999), Levine and Smolak (1994), Osvold and Sodowsky (1993), Thompson and Heinberg (1999), and others. As an extension on the influence of the media, but also a factor indirectly influencing anorexia and bulimia, the Western lifestyle with its pressure to be thin, the apparent fashion and beauty ideal as well as the health and fitness boom currently occurring in Western cultures were reviewed, with material from Barber (1996), Bruch (1973), Gordon (1990), Lau and Alsaker (2001) Sardar and Saunders (2001), Lelwica (1999) having been consulted. In addition, the socio-cultural approach

supported in this research project required an in-depth investigation into the assumption as to whether anorexia and bulimia are "culture-bound syndromes". For this purpose, literature from Banks (1992), DiNicola (1990a; 1990b), Gordon (1990), Helman (1994), Prince (1985), Ritenbaugh (1982), Shefer (1986), and Swartz (1985) was consulted and processed. Other perspectives concerning the eating disorders anorexia and bulimia have also been considered. Barlow and Durand (1995) as well as Gremillion (1992) are authors presenting ideas concerning the biomedical perspective relevant to eating disorders. A very popular approach to eating disorders is the psychological approach as presented by Bruch (1973), Gremillion (1992) and Lelwica (1999), as well as the more recent feminist publications by Bordo (1993), Boskind-White and White (1983), Chernin (1981), Lelwica (1999), Orbach (1978) and Shefer (1986).

The above-mentioned reading constituted the core of the literature study. To it was added a diverse list of other sources such as books, journals, magazines and websites on the Internet. The aims of studying this additional material were mainly to obtain information on research methodology, which included drawing up questionnaires as well as giving guidelines on effective interviewing and other fieldwork strategies.

1.4.3 Data collection

1.4.3.1 Questionnaires

Research participants were asked to complete three separate standardised questionnaires, which are usually used in studies focusing on eating disorders, namely the Body Shape Questionnaire (BSQ), Socio-cultural Attitudes Towards Appearance Questionnaire (SATAQ) and Eating Attitudes Test (EAT 40). The fourth questionnaire was drawn up by the researcher and named, for convenience sake, the "Cultural Background Questionnaire". The researcher in a face-to-face meeting with all of the research participants compiled it. Additionally, a self-report dietary intake schedule was handed out to all of the participants in order to gain deeper insight into their dietary habits. Lastly, qualitative data were collected through the use of a semi-structured interview schedule in face-to-face interviews.

Because of the small number of research participants it was decided that a pilot study was not necessary. A small-scale trial (pre-test) to revise methods, language and logistics of the questionnaires was undertaken one week before the scheduled start of the actual research procedure. Five Bloemfontein girls between the ages 15 – 25 were chosen for this, and the standardised questionnaires as well as the Cultural Background Questionnaire were tested. The result of the pre-testing showed that the sequence of questions had been compiled in a logical way, that the wording was perfectly clear to all participants and that the space for writing answers was adequate. The relative time needed for the respondents to answer the questions could also be established, making it easier to calculate the number of days approximately needed for the collection of the quantitative data.

1.4.3.2 The standardised questionnaires

a) The Eating Attitudes Test (EAT 40)

The Eating Attitudes Test (EAT) was the first questionnaire developed to assess the eating disorder symptoms. Eating disorder specialists Garfinkel and Garner originally constructed this 40-item self-report questionnaire "as an objective and valid index of symptoms frequently observed in anorexia nervosa" (Garfinkel and Garner 1979 : 276). According to the authors (Garner and Garfinkel 1982 : 29) the EAT measures symptoms which are commonly found in anorexia nervosa but it has also been useful in identifying eating disturbances in non-clinical samples. A cut-off score to diagnose anorexia nervosa is used. The researchers argue that due to the fact that on a self-report questionnaire people do not always respond honestly, a high score on the EAT does not invariably reflect anorexia nervosa nor does a low score rule it out. However, the team (Garner and Garfinkel 1982 : 29) found that the EAT appears to have great utility as a screening device for assessing the symptoms commonly found in eating disorder patients, such as anxiety about eating, preoccupation with food, vomiting, dieting, and weighing oneself frequently. According to Mintz and O'Halloran (2000 : 489) the EAT is perhaps the most widely used of all the self-report eating disorder instruments, and Raciti and Norcross (1987 : 579) described it as "the most popular and influential instrument to identify patterns associated with Anorexia Nervosa". In

combination with the other data collection techniques, this assessment strategy was found to be very important in differentiating anorexics from normal-weight female individuals. Additionally, the symptoms commonly found in eating disorders could be identified and used as an indicator for further in-depth investigation.

b) The Body Shape Questionnaire (BSQ)

Body shape concerns were measured using a 34-item Body Shape Questionnaire (BSQ) developed by Cooper *et al.* (1987). The questionnaire is scored similarly to the EAT, using a six point Likert scale. A cut-off point is usually used to indicate cases of bulimia, obese dieters and people with distorted body images. This valid and often-used standardised measure identifies women's concerns about their body image as well as body weight, size and shape. For the purpose of this study, the questionnaire was used to establish issues such as feeling too fat, wanting to be thinner, feeling ashamed of one's body, having a negative relationship with one's body, and dieting practices.

c) The Socio-cultural Attitudes Towards Appearance Questionnaire (SATAQ)

In recent years, a tendency to internalise media messages regarding ideals for attractiveness has been suggested as one potential mediator between exposure to those messages and the development of eating and shape-related disturbances. Heinberg *et al.* (1994) developed the Socio-cultural Attitudes Towards Appearance Questionnaire (SATAQ) in order to assess women's recognition and acceptance of societally sanctioned standards of appearance. This 14-item self-report measure reflects awareness ("It's important for people to work hard on their figures/physiques if they want to succeed in today's culture") and internalisation ("Music videos that show thin women make me wish I were thin") of societal attitudes about thinness and attractiveness. Thompson and Heinberg (1999 : 342) found that internalisation is a significant correlation of body dissatisfaction and eating disturbances and predicts variance beyond that associated with simple

awareness of pressures and other risk factors, such as negative feedback (teasing) about appearance.

1.4.3.3 The Cultural Background Questionnaire (CBQ)

After comparing the various questions in the above-mentioned structured questionnaires, it became clear that, apart from biographical information, there were areas concerning culture that still needed to be covered. The Cultural Background Questionnaire included two types of questions, namely closed- and open-ended questions. The former were used to obtain information concerning the person's demographical situation where the possible responses were known, as well as certain aspects on the issues of food, eating, body shape and eating disorders where no in-depth information was needed. Further, some of the closed-ended questions were used to get the respondents to express their opinions by choosing rating points on a scale. Usually five different points were listed, ranging from very likely to highly unlikely. In more detail, the closed-ended questions tried to gain information concerning the individual's leisure time activities and the time spent watching television, relationships with family, the socialisation style of the parents, preferred foods, perceptions concerning weight, preferred methods used to control weight, as well as, in the case of eating disordered participants, an indication of treatment received.

The open-ended questions were found useful to obtain information concerning the respondent's opinions, attitudes, and suggestions on the sensitive issues of food, eating, body and the consequent eating disorders. These questions are supposed to reveal more complex, "high-context" explanations not revealed by the closed-ended questions. Examples of these questions include: perceptions concerning health and ill-health; eating habits; information regarding participants' relationship with food; personality; the influences of siblings; perceptions of the family's lifestyle; friends and their importance and influence on the individual; and male friends and their perceptions of a preferred female body.

As part of the CBQ, each participant was requested to complete a dietary intake schedule. The motivation for including this schedule is briefly discussed below: Ethnography often entails fieldwork through participant observation. This includes

research of the wider context of people's social and natural environment. Therefore, the researcher has to observe what the people actually do, what they say they think, believe or do as well as what these people actually think or believe (Norton *et al.* 1991 : 110). However, this data collection technique, which is usually seen as a very important way of doing research within the field of anthropology, could not have been used, for two reasons: Firstly, observing separately about 24 informants in their natural and social environment for a long period would have been extremely time-consuming. Secondly, in the case of such a secretive topic, with individuals suffering from eating disorders mostly denying their contraction of the illnesses, and the rest of the family rather not wanting to talk about it, it was perceived as almost impossible to use this continuous version of in-depth investigation.

As an alternative (although not used as a replacement for participant observation), participants were asked to complete a dietary intake schedule. These schedules included a whole week's detailed description of which foods and fluids were consumed, when, where and with whom. Further, the exact method of preparation (i.e. boiled, fried, cooked, baked) was to be listed. The idea behind the food schedules was based on a thorough investigation on the amount of food the participants consumed, as well as whether their perceptions of living healthy/unhealthy lifestyles as reported in the Cultural Background Questionnaire, were consistent with their eating habits.

1.4.3.4 The semi-structured, in-depth interview

According to Bernard (1995 : 209) semi-structured interviewing has much of the freewheeling quality of unstructured interviewing but it is based on the use of an interview guide – a written list of questions and topics that need to be covered in a particular order. The reason for this combination of techniques lies in the holistic perspective of the study. In addition, to get an even broader perspective, these in-depth interviews, which resemble day-to-day conversations allowing for longer questions as well as probing, were mostly (where possible) held in the homes of the participants. As a result, it was possible at least to assess rapidly as much background information as possible while the main focus was kept on the in-depth interviewing.

Hardon *et al.* (1994 : 166) perceives in-depth interviewing as one of the most important techniques in medical anthropology. Instead of asking questions in rapid succession, this kind of data collection enables the researcher to go back and review points that are not clear. Sometimes, the participant may even ask the ethnographer questions, making the hierarchy between researcher and research subject less apparent and leaving a more relaxed atmosphere between both.

The purpose of using ethnographic interviewing was to draw out categories of meaning, eliciting what people think, and how one person's perceptions compare with those of another. The types of questions used for the in-depth investigation were structural as well as descriptive in nature. It was found that these questions supplemented each other, with the former giving a framework for deeper discussion (i.e. "Do you think the current societal standard of beauty is appropriate?") and with regard to the latter, personal experiences were elicited (i.e. "Have you ever dieted?", "Do you think dieting works?"). In addition, the leading questions were divided into 8 different sections. In section one, themes concerning "The body" were investigated. Here, perceptions surrounding the concept of beauty as well as body weight were established. In the second part, focusing on "Dieting", the emic perspective of participants concerning dieting behaviour was the main concern. Section three included issues surrounding "Food", with the researcher being interested in personal perceptions concerning what is considered as food and what not, as well as what is considered 'good' or 'bad' about food. The daily use of food and its meaning was also investigated in-depth. This was then followed by questions concerning "Eating disorders", where the participants were asked to air their views on the topic. "Media/Peers/Magazine influence" was included in the last section. Here, personal viewpoints concerning the influence of media, peers and magazines in connection with their own lives were established. The next section "Anorexics and Bulimics only" was, as the heading quite clearly indicates, only for Group 1 participants who had been diagnosed with at least one of the eating disorders. Their case histories relative to the illness were written down, focusing on personal feelings and perceptions concerning the illness. The section for the females who belonged to Group 2 and 3, "Models only" and "Dancers only", included questions concerning their leisure time activities, their personal viewpoints regarding these activities and the connected weight issues so important to individuals participating in dance or modelling.

A tape-recorder was used in the interviews with members of Group 1 – the anorexic and bulimic participants. It was found that when their case histories concerning the illness (i.e. "When it started?", "How it started?", "Why it started?", "How the illness was perceived?", "Feelings in connection to the illness?", "Whether the illness is cured?") were enquired about, a great amount of very important information loaded with personal feelings and expressions was given. This information was perceived to be extremely important for the anthropological understanding of the illness and in order not to lose any of this verbal information, the section on "Anorexics and Bulimics only" was recorded.

1.4.3.5 Additional remarks concerning the data collection process

Traditionally, anthropologists are linked with far-away places, studying people with very different ways of viewing the world in comparison to their own. Because of the 'exotic' strangeness, the anthropologist mostly felt at a disadvantage. Apart from the basic etiquette and language barriers he/she also had to cope with different ways of thinking and expression. In the case of this research project, however, the researcher grew up and was socialised into the general culture of the Western world, with the same values and perceptions concerning food, weight and the body being of primary importance. As a result, it was often found difficult to remain objective and not to take Western worldviews for granted. Further, the researcher's own age and gender were similar to those of the research participants. Being a young female with more or less the same background experiences often made it difficult to remain detached and maintain the necessary researcher-participant position. Thus, there was no hierarchy between researcher and participants and as a result it was often difficult to keep to the scheduled time and not to get lost in exchanging similar experiences.

The fact that the researcher was a young female with largely similar perceptions of body, weight and food, was not necessarily a totally negative experience. On the contrary, trust was quickly established and because of mutual respect for and interest in each other a great deal of very important information could be collected. The fact that the researcher is originally from Austria was especially interesting to most of the participants. However, as mentioned, the researcher's viewpoints did not vary significantly from these of participants regarding food, diet and lifestyle. It was also

found that the girls opened up very quickly and even though the topic under research was a very secretive one, most were perceived to be grateful to talk about the issue to a stranger who understands. In addition, questions concerning puberty, menstruation, boyfriends, etcetera were not perceived as threatening an answered with ease.

Furthermore, anorexia and bulimia are deadly diseases and treatment is usually extremely unsuccessful. Even though from the start it was explained to the participants that this research was not being undertaken to treat anybody in any way, but rather to gain data on the production of the disorders, some of the participants had high expectations of being "cured" after the interviews. Therefore, it was often very sad and frustrating to see these girls joining the research project with high hopes for treatment. Fortunately, due to an extensive preliminary data collection process, in which most of the influential Bloemfontein psychologists, psychiatrists and dieticians were consulted, eating disorder specialists were identified and some of the participants took the advice to contact them.

Overall the whole data collection process was very enriching and a wonderful experience, as a great many helpful, wonderful people were met.

1.4.4 Data analysis

Analysis of data obtained from the responses to the standardised questionnaires, the structured questionnaires as well as the semi-structured, in-depth interviews, involved two steps. The separate sets of quantitative and qualitative data were analysed independently. In both sets of data, however, the first task was to get the information into manageable proportions. Quantitative information was arranged through the application of principles used in descriptive statistics. The qualitative data was summarised and described in terms of connections, patterns and themes. In the second step of analysis, the information gained through both quantitative and qualitative methods, was combined and interpreted by linking the themes, patterns and connections to the theoretical frame of reference.

1.5 DEFINITION OF KEY CONCEPTS

Although the main concepts used in this research report are incorporated, defined and discussed in Chapter 2, it was found that it would be more convenient for the reader to be able to have a complete overview of the key concepts used in this study. Therefore, definitions of the concepts used most are listed as a separate section in this Chapter.

- *Culture*: Culture can be defined as "a set of guidelines (both explicit and implicit), which individuals inherit as members of a particular society, and which tells them how to *view* the world, how to *experience* it emotionally, and how to *behave* in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual" (Helman 1994 : 3).

- *Food*: Anything which, when taken into the body, serves to nourish or build up the tissues or to supply body heat; aliment; nutriment (*Dorland's Illustrated Medical Dictionary* as quoted by Fox and Cameron 1989 : 2).

- *Social Food*: Social foods – "those that are consumed in the presence of other people" – usually tell the participants much about their relationship with one another and with the outside world (Helman 1994 : 45 – 46).

- *Dieting*: Dieting can be defined as an intentionally low calorie intake (Axelson as quoted by Lau and Alsaker 2001 : 25).

- *Body Image*: Body image is a multidimensional construct broadly describing internal, subjective representations of physical appearance and bodily experience. It includes perceptual and cognitive elements of these internal representations of one's own body and the bodies of others (http://www.health.uottawa.co/hkgrad/mllab/eatimage.html).

- *Culture-Bound Syndrome*: A constellation of symptoms which has been categorized as a dysfunction or a disease, and which cannot be understood apart

from its specific cultural or subcultural context. In addition, the aetiology summarizes and symbolizes core meanings and behavioural norms of that culture, the diagnosis relies on culture-specific technology as well as ideology, and the successful treatment is accomplished only by participants in that culture (Ritenbaugh 1982 : 347).

- *Western culture:* Rather than being fixed to a geographical location, the in the Western world originated culture is found world-wide today among people who share a lifestyle including values, norms, a standard of living as well as certain behaviour patterns.

- *Anorexia nervosa*: The most recent diagnostic definition of anorexia nervosa by the American Psychiatric Association (1994 : 544 – 545), states the following:

  a) "Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85 per cent of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85 per cent of that expected).

  b) Intense fear of gaining weight or becoming fat, even though underweight.

  c) Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape in self-evaluation, or denial of the seriousness of the current low body weight.

  d) In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A women is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration").

- *Bulimia nervosa*: The current clinical and research criteria for bulimia nervosa as stated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) (American Psychiatric Association 1994 : 549 – 550) include the following:

a) "Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

b) Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

c) The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.

d) Self-evaluation in unduly influenced by body shape and weight.

e) The disturbance does not occur exclusively during episodes of Anorexia Nervosa".

1.6 COMPOSITION OF REPORT

Chapter 1 introduces the reader to the problematic increase of eating disorders over the last century, especially in the Western world. The general as well as the specific objectives are presented in detail, followed by an in-depth discussion concerning the selection, process of acquaintance and characteristics of the research unit. Further,

research methods and techniques as well as the data collection processes are discussed for a better understanding of the course of the research project. Ultimately, major key concepts best suiting the purpose of this study are defined as presented in the consulted literature.

Chapter 2 starts out with a discussion of the concept of culture and its characteristics. Thereafter, the apparent connection between culture and food is investigated, with the social aspect of food given special attention. An extensive description of anorexia nervosa and bulimia follows. Here, an overview of the literature describing the history of eating disorders, the characteristics of anorexia and bulimia as well as various theoretical approaches concerning eating disorders are presented and discussed. Special attention is given to the socio-cultural approach to eating disorders. For this purpose, special attention is given to contemporary trends in the Western culture concerning the ideal of thinness. Further, the apparent fear of obesity and the consequent weight control methods (dieting and exercising) are inquired into. In the last part of this chapter, the nature and role of three socialising agents (the family, peers and the media) in promoting the ideal of thinness are investigated.

A detailed discussion on the empirical research findings is presented in *Chapter 3*. The quantitative and qualitative results concerning the research participants' perceptions on food and eating, weight control methods and their body shape is presented. In addition, information regarding the influence of the family, peers and media in promoting the development of eating disorders is discussed.

Chapter 4 is comprised of an overall summary and conclusions based on the research findings from both the literature study and the data collected during fieldwork.

CHAPTER 2: CONCEPTUAL AND THEORETICAL FRAMEWORK

"There is no human society that deals rationally with food in its environment. ... Eating is always closely intermingled with interpersonal and emotional experiences and its physiological and psychological aspects cannot be strictly differentiated. ... People misuse the eating function in their efforts to solve or camouflage problems of living that to them appear otherwise insoluble."
(Bruch 1973 : 3)

2.1 INTRODUCTION

Chapter 2 serves as a conceptual and theoretical frame of reference for the empirical investigation of this research project. It is a broad frame of reference and does not imply that each and every conceptual and theoretical statement will be tested in the field. However, it provides guidelines, explicit and implicit, in terms of which the influence of culture on anorexia nervosa and bulimia nervosa can be interpreted and explained.

In the first part of the chapter the concept of culture and relevant characteristics of culture will be discussed. It is not the intention of the researcher to elaborate on the theoretical issues of the present-day debate on culture. It should rather be interpreted as assumptions that guide the human-culture relationship.

The anthropological study of anorexia nervosa and bulimia nervosa almost naturally requires a look into the cultural understanding of food. In this regard, attention will be given to the concept of food, the possible reasons for our underlying urge to eat as well as the social side of food. In the next section, anorexia nervosa and bulimia nervosa will be discussed. The aim is to provide the reader with relevant information in order to understand the nature and character of the phenomena, the history and rising incidence of eating disorders, the female prevalence, onset in adolescence and the connection with social class and non-Western cultural contexts. Scholars of various

disciplines have done research on eating disorders and therefore it was deemed necessary to explain some of the dominant theoretical approaches found in the literature. One of the approaches strongly advocated in anthropological literature is the view of eating disorders as "culture-bound syndromes".

If one argues that anorexia nervosa and bulimia nervosa could be perceived as culture-bound syndromes and that culture is learned behaviour, then it becomes apparent that one should also look into the socialisation processes through which these disorders (i.e. the beliefs and behaviour associated with them) are 'transmitted' from generation to generation. For this purpose, three socialisation agents will be discussed namely the family, the peer group and the mass media. However, culture should always be understood within the wider historical, social and economic context. Therefore, an anthropological study of eating disorders should also address questions such as: What are the trends in Western cultures that promote the idea of thinness? and What are the possible solutions to comply with this ideal?

2.2 CULTURE

2.2.1 The concept of culture

"Culture" to anthropologists is the equivalent of a theological issue to a priest, and there are almost as many definitions of it as there are anthropologists. It can be as easily defined as the whole way of life of a human society. The difference between "culture" and "society", however, is not always clear, especially to non-anthropologists or people not working with both terms the way anthropologists do. Sometimes "culture" is even used interchangeably with "society", but the two are completely different. "A society is an organised group of people and their culture is what those people share with one another. Whether what is shared is considered to be tools and techniques or language and symbolic constructs; its content is not human beings. People are not 'members' of cultures; they are members of a society who share a common culture" (Nicholas 1991 : 19). It is obvious that there can be no culture without a society, just as there can be no society without individuals. Conversely, there are no known human societies that do not exhibit culture (Haviland 1994 : 305).

Anthropology achieves integration through the concept "culture" and it is this very concept, which is the core of this research project. Culture is not something one can acquire or "catch" by listening to Mozart, going to the opera hall, or visiting a museum. According to anthropological definitions (Miller and Weitz 1979 : 299), none of these activities are necessary – everybody has culture by virtue of having been raised in a society. We express culture in such everyday activities as eating, shopping, and going to church. Perhaps the most famous definition is that coined by the British anthropologist Sir Edward Burnett Tylor in 1871: "That complex whole which includes knowledge, belief, art, law, morals, custom any other capabilities and habits acquired by man as a member of society" (Haviland 1994 : 304; Helman 1994 : 2; Swartz and Jordan 1980 : 9). Tylor's view includes things in people's minds (knowledge, belief and morals), the way people behave (customs and habits), and things that people produce (art and law). Toni Tripp-Reimer (as quoted by Sargent and Johnson 1996 : 102), a nurse-anthropologist, defined culture as the "total lifeways of a human group. It consists of learned patterns of values, beliefs, customs and behaviours that are shared by a group of interacting individuals. More than material objects, culture is a set of rules or standards for behaviour". In this view, culture is a neatly demarcated entity, distinctive of a group of people. In the last three decades, however, this view of culture has come under heavy criticism. One of the significant outcomes of the ongoing debate is greater focus on the individual and the dynamics of his/her experience. According to Guarnaccia (1996 : 420) more recent approaches to culture in anthropology provide a more dynamic perspective. Although not discarding the importance of a person's cultural inheritance of ideas, values, feelings, ways of relating and behaviours, recent views of culture have focused equally on the importance of viewing culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships and migrations (Good as quoted by Guarnaccia 1996 : 420). Recent approaches have also focused on the emergence of culture from the daily social practices and life experiences of individuals and small groups. Therefore, to Guarnaccia (1996 : 420) culture is both "a product of group values, norms, and experiences and of individual innovations and life histories".

In Chapter 1, paragraph 1.5, the definition of Helman (1994) was quoted as the guiding definition of culture to be followed in this research. In his definition Helman (1994) distinguishes between culture as ideas, as behaviour and as emotional experience.

Although the author does not use the same arguments as Guarnaccia (1996), Helman gives equal importance to culture and individuals. In the study of anorexia nervosa and bulimia nervosa one could concentrate only on the individual as patient, her experiences and view of the illness. However, it would be anthropologically sound to take cognisance of the cultural context to which the individual belongs.

Anorexia nervosa and bulimia nervosa are, like many other disorders, often explained by the versions of reality that practitioners and medical personnel carry around. These understandings of the world, built on concrete foundations of biomedical knowledge, might explain the criteria for diagnosing disorders. However, they seldom explain the causes of illness or the individual treatment needed. Certainly, physiological processes and anatomy are real and observable to medical practitioners. It is clear to them that if a person cannot maintain a body weight of over 85 percent of that expected, the diagnosis will be anorexia nervosa. It is often not so clear though, that the complex whole called culture might be the cause. Culture, however, cannot be seen as a concrete entity – like a virus or bacteria – it has to be viewed in a wider context. Firstly, one has to *understand* holistically the person's individual experiences, and way of viewing the world as well as the social and environmental circumstances. From a holistic perspective, this means that the culture of any group of people has to be viewed in its particular context. Further, culture is *always*, at any particular point in time influenced by historical, economic, social, political and geographical elements. It is therefore impossible to isolate "pure" cultural beliefs and behaviour from the social and economic context in which they occur (Helman 1994 : 4 – 5). The social pressure for thinness in the Western world, for example, influences the individual's view of the body, which in turn might influence the production of eating disorders.

With this in mind, the above-mentioned definition by Helman (1994 : 3) seems, due to its rather unrestricted nature, applicable in this research. It allows the investigation, necessary for this study, of how people view a specific illness/disorder, how they experience it emotionally and how they react to others as a result of it.

From this discussion it might seem as if the concept of culture is a rather vast and complex phenomenon. Because of the great complexity, anthropologists have arrived

at classifying certain key qualities, or *characteristics*, that could be found in various contexts.

2.2.2 The characteristics of culture

Culture is an attribute of individuals as member of groups. According to Haviland (1994 : 304) "culture is a set of shared ideals, values, and standards of behaviour; it is the common denominator that makes the actions of individuals intelligible to the group". Because people *share* a common culture, they can predict how others are most likely to behave (Haviland 1994 : 304). However, it is very important to realise sharing culture does not mean uniformity. At the very least, there are differences between the roles of men and women. (More concerning gender and the differences in socialisation will be presented later in this chapter, paragraph 2.7.3.2.) Culture gives meaning to these differences by explaining them and specifying what is to be done about them. Gender, which refers to the cultural elaborations and meanings assigned to the biological differentiation between sexes, is defined by each culture in its own way, creating tremendous variations from one society to another (Haviland 1994 : 305). Furthermore, in pluralistic societies where a diversity of cultural patterns exist, not all members of a society share the same culture (Haviland 1994 : 307).

However, staying with the "shared" aspect of culture, this research report requires the explanation of two different shared cultural aspects. Firstly, the very nature of eating is culturally defined and therefore a shared concept by members of a society. This will be explained in more detail in paragraph 2.3.4, under the heading 'The social side of food'. Secondly, the members of a society normally share perceptions concerning health and illness. In most cases, "health" is seen as more than just an absence of unpleasant symptoms. The World Health Organisation (WHO) defined it in 1946 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO as quoted by Helman 1994 : 108). If the perceptions concerning health are cultural phenomena, then those influencing ill health must be so as well. To illustrate the complexities of modern cultures Hardon *et al.* (1994 : 12) analytically distinguishes between disease, illness and sickness. "Disease is the definition of a health problem by a medical expert; Illness refers to the experience of the problem by the patient; and Sickness is the social role attached to a health problem

by the society at large" (Hardon *et al.* 1994 : 12). "Illness" therefore, stands for "what the patient feels when he goes to the doctor" and "disease" for " what he has on the way home from the doctor's surgery". In other words, disease is something an organ has, illness something a human being has (Cassell as quoted by Helman 1994 : 107). An example thereof would be a Western medical practitioner diagnosing a person 25 percent below his or her body weight as being anorexic. The patient, however, might see the excessive food refusal as plainly avoiding putting on weight. Thus, people share only partly the same beliefs and practices. Even when, on the surface, it seems as if they share alike, members have different experiences and understandings and they express different behaviours. Therefore, in studying societies, the researcher should be careful in determining cultural patterns.

Anthropologists agree that all culture is *learned* rather than biologically inherited. According to Haviland (1994 : 308) one learns one's culture by growing up with it and the process whereby culture is transmitted from one generation to the next is called socialisation. Ember and Ember (1996 : 196) explain this by using the example of eating. Eating is not cultural. Humans eat because they must, but what and when and how they eat are learned and vary from culture to culture (Ember and Ember 1996 : 196). Therefore, through the process of socialisation one learns the socially appropriate way of satisfying one's biologically determined needs.

Leslie White, a major theoretician in cultural anthropology, observed that all human behaviour originates in the use of *symbols* (Haviland 1994 : 311). This constitutes another important characteristic of culture. According to Haviland (1994 : 311) art, religion and money involve the use of symbols. A Christian cross or an Islamic crescent are two examples of the many different symbols people use. Furthermore, all people known to anthropologists, regardless of their kind of society, have had a complex system of spoken, symbolic communication, which is called language (Ember and Ember 1996 : 197). Language – the most important symbolic aspect of culture – is the substitution of words for objects (Haviland 1994 : 311). This means that a word or a phrase can represent what it stands for whether or not that thing is present (Ember and Ember 1996 : 197). Through language, humans are able to transmit culture from one generation to another and learn from cumulative, shared experience. Without it, one could not inform others about events which they were not involved in (Haviland

1994 : 311). In this study it is evident that the media, leisure and health industries communicate mainly through the use of symbols. For example, numerous people from the entertainment business as well as fashion models became symbols of the ideal body shape through the manipulation of the media.

Yet another characteristic of culture anthropologists observed, is that it is comprised of different parts which function as an interrelated whole (Haviland 1994 : 313). This means that cultural aspects such as economic, political, social and religious organisation are *integrated* and therefore influence one another. An example of this is food, which is hardly ever just food – a source of nutrient. In all human societies it plays many roles, and is deeply embedded in the social, religious and economic aspects of everyday life (Helman 1994 : 37). More concerning the social side of food as an example of the integrated nature of culture will be discussed in paragraph 2.3.4, the social side of food.

Culture change – the last feature of culture explained for the purpose of this study – is both necessary and inevitable. It is often set in motion through innovation, cultural diffusion, or modification of behaviour and values within the culture (Popenoe 1995 : 67). Haviland (1994 : 319) explains culture change by using the example of dress: In the past few decades, it has become more culturally permissible for men and women alike to bare more of their bodies. Along with this has come greater permissiveness about the body in photographs and movies. Finally, the sexual attitudes and practices of North Americans have become less restricted. These changes in turn are interrelated, reflecting an underlying change in attitudes towards cultural rules regarding body image and sex. This will be discussed in greater detail in paragraph 2.5, under 'Contemporary trends in Western culture promoting the ideal of thinness'.

From this discussion on the concept of culture as well as its characteristics, it should be clear that, in humans, it is culture that sets the limits of behaviour and guides it along predictable paths. Therefore, when conducting research on anorexia nervosa and bulimia nervosa from a cultural perspective, it means inter alia that ideas and practices surrounding the illness are shared to a certain extent in Western communities. It also implies that over generations, members of these societies have learned ideas about food, their bodies, what is acceptable behaviour, etcetera and that these ideas are

deeply embedded in their way of thinking. Therefore, culture change took place in all aspects of culture. As mentioned in Chapter 1, there is a growing concern over the increasing number of eating disorder sufferers in the Western world. Thus, in the last couple of decades, especially young people came under the allure of a certain body image and ways of controlling body weight that were unknown in previous centuries. The consequences of this changing view of the body and eating could have a big impact on the rest of an individual's life. Because culture is integrated, it is not only a change in perceptions on the body and eating, but also a change in lifestyle.

2.3 FOOD AS CULTURE

2.3.1 Introduction

Food, a substance that nourishes the body and which is consumed to sustain life, is more than just a source of nutrients. It plays many different roles in all human societies and is deeply embedded in the social, religious and economic aspects of everyday life. Social foods, those consumed in the presence of others, often show what kind of relationships the people eating together share. Therefore, many aspects of people's social life, like a person's status, his or her esteem, the possession of power, or even gender relationships, are defined by the powerful source of nutrition.

The first question any anthropologist would ask when studying the role of culture in the development of eating disorders would be on the nature of food perceptions and practices within the context of the research which is being conducted. The main reason for this focus is to get an understanding of the norm within culture in order to be able to interpret the deviations thereof. In other words, to penetrate the possible causes of eating disorders, one has to study the "normal" situation.

2.3.2 The concept of food

From early childhood, people are taught that the basic physical needs of humans are food, shelter, and clothing. Since the beginning of recorded history, people have struggled desperately to acquire enough to eat. History only records a few people, like King Henry VIII, who indulged heavily in the consumption of excessive food. The

mass of humanity, however, has been highly concerned with "filling its stomach", not questioning whether the food had a purpose or a function as long as it relieved hunger (Lamb and Harden 1973 : 1). Lamb and Harden (1973 : 1 – 2) state that the function of food has only been given serious consideration by men in research and medicine since the 1880s. It was around this time that people started to try to describe a "recommended diet" for a long healthy life. Today we know that the basic function of food is to keep us alive and healthy. Food is actually such an essential part of everyday life that it might be presumed that its nature would be universally understood. However, what is considered food for some people might not be so for others. So what then is food?

The concept is quite difficult to define and this can be seen from the many different definitions used. *Dorland's Illustrated Medical Dictionary* (Fox and Cameron 1989 : 2) defines it as "anything which, when taken into the body, serves to nourish or build up the tissues or to supply body heat; aliment; nutriment;". The *South African Pocket Oxford Dictionary* (1994 : 359) states that food is "a substance taken in to maintain life and growth and a mental stimulus". The essence of both definitions is that unless what we eat fulfils the function of physical nourishment, it should not be classed as food.

Fox and Cameron (1989 : 2) made the whole question of what food is and what it is not into a paradox: food, they explain, is what we eat, but not everything we eat is food. The explanation for this lies in the fact that food has a biological function – to keep us alive *and* healthy – and unless what we eat contributes to this function in some way, it should not strictly count as a food. They (Fox and Cameron 1989 : 2) give the example of salt and pepper. Salt, they explain, is food because, in addition to being a seasoning agent, it acts as a regulator of body functions. Pepper, on the other hand, has no function except as a flavouring agent and is therefore not a food. In this view on food, Fox and Cameron (1989) have refined the above-mentioned definition of food as "keeping us alive", by emphasising also that food should contribute to our health.

According to the nutritional view, substances are considered as food when they are eaten, absorbed by the body, produce energy, promote the growth and repair of tissues or regulate these processes. The chemical components of food, which perform these functions, are called nutrients. Nutrients consist of six types, all of which are present in

the diet of healthy people. The six types are: fats, carbohydrates, proteins, water, mineral elements and vitamins. Lack of the necessary minimum amount of any of these nutrients will lead to a state of malnutrition, while a general deficiency of all nutrients produces under-nutrition and in extreme cases, starvation (Fox and Cameron 1989 : 3).

Despite the fact that humans need the nutrients of food in order to survive, food is more than just a source of nourishment and nutrition. From a cultural perspective food is not simply an organic product with biochemical qualities that may be utilised by living organisms, but it also represents culture. Each culture defines which substances are edible and which are not. In France, for example, frogs' legs and snails are delicacies whereas in other countries like the UK, they are rejected despite their nutritional value (Helman 1994 : 38). No group, according to Foster and Anderson (1978 : 265), even under conditions of extreme starvation, utilize all available nutritional substances as food. Superstitions, health beliefs, religious taboos, etcetera, are factors excluding some foods from the diet and viewing them as "not food". Hilde Bruch (1973 : 3), in her famous book on eating disorders, *Eating Disorders, Obesity, Anorexia Nervosa and the Person Within*, formulates the cultural complexity surrounding food: "There is no human society that deals rationally with food in its environment, that eats according to the availability, edibility, and nutritional value alone. Food is endowed with complex values and elaborate ideologies, religious beliefs, and prestige systems. ... It is these aspects that give to eating habits and food traditions their special cultural and national character, and to the food habits of one's background and family the emotional connotation of warmth and home." It is also within these factors that one should search for explanations for eating disorders.

2.3.3 Why we eat

According to this discussion on food, culture could be seen as a dominant defining factor of food. In a further analysis of the biological understanding of food as nourishment, certain concepts such as hunger, appetite and satiety were also found to be central to the study of food in relation to eating disorders.

People eat for many reasons, but the most obvious is *hunger*. Hunger, the feeling of discomfort or exhaustion caused by a lack of food (*South African Pocket Oxford Dictionary* 1994 : 456), builds up slowly in the absence of food and becomes stronger, the longer the drive stays unsatisfied. This gut sensation that can range from being rather pleasurable to frankly painful, is a complex physical process, a stirring of the stomach and intestines, progressing to general irritability and restlessness, combined with cold and fatigue (Dally and Gomez 1980 : 13). Dally and Gomez (1980 : 13) further describe the feelings of hunger as a sensation which in some people causes headaches and even feelings of nausea. The hungrier a person gets, the more readily he/she will satisfy the drive by eating simple and unsophisticated food. As hunger is assuaged, so appetite takes increasing charge.

According to Foster and Anderson (1978 : 266), appetite and hunger are related but distinct phenomena. The concept of *appetite* is defined in the *South African Pocket Oxford Dictionary* (1994 : 37) as "the natural craving for food". Foster and Anderson (1978 : 266), however, are of the opinion, that appetite is a cultural concept that may vary greatly from one culture to the next. Hunger, on the other hand, they see as a basic nutritional deprivation – a physiological concept. In the article, "The civilising of appetite", Mennell (1987 : 373) argues that there is no simple relationship between the two concepts. Hunger is a body drive, which recurs in all human beings in a reasonably regular cycle. Appetite, however, is "basically a state of mind, an inner mental awareness of desire that is the setting for hunger.... An individual's appetite is his desire and inclination to eat, his interest in consuming food. Eating is what a person *does*. Appetite is what he *feels* like doing, mostly a psychological state" (Cappon as quoted by Mennell 1987 : 374). According to Dally and Gomez (1980 : 13) appetite – alongside habit – dictates what food we fancy or reject. It anticipates pleasure and often people go on eating even after hunger has been satisfied. Occasionally however, appetite may conflict with hunger in an inhibitory way, making food repulsive. An example would be the hungry traveller in the desert, offered a stew of fat with maggots and sheep's eyes. Sometimes, a person starves in the midst of plenty, as is the case with anorexia nervosa. Then appetite and hunger combined tempt the person to eat, but not strongly enough to crush the fear of the consequences. Appetite, therefore, is by far more complex than hunger (Dally and Gomez 1980 : 14).

Satiety is a positive sensation of having had enough, with cessation of the urge to eat. Usually it is accompanied by a feeling of gastric fullness (Dally *et al.* 1979 : 29). Fullness, however, is not the only factor determining satiety. Dally *et al.* (1979 : 29) argue that if fullness were the only factor, then a solution for obese people to eat less would be filling their stomach with methyl-cellulose. Satiety – especially in adults – seems also to involve a change or relaxation of mood. Patients with eating disorders, however, often do not experience satiety, fullness or a relaxation of mood after a meal. Often, it is difficult for these people to separate hunger from the preoccupation with food, which they have to contend with most of their time. Appetite, which is usually enhanced by hunger, is denied. Food is feared and avoided only for its effect on weight. Most anorexics would eat with enjoyment if they were convinced that no weight gain would result (Dally *et al.* 1979 : 27 – 30).

To conclude, hunger, appetite and satiety have strong physiological origins. They have also a clear connection with the mental state of an individual. It is this relationship, which gives a better understanding of eating disorders. The person suffering from anorexia or bulimia wants to control the intake of food out of a fear of gaining weight and in the process she might be in danger of changing basic human characteristics. In any study on eating disorders the content of hunger, appetite and satiety should be investigated.

2.3.4 The social side of food

In paragraph 2.3.2, it was argued that food is much more than a means to keep humans alive and healthy. Social foods – "those that are consumed in the presence of other people" – usually tell the participants much about their relationship with one another and with the outside world (Helman 1994 : 45 – 46). Rosman and Rubel (1981 : 162) explain that who does or does not eat together serves to define social units. In our society, the nuclear family is the unit that eats together. Most meals are sociable occasions: not only is food shared, but also news, plans, ideas and feelings. People who are alone usually take a tray and eat by the television set, or the fireside for "companionship" (Dally and Gomez 1980 : 16). To habitually eat – by choice – alone, is unusual and a sign that all is not well. It indicates an exclusion from the social group, or rejection. Dally and Gomez (1980 : 17) give the examples of lonely children

who eat their sweets alone; compulsive eaters who stuff in shameful secrets; and girls with anorexia nervosa who eat their tiny morsels alone, away from the rest of the family.

Social status is often indicated by the meals people share. Cocktail parties are held for acquaintances (Rosman and Rubel 1981 : 162), meals preceded by alcoholic drinks are for close friends and social intimacy is symbolized by an invitation to a complete meal (Helman 1994 : 46). Breaking bread with one's enemies is usually not considered appropriate, as giving food is a symbol of goodwill and peaceful relationships (Rosman and Rubel 1981 : 162). Food gifts signify love and/or friendship and are universal symbols for this purpose. In Western societies, a bottle of wine is often brought along in exchange for a meal, a gift of candy is expected at Valentines Day, and fudge, brownies or special foods are prepared to strengthen relationships (Eckstein 1980 : 239).

Food can also provide the feeling of safety and security. The act of eating therefore is closely related to emotions. Eating may mean accepting love, while sadness might be expressed by not eating, and loneliness sometimes triggers overeating or the complete rejection of food (Keeling 2001 : 154). Many obese people feel unworthy of warm, satisfying, emotional relationships and use food to compensate for the feeling of loneliness (Dally and Gomez 1980 : 24 – 33). This is, however, not a problem of obese people only. The psychological security value of food is known to a great many people who eat more and snack between meals in order to combat unhappy feelings or stress. Another example is that of travellers, living overseas. Frozen, canned and packaged food from home gives a feeling of security as well as feelings of warmth and safety (Foster and Anderson 1978 : 270).

a) Food and power

Apart from the fact that food influences social occasions and indicates the social status of people, topics such as food and power, food and gender and food and the family are emphasised in the literature on food as a social phenomenon. All three mentioned subjects have some connection with the cultural factors that play a role in eating disorders.

As already mentioned above, food is essential to life and must enter our bodies daily in substantial amounts if we are to live. Due to this intense need of it, Arnold (1988 : 3) suggests that "food was, and continues to be, power in a most basic, tangible and inescapable form". Worldwide the fortunes of a state have – across history and time – been closely bound up with the containment or prevention of famine and, more generally, with provisioning the populace (Arnold 1988 : 96).

Class, caste, race and gender hierarchies are maintained through differential control over and access to food. As Goody (1982 : 113) says, "the hierarchy between ranks and classes takes a culinary form. In India, caste is marked quite conspicuously by different food habits and prohibitions against eating with those of lower caste" (Goody 1982 : 116). Further, race, class and gender distinctions are manifest through rules about eating and the ability to impose rules on others. In the Western world, we value thinness. Counihan (1999 : 9) argues that the dominant culture – manifested in advertising, fashion, as well as the media – projects a belief that thinness can be associated with control, power, wealth, competence and success. This standard is stricter for women than for men, which means more women fall outside the prescribed norms and feel less valued. Whiteness and greater wealth go along with thinness, while being poor, female and of non-white origin are often accompanied by a high rate of obesity and low status. The standard of thinness therefore upholds a class structure where men, whites, and the rich are superior to women, people of colour and the poor (Counihan 1999 : 9).

b) Food and gender

Counihan (1999 : 96), an expert in the field of the anthropology of food and gender, suggests that there is an universal connection between women and food. Women have a universal responsibility for food production and consumption. They are often defined as nurturers and carry out this role principally through feeding. During pregnancy and lactation, they themselves become a source of food for their children, intensifying their identification with food and its relevance as symbol (Counihan 1999 : 96).

The connection between power and food can also be seen when looking at the power of sexes. Control of money and food purchases is a key index of the husband-wife balance of power. Men can exert power by controlling the food purchases and they often claim authority to judge the meals women cook. Furthermore, they can disparage the food or demand certain dishes. They are also able to show their power when they refuse to provide for food or stop eating the dishes prepared by the women (Adams; Charls and Kerr; DeVault as quoted by Counihan 1999 : 11). Counihan (1999) also gives examples where women may wield the power. They can, for example, refuse to cook, cook food men dislike, force them to eat, or manipulate the status and meaning systems embodied in foods. Counihan (1999 : 11) explains the latter via recorded cases of women in the 18th century, who "tamed" husbands' abusive behaviour by preparing food containing bits of menstrual blood or other "magical" matter.

In addition, in all cultures maleness and femaleness are associated with specific foods, and rules often exist to control the consumption of those foods (Brumberg 1988 : 176 – 78). American college students, for example, associate "light" foods like salad, chicken, or yoghurt with women, and "heavy" foods like beef, beer, and potatoes with men (Counihan 1999 : 10). As a result, their rules about the appropriate food consumption define men as powerful and women as weak. Counihan (1999 : 11) states that U.S. women report that men gain power over them by saying they eat too much or they are too fat. The result is that a lot of women feel too ashamed to eat in front of men. In many cultures, plumpness is preferred, especially for women, because it is associated with fertility, hardiness, power, good nurturance, and love. Counihan (1999 : 11) underlines this statement with the example of the people living in Fiji. There, a plump body is preferred because it is associated with care, generosity, and social cohesion.

Sexuality too is often associated with food. Food and sex are metaphorically overlapping. Among the Mehinaku Indians, "to have sex" is defined literally as "to eat to the fullest extent". The essential idea, according to Gregor (as quoted by Counihan 1999 : 9) is that the genitals of one gender group are the "food of the others". In many cultures, food gifts may be an important path to sexual liaison, as with the Amazonian Indians. Holmberg (as quoted by Counihan 1999 : 9) says,

"Food is one of the best lures for obtaining extra-marital sex partners, and a man often uses game as a means of seducing a potential wife".

In many cultures, eating, intercourse and reproduction can be associated with one another. The drive for food and sex is similar, and they often take on overlapping symbolic associations. The father of psychoanalysis, Sigmund Freud (1962 : 175), claimed that there is a lifelong connection between oral and sexual gratification. Eating together implies intimacy, both sexual intimacy and kinship. According to Counihan (1999 : 9 – 10) both eating and copulation cause and symbolize social connection. This connection between sex and food, however, can be dangerous or even threatening when carried out under adverse conditions or with untrustworthy people. Bronislaw Malinowski (1929 : 75), in his research among the Trobriand Islanders, found that "two people about to be married must never have a meal in common. Such an act would greatly shock the moral susceptibility of a native, as well as his sense of propriety. To take a girl out to dinner without having previously married her – a thing permitted in Europe – would be to disgrace her in the eyes of a Trobriander".

c) Food and the family

One very important aspect of food is its relation to the family. Feeding is one of the most important channels of infant and child socialisation and personality formation. In some cultures, the family may be most effectively conceptualised as those people who share a common hearth (Weismantel 1988 : 169). Feeding, according to Counihan (1999 : 17), is a very important criterion in the establishment of the parent-child relationship. This is highlighted by Young's (as quoted by Counihan 1999 : 17) description of the people of Kalauna, Goodenough Island, where fosterage is wholly conceived in terms of feeding. The father establishes his paternity by providing food for his pregnant wife. The role of the mother is self-evident but the father can only reinforce his own role as caretaker by feeding his pregnant wife, which is explicitly seen as nurturing the foetus.

According to Freud (1962), the child's earliest experiences of eating are the stage for important developmental processes and shape his or her lifelong personality.

Margaret Mead (1967 : 70) suggests that through the infant feeding relationship, "every child learns something about the willingness of the world to give or withhold food, to give lavishly or deal out parsimoniously". Counihan (1999 : 18) states that breastfeeding is part of the process of individualisation for the child. The child recognises that the mother is "other", and that the source of food is outside of his- herself. Through this process of learning, the child gradually establishes an autonomy, bounded, and subjective identity.

In her detailed discussion on eating disorders, Hilde Bruch (1973 : 54 – 58) formulated a model of child development including appropriate feeding practices. In her model, "good mothering, loving care, can be expressed in functional terms as providing careful and discriminating attention to a child's expression of biological needs, such as giving food when his cry indicates nutritional need." However, when food is given without regard for the real reason for the child's discomfort, or as a reward for good behaviour, and withheld as a means of punishment for undesirable and disapproved actions, the child will grow up unable to differentiate between various needs. This in turn affects the child's personality because he/she is not able to differentiate between various needs, leaving him/her feeling helpless in controlling biological urges and emotional impulses (Bruch 1973 : 57 –58).

From the above, it becomes clear that food is not only essential to life, but also to social interaction. Where it is not, food is symbolically manipulated to express the perception of relationships between people. It is, therefore, hard to imagine what people's social life – not to speak of physical life – would be like without it (Foster and Anderson 1978 : 268). Food itself, of course, is incapable of creating social relationships, emotions and needs, but its procurement, preparation, and service can all be important events, deeply endowed with emotional tones and nuances (Keeling 2001 : 154).

2.4 ANOREXIA NERVOSA AND BULIMIA NERVOSA

2.4.1 The history of anorexia nervosa and bulimia nervosa

In the popular consciousness, anorexia nervosa is something relatively new. Indeed, prior to the 1970s, the disorder was unheard of by all but a few medical specialists, when it suddenly burst into public view (Gordon 1990 : 12). But in fact, as a clinical entity, the history of anorexia nervosa probably extends back as far as five centuries ago.

Simone Porta o Portio (1496 – 1554) is sometimes claimed to have given the first description of anorexia nervosa. He described a girl who stopped eating totally when she was ten. For 40 days, apparently under constant observation, she refused all nourishment, claiming that she no longer required food. Simone Porta concluded that she lived exclusively on air (Dally *et al.* 1979 : 1). In 1689, Thomas Morton, a religious nonconformist and English physician, wrote the first unmistakable account of anorexia nervosa. This clear medical description of anorexia which he called "nervous atrophy" (Thomä 1967 : 4; Dally *et al.* 1979 : 1) indicated a "wont of appetite" and weight loss that were not accompanied by other typical symptoms of consumption (for example fever and coughing), and which was apparently attributable to "sad and anxious cares" (Gordon 1990 : 12).

Anorexia was only rarely mentioned in scattered medical reports over the next two centuries (Thomä 1967 : 4). The revival of interest in the disease was stimulated in the 1870s by Sir William Withey Gull in the UK and the neuropsychiatrist Ernest Charles Lasègue in France (Lee 1998 : 128). In 1868 Gull described "a peculiar form of disease" occurring mostly in adolescent girls and young women (15 to 23 years). He first called the disease "apepsia hysterica" or "anorexia hysterica" (DiNicola 1990a : 168-169). Unbeknown to Gull, in 1873, the French doctor Lasègue also published a detailed account of this condition. He named it "anorexia hysterique". In the following year, Gull independently produced another paper, which contained his revised attempt to name the illness. He was the first to call it *anorexia nervosa* and the name soon became widely accepted (Welbourne and Purgold 1984 : 14 – 15). There seems to be no doubt that Gull and Lasègue recognized the illness and developed their ideas

independently of one another (Dally *et al.* 1979 : 3). It is interesting to speculate whether Gull and Lasègue's simultaneous discoveries were responses to an actual sudden increase in the number of cases of the disorder, or whether they were redefining behaviours or symptoms that were already prevalent but had just gone unrecognised. According to Gordon (1990 : 13) it is plausible, on historical grounds, that there was in fact, even at this early stage, an actual increase in the prevalence of the condition at the time.

In the century following Gull's and Lasègue's pioneering papers, anorexia nervosa was extensively written about, but little understood. In the early decades of the twentieth century, it was mistakenly viewed as an endocrine disease (Simmond's disease) and for years through the 1920s, anorexic patients were treated with thyroid extracts. When it became clear during the 1930s that anorexia and Simmond's disease were different clinical entities, psychological explanations came to the fore, particularly in the form of psychoanalytic interpretations that argued for the disorder's sexual origin (Gordon 1990 : 13). Anorexics were conceptualised as young girls refusing to grow up and develop into sexually mature women. Ultimately, both explanations proved of little value to the anorexic patient and a more encompassing framework was needed. A watershed was the emergence of the work of the psychoanalyst Hilde Bruch. She was the first to consider the essential psychodynamic disturbance in the disorder to be a disturbance in body image and of recognition of bodily states and a sense of ineffectiveness. Perhaps Bruch's greatest contribution was her elaboration of the fact that in anorexia there is not a true loss of appetite but rather a preoccupation with food and eating (Bruch 1973 : 267).

In 1979, out of his research into anorexia nervosa, London physician Gerald Russell identified what he termed "an ominous variant of anorexia nervosa" (Button 1993 : 9). *Bulimia nervosa*, which is characterized by cyclical episodes of bingeing and purging (the latter including self-induced vomiting), use of laxatives and/or diuretics and strict dieting or fasting to counteract the weight gain associated with excessive caloric consumption (Crowther *et al.* 1992 : 1), already existed in ancient and medieval times. The upper and middle classes of the Roman Empire institutionalised bulimia in their social rituals. As a form of conspicuous consumption, wealthy citizens would give great banquets and their guests would consume twenty or more courses daily. To

handle this alimentary load, the men and women would be escorted between courses to adjacent bathrooms where they could purge themselves of previous courses. These 'vomitoriums' became an integral part of Roman life (Giannini and Slaby 1993 : 18). The Egyptians, on the other hand, believed that food was a predominantly etiological factor in disease and therefore deliberately purged on a monthly basis. The word "bulimia" was first used by Trevisa in 1398. Its initial meaning included only immoderate appetite. In the 14th century the compulsive overeating practices of King Henry VIII (England) were copied further down the social ladder (Giannini and Slaby 1993 : 19). While the dietary intake persisted over the centuries, at least among the upper and middle classes, the incidences of forced engorgement seemed to have been reduced. The expansion of the middle class left people with more leisure time and a variety of different attractions which, in addition to the new technological developments of this time, made engorgement a less attractive 'game' (Giannini and Slaby 1993 : 20). As reports of a syndrome characterized primarily by episodes of uncontrolled eating began re-emerging in the 1970s, Giannini and Slaby (1993 : 20) indicate that various diagnostic terms were introduced, including compulsive eating (Ondercin 1979), the dietary chaos syndrome (Palmer 1979), bulimarexia (Boskind-Lodahl and Sirlin 1977), bulimia nervosa (Russell 1979), and bulimia (American Psychological Association 1980).

The conclusion of comprehensive surveys of the literature is that disordered eating is as old as history itself – but what is new is the shift in the idealized female shape from the voluptuous, curved figure to the more angular, lean look. It is this shift that causes thousands of women every year to diet and eventually starve themselves to death. According to Wolf (1990 : 150) dieting and thinness began to be a female preoccupation when Western women received the vote around 1920. The rapidity with which the new, linear form replaced the more curvaceous one was startling (Wolf 1990 : 150). After the regressive 1950s, when women's natural fullness could be briefly enjoyed once more because their minds were occupied with domestic seclusion, women came en masse into male spheres. Twiggy appeared in the pages of *Vogue* in 1965. Her thinness, now commonplace, was shocking at the time (Wolf 1990 : 151). *Vogue* introduced the model with anxiety, explaining that they had given the name to the model because "she looks as though a strong gale would snap her in two and smash her to the ground...." (*Vogue* as quoted by Wolf 1990 : 151). In the following years,

the ideal body form shifted to a preference of extreme thinness in women. Data from magazine centrefolds and Miss America Pageant contestants reveal a significant trend towards a thinner standard (Garfinkel and Garner 1980 : 648).

The Western trend for thinness as well as consumerism cannot escape one's notice. In societies where poverty is rife, obesity is regarded as a sign of wealth and privilege. To be thin means to be thin and lowly (Dally *et al.* 1979 : 25). The Second World War was a turning point in Europe. It then became fashionable for women of all classes to aim at slimness (Dally *et al.* 1979 : 25). However, Furnham and Alibhai (1983 : 829) are of the opinion that the apparent shift in idealized female body shape took place only in the sixties. They further note that the awareness of the danger of being overweight and therefore unhealthy has been primarily responsible for this shift (Furnham and Alibhai 1983 : 829). Furthermore, the sixties were also responsible for women's encountering a new set of pressures, demanding an orientation towards achievement, competitiveness and independence, a set of values that conflicted sharply with the traditional Western definition of the female role (Gordon 1990 : 52). In Britain, slimness has been equated with self-control, elegance, social attractiveness and youth (Furnham and Alibhai 1983 : 829). Today, the all-consuming drive for thinness in the Western world leaves as many as 60 to 80 percent of White adolescent females dieting at any given time (Parker *et al.* 1995 : 103). As a result, many of them find themselves being victims of eating disorders trapped by a vicious circle of starvation, binging and purging.

2.4.2 The rising incidence of anorexia nervosa and bulimia nervosa

In 1963 an American publisher resisted the idea of an English translation of a book by Italian psychiatrist Maria Selvini Palazzoli on the grounds that 'it dealt with a rare disease of interest to too few specialists'. The book is now widely recognized as one of the classic works on anorexia (Gordon 1990 : 34). The first formal documentation of an increase of anorexia nervosa did not appear until the 1970s, when a Swedish psychiatrist, Sten Theander, made known his findings. Theander surveyed the archives of all departments, medical as well as psychiatric, of the two major university hospitals in an area of southern Sweden over the period 1930 to 1960. From these records, he unearthed 11 cases of anorexia nervosa in the first decade of the study, 25 in the

second and 58 in the last: there was virtually a fivefold increase in incidence over the three decades (Gordon 1990 : 34).

Van den Heuvel and Hutschemaekers (as quoted by Van t'Hof 1994 : 111) studied the case registers of nine hospitals and clinics in the Netherlands during the period 1900 – 1985. Until 1935, no diagnoses of anorexia nervosa were encountered. From then on, however, the frequency of diagnoses increased significantly up to 1985. Yet another study highlighting the increase of anorexia nervosa was conducted by Lucas *et al.* (as quoted by Van t'Hof 1994 : 111). Conducted in the area of Rochester, Minnesota, USA, the study focused on the period 1935 – 1979, finding that the rates in anorexia had increased from 13.7 per 100,000 in the earlier years to 48.6 per 100,000 between 1965 – 1979. In Switzerland from 1956 to 1958, the number of new cases of anorexia nervosa under treatment among females between the ages of 12 and 25 was 3.98 per 100,000. This figure increased to 16.76 per 100,000 during the 1973 – 1975 period – a fourfold increase (Barlow and Durand 1995 : 299).

Even more dramatic evidence of the current epidemic is present for bulimia nervosa. At a major eating disorder centre in Canada the referral rates for anorexia rose slowly, but there was a dramatic and remarkable increase in the rates of referral for bulimia – from virtually none in 1975 to 140 in 1986. This rapid increase in numbers of cases actually led to the identification of a separate group of disorders in the DSM-IV (Barlow and Durand 1995 : 299). According to Gordon (1990 : 41) the first epidemiological survey of bulimic symptoms, carried out at the State University of New York in 1981, revealed that fully 13 percent of a group of summer-school registrants met all the DSM-III criteria for bulimia. Thereafter, much research was conducted on college campuses and most of these surveys suggest a prevalence of bulimia for this at-risk population of between 10 to 20 percent (Gordon 1990 : 42). Today, it is still suggested that college students comprise the greatest number of bulimics in the Western world. Heesacker *et al.* (2000 : 572) suggest that disordered eating is the rule rather than the exception among these women. Raudenbush and Zellner (1997 : 95) and Tsai *et al.* (1998 : 163) state that about 40 percent of college women intentionally vomit to control their weight, with 88 percent of these women being reported as wanting to be thinner. Mintz and Betz (as quoted by Kirk *et al.* 2001 : 123) reported that between 15 – 62 percent of college women seem to have

pathogenic weight control behaviours, meaning that various harsh methods of weight loss, including self-induced vomiting, use of laxatives, diuretics and diet pills and excessive exercise are used. The *Harvard Mental Health Letter* (2002 : 1) states that at present, about 3 percent of women have suffered from bulimia or a binge eating disorder at some time. In addition, more than two-thirds of college women indulge in an eating binge at least once a year, and more than 15 percent have deliberately induced vomiting or used laxatives afterwards.

One of the only prevalence studies carried out in South Africa which attempted to establish the incidence of anorexia nervosa among Johannesburg schoolgirls was undertaken by Ballot *et al.* (1981 : 993). This research indicates that 2.9 percent of the girls were more than 20 percent underweight. Ballot *et al.* (1981 : 993) suggest a prevalence rate of anorexia nervosa in South Africa of nearly 3 in every batch of 100 schoolgirls studied. Shefer (1986 : 19) however, criticises this research on the grounds that only the weights of the girls were used as a criterion for diagnosis. As such, their findings cannot be seen as representing a prevalence rate of anorexia nervosa, but only a 20 percent underweight figure for schoolgirls, because the DSM-IV diagnostic criterion for anorexia nervosa includes more than weight loss.

In an extensive overview on the prevalence of eating disorders, Killian (1994 : 312) suggests that estimates for anorexia range from less than 1 percent to 3 percent of adolescent females. Hsu (as quoted by Lee 1998 : 128) estimates a lifetime incidence of anorexia nervosa at around 0.1 to 0.3 percent (100 – 300 per 100.000) of Western women, while Hoek (as quoted by Lee 1998 : 128) put the prevalence rate among young women at 0.28 percent. Using archival data and large scale populations, Killian (1994 : 313) suggests that the lifetime prevalence of anorexia in the United States is in the range of 0.1 to 0.7 percent.

The prevalence of bulimia is more difficult to determine because bulimics, unlike anorexics, typically do not exhibit weight loss, and, very much like anorexics, are highly resistant to seeking help or discussing their problem with a physician. Estimates range from 0.9 percent to 13 percent of adolescent females suffering from bulimia. Hoek (as quoted by Lee 1998 : 128) suggests a lifetime incidence rate of 1 percent. Rand and Kuldau (as quoted by Killian 1994 : 313) using a random sample of 2,115

American adults between the ages of 18 and 30, were able to report a four times higher result with 4.1 percent of the women being bulimic.

2.4.3 Characteristics of the two eating disorders

The terms 'anorexia' and 'bulimia' are used to describe girls' and women's problems with their appetites and bodies, but they actually tend to confuse as much as they clarify. Generally speaking, 'eating disorders' refers to anorexia nervosa and bulimia nervosa (American Psychiatric Association 1994 : 539; Barlow and Durand 1995 : 299; Lelwica 1999 : 16). Obesity is not generally classified as an eating disorder, but there is little doubt that obese people are more vulnerable than more slender people to develop the kind of eating disorders to which this study refers.

a) Anorexia nervosa

It is now a little over a century since Gull (1874) and Lasègue (1873) identified the disorder known as *anorexia nervosa*. Their strikingly similar descriptions drew the attention of the medical world to this still baffling disorder, but it is likely that the earliest systematic identification was offered by Morton in 1694 under the title of "a nervous consumption" (Button 1993 : 4). Gull's term has so far stood the test of time. In English usage, the term *anorexia nervosa* indicates "a nervous lack of appetite" (*South African Oxford Dictionary* 1994 : 32). The Greek prefix "an" signifies being without, and the second part of the word, "orexia" indicates desire for food. This precise derivation of the name *anorexia nervosa* suggests that those who develop this distressing complaint have in fact lost their appetite and therefore do not eat because they find food of any kind to be unattractive or unappealing (Welbourne and Purgold 1984 : 3). In this context, however, *anorexia* is a misnomer since it is known that in the early stages at least, patients do suffer from hunger although they try to suppress and deny it. Most patients report normal awareness of hunger but express terror at giving in to the impulse to eat (Garfinkel and Garner 1982 : 5). Later however, as a state of biological starvation sets in, hunger does diminish (DiNicola 1990a : 170). According to Welbourne and Purgold (1984 : 3), however, people who develop anorexia nervosa are conscious of having a strong (sometimes an almost

overwhelming) interest in food. They feel that their appetite is too powerful and therefore it must be curbed at all costs. The control they exert is severe. For the anorexic *fat is bad* and this preoccupation with weight control and the constant all pervasive fear of weight gain is the single most important characteristic symptom of anorexia nervosa (Welbourne and Purgold 1984 : 4). In the modern French and Italian medical literature the disorder is called "mental anorexia". A translation of the Chinese term reads "disease of being fed up with eating", another misnomer. The German term "Pupertätsmagersucht" or "pubertal addiction to thinness" is more consistent with current theories. Perhaps "selfstarvation" is the simplest, most descriptive and accurate term (DiNicola 1990a : 170).

In addition to the inappropriate meanings the diseases were given, neither *bulimia* nor *anorexia* etymologically conveys the intense body dissatisfaction that accompanies women's eating problems. Both of these terms originated in psychiatric discourse (Lelwica 1999: 16). This means, that these problems are viewed through a medical or disease model, which sees them as individual "pathologies", ignoring the cultural values and social conditions that encourage and reward women's obsession with their bodies. Even though these terms have become part of our daily vocabulary during the past decades, they can be stigmatising (Lelwica 1999 : 16).

Eating can be disordered in a number of different ways. Many illnesses, other than eating disorders, lead to a reduction in eating and some can lead to overeating. Conversely, it is often argued that eating can affect our physical health. This, for example, becomes evident in the occurrence of heart disease. Further, depression and anxiety are also often related to a loss of appetite, as both are psychological factors influencing the intake of food. Children, in particular, are prone to use food as a weapon to control their parents (Button 1993 : 3) Thus, the term "eating disorder" has come to have a relatively narrowly defined meaning, particularly in the area of mental health. As mentioned above, it seems to be quite troublesome to define the concepts anorexia and bulimia nervosa. Still, a precise and descriptive definition is needed in order to classify and diagnose people suffering from these diseases. The "*Diagnostic and Statistical Manual of Mental Disorders*" (DSM-IV) is the most influential and widest accepted manual defining the concepts of

anorexia nervosa and bulimia nervosa. The most recent diagnostic definition[1] of anorexia nervosa by the American Psychiatric Association (1994 : 544 – 545), lists the following criteria: a) refusal to maintain body weight at or above a minimally normal weight for age and height; b) intense fear of gaining weight or becoming fat, even though underweight; c) disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape in self-evaluation, or denial of the seriousness of the current low body weight; and d) in postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles.

Although these criteria are widely applied in the research literature, none are without problems. The clarity of these diagnostic "essences" is blurred when one considers that a minimum normal weight is always relative; the intensity of fear of fatness difficult to measure, and that the experience of a person's body weight or shape poses a problem in capturing. Most females in the United States are afraid of gaining weight, many of them (including those who are underweight) overestimate their body size and "normal body weight" varies among girls and women, depending on their social circumstances and physical histories (Lelwica 1999 : 17). Body image, according to Sloan (www.ohioline.ag.ohio-state.edu), can be defined as how we perceive our physical appearance, as well as how we think others perceive us. How we perceive and relate to our physical aesthetics or body image is influenced by cultural and social factors. These are what others say about us, the environment in which we grew up and the timing of certain events in our lives. In addition, cultural ideas of what is desirable and attractive have important implications in the development of our body image. Therefore, a disturbed perception of body image may not be prominent among non-Western anorexic patients and the expressed motivation for food restriction may not be to lose weight. Lee *et al.* (as quoted by Lake *et al.* 2000 : 84) note that this characteristic may be undetectable or absent in Hong Kong anorexic patients, suggesting that the DSM-IV should delete this criterion from its manual.

In the tradition of modern science, the standard diagnostic criteria are meant to function as objective norms rather than value-laden interpretations that are

[1] The complete definition of anorexia nervosa and bulimia nervosa as stated in the DSM-IV (American Psychiatric Association 1994) are given in Chapter 1, paragraph 1.5.

historically conditioned. Moreover, in the name of scientific "objectivity", the voices of those who suffer from these problems are excluded from the knowledge making process of categorization (Lelwica 1999 : 18). Further, despite the wide recognition that culture is involved in contemporary anorexia nervosa, the DSM definition does not include the fact that cultural and social factors do not only influence the frequency of a disease but also the illnesses themselves. As construed by Kleinman (as quoted by Banks 1992 : 868), illness is created by personal, social, and cultural reactions to malfunctioning biological or psychological processes and can only be understood within defined contexts of meaning and social relationships. In today's research literature it is widely accepted that socio-cultural factors play a big role in the production of eating disorders and that treatment without the consideration of these factors is almost impossible (Banks 1992 : 872; Furnham and Alibhai 1983 : 829; Garfinkel and Garner 1982 : 100 – 186; Haworth-Hoeppner 2000 : 212; Lee 1998 : 131; Stierlin and Weber 1989 : 2; Swartz 1985 : 725). Given the great uniformity of leading researchers in recognizing individual as well as socio-cultural factors as highly influential in the aetiology of eating disorders, the standard diagnostic criteria for eating problems can be seen as exceedingly narrow. This narrow rigidity of standard criteria creates an either/or approach to eating disorders: either she has an eating disorder or she has not. This erases the variations in degrees, forms and functions of food and body obsessions among girls and women from different generational, economic, religious, sexual and ethnic backgrounds (Lelwica 1999 : 18). The feminist therapists Brown and Jaspers (1993 : 54) advise: "We cannot stigmatise anorexia and bulimia as individual pathologies or diseases, at the same time that we approve, even praise, the behaviour of those women who exercise and diet to attain the culturally prescribed body ideal. The tendency to separate the social obsession with thinness from anorexia and bulimia allows the latter to be treated as individual problems and isolated diseases, disconnected from popular culture and patriarchal society."

b) Bulimia nervosa

Bulimia nervosa is also characterised by severe disturbances in eating behaviour as well as an overwhelming, all-compassing drive to be thin. The relationship

between anorexia and bulimia is often seen as a source of confusion. Whether these problems are qualitatively distinct or only variants of the same pathology is not entirely clear. In part, the confusion stems from the physical overlap between anorexia and bulimia (Lelwica 1999 : 17). About 50 percent of anorexics become bulimic in the course of their illness, and the same percentage of bulimics have a history of starving themselves, but not to the point of becoming anorexic. Amid this confusion, some have suggested that differences in weight may be the most reliable way to distinguish anorexia and bulimia. Whereas anorexics lose about 20 percent of their original body weight, bulimics tend to remain slightly below or above or even at a weight that is deemed desirable for their height and age (Garfinkel and Garner 1985 : 513, 541). Peter Slade, a clinical psychologist who did a great deal of work with sufferers from anorexia, describes bulimics as anorexics who do not succeed in restricting their eating. He calls them "failed starvers" – people who are helplessly entrapped in the binge-vomit or binge-purge cycle and who are not successful in achieving weight loss (Welbourne and Purgold 1984 : 6).

The word *bulimia* derives from the Greek "bous", meaning ox, and "limos", meaning hunger (*South African Oxford Dictionary* 1994 : 114). Despite the bulimics' 'hunger like an ox', sufferers from the disease are unlikely to stand out in a crowd. Bulimics are mostly average in weight and do not look ill. Feelings of guilt and disgust at their behaviour lead them to be secretive (Button 1993 : 8). Russell, who established the distinction between anorexia nervosa and bulimia nervosa in 1979, describes the criteria for bulimia as powerful and intractable urges to overeat; the avoidance of the fattening effects of food by inducing vomiting and/or abusing purgatives, and a morbid fear of becoming fat (Button 1993 : 9).

The current clinical and research criteria for bulimia nervosa as stated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) (American Psychiatric Association 1994 : 549 – 550) include the following: a) recurrent episodes of binge eating which are characterised by eating, in a discrete period of time an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances and a sense of lack of

control over eating during the episode; b) recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medication as well as fasting and excessive exercise; c) self-evaluation is unduly influenced by body shape and weight; and d) the disturbance does not occur exclusively during episodes of anorexia nervosa.

The official DSM-IV criteria for diagnosing bulimia have similar problems, as do those with anorexia. The criteria of the so-called "inappropriate behaviour to prevent weight gain" become fuzzy when one recognizes that many "normal" girls and women in the Western world measure their self-worth on the bathroom scales and that a number of them regularly "compensate" for overeating through restrictive dieting and excessive exercise. These methods of weight control, though, have been deemed "healthy" by mainstream fitness and diet industries (Lelwica 1999 : 17).

Diagnostic definitions are of importance for the purpose of scientific clarity, but they do not really communicate how the symptoms of disordered eating are really experienced. For this, I quote the following graphic description of a bulimic episode:

"I would go out ... to the supermarket down the block and buy a gallon, or maybe even two gallons of maple walnut ice cream and a couple of packages of fudge-brownie mix. ... On the way home, the urge to binge would get stronger and stronger. ...There was a doughnut shop that I passed on the way home. ...I'd stop the car, buy a dozen doughnuts and start munching on them even before I was walking out the door. On the way home I invariably finished all twelve doughnuts. ... I'd hurry up to the apartment ... mix up the brownie mix. ... Then, while they were cooking, I ate the ice-cream. ... Sometimes I'd finish the whole gallon even before the brownies were done. ... I'd take the brownies out of the oven. ... I'd start eating the brownies. Pretty soon, I'd have put away about fifteen or twenty of the brownies, and then I'd be overcome with embarrassment. What if one of my roommates were to get home and see that I had twenty brownies! The only way to disguise it was to finish the other fifty-two brownies myself, wash the pan, and

clean everything up. ... Seventy-two brownies later, the depression hit. I'd go to the bathroom, stick my finger down my throat, and make myself throw up. I was so good at it, it was almost automatic – no effort necessary, just instant vomiting, over and over until there was nothing coming out of my stomach except clear pale-green fluid" (Crisp and Kalucy 1974 : 358).

2.4.4 Epidemiology and occurrence

Epidemiological research conducted on anorexia nervosa and bulimia nervosa suggests that both eating disorders occur in persons of a particular age, gender and, according to some researchers (Crowther *et al.* 1992 : 17; Garfinkel and Garner 1982 : 100; Gordon 1990 : 40 – 49), even within a particular social class. This, and the fact that eating disorders occur predominately in Western cultures, highlights that socio-cultural factors may be important determinants of the disorder in those who are vulnerable or predisposed to it.

2.4.4.1 Female prevalence

Gordon (1990 : 32) argues that "if there is any one fact that would evoke nearly universal agreement, it is that the overwhelming number of people who develop eating disorders are female". This association between being anorexic and being female extends back to the nineteenth-century history of anorexia (all of Gull and Lasègue's patients were female, for example). Contemporary studies tell us with almost near uniformity that the ratio of female to male anorexics (and bulimics) is at least 9.1 to 1 (Bruch 1973 : 287; Button 1993 : 13; Szmukler *et al.* 1995 : 181), and some suggest that it is far higher than this (Crosscope-Happel *et al.* 2000 : 365; Dally and Gomez 1980 : 98; Gordon 1990 : 32). The extremely skewed sexual incidence of anorexia nervosa and bulimia is widely acknowledged and reflected by a growing number of studies from different locations in the Western world.

Along with the high female prevalence, it is also important to note that clinicians who treated males as long ago as the seventeenth century (Bruch 1973 : 285; Dally and Gomez 1980 : 98) consistently noted that similarities outweigh differences in the symptomatology, course, and outcome of these illnesses, and that there are no

observable gender-dependent differences in the clinical presentation, epidemiology, endocrinology, or psychometric profile of these patients (Eliot and Baker 2001 : 535). In their study of a group of 40 adolescent males with anorexia and bulimia, the findings were consistent with Burns, and Crisp's conclusion that the course and outcome of the illness are remarkably similar between the sexes (Eliot and Baker 2001: 535 – 544). Nonetheless, Anderson (1990 : 147) is of the opinion that there is a great opportunity for diagnostic error in males. The reason therefore lies within the assumption that males may express conflicts regarding body image in ways which differ from those of females. They tend to diet more defensively in sports which demand weight control, or when other male family members have been warned about the medical consequences of obesity or illness (Anderson 1990 : 147). In 1992, Anderson (as quoted by Crosscope-Happel *et al.* 2000 : 366) reports further, that he doubts that there is a close connection between the eating disorders and the sexes because the individual life story behind each patient unfolds to reveal differences in predisposition, course and onset. Furthermore, females diet because they feel fat, whereas males diet because they have been overweight at some point in their lives (Anderson as quoted by Crosscope-Happel *et al.* 2000 : 366).

A further aspect of discussion among eating disorder specialists is the rarity of eating disorders in males. Giannini and Slaby (1993 : 134) explain this as a protective factor afforded by maleness itself. Boys reach puberty later than girls and are therefore granted more time to adjust emotionally to the biological, psychological and social vicissitudes of puberty. Another partial protective factor for males is that society does not place upon them the same pressing ultimatum to be thin (Giannini and Slaby 1993 : 134). Rather society emphasizes masculinity, which is translated into aggressiveness and an analogously strong, muscular and well-built body (Dally *et al.* 1979 : 145; Giannini and Slaby 1993 : 134). Furthermore, the female figure changes during puberty in such a way that the girl cannot help but be aware of her body. Growing breasts, enlarged hips and a more rounded female body shape do not conform to the Western standards of slimness. The media has taught us that the preferred ideal of a female body is comprised exclusively of skin and bones and that the once voluptuous, curved female shape is not acceptable today.

2.4.4.2 Age of onset and social class

Another point on which most scientists agree is the age of onset of anorexia nervosa as well as bulimia nervosa. According to eating disorder experts Garfinkel and Garner (1982 : 103), the bimodal risk age for the onset of an eating disorder is 14 and 18 respectively, making it a disorder occurring mostly in adolescence. Szmukler *et al.* (1995 : 181) confirm this statement: "Clinical and register-based studies suggest that these disorders reach a peak age of onset in mid to late adolescence". Underlining this argument, Banks (1992 : 872) reasons that anorexia nervosa is caused by the demands of an aesthetic ideal that stresses youth and androgyny rather than the mature female body. Girls in the North American culture commonly believe that thin is beautiful as early as age seven – or even younger. Even though some of these girls do not act according to this ideal, there seems to be a gradual shift of young children believing that being thin is a cultural norm in need of being obeyed.

At this stage it has to be indicated that it is widely accepted that adolescence can be regarded as that time in a girl's life, where she is especially vulnerable to external influences like the ideal of being slim. It seems that in the last decades, especially peers and boyfriends more often choose the girl's physical appearance as indicator for acceptance, and as a result social relationships are regarded as successful only if the girl conforms to these group pressures. This vulnerability experienced by many in their teenage years might lead to the negative evaluation of one's own body, and the desires to change the given physique.

Although the relationship between eating disorders and age and gender is clear-cut, the discussion on whether an association with socio-economic class exists in respect of the aetiology of eating disorders, is still going on. Anorexia nervosa was traditionally thought of as a disorder of the affluent – a "rich girl" syndrome. However, as the incidence of anorexia nervosa increased, it became apparent that class distribution was actually not as skewed as it was thought to be, with an increasing number coming from the middle and lower-middle classes (Gordon 1990 : 44 – 45). Szmukler *et al.* (1995 : 181 –182) also suggest that there is little evidence of an association only with the upper social class. In the case of bulimia, however, Gordon (1990 : 45) mentions a substantial prevalence of bulimic disorders among career women, particularly those in

high-status occupations or competitive professional settings. Lelwica (1999 : 20) is of the opinion that exactly the opposite is true, arguing that while anorexic girls and women are more likely to come from a smaller, affluent slice of society, bulimics tend to be socially more diverse. On the other hand, Barlow and Durand (1995 : 300), authors of the psychology book *Abnormal Psychology*, introduce their chapter on eating disorders with the statement: "Over 90 percent of the cases of severe eating disorders are found in young, white females of upper socio-economic status who are living in a competitive environment". In Gard and Freeman's article, *The Dismantling of a Myth: A Review of Eating Disorders and Socioeconomic Status* (1996 : 1), the most important articles written between the early 1970s and the early 1990s which include assessment of socio-economic status, are reviewed, and the evidence for and against the stereotype is examined. It was found that the majority of existing research fails to support the traditional view of a preponderance of eating disorder cases in upper socio-economic groups. Gard and Freeman (1996 : 1) suggest further that the relationship between anorexia nervosa and upper socio-economic status is not proven, and that increasing evidence shows a relationship between bulimia nervosa and lower socio-economic groups. Thus, the traditional association between eating disorders and a higher socio-economic status has at best yet to be demonstrated, and at worst, represents information created by clinical and empirical processes.

2.4.4.3 The association between anorexia, bulimia and non-Western cultures

It is clear now that most research on eating disorders suggests that cultural pressures on women to be thin may have a causal role in the manifestation of anorexia nervosa and bulimia nervosa (Barlow and Durand 1995 : 300; Bruch 1973 : 9; Garfinkel and Garner 1982 : 100; Gordon 1990 : 32; Lelwica 1999 : 12; Szmukler *et al.* 1995 : 177) However, if socio-cultural factors actually influence disordered eating, cultures without an emphasis on thinness should show less disordered eating. For example, disordered eating patterns should differ in non-Western cultures because they often hold standards of beauty that do not emphasise thinness. In fact, according to Heesacker *et al.* (2000 : 573), plumpness is considered attractive in much of the non-Western world and obesity is sometimes even considered to be a secondary sexual characteristic. The impression of psychiatrists and other health workers in non-Western, non-industrialised countries is that anorexia nervosa and bulimia nervosa are

rare, and when they are found, they occur in the westernised segment of the population (Szmukler *et al.* 1995 : 186).

Furnham and Alibhai (1983 : 829) investigated how Kenyan Asian, British and Kenyan British females perceived body shapes. The Kenyans rated larger figures more favourably and smaller figures less favourably than did the British. The researchers' results stated that social and cultural factors play a dominant role in the perception of one's own and others' body shape. In addition, according to the researchers (Furnham and Alibhai 1983 : 829), the results revealed that in Britain preferences for small body shapes to the point of being anorexic are not uncommon.

Due to the heightened degree of globalisation in most non-Western countries, however, recent research mainly focuses on the exposure to Westernisation as a significant predicting factor in the production of eating disorders. Geller and Thomas (1999 : 279) reviewed the existing literature concerning the prevalence of eating disorders in non-Western countries as well as among ethnic minorities in the West. They conclude that in many non-Western countries traditional beliefs and concepts of beauty exclude thinness as being socially desirable. Heavier figures are seen as more beautiful and are often considered a sign of womanhood, health, fertility, motherhood and success. These countries report an absence of eating disorders. DiNicola (1990b : 258 – 260) reported similar results when summarising findings from different continents where studies were undertaken in order to gain deeper insight into the prevalence of anorexia and bulimia. He concluded that the prevalence of eating disorders appears to be almost non-existent in Africa, Asia and the Middle East. However, Geller and Thomas (1999 : 279) indicated that in countries with rapid economic, social and political changes, like South Africa, the United Arab Emirates and India, an increase in eating disorders has been reported. Another study showing the negative effect that Western culture has on ethnic minorities as they acculturate, is presented by Osvold and Sodowsky (1993 : 150). They reflect on a study by Nasser, who compared the incidence of bulimia between two similar groups of Arab undergraduate female students. The one group attended a university in Cairo whereas the other group attended a university in London. Bulimia occurred among the Arab women in London, whereas no women met the criteria in Cairo. The London Arab students were similar to European students in dress

and level of Westernisation, whereas the Arab students in Cairo were more traditional in their dress and lifestyles.

A similar example from an acculturative context was found in the United States. In this case the author (Bulik 1987) focuses more specifically on *how* the change in attitude could occur. It is widely accepted that women in Western countries encounter daily messages about food, body weight, and the ideal image of beauty as a very slim, toned woman. Urged to purchase and eat the many convenient foods so easily available, women in these countries simultaneously receive contrary messages to obtain and maintain a very slender body size through whatever means necessary. One study of is worth mentioning here. Bulik (1987 : 138), who studied two Eastern European immigrants in the United States, stated that these two young women, having shown no signs of eating disorders previously, developed bulimia and anorexia nervosa within two years of their arrival in the United States. Both women were aware of the "double message" they saw in advertising, where very thin women were shown consuming high caloric food. Eventually, both women became aware of the value placed upon being able to control one's weight in America. Their self-worth was measured on the basis of their bodies and the ability to control their appetites.

After having addressed the socio-cultural side of eating disorders, this study, in order to be complete and holistic, has to focus further on other approaches to the aetiology of eating disorders.

2.4.5 Approaches to eating disorders

Scientists specialising in eating disorders represent different views (models) in explaining the causes of anorexia nervosa and bulimia nervosa. Even though there is said to be an overlap among the different approaches and many experts talk about acknowledging the multidimensional nature of eating disorders, a high level of specialisation among professionals makes dialogue across disciplinary boundaries difficult at best (Lelwica 1999 : 22). In addition to the above-mentioned socio-cultural model to eating disorders, four approaches can be determined: The biomedical, psychological, feminist and multiple-determination approach.

2.4.5.1 Biomedical model

Since the discovery of anorexia nervosa in the 1870s, great effort has been devoted to the search for biological factors that may play a role in its aetiology (Gordon 1990 : 19). Biomedical perspectives see eating disorders as rooted in physical, rather than mental, disturbances. In this view, anorexia and bulimia are involuntary illnesses, not consciously chosen (Lelwica 1999 : 23). This was the first perspective to become systematically adopted and it follows the tradition that Gull established in locating physiological causes of the illness (Gremillion 1992 : 60).

The physical complications accompanying anorexia and bulimia (e.g. electrolyte disturbances, cardiac irregularities, kidney dysfunctions, endocrinological imbalances, dental deterioration) make the biological aspects of the problems hard to ignore (Lelwica 1999 : 23). Even though most scientists viewed the physiological imbalances as central to these illnesses, there always was – and still is today – great disagreement as to whether these aberrations are genetic or neurobiological. Scientists focusing on the genetic predisposition argue that eating disorders run in families and that relatives of patients are four to five times more likely than the general population to develop an eating disorder themselves (Strober and Humphrey as quoted by Barlow and Durand 1995 : 318). While mother-child concordance for anorexia nervosa is quite rare, the occurrence of multiple cases in a single family is not (Garfinkel and Garner 1982 : 170). Garfinkel and Garner (1982 : 170) quoted Hall and Thöma, who respectively reported 2 out of 50 patients and 2 out of 30 patients having sisters with anorexia respectively. However, this representation of anorexia in siblings does not imply a genetic predisposition but rather a common environmental pathogenesis (Garfinkel and Garner 1982 : 171).

The second group of scientists in favour of a biological predisposition to eating disorders focus on neurobiological factors. Here, the hypothalamus dysfunction is the most popular contemporary hypothesis (Barber 1996 : 303; Barlow and Durand 1995 : 319; Gremillion 1992 : 60, Lelwica 1999 : 24). Scientists agree that the hypothalamus is that part of the brain that regulates hunger, thirst, body temperature, and so forth (*South African Oxford Dictionary* 1994 : 459). However, their opinions differ when it comes to the role the hypothalamus plays in the production of eating disorders.

Norepinephrine was suggested to decrease eating if present in some part of the hypothalamus, therefore possibly leading to the development of anorexia nervosa (Barlow and Durand 1995 : 319). On the other hand, bulimia especially has been linked to hypothalamus related dysfunctions in connection with serotonin, a neurotransmitter that contributes to the regulation of satiety (Barlow and Durand 1995 : 319; Lelwica 1999 : 24) Cravings seem to be triggered by low levels of brain serotonin and bingeing seems to increase the amount of serotonin in the brain. Endogenous opioid peptides also seem to be related to food intake. Some researchers speculate that individuals with eating disorders become "addicted" to the release of these opiates in their bodies during dietary restriction, and thus they maintain their cycles of starvation, alternating with bingeing, since these cycles continually stimulate the production of the opiates (Barlow and Durand 1995 : 319).

A detailed review of these findings could easily fill an entire chapter, but amid the great number of sophisticated research methodologies (Gordon 1990 : 20), one crucial fact, confirmed by most eating disorder scientists (Barlow and Durand 1995 : 319; DiNicola 1990a : 182; Gordon 1990 : 20; Lelwica 1999 : 25), stands out: the various physiological impairments for the most part return to normal levels when weight and nutrition have been restored. Therefore, biomedical models become implausible to the extent that they view physical aberrations as causes rather than components of eating problems (Barlow and Durand 1995 : 319; Lelwica 1999 : 25). Furthermore, the biomedical hypothesis cannot explain why both disorders affect selected groups (young female women) and why their incidence is dramatically increasing (DiNicola 1990a : 182; Gordon 1990 : 21). It seems as if the biomedical theories tend to ignore the ways by which physical processes are influenced both by socio-cultural as well as by individual factors.

2.4.5.2 Psychological model

Some of the most popular approaches to eating disorders share a common view that both anorexia and bulimia are disturbances in psychological development and functioning (Lelwica 1999 : 22). Most of the psychological approaches fall under one of three interpretive models: psychoanalytical, family systems, or cognitive-behavioural.

The psychoanalytic model builds on the Freudian "depth psychology", where human illnesses are seen as purely mental, deeply internal, intra-psychic phenomena, retained by the passivity of the individual (Gremillion 1992 : 61). According to Gremillion (1992 : 61), the classic psychoanalytic formulation for anorexia and bulimia is that of oral ambivalence, with food refusal being a defence against the fantasy of oral impregnation, the desire for which may be expressed by periodic gorging – followed by guilt, disgust, and a purification rite such as vomiting. The publication of Hilde Bruch's groundbreaking book on eating disorders in 1973 signalled a major breakthrough in psychoanalytical theory and practice, moving away from Freud's theory of the problematic female who generates fantasized problems onto her body. However, Bruch (1973 : 276 – 277), like Sigmund Freud, focuses on the age of onset (which is mostly in adolescence) as the key to understanding eating problems: the desire to keep a childlike body signifies the female's fear of the demands of adult female sexuality. Freud's belief that troubled eating expressed underlying sexual disturbances was not supported by Bruch (Lelwica 1999 : 22). Rather, she insisted that sexuality is only one aspect of a patient's life and that anorexia nervosa had to be understood in terms of the development of the total personality (Bruch 1973 : 63; 215). Often, a desire for control in addition to a feeling of ineffectiveness, as well as a fear of ordinariness (despite their usual high intelligence and high achievement orientation (Lelwica 1999 : 22)) are noted as fundamental problems within starving anorexics. Self-devaluation therefore, is seen as the essence of the illness and the key to getting better is the acceptance of the genuine self. Thus, in the spirit of Freud, Bruch (1973 : 334) upheld the psychoanalytic method of treatment by using, as Lelwica (1999 : 22) terms it, the "talking cure".

The core of the psychoanalytic model, which focuses on adolescent development and identity formation, is also incorporated into the second psychological model, the family system approach. Here, eating disorders are seen as family pathologies, rooted in familial dynamics that impede a young woman's growth as an individual (Lelwica 1999 : 22). Which role the family plays in the development of eating disorders is far from clear. Most psychologists agree however, that eating disordered patients come from a psychosomatic family, which is characterised by enmeshment, over-protectiveness, rigidity and lack of conflict resolution, with an additional pattern of dysfunction (Bailey 1991 : 252; DiNicola 1990a :184; Wallin and Hansson 1999 : 29).

High achievement as well as perfectionism has high priority with most of the families in anorexic or bulimic daughters. Frequently, the mother, rather than the father, is implicated in the child's failure to develop into a healthy and stable adolescent. Mothers of eating disturbed children are often viewed as frustrated, depressed, perfectionistic and passive (Bruch 1973 : 82; Lelwica 1999 : 22). Bruch (1973 : 82) notes that fathers are often enormously preoccupied with outer appearances, admiring fitness and beauty. It is no surprise that family therapy is the centrepiece of treatment in this model (Lelwica 1999 : 23).

Cognitive-behavioural therapy presents a third psychological model. This approach focuses on the eating disordered person's mind, taking it as a blank slate. The mind is considered to be little more than a privatised, internal "processing centre" of external input and internal output. Therefore, the environment completely structures the patient's reality, and the psychologist restructures that reality (Gremillion 1992 : 62). This model therefore seems to be related to the socio-cultural model of eating disorders because both approaches see the environment (a person's culture) as the primary trigger of anorexia and bulimia.

Within the psychological approaches, two further subjects of interest could be found. Some psychologists consider the study of the personality of individuals as a key to understanding and treating eating disorders. Depression is another mental state, which, according to some psychologists, could have a connection with eating disorders. Many psychologists and eating disorder specialists (Ashby and Kotman 1998 : 261; Button 1993 : 16 – 17; Garfinkel and Garner 1982 : 199 – 200; Podar *et al.* 1999 : 133; Pryor and Wiederman 1996 : 414; Segall 2001 : 22; Van der Ham *et al.* 1998 : 79) are of the opinion that certain personality traits might be typical for anorexic and bulimic women. Broadly speaking, in the case of the anorexic, predictive phenomena such as emotional over-control, conceptual rigidity and a lack of development of the self, as well as a great need of approval from others, conformity, conscientiousness, and a lack of responsiveness to inner needs have been described (Button 1993 : 16; Garfinkel and Garner 1982 : 200). Clinical descriptions typically portray the anorexic as being inclined towards over-compliance and perfectionism. In fact, the perfectionist trait in girls with anorexia nervosa is identified by many authors writing on eating disorders (Ashby and Kottman 1998 : 269; Button 1993 : 16; Segall 2001 : 22). Ashby and

Kottman's (1998 : 269) research on perfectionism found that girls with eating disorders may be more perfectionistic in maladaptive ways, meaning that they show tendencies of an overconcern about mistakes, and anxiety about performance and procrastination.

Personality characteristics of women suffering from bulimia nervosa are often described as more social, impulsive and affectively liable (Pryor and Wiederman 1996 : 414 – 415). Podar *et al.* (1999 : 134), argue that bulimic patients are, in addition to being in general distress, unable to control their cravings and urges. Additional sources of feelings like fear, anger, guilt and disgust are often mentioned as well.

Further, some scientists argue that eating disorders are linked to affective disorders like depression (DiNicola 1990a : 182; Lelwica 1999 : 24). Patients suffering from anorexia nervosa and/or bulimia nervosa often come from families in which depression is common, and a third of those suffering from an eating disorder have themselves experienced an episode of depression before the onset of the disease. This has led to the suggestion that an inherited tendency to depression raises the risk of someone developing an eating disorder (Barber 1996 : 302). However, one could just as easily explain this phenomenon in other psychological terms. Having a depressed parent might produce circumstances which raise the chances of low self-esteem, which then might make the person more vulnerable to the development of an eating disorder (Cooper 1993 : 14).

2.4.5.3 Feminist approach

Feminist theorists have recognised the body as an important site of women's oppression at an early stage in the development of Feminism (Shefer 1986 : 88). Therefore, their primary focus on the female body makes their approach a very important one when considering the nature of eating problems. It has to be mentioned that Feminism does not comprise a homogenous group of theories. There are a number of different theoretical perspectives in feminist literature, some of them pointing in very different directions.

Feminist theorists indicate different possible causes when trying to establish the aetiology of eating disorders. Two major causes identified throughout feminist writings are the visual representations of women in the media and advertising and female oppression in a male dominated society.

a) Media and advertising

It has often been found that visual imagery is the central area of production of femininity and masculinity, in so far as they perpetuate the emphasis on women's bodies, setting up ideal images for them to conform to. Famous feminist writer Kim Chernin (1981 : 87) argues that "fashion lets us know what our culture expects us to be, or to become, or to struggle to become, in order to be acceptable to it, thereby exercising a devastating power over our lives on a daily basis. The image of women that appears in the advertisement of a daily newspaper has the power to damage a woman's health, destroy her sense of well-being, break her pride in herself, and subvert her ability to accept herself as a woman." Bordo (1993 : 46), who is yet another representative of the feminist approach to eating disorders, states that "the media, Madison Avenue, and the fashion industry typically were collectively constructed as the sole enemy – a whimsical and capricious enemy, capable of indoctrinating and tyrannizing passive and impressionable young girls by means of whatever imagery it arbitrarily decided to promote that season" (Bordo 1993 : 46). For example, the construction of women's attitudes towards food has also received attention. According to Shefer (1986 : 109) many of the attitudes associated with eating disorders, for example guilt about eating, as well as a constant preoccupation with restricting intake, can be traced to the language about food. It is mostly the media which creates feelings of guilt and anxiety associated with eating. "Bad foods" – the ones which are "fattening" and "unhealthy" – are viewed as demons, desired by women but prohibited.

Under influence of the media and advertising industry women are turned and turn themselves into objects of vision (Berger 1973 : 47). In this objectification process, women are the "defined" sex, and a defined sex is a sex controlled (Coward 1984 : 30). Here, the media is attacked for creating images of women

that connote passivity and powerlessness in opposition to male activity and power. As Coward (1984 : 81) puts it: "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." Therefore, male supremacy depends on the ability of men to view women as sexual objects.

The feminist authors suggest that in Western societies, female sexuality is not venerated but rather degraded and objectified. "In fashion and the media, women are repeatedly presented with idealised, objectified, and sexualised images of themselves" (Chernin 1981 : 82). Pornography, according to Chernin (1981 : 82) which can be regarded as degrading sexual violence, is "directed at women with the most splendidly voluptuous female bodies, while patriarchal U.S. media and advertising idealise as beautiful a standard of thinness that for most adult women is inaccessible. An attractive woman with a normally curvaceous body is subject to leers, whistles, come-ons, and vulgar comments from men." Therefore, some women attempt to flee from the objectification and degradation of their sexuality by becoming asexual through excessive thinness.

b) Male domination

The feminist writers have also politicised the body by regarding the emphasis on women's bodies as an integral part of women's general oppression within a male-dominated society. Feminists often see male control over femininity as inherent in patriarchal culture. Men are considered to control and possess women, and especially their sexuality and body, through marriage and in the family. Violence against women, rape and battering have been understood in this context as well, that is, as an extension of the control that men are allowed over women (Shefer 1986 : 94).

The striving towards the ideal image for women and being preoccupied with the body and its appearance are 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 a reproducing power between men and women (Shefer 1986 : 97). This power struggle between men and women is then

often internalised by the female gender, producing a psychological problem women have to face in relation to their appearance and body.

Most feminist writings present the opinion that "the denigration of women's physicality parallels the cultural subordination of their values and ways of being, which extends even to the muting of their voices" (Chernin 1981 : 83). The traditional requirements that woman should be selfless, nurturing, and caring for others (especially for their families) are still expected of them. In addition, new pressures on women to be independent, self-reliant, and successful in the public sphere have arisen (Lelwica 1999 : 26). They are educated to be passive and compliant but find these postures unsuited to success in the workplace.

Not being able to control and comply with the ambiguous demands of society, bulimics and anorexics are turning against societal and familial programs by choosing their own path. Food then becomes the one and only way they can exert control in the world: "When the rest of my life is going out of control I always say to myself, there's one thing I can control: what I put in my mouth" (Orbach 1978 : 26). Control exists through the denial of food; starvation is the channel of achievement. However, food might also be a channel for losing control, for attaining release and response. Bulimics describe almost without exception the oblivion and ecstasy they achieve while bingeing. The feelings of guilt and the shame of overindulging and getting fat are eliminated by getting rid of the "evil" food. As a result, a feeling of great satisfaction as well as relief are often experienced.

Another area of male domination over women is the way in which women experience and present their sexuality and sexual identity. While men may achieve a sense of value as well as self-worth within other social realms of activity, women are taught from an early age that looks and self-worth are interrelated phenomena. According to feminist literature, women are characteristically dissatisfied with their bodies. In the case of anorexics and bulimics it becomes an obsession with size and weight, but also with sexual attraction. According to Bruch (1978 : 73) most anorexics and bulimics feel disgust as well as fear towards sexual contact. Insecurity towards their own

sexuality and unsatisfied longing for sexual intimacy (Orbach 1978 : 60) all contribute to a disturbed feeling about their body. As Boskind-White and White (1983 : 113) argue: "Sexuality is a great wasteland of unfulfilled pleasures, confusion, guilt, fear, and disgust. Through being excessively thin the cultural ideal of 'slim is beautiful' is fulfilled". Moreover, the thinness isolates women from sexual encounters. The excessive pursuit of weight loss results in androgyny: a boyish body without breasts or menstruation, the overt and insistent symbols of femininity (Bruch 1978 : 64 – 65; Orbach 1978 : 169).

2.4.5.4 Multiple-determination approach

There are not many eating disorder specialists who, when researching the nature of anorexia nervosa and bulimia nervosa, acknowledge the multidimensional side of the problem. A possible reason for this could be a high level of specialisation among professionals, which often makes dialogue across disciplinary boundaries difficult at best.

The most common way for scientists to articulate the role of culture within the scope of 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 : 188 – 213) multiple-determination approach to anorexia nervosa. Both eating disorder specialists acknowledge other proposed theories of anorexia nervosa, maintaining that all of them have something to say for a better understanding of the causes of anorexia. However, according to them, the Western culture is one of the strongest determinants of the disorder (Shefer 1986 : 66). To Garfinkel and Garner (1982 : 107), cultural pressures are so important that they even consider the continuum notion that anorexia nervosa is an extreme form of dieting. Nevertheless, after considering the important factors of psychodynamic development and familial influences, they come to the conclusion that even though they "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" (Garfinkel and Garner 1982 : 118). Thus, for the authors there is no single pathogenesis for anorexia nervosa. Further, at the present time there is not much known about the interactions that result in or perpetuate anorexia nervosa (Garfinkel and Garner 1982 : 188). In not being able

to specify one specific trigger of eating disorders, the authors created a scheme in which they grouped different predisposing factors together. They divide the latter into three groups:

- *individual factors*: conflicts around autonomy, identity, separation; perceptual disturbances; weight disturbances; personality development; cognitive processes; perinatal trauma etc.;
- *family determinants*: demographic characteristics (parental age, social class); magnification of the culture (weight, eating, fitness, performance expectations); parental history of illness; genetic components; parent-child interactions;
- *cultural determinants:* pressures for thinness; performance expectations.

In comparison with the other approaches to anorexia nervosa and bulimia nervosa, the multiple-determination theory is important because it acknowledges socio-cultural factors and their possible role in the production of eating disorders. For the 1980s the study of Garfinkel and Garner focuses on a level which other eating disorder specialists have historically ignored in their literature (e.g. Bruch 1973). Even some twenty years later, social scientists (e.g. Lelwica 1999 : 23) still call for a broadened view concerning eating disorders, one in which social conditions and cultural values promoting and rewarding women's self-neglect are not completely ignored. However, the multiple-determination approach may be criticised for its almost too liberal point of view. Shefer (1986 : 68) argues that Garfinkel and Garner lump theories together which are often informed by contradictory metatheoretical assumptions. Therefore, a potential for contradictions within the broad theoretical framework is created. Further, little attempt has been made to develop a theory as to how the cultural determinants of slimness and performance expectations function as triggers in the development of eating disorders. This broad approach could be criticised for perceiving the cultural determinants as merely another level of determination, acting together with familial and individual factors in creating the full-blown syndrome of anorexia nervosa. Thus, the level of the social is largely a descriptive level, meaning that it is assumed to play a role but how it does so is not clarified (Shefer 1986 : 68).

Apart from Garfinkel and Garner (1982), few other researchers of anorexia nervosa and/or bulimia nervosa focus on a multiple-determination approach to eating disorders.

Two further publications in this field are the work by Brumberg (1989) and the contribution by Szmukler *et al.* (1995). Historian and eating disorder specialist Joan Jacobs Brumberg (1989 : 38) argues that if one wants to understand anorexia nervosa more clearly, it is necessary to view the disease as an interactive and evolving process. "I find the model of 'addiction to starvation' particularly compelling because when we think about anorexia nervosa in this way, there is room for incorporating biological, psychological and cultural components". Brumberg (1989 : 38) demonstrates this by indicating that a person might begin to restrict food because of aesthetic and social reasons related to gender, class, age and sense of style. This can then be termed the initial "recruitment" stage. In this stage it is very likely that many of the person's friends may also restrict their food intake because the environment in which they live teaches them that being a fat female is a social and emotional liability. The result is that the individual's dieting moves from normal to obsessional (Brumberg 1989 : 38 – 39). The reason for this happening, according to Brumberg (1989 : 39), is that emotional and personality issues, as well as personal physiology and body chemistry come into play. Food refusal may serve a woman's emotional needs (e.g. seeking attention), and prolonged fasting may then become more and more difficult to back off from. Then, after weeks and months of starvation, the young woman's body and mind "become acclimated to both the feeling of hunger and nutritional deprivation" (Brumberg 1989 : 39). A second stage of the disorder is then reached. Hunger pangs may decrease and the body gets used to the state of starvation – to a negative energy balance. Brumberg (1989 : 39) argues that for some girls, starvation is actually satisfying or tension relieving – "a state analogous perhaps to the well-known 'runner's high'". A shift from chronic dieting to dependence on starvation may now occur because of a physiological substrate as well as emotional and family stresses. According to Brumberg (1989 : 39), this is where the biochemical explanations (elevated cortisol levels in the blood; neuroendocrine abnormalities) come into play.

A more recent model in the multiple-determination approach integrates the psychological understandings with a socio-cultural point of view. This integrated model was developed by Szmukler *et al.* (1995 : 133). They state that the causes of eating disorders lie outside as well as inside the person. The external forces then become incorporated, in some way, into the psychology of the individual. According to Szmukler *et al.* (1995), a person develops an eating disorder when these forces

become internalised. The authors further argue, that the aetiological forces that generate eating disorders engender dramatic differences in the incidence of the disorder between men and women. They explain that in the Western culture, food is available in excessive amounts but some very demanding expectations about body weight and shape – especially for women – influence the way women feel about their bodies.

To illustrate this view, Szmukler *et al.* (1995 : 134) focus on the gender socialisation and the different treatment a newborn baby girl or boy receives. Here the authors combine the psychology of identity formation (anal phase) with a socio-cultural point of view. Not only do the parents socialise their children in a culturally determined way, but also the different phases the child finds itself dealing with are integrated into the developmental process. Szmukler *et al.* (1995 : 134) refer to toilet training that occurs in some cultures and may represent a contest between adults and their offspring as to who is in charge of the activity and personality of the child. Further, in most contemporary Western societies, it is mostly women's duty to raise the children. The baby that becomes a woman has an easier task than does a male. For the girl, however, it is soon apparent that the role she will have to play in life is that of a primary carer, shifting the needs of herself, her interests and loves aside. This is exactly where the problem starts. The girl who becomes an anorexic is not able to cope with the demands made on her. She feels she cannot develop into the person she wants to be but must attend to the expectations and wishes of others. Szmukler *et al.* (1995 : 135) see the intense concern over food intake as a message from the girl to the outside world: "This is an area in which I am in control, which makes me feel I am being myself, by which I can defy the demands of others". On the other hand, and at the same time, the disordered eating behaviour might indicate: "I am only a little child, I cannot live by myself, I have to be looked after, I am not going to take up much space, I do not want to make demands on resources".

In this integrated model by Szmukler *et al.* (1995 : 133 – 138), body shape, gender identity and a psychodynamic formulation are integrated. A biological predisposition to eating disorders is rejected by the authors, whereas the obvious somatic components to starvation are recognised as secondary to the causation of anorexia nervosa and bulimia nervosa.

To sum up, integrative thinking as to what causes eating disorders is necessary for it allows scientists to broaden their view and gain deeper insight into the realm of eating disorders. However, specialisation – whether cultural, psychological or biological – is necessary for an in-depth understanding of the problem.

2.4.6 Eating disorders as culture-bound syndromes

It becomes apparent throughout this research project that the role of culture in the prevention, causation and treatment of anorexia nervosa and bulimia nervosa is of special interest not only to sociologists, but to psychiatrists, psychologists, feminists, historians and anthropologists (Banks 1992 : 867). It is clear to most of these scientists that there is a necessary connection between anorexia and bulimia on the one hand, and culture on the other. How this connection is conceived is often discussed. DiNicola (1990b : 245 – 246) argues that there are three different views scientists hold concerning the issue of culture and eating disorders. The first thesis of this connection is that culture acts as a *cause* by providing a blueprint for anorexia nervosa. Orbach's (1986) feminist hypothesis of anorexia nervosa as a "hunger strike" holds this claim. A second thesis is that specific cultural factors *trigger* the illness, which is determined by many factors. Family interactions and culture change are examples of these "triggers". One representative of this view is DiNicola (1990b : 245), who sees an eating disorder as a culture change syndrome. As discussed in greater detail in paragraph 2.4.4.3, culture change can trigger the emergence of anorexia nervosa bulimia and nervosa in adolescent girls from immigrant families living in highly industrialized Western societies (DiNicola 1990b : 245; Furnham and Alibhai 1983 : 829; Garfinkel and Garner 1982 : 132; Lake *et al.* 2000 : 87). The third thesis is that culture is an *envelope* for the emergence of eating disorders. This means that culture is a specific socio-cultural address, container or envelope for the expression of the illness (DiNicola 1990b : 246).

Before defining the term culture-bound syndrome in full, it is necessary to explain the meaning and function of the concept "syndrome". First, a word about the context. Folk illnesses or syndromes from which members of a particular group claim to suffer and for which their culture provides an aetiology, a diagnosis, preventative measures and

regimes of healing (Rubel as quoted by Helman 1994 : 113), have been described by anthropologists from around the world. Each of these folk illnesses has its own unique configuration of symptoms, signs and behavioural changes. As in folk medical traditions in general, Western folk medicine, now and in the past, harbours many popular designations for illnesses. Prince (1985 : 197) explains this with reference to seventeenth century English folk medicine, which used labels such as apoplexy, bloody flux, fever, French pox, purples and many others. These folk designations are not unlike flu, lumbago, low-blood pressure and diarrhoea, colds and chills, which are expressions of forms of illnesses in much of the modern English-speaking world (Helman 1994 : 113; Prince 1985 : 197). Anthropologists have also described dozens of folk illnesses in other cultures. Examples of these are *amok* in Malaysia, which is characterised by a frenzied killing spree among males; *susto* – a depressive-anxiety condition described throughout Latin America; *windigo* – a cannibalistic obsession described for the Indians of north-eastern America; *koro* – a fear among Chinese males that the penis will withdraw into the body; and *latah* – a hysterical imitative reaction similar to the Siberian form of arctic hysteria (Foster and Anderson 1978 : 96; Gordon 1990 : 101; Helman 1994 : 113).

According to Prince (1985 : 197), a shift from folk medicine to scientific medicine occurred in the seventeenth century in Europe. This important step was characterised by the clear perception that each illness or disease is comprised of its own distinctive symptom pattern and natural history. The general disease theory (e.g. imbalances of humours) moved to a specific disease theory, where fever for example was separated from disease patterns bearing labels like malaria, tuberculosis, and scarlet fever. Prince (1985 : 197) states further that people realised that if the physician was able to distinguish which of these distinctive diseases he was dealing with in the particular patient, the prediction of the outcome as well as the treatment were greatly facilitated. This realisation of the importance of the symptom pattern or *syndrome* is especially associated with the name of Thomas Syndenham (Prince 1985 : 197).

Turning now to the culture-bound syndrome concept, it has to be mentioned that for a long period of time, and maybe even up to today, these illnesses are not really a part of Western medicine or mainline psychiatry. According to Prince (1985 : 197), Western medicine is aware of the unequal distribution of diseases around the world but

variations to genetic, dietary or demographic factors are generally thought of as influencing the frequency of disease rather than disease syndromes per se. The fact that coronary heart disease, for example, is quite common in the West but relatively rare in Africa, is explained by contemporary Western medicine as being a result of dietary variations or demography rather than culturally related differences in psychosocial stressors (Prince 1985 : 200).

But what then is a culture-bound syndrome? Anthropologist George Devereux was one of the first to write extensively about the complex relationship between culture and psychopathology. His work, which spanned five decades (his most important and provocative article was published in 1955), was not only of enormous scope, but offered great insight into the relationship between culture, the individual and mental disorders (Gordon 1990 : 6). According to Gordon (1990 : 6), Devereux was fascinated by the relationship between the normal and the abnormal, and especially by the way in which psychological disorders express core anxieties and unresolved problems of a culture. Central in his exploration of these relationships was the concept of an "ethnic disorder" – a syndrome pertaining centrally to one culture (Gordon 1990 : 6). Devereux (1980 : 42) explains that the deviant behaviour patterns which become prevalent in a society tend to follow particular models or templates that are immediately and widely recognized by members of the culture. Patterns of misconduct are known to the actor as well as to the observer and Devereux (1980 : 34) explains this by the statement: "Don't go crazy, but if you do, you should behave as follows."

The expression culture-bound syndrome (CBS) was then finally coined in the 1960's by Pong Ming Yap, a Western-trained Chinese psychiatrist working in Hong Kong (Aderibigbe and Pandurangi 1995 : 236; DiNicola 1990b : 246; Lee 1996 : 22; Prince 1985 : 198). Sing Lee (1996 : 22), referring to the findings of Yap, states that when exotic psychopathology is produced by certain systems of implicit values, social structures and obviously shared beliefs indigenous to certain geographical areas, it could be described as a CBS. In order to get a clearer picture of the expression, one can also turn to Ritenbaugh's definition (1982 : 347) which explains the term as "a constellation of symptoms which has been categorized as a dysfunction or a disease, and which cannot be understood apart from its specific cultural or subcultural context". Further, the "aetiology summarizes and symbolizes core meanings and behavioural

norms of that culture, the diagnosis relies on culture-specific technology as well as ideology, and the successful treatment is accomplished only by participants in that culture" (Ritenbaugh 1982 : 347).

At this stage it has to be mentioned that, today, the term culture-bound syndrome is mostly used to describe illnesses of mental origin. Indigenous expressions like the previously mentioned *amok*, *susto*, *latah* and *windigo* are now referred to as culture-bound syndromes rather than folk illnesses. According to Swartz (1985 : 726) "mental disorders are generally viewed as being optimally treated by members of the sufferer's culture, in spite of the proliferation and success of purely biomedical treatments".

Kleinman (1977: 3) has contrasted two approaches to cross-cultural psychiatry and each of these implies a certain way of understanding culture-bound syndromes[2]. What Kleinman terms the "old transcultural psychiatry" is a discipline, which uses Western diagnostic systems to look for disorders such as depression and schizophrenia throughout the world, at different times and places. This approach implies that disorders can be understood apart from their specific cultural or subcultural contexts, supporting universalistic claims that anorexia nervosa and bulimia nervosa have always existed. According to Shefer (1986 : 77) "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". Therefore, by looking back in history and comparing for example the "holy anorexics" with the girls suffering from anorexia today, scientists might come to the conclusion that anorexia then was the same as it is today because the symptoms of starvation are the same. A close holistic study, however, often reveals that the meaning for the patient suffering from "holy anorexia" was very different from the meaning that anorexia appears to have today.

The second approach brought forward by Kleinman (1977 : 3) is termed the "new cross-cultural psychiatry" and is more interested in the way categories are made by those within cultures. According to this approach, CBS's are often examined not for whether they are similar to others or even for whether they constitute "madness" in any general normative sense. Instead, culture-bound syndromes are looked at in terms of

[2] Hahn (1985 : 165) also identified two different classifications in connection with CBS. He termed them exclusionist interpretation of CBS and inclusionist interpretation of CBS.

the specific cultural preoccupations and meanings they reflect (Swartz 1985 : 725). This view coincides with Prince's designation of anorexia nervosa as a culture-bound syndrome, namely that anorexia is largely confined to Western cultures or those non-Western cultures undergoing the process of westernisation. Prince (1983 : 300) further states that anorexia nervosa is a Western culture-bound syndrome "rooted in Western cultural values and conflicts". To Swartz (1985 : 725) a rather unfortunate consequence of this approach to anorexia nervosa is that cross-cultural comparison is almost impossible. Further, the author argues that any disorder, even if it does occur universally, has culture-specific features in different societies, which leads to the question: What does not constitute a culture-bound syndrome (Swartz 1985 : 725)?

One may choose numerous contexts for the examination of mental illnesses, each with a different task and pursued with different conceptual tools. Arthur Kleinman (1977 : 3), who presented the above mentioned dichotomy between "traditional transcultural psychiatry" and the "new cross-cultural psychiatry", was not only concerned with mental illnesses and their relation to specific cultures but also focused on the processes by which illness is patterned, interpreted and treated. According to Kleinman (1977 : 3) "in comparing diseases one is always comparing explanations not entities ... Culture shapes diseases first by shaping our explanations of diseases – disease is an explanatory model not a thing".

Helman (1994 : 111) interprets Kleinman's explanatory model (EM) as "a way used by individuals to explain, organise and manage particular episodes of impaired well-being". It has to be kept in mind, however, that not only the person suffering from an illness episode is influenced by culture. It is very important to note that the clinician also gives meaning to the patient's illness. Clinician and patient then negotiate on the meaning of the patient's illness. Shefer (1986 : 78) explains this as a process in which both modify their behaviour according to what they see as the expectation of each other. There is not necessarily a distinction between popular conceptions of anorexia and bulimia (held presumably by the patient) and academic/professional views of the syndrome (held by the clinician). Swartz (1985 : 725) argues that 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.

According to DiNicola (1990b : 249 – 252), this cognitive cultural psychiatry, where the illness is understood as explanation, has a variety of limitations. To him (DiNicola 1990b : 250 – 252), not all personal or cultural experiences of mental illness can be fitted into the cognitive cookie-cutter that Kleinman calls "explanatory models". From the examples given by DiNicola (1990b : 250 – 251) it is clear that some experiences of illnesses are cognitive only in part. This means that human life is experienced and enacted, processed and organised, symbolised, celebrated and consecrated through many vehicles, including emotional, ritual and spiritual ones. However, when experience is constructed cognitively, it is not necessarily rational and certainly not always amenable to negotiation with an interlocutor. According to DiNicola (1990b : 250) the question is whether the patient will be prepared to present the model in a discourse where it has to be defended on logical grounds. Furthermore, asking patients to present their own explanatory models to a physician is a powerful demand – people often value direction and authority in medical matters over autonomy, insight and informed consent; they do not always readily share their implicit explanatory models and therefore might present "empty vessels" waiting to be taught and healed. When a person is asked to explain something that cannot be put into words, explanatory models become a demand, which can only be met with embarrassment, frustration or confabulation. These are just some of the limitations DiNicola (1990b : 250 – 251) pointed out. It has to be said that the above-mentioned problems can to a certain extent be overcome with appropriate research methodologies. To anthropologists as well as to many other scientists, it is clear that, however difficult, the consideration of the personal explanation of illnesses is a necessity without which the "why?" of the illness could never be established.

This research on anorexia nervosa and bulimia nervosa builds upon Kleinman's explanatory model and therefore accepts as fundamental that all disorders mean something to the sufferers as well as to the clinician. Scientists, especially anthropologists, need to recognise core values and meanings of symptoms held by patients themselves, as well as the necessity of realising that cultural values may be built into the diagnostic and biomedical system. Anorexia nervosa and bulimia nervosa, like any other disorder, present certain signs and symptoms, which are related to biological dysfunctions caused by starvation and weight loss. Sufferers from these disorders consciously understand and give meaning to the symptoms using culturally

explicit and objective symbols, beliefs and language. But why is it so important to take the patient's own subjective view into account?

A possible answer lies in the success rate of treatment. The differences between etic and emic meanings and interpretations of symptoms of anorexia nervosa and bulimia nervosa can easily result in opposing definitions of "abnormal" and "normal" behaviour (Banks 1992 : 869). This may result in a gap of understanding between healers and patients, leaving both dissatisfied with the unsuccessful treatment. Only when the treatment relies on a culture-specific ideology, with an exchange of the patient-clinician explanatory model, can the sufferers of eating disorders start recovering. Forty to 50 percent of anorexics never recover completely and, taking the given death rate of 19 percent into account (Wolf 1990 : 149), one can conclude that the reason therefore most probably lies in the failure of healers to take the anorexic's or bulimic's own subjective meanings – and the role of culture in these meanings – into account.

In this report, anorexia and bulimia are viewed as culture-bound syndromes. Giving cognisance to the Western trend of thinness and consumerism, the related rise of prevalence of the syndrome, the rarity of occurrence in non-Western cultures, as well as the degree of increase of prevalence in accordance with an increase of Westernisation, it is clear that eating disorders are not universally found in human populations. Anorexia and bulimia therefore are restricted to the Western culture, which cannot be understood apart from attitudes, conflicts, and strivings of Western societies. Anorexics and bulimics draw upon the common cultural vocabulary of their time. Dieting, thinness and food control have become endemic to the advanced industrial societies and women are trying harder than ever to be in control of their female body and therefore to conform to the prevailing standard of beauty (Gordon 1990 : 11). It has to be noted, however, that even though anorexia nervosa and bulimia nervosa are termed as culture-bound syndromes in this research report and often referred to as "Western diseases", it should be kept in mind that many socio-cultural elements (e.g. industrial capitalism, urbanisation, immigration, abundance of food, rising population weight norms, advanced information technology, proliferation of body-orientated advertisements, decreased birth rate and changing social roles of women) could influence the occurrence of both disorders (Lee 1996 : 23). Therefore,

eating disorders may be considered to be bound to the culture of "modernity" rather than to a specific geographical site.

2.5 CONTEMPORARY TRENDS IN WESTERN CULTURE PROMOTING THE IDEAL OF THINNESS

Aesthetic perceptions and feelings towards for example nature, objects of art in their various forms, lifestyle and human beings are worldwide phenomena. Being part of culture, beauty concepts change over time. This is/was indeed the case concerning the female body within Western culture. The more rounded body shape of women during the fifties of the twentieth century made way for the thinness ideal of nineties.

The ancient Greeks, according to Bruch (1973 : 17) envied their cultural predecessors, the Cretans, for having known of a drug that permitted them to stay slim while eating as much as they wanted. The Romans and the Greeks, like the Spartans disliked obesity, with the latter being punitive and stern in their attitude toward a fat body. Once a month, young people where checked in the nude, and those who had gained weight were forced to exercise to keep the extra kilos off (Bruch 1973 : 17).

With the rise of modern society, a new mode of restricted eating emerged. Not only was there enough food for people not to go to bed hungry, but also perceptions concerning health and disease as well as the body, changed. The emergence of a mechanistic worldview turned the body into an object of scientific scrutiny (Lelwica 1999 : 71). An increasing understanding of obesity as causing a variety of serious illnesses led scientists to advocate regulated exercising and eating. The aim of these programmes was not slenderness per se but the improvement of health and prolonging life (Garfinkel and Garner 1982 : 106; Lelwica 1999 : 71). People were encouraged not just to eat what they wanted because the vital components of foods are hidden (calories, fats and vitamins) and science has a set of rules and measures that can prevent illness and increase longevity (Lelwica 1999 : 72). Eventually, with the help of government channels, the rise of giant food corporations, the spread of mass advertising, and the new female science of home economics, individuals began increasingly to supervise their bodies, take charge of their health and monitor their appetites (Lelwica 1999 : 72). Moreover, the end of the nineteenth century marked a

link between the symbolism of thinness and the idea of social class. Veblen (as quoted by Gordon 1990 : 77) wrote about the wife of the wealthy man of his time: "There are certain elements of feminine beauty .... The ideal requires delicate and diminutive hands and feet and a slender waist. ... It results that at this cultural stage women take thought to alter their persons, so as to conform more nearly to the requirements of the instructed taste of time." Obesity was coming under harsh criticism, and the burden of weight control fell particularly heavily on women. Gordon (1990 : 77) further quotes an article presented in the 1908 issue of the famous fashion magazine *Vogue*, which stated that "the fashionable figure is growing straighter and straighter, less bust, less hips, more waist, and a wonderfully long, slender, suppleness about the limbs .... How slim, how graceful, how elegant women look!"

In the 1920s, dieting and thinness began to be a female preoccupation and with rapidity, the new, linear form replaced the more curvaceous figures. In the regressive 1950s, women's natural fullness could be briefly enjoyed once more because the post-war period required a "domestic female" (Wolf 1990 : 150). But large-breasted Marilyn Monroes were only short-lived. Sales of weight-loss aids, from bathroom scales, to diet books, to low-calorie foods, to amphetamines, began to soar (Lelwica 1999 : 74). Twiggy appeared in the pages of *Vogue* in 1965, simultaneously with the contraceptive pill, and brought with her an almost boyish and pre-pubertal trend (Wolf 1990 : 150; Gordon 1990 : 78).

In the 1970s then, a consumer culture emerged that was obsessed with youth, haunted by the spectre of ageing, and ready to exploit and absorb free sexuality. The profits of commercial diet centres grew exponentially, despite statistics indicating that up to 95 percent of those enrolled in these programmes regain their weight – and more – within a couple of years (Lelwica 1999 : 74). In the 1980s, the emphasis on youth was driven to an even greater extreme by the enormous expansion of fashion markets for teenagers (Gordon 1990 : 79). Over- the-counter-drugs for weight control became popular – and profitable, with sales climbing 20 percent each year in America. Meanwhile, sales of diet food and soda were increasing three times as fast as those of regular foods and beverages (Lelwica 1999 : 74). Garfinkel and Garner's (1982 : 107 – 110) examination of collected data from centrefolds of *Playboy*, Miss America Pageant contestants, and diet articles from popular women's magazines between the years 1959 and 1978, led

them to the conclusion that there is an apparent shift in our culture's standard for the feminine beauty and the consequent pressure to diet. The change indicated a trend toward a more "tubular" or androgynous body form. Similar results were stated by Wolf (1990 : 151) who referred to a 1985 survey saying that 90 percent of questioned respondents thought they weigh too much. "On any day, 25 percent of women are on diets, with 50 percent finishing, breaking or starting one" (Wolf 1990 : 151). In fact, by the end of the 1980s the majority of "ideals" of Western beauty were found to be 13 – 19 percent below expected weight (Wiseman *et al.* as quoted by Haynes 1995 : 7), and as such would fulfil the first criterion of the DSM-IV diagnostic features for anorexia nervosa (American Psychiatric Association 1994 : 544).

Today, the requirement for overall slenderness remains, particularly in the hips and waist. Actually the current idealized body form for women is for a bony thinness. Moreover, a fitness boom in the 1980s struck the Western world and in case that the preferred outcome was still not satisfying, cosmetic surgery could help to produce the necessary modifications (Gordon 1990 : 80). In 1997, weight loss was estimated to be a 50 billion dollar business, and predictions for the new millennium stated that Americans would spend about 77 billion dollars in order to shed their "excess" flesh (Lelwica 1999 : 74). "Culture Lite", manifesting itself through a fat-free body with every muscle being toned and slogans like "Get healthy! Feel fit! Lose weight!" emerged.

A comprehensive history of the preferred morphology of the body has yet to be written. Nevertheless, a certain amount of cross-cultural and historical studies have been conducted (Gordon 1990 : 76). For the majority of human societies, fatness has been valued over thinness, particularly in women. As stated by Rich and Wilson (1977 : 195): "Eating made one handsome. A thin wife brought disgrace to a peasant. But of a plump wife it was said that 'a man will love her and not begrudge the food she eats'." Preferred body weight is a complex social construction, and most probably not only a result of economic factors. Gordon (1990 : 76) suggests that one factor – most likely the most important one – is the value placed on reproduction. This connection is nowhere more dramatically evident than in Eastern and Central African countries, where, after puberty, girls were sent off to "fattening sheds", where they were intentionally overfed, and then their ample bodies displayed at "fattening ceremonies".

These ceremonies had the function of celebrating the girls' productive potential as well as their economic status. Bruch (1973 : 14) indicates that even before modern anthropologists made their detailed studies, ancient travellers had reported the curious custom of some African cultures, where young girls at puberty were sent to fattening houses to "grow" beautiful before marriage. These customs are still practiced today in certain rural settings on the African continent.

This view is often accepted by social scientists, who have tended to emphasise the role of a strongly gendered society in which political, social and economic power is vested in men to a much greater extent than in women. The majority view among sociological analysts, according to Lee (1998 : 126), is that eating disturbances arise from the centrality of appearance for success in the female gender role, combined with the contemporary thin ideal.

Maybe, however, it is not only the male-determined world in which women struggle to succeed but also the transition to a new female identity, which has left many women vulnerable. The new emphasis on female achievement and performance represents a sharp reversal from previous role definitions that emphasised compliance, deference and unassertiveness. The new sexual ethos, focusing on greater permissiveness and a loosening of traditional controls, often make women vulnerable to exploitation and anxieties (Gordon 1990 : 63). Some young women, therefore, find themselves caught up in the uncertainties and ambiguities of a drastically altered set of expectations.
There is also increased pressure on women to fill a wider range of roles in vocational achievement (for example mother, wife, successful career- and business woman). This dramatic shift in roles and expectations may pose adjustment problems for some women. For others, these cultural pressures to perform, to be perfect, and to be slim are just too much and might lead to the development of serious eating disturbances (Garfinkel and Garner 1982 : 118). Gordon (1990 : 63) is of the opinion that "most contemporary women feel that along with the increased expectations for achievement and performance, the pressure to be traditionally feminine – in the sense of being attractive, pleasing, and unassertive – is as powerful as ever before". Women do not only have to maintain traditional standards of beauty but also have to assimilate the heightened demands for professional performance and success (Garfinkel and Garner 1982 : 118).

Popular culture developed the myth of "the superwoman". She is both competent, achieving and ambitious, and yet pleasingly feminine, sexual and nurturing. Besides all of the above-mentioned duties, the perfect picture of the superwoman includes considerable attention to her appearance and a perfectly thin body (Gordon 1990 : 63). Thinness in the Western world can therefore be associated with self-control and success. Not being able to control all the outside demands thrown onto women, some individuals might respond by imposing greater self-control and discipline onto the body. A particular form of self-control for women is dieting – "at least my body is my domain, and I can resist the threatening chaos of a formless world in the narrow confines of my skin" (Garfinkel and Garner 1982 : 106 – 107).

Yet another viewpoint on why "thin is in" is that our society began to attach stigma to fat, and often obesity is equated with low class. Lelwica (1999 : 57) quotes Beth McInnis (1993), who wrote in her book *Fat Oppression* that: "obesity, as defined by the medical community, is seven times more common among working-class women than among women of any other socio-economic status; in fact, the American socio-economic group with the highest percentage of fat members is that of Black women below poverty level." Often such data find their way into mainstream news reports without mentioning the injustices contributing to this situation – that nutritious food, a place to exercise and regular health care are not available to everybody. This negative association between low socio-economic status and the prevalence of obesity presents a symbolic linkage. In the affluent societies, thinness is the symbol of status, whereas obesity becomes *déclassé* (Gordon 1990 : 87).

Osvold and Sodowsky (1993 : 146) argue that it is difficult to determine exactly how much socio-economic class influences weight as opposed to weight determining socio-economic class. There is no doubt, however, that many women see dieting, and the result of it – extreme thinness – to be a way to gain power, status and economic security (Osvold and Sodowsky 1993 : 146). As the Dutchess of Windsor put it: "You can never be too rich or too thin" (Gordon 1990 : 81).

Undoubtedly, obesity is a serious medical problem, which is often linked with a variety of health problems. The social bias against obese women is much greater than it is against men, making the medical problem a complex cultural construct (Gordon

1990 : 88). Women often define themselves through their bodies, and images of the "larger" or "flabby" female bodies are associated with negativity. She "let herself go" or she "ate out of control" are possible remarks (Lelwica 1999 : 55). In the Western world of undefined limits, where people could eat almost anything, the fatless body is "in". However, people do not simply want to be thin, or reduce weight in order to live a healthy life. No, fat is *hated* (Gordon 1990 : 89). "In contemporary Western societies", according to Gordon (1990 : 89), "the obese have become a despised underclass, victims of discrimination in employment and social life. The moral stereotypes of obesity include attributions of laziness, self-indulgence, greed." Lelwica (1999 : 56) draws on the work of writer Sallie Tisdale (1994) who is of the opinion that: "Fat is perceived as an act rather than a thing. Fat is now a symbol not of the personality but of the soul – the cluttered, neurotic, immature soul." Fat therefore also signifies a moral flaw, a chaos-driven lack of self-control, and something one is disgusted with and afraid of.

To comply with the thin ideal, women act in two ways: dieting and exercising. Both of these apparent solutions to reach the idealised body shape will be discussed in the next section.

2.6 POSSIBLE SOLUTIONS TO COMPLY WITH THE THINNESS IDEAL

The importance of dieting and excessive exercising as a cultural institution is indicated by the economics of highly variegated "health" industries in the Western world. Gordon (1990 : 93) states that Americans, for example, spend billions annually on diet goods and services. Physicians, weight-loss programs, weight spas, reducing pills, diet foods, fitness centres, etc., are underlining the importance of losing weight, which has become an obsessive component of the Western world's life style.

a) Dieting

Dieting, which according to Axelson (as quoted by Lau and Alsaker 2001 : 25) can be defined as an intentionally low calorie intake, is reported to be so widespread among adolescent girls in Western societies that it could be

considered normative behaviour for this group. "In America, land of maldistributed abundance, most girls know the language of dieting – often from first-hand experience – by the time they are ten years old. Rituals of avoiding food while measuring others are not only common among females in this culture: they are habitual" (Lelwica 1999 : 70). According to the magazine *Health News & Review* (1993 : 2), American women are obsessed with their weight. A 1984 survey, which included 33,000 women, indicated that while only 25 percent were overweight, 74 percent of the respondents perceived themselves as overweight.

In Great Britain, two in five women are on a diet, while one in ten, according to estimates, dies in a desperate attempt to lose fat (Sardar and Saunders 2001 : 46). This is hardly surprising given the advocated starvation rations of some popular diets not exceeding 1,000 calories. Even in India, a less industrialised and one of the poorest countries in the world, women can consume on average more than 1,400 calories a day (Sardar and Saunders 2001 : 46). Wolf (1990 : 171) goes as far as comparing the self-induced starvation of today's females with the Holocaust phenomenon in the 1940s. Under the German occupation of Holland in 1940, the Dutch authorities maintained rations at between 600 to 1,600 calories a day. The worst sufferers, who were defined as starving, were those who had lost 25 percent of their body weight. At this low body weight, they were given extra nutritional supplements (Wolf 1990 : 160). Today, anorexia in a girl can only be diagnosed when she has lost 25 percent of the body weight. The nutritional food supplement often given to anorexics during treatment sessions is, however, not as welcome as it was with the Holocaust sufferers.

It seems as if this tragic obsession with losing weight in order to attain the slim and slender body ideal of the West has an impact on a great number of young females. According to Lau and Alsaker (2001 : 25), who are both psychologists at the Department of Psychology at Bergen, Norway and Bern, Switzerland respectively, the point prevalence rates for dieting in young women from Western countries range from 30 to 40 percent and indicate that there is a marked gender difference in restricted food intake which mostly appears during adolescence. Another American study found that 57 percent of 8^{th} grade females and about 64 percent of 10^{th} grade females reported dieting behaviour, whereas dieting in boys

from all grades was reported at approximately 28 percent (Perry-Hunnicutt and Newman as quoted by Lau and Alsaker 2001 : 25). In an Australian sample, 54 percent of girls reported having dieted at least once, while only 16 percent of boys had ever dieted (Paxton *et al.* as quoted by Lau and Alsaker 2001 : 25). Lau and Alsaker's research on the dieting behaviour in Norwegian girls confirmed the above-mentioned studies with the females restricting their food intake three times more than the boys did. The girls however, did not always use dieting to reduce an unhealthy weight, but to reduce a psychological strain that might be caused by inappropriate perception of their bodies (Lau and Alsaker 2001 : 25).

Yet another tragedy, which has to be mentioned here, is that the ages of girls who are becoming obsessed with their weight and as a response begin to diet, have decreased markedly. The magazine *Health News & Review* (1993 : 2) reported that a study conducted at the University of California found that 80 percent of 4th grade girls said they were dieting. Research has shown that dieting to lose weight as well as a fear of fatness are common in girls as young as nine, and these attitudes and behaviours escalate significantly during adolescence. As a consequence, the risk of developing an eating disorder is eight times higher among dieting girls than among non-dieting friends (Garner and Kearney-Cooke 1996 : 55). Research conducted by the Royal Children's Hospital Research Institute Melbourne (Children's Service Report 1999 : 9) exceeds these statistical findings by Garner and Kearney-Cooke (1996 : 55) by stating that adolescent girls who go on strict diets to lose weight are 18 times more likely to develop an eating disorder than are girls who do not use dieting as a means of weight loss. A similar finding was made in Australia in a study of 2000 boys and girls of ages fourteen and fifteen. It was found that 60 percent of the girls surveyed had dieted moderately, and eight percent severely. Two-thirds of the cases of eating disorders that were detected were among the girls who had dieted moderately (Children's Services Report 1999 : 9).

In the beginning of this section on dieting, it was mentioned that dieting could be regarded as normative behaviour among adolescent girls. However, the term normative connotes that something in one's society is established as a norm (*South African Pocket Oxford Dictionary* 1994 : 648). The mere fact that

behaviour becomes normative does not imply that it is healthy (for example, smoking is normative in many societies but definitely not healthy). In fact, while dieting seems to be harmless for many adolescents, it has been shown that it can be a predictor of the development of eating disorders, like anorexia nervosa and bulimia nervosa.

b) Fitness

Perhaps even more than dieting, contemporary Western cultures extol and glamorise exercise (Gordon 1990 : 96). According to Gordon (1990 : 96), the fitness explosion is the contemporary expression of a long-standing national fascination with sports and physical fitness in the United States. This "fitness ethic", as Lelwica (1999 : 74) terms it, actually started out as a counter-cultural challenge to mainstream eating and dieting practices. It originally promoted nutritious food and moderate exercise as means of mental, spiritual and social renewal. As already mentioned, however, this alternative was taken over by the very powers it meant to criticise: the giant food and weight-loss industries. According to Lelwica (1999 : 74), concerns about eating healthily and living "lightly", came to mean counting calories and fat grams.

The difference between the mainstream weight-loss practice and those comprising the "fitness ethic" is far from clear. The call to "overall health and fitness" is not easily distinguishable from the mandate to lose weight. Given the Western culture's preference for female slenderness, fitness, like dieting, implies the need for women to reduce (Lelwica 1999 : 74). It is sad to say that many Western women exercise primarily to lose weight. The magazine *Women's Sports & Fitness* (1999 : 58) addresses exactly this issue and explains to the American women how "easy" it is to achieve the preferred slender body: "Lose weight, huh? Well, it's a combination of three things: diet, exercise and proper rest. The formula is pretty simple: You've got to burn more calories than you take in. You can do this by decreasing your calorie intake or increasing your calorie output. I usually recommend the latter or some combination of the two. .... Bottom line: You can lose weight with a minimum of equipment – your feet, your hands, and your teeth."

The fitness trainer Pat Manocchia (1999 : 58), who suggested the above-mentioned "successful" way to lose weight, seems to forget, however, that in the age of bony thinness and eating disorders, this combination of not eating and excessive exercising can become very dangerous. An article in *Women's Health Weekly* (Marble 1997 : 12) explains that this combination can have a very negative impact on young girls. An 18-year-old Florida State University freshman explains the situation: "I pray there will be a day when I won't think about the food I eat or the exercise I do." Calories have to be "earned" through excessive exercising. On the other hand, in the case of eating too much, punishment through hard exercise follows. "All I did was worry about when I could exercise and how much I could eat."

Self-starvation and strenuous exercise, in concert, may interact and become a self-perpetuating syndrome that can lead to eating disorders (*Women's Health Weekly* 1998a : 7). This is especially true of girls, who in the pursuit of a career as an athlete, have to exercise excessively and watch what they eat.

In ballet, for example, there are particularly intense pressures to attain a thin body shape, a requirement that is attributable to the contemporary aesthetic standard of the art form. Ballet dancers should trace out a sharp, moving contour and slight body bulges are seen as a drastic impairment (Gordon 1990 : 72). Furthermore, the aspirant dancer is punitively socialised into the belief that the only way to succeed in the highly competitive environment is to develop the wiry and extremely thin body that represents the world-class dancer (http://www.somethingfishy.com/ed.5htm). In 1980, Garfinkel and Garner (1982 : 62) compared a large group of aspiring ballerinas to a group of college students regarding their scores on the Eating Attitudes Test (EAT), a screening device also used in this study. Of 131 ballet students, over 30 percent obtained scores on the EAT comparable to those obtained by anorexic patients, whereas only 12 percent of the college students scored in this range (Gordon 1990 : 72). A recent study of adolescent ballet dancers conducted in South Africa (Montanari and Zietkiewicz 2000 : 38) concluded that the young dancers studied are exercising traits which are a cause for concern. The South African dancers showed cognitive disturbances surrounding body image (body dissatisfaction, drive for thinness) and possible

eating disorder behaviour. The allegations that the sylph-like physiques of dancers are not the result of a natural predisposition to training but rather the result of disturbed eating behaviour were confirmed (Montanari and Zietkiewicz 2000 : 32).

Similar traits can be found in female college students who regularly participate in sports. Women athletes, according to Kirk *et al.* (2001 : 123) often feel tremendous pressure to strive for low body weight in order to please a coach, make the team, or maintain a competitive edge in a sport. Girl athletes know from experience that judges, influenced by popular culture, tend to reward thinness, independent of a girl's skill in the sport (Lamb 2002 : 12). Evidence suggests that eating disorders, particularly in female athletes are on the rise. According to Dr. Craig Johnson (as quoted by Lamb 2002 : 12), 13 percent of female athletes suffer from eating disorders as opposed to 3 percent of the general U.S female population. According to Lamb (2002), the Penn State Centre for Sports Medicine in America reports that as many as 70 percent of collegiate athletes may be involved in some form of harmful weight control behaviour. Kirk *et al.* (2001 : 127), however, reported a negative correlation between collegiate female athletes and a higher incidence of disordered eating than among non-athletic college girls. The reason for this finding, according to the authors, might lie in a growing awareness, as well as better support and guidance networks of athletic departments, about the incidence and risk of eating disorders among female athletes.

It is well established in the literature that prudent eating and regular exercise will improve the health status of all people, regardless of body size. Furthermore, much literature explains that fitness, not fatness, is a determinant for disease and mortality (Miller 2001 : 65). It is not the purpose of this study to discuss the positive and negative effects of fitness and sport. However, it is necessary to bear in mind that excessive participation in some or other sport may lead to the development of eating disorders like anorexia nervosa and bulimia nervosa. Obviously sport is by no means the only possible determinant. It is therefore necessary to investigate the phenomenon of eating disorders from a holistic perspective.

2.7 THE NATURE AND ROLE OF SOCIALISING AGENTS IN PROMOTING THE IDEAL OF THINNESS

2.7.1 Introduction

In 1690, the British empiricist John Locke presented his theory concerning human understanding. According to Locke, every human being starts his life as a *tabula rasa,* or blank page (Haviland 1994 : 356). This theory implies that the newborn human is born without any personality traits. All individuals are biologically identical at birth in their potential for personality development, and adult personalities are exclusively the products of their postnatal experiences which differ from culture to culture (Haviland 1994 : 356). Therefore, as the human being progresses, individual experiences are gained which form the person's personality. Life, to Locke, is like writing on a blank page.

Today, more than 300 years later, Locke's theory is unacceptable, for it is known that each person is born with unique inherited tendencies that will influence his/her personality. It is also known, however, that genetic inheritance sets certain broad potentials and limitations, and that life experiences shape unique individual personalities (Haviland 1994 : 356). Culture, which is created and learned rather than biologically inherited, ensures its adequate transmission from one generation to the next.

The process whereby the individual becomes a member of a social group by learning to conform to the socio-cultural behaviour of the group is called socialisation (Louw 1991 : 9). Socialisation begins the moment parents first hold their babies. This human contact is the first step in a long process through which babies learn to see themselves as distinct individuals, to build social relationships, to develop moral concepts and to learn language (Popenoe 1995b : 116). Louw (1991 : 10) explains that, through the process of socialisation, the individual acquires knowledge of the rules, attitudes, beliefs, habits, values, role requirements and norms prevailing in the social environment and learns to accept the social norms as his own or at least to take them into consideration in his behaviour. Due to the fact that social norms, particularly those of a modern technological society, are often inconsistent or even contradictory and are

constantly changing, socialisation is a complex process. A person's social environment therefore influences him/her by means of personal social contact with individuals and groups (such as parents, friends and teachers), mass communication media (such as printed matter, radio and television), and in many other ways (such as observation of people, works of art and other cultural products) (Louw *et al.* 1998 : 23). In this process of socialisation, individuals learn how to get along with the unique personalities making up the social groups into which they were born or which they have joined. No two families are exactly alike. The father may be strict and the mother lenient, or vice versa. Both may be strict or both lenient. There are different adjustment situations for the eldest child, the youngest or the only child. Therefore, the child has to learn to discriminate between individuals and adjust its behaviour accordingly (Holmes and Parris 1981 : 191).

2.7.2 Strategies of socialisation

With regard to the socialisation process, two different models can be presented on a continuum. Writers refer to these socialisation models as individualistic versus collectivistic (Popenoe 1995a : 17); broad versus narrow (Arnett 1995 : 617); authoritarian versus permissive (Popenoe *et al.* 1998 : 90); and dependence versus independence training (Haviland 1994 : 363 – 365). Cultures characterised as individualistic, broad, permissive and independent encourage individualism, independence and self-expression. As a result, a broad range of individual differences in paths of development, which can be predicted from socialisation practices that emphasise individualism and independence are likely to be found. Collectivistic, narrow, authoritarian and dependence socialisation holds obedience and conformity as highest values and discourages deviation from cultural expectations. It is therefore narrow in the sense that a restricted range of variations can be predicted when individuals are pressed toward conformity to a certain cultural standard.

Writers like Baumrind and Haviland make provision for a third stance between the above-mentioned positions. Baumrind (as quoted by Popenoe 1995b : 125) concluded after a protracted study on child-rearing practices, that the parents who are most effective at raising independent, socially responsible children are neither authoritarian nor permissive, but rather authoritative. Authoritative parents try to strike a balance

between the children's rights and duties, depending on their particular stage of development. The child-parent relationship is then considered complementary, meaning that both parents and children have responsibilities towards each other. Haviland (1994 : 365) refers to this middle stance as characterised by combined elements of independence and dependence training. "Share and share alike" is the keyword, discouraging competitive behaviour without much pressure for compliance. These combined practices of training children encourages individuals to be more supportive of one another than is often the case in modern industrial societies. At the same time, personal achievement and independence are encouraged, for those individuals most capable of self-reliance will be the most successful in the food quest.

The above-mentioned three models have an important influence on how children are perceived in a culture context. Collectivistic, narrow, and authoritarian cultures focusing on dependency conceptualise the child as passive and he/she becomes a replica of its culture through the socialising process. A more recent perspective on socialisation recognises that children are active agents in the socialisation process (Chrisholm *et al.* 1990 : 19). The view sees human development as being a result of intra-individual and inter-individual interaction in a dynamic environment. Cultural context and historical moment determine how phases of development are defined and understood (Chrisholm *et al.* 1990 : 19). The child is an active member of development, involved by appropriating information from the environment to use in organising and constructing personal interpretations of the world (Corsaro 1997 : 11). Waksler (as quoted by Esterhuyse 2001 : 166) explains that adults often take it for granted that children as a category know less, have less experience, are less serious and less important than adults. By replacing less with different, Waksler (as quoted by Esterhuyse 2001 : 166) is of the opinion that adults will be able to comprehend children as unique social beings.

For the purpose of this study, it is accepted that the family, the child's peers as well as the media often seem to take over the child's training, trying to form the young individual according to prevailing cultural standards. However, the child is an active member of development, organising and constructing personal interpretations individually.

2.7.3 The family as socialising agent

It is clear that in every human society, the rearing of children as well as acting as the most important agent of socialisation have always been the duties of the family. The importance of the family stems from its position in the front line of socialisation during the critical years in a person's life. Socialisation usually begins at home, where children learn who they are, what they can and should expect from their society, and what their society expects from them (Popenoe 1995b : 126).

Before explaining how the human family socialises its offsprings, it is necessary first to explain what a family is and how it developed.

2.7.3.1 The nature of the modern family

As the first social institution in human history, the family probably arose because of the need for adults to devote a great amount of time to child-rearing. Human infants come into the world totally dependent and for a long period of their lives they need to be cared for and taught by adults (Popenoe 1995a : 15 – 16).

Historical and cross-cultural studies of the family offer many different family patterns (Haviland 1994 : 474). Because of this variety the term "family" is difficult to define (Henslin 1996 : 292). Henslin (1996 : 292) gives the example of the Western world, where the family is regarded as a unit consisting of husband, wife, and children. However, there are other groups in which men have more than one wife (polygyny) or women more than one husband (polyandry). Among the Banaro of New Guinea, for example, a woman must give birth before she can marry – however, she does not marry the biological father of the child.

But what exactly is a family? A few generations ago, this was a fairly easy question to answer. Haviland (1994 : 473) defines the human family as "a group composed of a woman, her dependent children, and at least one adult male joined through marriage or blood relationship". Today, the family has become a matter for controversy and discussion.

In 1949, George Murdock (1949 : 1) defined the family, on the basis of an analysis of about 500 societies, as "a social group characterized by common residence, economic cooperation, and reproduction". Murdock (1949 : 1) believed this definition to be universally applicable to all societies and he stated that the family consisted of "adults of both sexes, at least two of whom maintain a socially approved sexual relationship, and one or more children, own or adopted, of the sexually cohabiting adults". Today, more than 50 years later, this definition can be criticized for not including single-parent families, married couples without children, gay and lesbian couples, multigenerational families without sexual relationships, and elderly couples without children (Neubeck and Glasberg 1996 : 467).

One task, which families who have children cannot avoid, is child-rearing. Infants and children need, at a minimum, one adult to care for them. In the pre-industrial era, however, adult family members did not necessarily consider child-rearing to be their primary task. As a unit of rural production, the family's main focus typically was economic survival. Popenoe (1995a : 16) goes so far as to say that rather than the family being for the sake of the children, the children, as needed workers, were for the sake of the family. The extended family – a collection of nuclear families, related by ties of blood, that live together in one household – was the norm rather than the exception regarding the family unit (Haviland 1994 : 485).

From the above it is clear that a definition for the family which can be universally applied, is not possible. The only way to deal with the situation is to define the family within a broader cultural context, for example, the Western culture.

One of the most important family transitions in Western history was the rise in industrial societies of what we now refer to as the "traditional nuclear family" (Popenoe 1995a : 16). Social scientists have used the term "nuclear family" to describe a family consisting of a father, a mother and their children, living and striving together, bound to each other by mutual ties of affection and obligation (Berger 1999 : 21). With the industrialisation of Europe and North America, the nuclear family became isolated from other kin. Haviland (1994 : 475) argues that the reason therefore was the industrial economy's requirement of a mobile labour force; people needed to move to where the jobs were. The family therefore became a kind of refuge from the public

world that people saw as threatening to their sense of privacy, and which turned increasingly competitive, temporary, and contingent upon performance (Berger 1999 : 22; Haviland 1994 : 476). By the middle of the nineteenth century, a family-centred way of life emerged. In the late nineteenth and early twentieth century, nuclear family households reached their highest frequency with three-fifths of all households in the U.S. conformed to this model.

Over the past 40 years, however, Western societies have witnessed another major family transformation – the beginning of the end of the traditional nuclear family (Popenoe 1995a : 16). Elkind (1995 : 24) is of the opinion that the social, historical, and cultural events that have transformed the other institutions of Western countries, have had an equal effect upon the basic sentiments, values, and perceptions of the modern family. Feder (2001 : 9) even goes as far as describing the meltdown of the nuclear family as an erosion of civilisation's foundation. Data from the 2000 census of U.S social ecology rates report an increase in the number of unmarried couples from 3.2 million to 5.5 million. Households consisting of married couples with their children are now at their lowest level – falling from 45 percent in 1960 to just 25.6 percent in 1999. The rate of out-of wedlock births increased more than fivefold between 1960 and 1999 and 43 percent of American children spend at least part of their childhood in a single-parent family (Feder 2001 : 9). The divorce rate increased sharply – to a level currently exceeding 50 percent – and parents increasingly decide to forego marriage. Married women in large numbers left the role of full-time mother and housewife to go into the labour market, and the activities of their former roles have not been completely replaced. Further, the amount of time children spend with adults, especially with their parents, has been dropping dramatically. Absent fathers, working mothers, distant grandparents, anonymous schools, and transient communities have become the hallmarks of our era (Popenoe 1995a : 16).

According to Elkind (1995 : 27) the nuclear family is invaded by postmodern ideas. Because mothers moved into the work force, divorce became easier and more common, the privacy of homes was invaded by television and children began to be hurried to grow up fast, a new form of family emerged: the postmodern family. This form of family encompasses many different family kinship arrangements, nuclear families, two-parent working families, single-parent families, adoptive families,

remarried families, as well as gay- and lesbian parent families. The value of the postmodern family, according to Elkind (1995 : 27 – 28), is that of autonomy, the importance of individual choice and a personal life journey. The value of autonomy is most evident in the transformation of family mealtimes – the icon of togetherness is no longer held sacred. Today, soccer practice, a business meeting or a music lesson takes precedence over the necessity to share a meal together.

It is not within the limits of this study to elaborate in detail on the content of socialisation or how the human family integrates their offsprings to be members of the social group. For the purpose of this study, only three perspectives will be discussed: General remarks on the content of socialisation, gender socialisation as well as the family as a mediator of the thin ideal.

2.7.3.2 Content of socialisation

a) General remarks on the content of socialisation

It is important to recognise that family practices reflect and transmit the values of the culture as a whole. Parents do not simply create their parenting practices de novo; rather they are likely to follow to some extent the role requirements for parents in their culture, which they have in turn learned as a result of their own experiences of socialisation.

During the early years of a child's life, socialisation aims primarily at the elimination of undesirable behaviour. Not making a noise at the dinner table, not playing with food, etc., are two examples of teaching the child socially acceptable behaviour (Louw 1991 : 222). According to Louw *et al.* (1998 : 224) parents influence their children's socialisation in three ways: Firstly, they socialise their children through direct teaching, by showing them, for example, how to eat and how to dress themselves. Secondly, parents constitute role models through their interaction with their children. Parents who are warm and loving will have children who are warm and loving. Finally, parents control certain aspects of the children's social life that could have an influence on their social development, such as the neighbourhood they live in or the organising of visits to friends.

In our society, the persons who dedicate their life to the nurture of children are most likely to be female. In former times, children grew up in extended families, often being raised by parents, grandparents and older siblings. In the modern nuclear family it is not always the mother who takes care of the child. In order to maintain a standard of living above the poverty line, women are often forced to join the labour market. As a result, overburdened mothers have to use the facilities of day care centres for their children (Furstenberg and Frank 1999 : 34). In fact, a greater proportion of U.S children today are enrolled in pre-school programmes, and it is widely accepted in the Western world that children as young as two years of age "benefit" from educational programs. "Learning" and "performing" are key words Western youngsters have to grasp from a very early age. As a consequence, postmodern children have come to be seen as competent, ready and able to deal with all of life's vicissitudes. Schools are competitive, streets are violent and the media vulgar (Elkind 1995 : 27). Even though competitive and ambitious traits are highly valued in our society, and are seen as beneficial to the child, recent research has demonstrated that children of working mothers do "less well" than children of mothers who are not in the labour force (Furstenberg and Frank 1999 : 34). Whether the researchers are referring to school performance or life skill requirements is not clear.

Today, in the Western, industrialised countries, children are much less tightly embraced within the environment of the family, and much more exposed to socialisation influences outside of the family. Peer groups, child care workers, television characters, etc., influence children and characterise role models to which children owe obedience and respect (Arnett 1995 : 620). As a result, immaturity is no longer a fitting sequel to the perception of childhood competence. The new, postmodern, perception of childhood and adolescence, according to Elkind (1995 : 27), is that of so-called sophistication. Young children are sophisticated in matters of sex, drugs, media and computer technology. The social acceptance of premarital sexual activity has now extended down to adolescents, with the number of teenagers who are sexually active tripling since the 1960s. Information technology reduces the overall interaction between children and parents because the child is "always playing games on the

computer", says Bernardes (1997 : 94). Adults, on the other hand, often do not even provide for the organised activities of teenagers. Young people's needs for limit-setting, guidance and value-modelling are not being met. This lack contributes to new imbalances and to many stress-related problems of contemporary youth (Elkind 1995 : 27). Bernardes (1997 : 111) is of the opinion that the reason for today's youth suffering from imbalances and stress-related problems lies in the deep confusion about how exactly parents want their children to grow up. Considering the limited time children spend with their parents, there is popular rhetoric that emphasises conflicting behaviours such as obedience and educational success yet also aggressiveness and competition. This confusion often leaves children with a deep sense of bewilderment, not knowing how to react appropriately in different life situations. Elkind (1995 : 27) terms this the "new morbidity", which refers to the fact that a higher percentage of young people now die from stress-related causes, for example, accidents linked to substance abuse, suicide and anorexia.

b) Gender socialisation

Differential treatment and identification with role models from birth onward are primarily responsible for gender-role socialisation. As the child grows, he or she quickly learns what people mean by "masculine" and "feminine". Societal expectations vary across cultures and subcultures regarding what men and women are supposed to do and how they can be acceptable. However, some generalisations, according to Davenport and Yurich (2001 : 64), can be made transculturally. Bem (1975) and Scher (1979) (both quoted in Davenport and Yurich 2001 : 64) indicate that, overall, women are expected to be caregivers – gentle, nurturing, dependent – whereas men are socialised to be strong, sexually rapacious, powerful and in control of themselves and of their situations at all times. Peters (1994 : 913), in supporting this point of view, states that females are "socialised to be dependent, fragile, unaggressive, sensitive, nurturant and hesitant to take risks". Males, on the other hand, are "socialised in the home to be strong, confident, independent and daring" (Peters 1994 : 914).

In contemporary society, gender is a central organising principle in men's and women's images of themselves. The construction of their social world is influenced by the development of ideas of what is right or proper male and female behaviour, beliefs, aspirations and ways to relate to others (Spence as quoted by Peters 1994 : 914). Lambert (as quoted by Peters 1994 : 914) is of the opinion that children learn about the social order, which in time will appear to them to be a natural social order in the sense that they will come to take it for granted as the framework within which they think and act. South African school books verify this statement by presenting girls and boys with stereotyped pictures of the different roles of men and women in society and present girls and boys with different role models (Popenoe *et al.* 1998 : 251).

Not only does society socialise its offspring with the "appropriate" roles it identifies for the different sexes, but some scientists (Bartky 1982; Benson 1991; Berger 1973) argue that the difference in socialisation of the genders often lies within the inhibition of autonomy of women. Feminine gender socialisation in our society attaches great significance to women's physical appearance. Benson (1991 : 386) states further, that "becoming a thoroughly feminine woman involves near constant effort to measure up to complicated and ever-changing standards governing one's looks. These standards are organised by the goal of making women pleasing and exciting visual objects for men". Berger (1973 : 47) claims that "...men act and women appear. Men look at women. Women watch themselves being looked at". To Benson (1991 : 386) one of the messages most commonly conveyed in the socialisation of the female gender is that women's physical appearance is naturally deficient, and she "has to fix herself up", "do something about her body", or "sculpt herself". Often, young girls are instructed to measure their looks against standards, which are only attained after prolonged efforts at plucking, painting, toning, tanning, starving, and meticulously scrutinising their bodies. Benson (1991 : 386) underlines this statement with the example of an advertisement of a hair care product, where it is mentioned that the girl will "lose nothing but her imperfections". Women's autonomy is reduced to the extent that they are socially trained to value appearance more than their personal values and characters.

However, Benson (1991 : 395) adds that men, who develop their gender identity in Western societies that oppressively socialise women, are also liable to be blinded systematically to important reasons there are for them to treat women differently. In fact, the gender socialisation of women would be unlikely to have such widespread and devastating effects on women's attitudes toward themselves were men not also brought up to treat women in ways that promote the objectification of women (Benson 1991 : 395). While Benson (1991 : 386) is arguing that girls only attain the required look after working hard and relentlessly on their bodies, it has to be questioned whether the looks presented to women are not totally unattainable and out of reach. This will be discussed in greater detail in paragraph 2.7.5 on the role of the mass media in marketing a certain body image. This aspect of feminine socialisation is captured well by Bartky (1982 : 136), who states: "The fashion-beauty complex produces in woman an estrangement from her bodily being. On the one hand, I am it and am scarcely allowed to be anything else; on the other hand, I must exist perpetually at a distance from my physical self, fixed at this distance in a permanent posture of disapproval." Women find themselves in an endless struggle against their natural defects, always reminded that their looks never measure up well with the prescribed standards of Western society. Benson (1991 : 386) goes as far as seeing those who do not measure up as condemned by society. He suggests that if they do not live up to the norm, women are viewed as "lazy or selfish or ignorant or mentally or physically ill. Worse still, they might be mannish, not real women at all" (Benson 1991 : 386).

One can conclude that many women are brought up to believe that constructing a feminine appearance is indispensable to their personal worth. Western women are taught that securing attractiveness in men's eyes is a prerequisite for social success, physical health, stable identity-formation, and meaningful self-expression. With the prevailing Western standard of bony thinness, the necessity to conform to the beauty ideal can therefore have great negative implications concerning the health of many women.

c) The family as mediator of the thin ideal

As the primary socialising agent, the family is in a unique position to impart socio-cultural messages to young females (Stice 1994 : 647). Haworth-Hoeppner (2000 : 212) considers the family, which is a mediator of culture and operates as a formidable influence on identity, as one of the major contributors in the development of the self and the formation of the self-image. As indicated in the previous paragraph, young girls are socialised to get a sense of their self-esteem from their physical appearance rather than from what they do (Osvold and Sodowsky 1993 : 143). The necessity of the pursuit of a slim and slender body, which today is equated with self-control, elegance, sexual attractiveness and youth (Dally and Gomez 1980 : 64), is hammered into girls' heads from a very early age. Little boys are socialised to have a preference for a particular form, learning to evaluate negatively everything not conforming to the cultural standard of attractiveness. Silverstein (as quoted by Gordon 1990 : 83) concluded in his studies on sex roles within the family that parents often believe that a woman's place is within the home, that the mothers were dissatisfied with their own careers and that the father had a disparaging view of the mother's intelligence. This negative view, sometimes endorsed by both parents, creates the context within which the female child is brought up.

Talking from own experience, Lelwica (1999 : 63) explains that families are often the primary locus where the slender lines of acceptable womanhood are transmitted. This is often done without much subtlety: "When was the last time you looked in the mirror? ... You'd better lose weight... Your husband will look elsewhere. No one wants to go to bed with a baby elephant." These phrases were expressed by members of her family, showing how the language of slenderness is taught and learned, even by those who do not deliberately intend to speak its potentially harmful meanings.

Yet another reason for young girls to be over-conscious about their weight and dissatisfied and insecure with their bodies results from their parents' attitudes about their own weight. Peta Bee (2001 : 13) reports in *The Times* that researchers at the Glasgow University, who studied 100 three-to-four-year old children, came

to the conclusion that dieting parents, or those who are over-anxious about food, can be to blame for their children's unhealthy attitudes towards eating and their bodies. Dr John Reilly of the human nutrition department at Glasgow's Royal Hospital for Sick Children (as quoted by Bee 2001 : 13) stated that "a large number of the children who expressed a knowledge about calories and food intake were those with parents who were dieters or fussy eaters. In many cases the parents were doing what they thought was right, restricting the intake of sweets or fatty foods, but in doing so they were heightening awareness of the foods and drawing attention to them."

Children learn by example. If they see their parents shunning snack foods or counting calories they are likely to do the same. In particular, a mother's neurosis about her weight is likely to rub off on her daughter.

Different families mediate culture in divergent ways. In part, this can be attributed to certain characteristics of particular families (Haworth-Hoeppner 2000 : 223). "Direct parental pressure to be slender appears to be correlated with broader measures of weight concerns, dieting behaviour, and other forms of potentially unhealthy eating", according to Levine and Smolak (1994 : 472). The parental pressure may eventually lead to the production of eating disorders like anorexia nervosa or bulimia nervosa.

2.7.4 Peers as socialising agents

When children attend day care centres or, at the latest, when they start school, they become more heavily exposed to another important agent of socialisation, the peer group. Popenoe (1995b : 126) defines the term as a group of people who have roughly equal social status and are usually of similar ages. The members of a peer group, however, do not necessarily have to be friends. Mostly, especially in childhood, they are formed largely by accident. For example, the children in a given second-grade class are considered to be a peer group.

The prominence of peers in the process of socialisation varies among cultures. Peers are important as a socialisation influence in childhood in industrialized cultures

because children and adolescents in such cultures spend so much time with same-age peers both in school and in leisure time out of school (Arnett 1995 : 621). This raises the effect of peers as a socialisation influence and correspondingly diminishes the role of the family, given that the time spent in school and day care centres with peers is time which otherwise, historically in the West – and now even in many pre-industrialised cultures –would be spent with the family.

Peer groups, or "alternative reference groups" are groups to whom people look up for appraisal, guidance, and role models (Neubeck and Glasberg 1996 : 146). These groups may be an important factor influencing study habits, work aspirations and lifestyle goals. Additionally, by forming coalitions, a greater sense of autonomy from adults is developed. The people who are subject to prejudice or disapproval often form peer groups to resist stigma and reinforce the validity of their autonomy. Women, for example, often form peer groups to countervail against patriarchal treatment and share information that challenges the prevailing attitudes toward women's appropriate roles, rights and abilities (Neubeck and Glasberg 1996 : 146).

Popenoe (1995b : 126) is of the opinion that peer groups influence socialisation more and more with every passing year of childhood. Peers are especially influential in adolescence, as they help teenagers find their place in a society of equals. In the family, by contrast, the status of young people is always subordinate. As a result, adolescent peer socialisation may often be in conflict with socialisation from other sources – for example adolescent peers in the West encourage each other in respect of alcohol use, high-speed driving and other forms of reckless behaviour that is proscribed by the legal system and by many parents (Arnett 1995 : 621). Conformity is a key word of adolescent peer groups, and that is why adolescents choose peers similar to themselves in various ways. Young girls belonging to one peer group, for example, often have the same taste in music, dress, idols, etcetera. However, it is almost impossible to go against a peer group and anyone who does not do what the others want becomes an "outsider", a "nonconformist", an "outcast" (Henslin 1996 : 66). Usually, peer groups are separated according to gender, especially during childhood and adolescence. A team of sociologists observed children at two elementary schools in Colorado and concluded that the norms that made boys popular are athletic ability, coolness, and toughness. For girls, family background, physical appearance and an

interest in more mature social concerns – such as the ability to attract popular boys – were highly important (Henslin 1996 : 65 – 66).

Stice (1994 : 647) argues that peers play an important role in body image distortions by perpetuating the thin ideal. The reason therefore is that, during early adolescence, girls in particular value the opportunity to seek advice and support from friends about personal issues, such as attractiveness and self-control. This may suggest that peer influence reinforces the glorification of slenderness (Levine and Smolak 1994 : 473). However, Levine and Smolak (1994 : 473) cite a study done in Australia by Paxton *et al.*, which concluded that very few Australian middle school and high school students felt encouraged by friends who currently dieted.

On the other hand, it appears that adolescent girls do talk about these matters and encourage each other to lose weight and increase muscle tone. Thus, according to McCabe and Ricciardelli (2001 : 13), peers were perceived to pressure girls to move closer to the societal ideal. Approximately 50 percent of the 9th grade American girls surveyed by Desmond (as quoted by Levine and Smolak 1994 : 473) said they received information about weight control from their friends. Levine and Smolak (1994 : 473) found that about 41 percent of the middle school girls they surveyed reported talking with their friends about weight, shape, and dieting at least sometimes.

One phenomenon within peer behaviour that influences body image dissatisfaction, heightens shape consciousness, and increases a desire to be slender, is teasing about weight and shape. Gowen, of the Stanford Centre on Adolescence, quoted in the magazine *Women's Health Weekly* (1998b : 12), stated that there is a strong relationship between teasing and body image concerns among young adolescent girls. Fabian and Thompson (as quoted by Levine and Smolak 1994 : 473) found that the self-reported frequency of teasing was significantly correlated with low scores on a body esteem scale and high scores on the drive for thinness subscale of the Eating Disorders Inventory for girls ten to fifteen years of age.

2.7.5 The media as socialising agent

Cultures vary regarding the range of media they allow their members to consume. In most Western societies this range is extensive, reflecting the broad socialisation that predominates in the majority of cultures that set the standards for these societies. In complex societies therefore, the mass media (the means of communication, for example, newspaper, radio, television, Internet) have come to play an extremely important role in socialisation (Popenoe *et al.* 1998 : 94).

Of special concern to many people in recent years, including especially social scientists, are the effects of television viewing on children. Popenoe *et al.* (1998 : 94) quote Barwise and Ehrenberg, who state that more than 98 percent of American homes have at least one television set, with the average American household having the TV set turned on for six to seven hours per day. Further, it is estimated that by the time the average American child completes school, he/she will have spent 20 000 hours watching television. This figure exceeds the total time spent in the classroom. The figures for South Africa are probably not as high as those for America because according to Popenoe *et al.* (1998 : 94) only 58 percent of homes have television sets.

Given the statistics on how much time children actually spend in front of the TV set and knowing that they model their behaviour after people around them, the impact television has on children can be realised. Programmes screened on TV often provide much useful information and children can gain a broad knowledge of people, places and events. Other screened programmes, however, have potentially damaging effects on children. Aronson *et al.* (1997 : 451) explain that there is not only a high correlation between the number of violent TV programs watched and the viewer's subsequent aggressiveness, but the impact also accumulates over time, which means that the strength of the correlation increases over time. Commercials are also an important form of media socialisation. It has been estimated that by the age of 20, the average of American has seen about one million commercials (Popenoe *et al.* 1998 : 95). The success of the diet and beauty industries suggests that messages presented in commercials and television programmes concerning the ideal physical appearance do not fall on deaf ears but are projected onto a most receptive population (Haynes 1995 : 10 – 11).

The role of commercial interests and the media in promoting contemporary body ideals cannot be underestimated. Behavioural modelling is radically enhanced by the mass media (Gordon 1990 : 106), and it has been suggested that the media are the most potent and pervasive communicators of socio-cultural standards (Thompson and Heinberg 1999 : 340).

The mass media are defined as modes of communication that generate messages designed for very large, heterogeneous, and anonymous audiences with the goal of maximising profit (Harris 1999 : 10; Levine and Smolak as quoted by Thompson and Heinberg 1999 : 340). Thompson and Heinberg (1999 : 340) further state that "although images of beauty have historically been communicated through art, music, and literature, it is the ready accessibility and universality of today's print and electronic media that have been most harshly criticised by body image and eating disorder researchers." Furthermore, historically, figures of art were romanticised as otherworldly and unattainable. In contrast, print and electronic media images blur the boundaries between a fictionalised ideal and reality. Photographic techniques such as airbrushing, soft-focus cameras, composite figures, editing and filters may blur the realistic media messaging even further, leading consumers to believe that the models the viewers see are actual people rather than carefully manipulated, artificially developed images (Thompson and Heinberg 1999 : 340). Thus, contemporary culture is flooded with images of extremely thin and beautiful women, conveying the message that real women's bodies are inadequate and in need of work (Lee 1998 : 134). While proof of a causal relationship between media influence and idealisation of a thin shape has not been established, results from recent investigations have demonstrated empirically that exposure to television programmes and to advertising affects women's perception of their body shape and spurs on their attempts to reach the "ideal" (Stice 1994 : 648). The fact that the media-portrayed standard of thinness is unattainable for most women is, however, what makes it such an effective marketing tool. Encouraging women to measure themselves against this standard allows advertisers to exploit not only women's inevitable dissatisfaction with their own bodies but also their resulting feelings of failure and inadequacy (Wilson and Blackhurst 1999 : 114).

Women's magazines, probably more than any other form of mass media, have been criticized as being advocates and promoters of the desirability of an unrealistic and

dangerously thin ideal (Wolf 1990 : 163). Levine (2000 : 85) explains that many girls and young women "consume" mass media, thereby immersing themselves in the thinness schema. Levine (2000 : 84 – 85) lists this thinness schema as follows:

a) beauty is a woman's principle in life;
b) slenderness is crucial for success and goodness; "image" is real substance;
c) women are naturally self-conscious about and bound up with their bodies; fat announces your personal responsibility for weakness, failure and helplessness; and
d) a "willing" and "winning" woman can transform and renew herself through the technology of fashion, dieting, and rigorous exercise.

Women's magazines have a broad readership, but it seems as if most magazines focus on the younger generations. For example, approximately 2 million girls in the U.S. subscribe to the teenage magazine "Seventeen", and the estimated readership exceeds 11 million (Levine 2000 : 85). Thompson and Heinberg (1999 : 341) report that 83 percent of teenage girls report spending a mean of 4.3 hours a week reading magazines and 70 percent of girls who read magazines on a regular basis endorse them as an important source of beauty and fitness information. Research strongly indicates that a thin ideal is promoted by the print media, particularly magazines aimed at teenage girls and adult women (Levine *et al.* as quoted by Thompson and Heinberg 1999 : 341). For example, a cross-sectional study conducted by Field (2000 : 88) came to the conclusion that 69 percent of the girls investigated reported that magazine pictures influenced their idea of the perfect body shape, and 47 percent reported wanting to lose weight because of magazine pictures. The more frequently a girl read women's magazines, the more likely she was to have dieted to lose weight. The result therefore supports several cross-sectional studies by observing a positive association between weight concerns and frequency of reading fashion magazines, or trying to look like females in magazines or on television (Field 2000 : 89).

Wilson and Blackhurst (1999 : 112) take a closer look at the role of food advertisements in women's magazines. According to them (1999 : 113), food advertisers routinely make use of four strategies. They (a) normalise body dissatisfaction and weight preoccupation among women; (b) set up inevitable,

unfavourable comparisons between women's own bodies and the thin ideal; (c) evoke guilt and shame about women's appetites and body size, and (d) incite fear and anxiety about the potential consequences of unrestrained eating. One of the many examples Wilson and Blackhurst (1999 : 114) give in their article on food advertisement, is that of "0 Excuses", a campaign promoting Fat-Free Caramel Corn. Photographs of high calorie foods (chocolate candies, cookies, etc.) are shown, with slogans like "Did somebody move these buttons?", "The cleaner must have shrunk this", and "Weren't there more holes in the belt?" underneath the pictures. The advertisement further proclaims that if one uses their specific product, which provides only 50 calories, then there are "0 Excuses" needed for being too fat.

According to Thompson and Heinberg (1999 : 341) unrealistic ideals similar to those found in the printed media can be found on television. Garfinkel and Garner (1982 : 106), two prominent eating disorder researchers, argue that the most successful and beautiful protagonists in the popular programmed media are portrayed as thin, and that this association has led viewers to connect thinness with self-control and success. MacDonald (2001 : 1002) reflects on the words of Melanie Katzmann, a consultant psychologist form New York, who is of the opinion that the media actively market the thin ideal in association with success and the body is treated as a commodity. The consequent pursuit of thinness has become a new religion for Western women. Gordon (1990) says that the models presented on television are sometimes so skinny that the calf is larger than the thigh. This distortion of the natural proportions of the body pass unnoticed and are considered and accepted as the norm. "Some high fashion models appear to be literally anorexic (as indeed some may be)....", according to Gordon (1990 : 80).

To Gordon (1990 : 81) there is little question that the media with its commercial exploitation of insecurities regarding body image has had an impact on the rise of eating disorders. The magazine *USA Today* (2000 : 11), however, published an article called *Media not totally to blame.* Thompson, associate professor of communications, is quoted in the article as saying: "The media do not act as an initiating, but, rather, as a perpetuating force to those who suffer from an eating disorder. To these young women who are at risk, some of these beauty and fashion magazines can be as dangerous as giving a beer to an alcoholic." This rather narrow point of view is not

supported in this research project. Thompson seems to forget that, when from a very early age people are bombarded with the message that beer is a necessity for a happy and successful life, the probability of drinking a lot of it and in turn becoming an alcoholic, is far greater than it would be without the brainwashing effect of the media.

2.8 SUMMARY

In this chapter, a dynamic view of culture as a process is put forward in which the perceptions, emotional experiences and behaviour of the individual play a major role. It is also stated that the cultural context with the relevant historical, economical and political influences should always be considered. A selection of cultural characteristics are discussed and the conclusion is that the various characteristics of culture such as culture change, culture as a shared and learned phenomenon, and culture as a symbolic and integrated whole are instrumental in the understanding of eating disorders.

From the anthropological literature covering cross-cultural studies, it is clear that food always presented a rich field of information on how people perceive the world and interact socially and politically. In the more recent literature on eating disorders, it is just as obvious that scientists should take note of how patients and potential sufferers of eating disorders categorise and use food. It went even so far as to proclaim that culture is a dominant defining factor of food. This is especially clear when concepts such as hunger, appetite and satiety are investigated.

With regard to the nature, history and epidemiology of anorexia and bulimia, the following ideas are of importance: Even though anorexia nervosa and bulimia nervosa are relatively well known clinical and psychological diseases, more information is needed on the socio-cultural factors causing eating disorders. Social scientists became more interested in the study field as external changes in the Western culture occurred. In the second part of the nineteenth century and more tangible since the sixties, a shift took place in the ideals men and women held for the female body shape. The emphasis on the angular, lean female shape caused thousands of women in the Western world to start dieting as a way of life and striving (in most cases in vain) towards the impossible ideal. However, the most significant change took place in views on the female role and position in society. Partly under influence of the feminist movement and partly

because women became more involved in the economic sphere, the idea of being feminine broadened to include achievement and assertiveness. These contextual changes led to a heightened preoccupation with matters of weight, body shape and beauty. In the eighties, this was even more intensified with a growing emphasis on youthfulness, the fitness boom and the expansion of the fashion market for teenagers. Considering all these influences, the rising incidence of eating disorders was inevitable.

It has been argued that anorexia nervosa and bulimia nervosa are culture-bound syndromes that are transmitted from one generation to the next. In this process, three prominent socialisation agents are involved, namely the family, peers and the media. All three agents focus the attention of young females on the beauty ideal of thinness. Their combined message is brutal but clear: To be socially acceptable, one should be attractive and in control of the body.

CHAPTER 3: DISCUSSION OF EMPIRICAL RESEARCH FINDINGS

3.1 INTRODUCTION

There are various options in which the research findings could be presented. From an anthropological point of view, it is important to relate cultural practices, behaviour, perceptions and values to human beings – to give a human face to our research 'facts'. Further, in an effort to *understand* an illness/disorder such as eating disorders from a socio-cultural perspective (in opposition to a bio-medical perspective) it is necessary to focus on how people use and manipulate strategies and how they manage culture. With these assumptions in mind, the research findings in this chapter will be presented from the viewpoint of the individual. Although the participants are divided in groups and material is, where applicable, presented in a comparative way, the main emphasis will be on the person in relation to her family, food, eating, body, weight, friends, etcetera.

Further, results from the questionnaires are not presented separately. Rather, individual answers from the different questionnaires were organised around certain themes in order to fulfil the objectives set for this research project.

3.2 INTRODUCING THE RESEARCH PARTICIPANTS

It all started when I was 17. It was April 2000 and I took off from my favourite sport swimming. My body was tanned, toned and sexy. I really looked good. Because I didn't do any exercise, I decided to eat less. My weight plunged to about 49 kg and my parents brought me to the doctor. He referred me to a psychologist and a psychiatrist. Then I was hospitalised for 3 weeks. When I got out my parents thought that a holiday would do me good. They thought that it would distract me from the issues I had with eating. But it didn't. After a week's holiday I was hospitalised again. I was out for a day and then I had to go to Tara[1] for 3 months, from beginning of August till end of October. ...It was hell in there. The only thing we were allowed to do was eating and eating and eating. We were not allowed to move after we ate something. ... When I got

[1] Tara – *The Age Moross Centre* is a hospital in Johannesburg, which includes an eating disorder unit.

out of there, I was so glad that nobody controlled my eating anymore. And so I went back to my old eating habits. ...The least I ate was half an apple a day – not even. I knew I had to eat but I didn't want to. I would cut one piece of the apple and eat it over a long period of time. Meanwhile I was cleaning, washing dishes, and cooking. I cooked all the meals for my family. They were huge meals but I avoided the dinner table. The psychiatrist told my parents that they should not force me to eat. But my dad was as persistent as ever. He tried to force me to eat all the time. ...By January I was back in hospital for two weeks. I was discharged and a week later I went back again. It was a bad time. I was so weak that I could not carry my pillow anymore. I only weighed 31 kg. Still, I did not sit down or relax. I was constantly standing around – I had to burn calories. Then I turned blue under my skin. The doctor said it was because of my organs had started bleeding. He said that the organs had begun to use the tissue under the skin to keep me alive.

Then, one Thursday, I was standing in the kitchen and suddenly I was in the mood for a burger. I told my mum and she asked me if I was sure. My parents started crying. They couldn't believe that I wanted to eat. And so we went to buy the burger. I ate the whole big thing. Still, the doctors said it was necessary to go back to hospital. If I did not go back for tube feeding I would die anyway. I said I was not going. Even though I had no energy, was always tired and had absolutely no muscle control, I did not think I would die. Then, a legal battle started because I was under 18. My parents won. I was back in hospital. The doctors didn't think I would make it. I had starved my body so extremely that everything was messed up. I realised that if I didn't stop I might really die. ...When I was out of hospital, I had to learn how to eat again. It was weird. I had forgotten what my favourite foods were and how they tasted. So in the beginning I totally overate. I had to taste everything. In the next 4 weeks I gained 6 kg. Since then I have been eating normally. ...Today I know that there is a fine line between dieting and the illness. You get positive remarks for losing a bit. Then you want to lose more and more. The hungry feeling goes away, and there you have it, you can't eat. Anyway, you feel guilty about eating and if you eat you are full immediately. So you leave it. ... But I didn't think I had anorexia. I looked okay. Really, I actually still think that I didn't look that bad then. I definitely wouldn't mind going back to the weight I had then. Maybe a bit more. You know, I hate being fat and overweight. At the moment I

am definitely too fat. Oh, that soft, wobbly fat is so ugly and disgusting. I want to look good and be thin again. I could never, ever live with fat.

This is the tragic story of Cindy[2] – one of the anorexic girls of Group 1. Although she represents only one extreme individual case in the research group, her story nonetheless gives an indication of the complexity of anorexia nervosa and bulimia nervosa. Today, the girl realises that she was close to death and that she had caused her family great anguish and pain. However, even after intensive therapy involving psychiatrists, psychologists and dieticians, it is apparent that the participant still clings to the Western world's ideal of thinness.

As indicated in Chapter 1 (paragraph 1.3.2), the research data was obtained from 3 female groups. The first group (Group 1) consisted of 10 females previously clinically diagnosed with anorexia nervosa, bulimia nervosa, or both. The second group (Group 2) consisted initially of 7 and eventually of 6 individuals and so did the third group (Group 3). Both groups were selected on the basis of their leisure time activities and the positive connection thereof to eating disorders. Group 2 involved girls working part-time or full-time for a model agency, while Group 3 included young females who were members of a dance school.

Seven of the girls in Group 1 were previously classified as anorexics while 3 girls of the same group had been diagnosed as suffering from bulimia nervosa prior to the research. Among the 7 anorexic girls, 3 were troubled by bulimia after suffering from anorexia. On the other hand, 2 other girls from Group 1 were previously diagnosed with anorexia after having suffered from bulimia nervosa for a long period. Many eating disorder specialists (Bruch 1978 : 376; Garfinkel and Garner 1982 : 53; Lelwica 1999 : 17) have acknowledged the close relationship between anorexia and bulimia, especially when it comes to the physical overlap between the eating disorders. According to Lelwica (1999 : 17) 50 percent of anorexics become bulimic in the course of the illness, and the same percentage of bulimics have a history of starving themselves. Furthermore, while 4 of the girls of Group 1 felt the eating disorder was relatively under control at the time of the interviews, 3 of them were going through a phase with extreme symptoms of bulimia, and 3 girls were engaged in starvation

[2] Name has been changed in order to maintain privacy and autonomy.

behaviour. When questioned as to whether they considered themselves to be currently suffering from an eating disorder, 7 of the girls answered with a definite "yes", while 2 answered with "yes" only because "everybody else thinks so". One girl was of the opinion that she was healed, because she only vomited sometimes after meals. The close relationship between anorexia and bulimia explains why little or no differentiation is indicated in the presentation of research results of Group 1.

Of the 10 eating disordered participants, 7 had been hospitalised for anorexia nervosa, with 1 girl also having been admitted to an eating disorder clinic to be, as she termed it, "force fed". A local psychiatrist treated 7 of the girls, and 9 additionally sought psychological help at some stage of their illness. Nine out of the 10 eating disordered girls were also referred to a dietician.

When questioned as to whether the received treatment has been of any help, 7 girls answered with a definite "no". Most of them indicated that, firstly, the illness has to be acknowledged. Being of the perception that one's behaviour is under control and that it does not deviate from the norm is especially common amongst the eating disordered girls. Further, most participants of Group 1 were of the opinion that for the treatment to be successful, one's own mindset has to change, and one has to want the change more than anything. One girl was of the opinion that knowledge concerning eating disorders is rather limited in Bloemfontein, and where there is no education regarding an illness, people cannot be helped. Three out of the 10 girls perceived the received treatment as very positive, with all of them being thankful to either their psychologists' or psychiatrists' help.

Participants from Group 2 (the members of the model agency) as well as the Group 3 (the dance school girls), were, at the time of the interviews, not suffering from an eating disorder. As already mentioned, the 2 dancers who were suffering from anorexia and bulimia at the time of the selection of research participants, had been immediately included into Group 1. Even though eating and body problems were detected amongst Group 2 and 3 participants in the course of the analysis, no clinical diagnoses were carried out.

According to the Group 2 and 3 girls, none of them had ever been treated for an eating disorder like anorexia nervosa or bulimia nervosa, nor for any other weight related problems.

3.3 PERCEPTIONS AND BEHAVIOUR CONCERNING FOOD AND EATING

"Food ... is not only a collection of products that can be used for statistical or nutritional studies. It is also, and at the same time, a system of communication, a body of images, a protocol of usages, situations and behaviour"
(Barthes as quoted by Counihan 1999 : 19).

As indicated in Chapter 2, paragraph 2.3.2, each culture classifies substances into food and non-food. The findings concerning what can be construed as food, and what not, to the participants, were interesting and confirmed the connection between food and health common in Western cultures. It seemed as if the so-called cultural stamp of approval concerning what can be considered as food and what not, was often identical to what the participants considered as healthy and unhealthy. Most of the interviewees viewed food, as one girl termed it, as "the healthy stuff". This included vegetables, fruits, fish, red meat, chicken, pork, cheese, rice and potatoes. Non-food was generally considered to be sweets, chocolates, junk food and liquids like water and juice. As one of the model participants explained: "Sweets and chocolates are not food because even though they are filling, they don't make you healthy."

However, some of the girls had a different perception concerning food and non- food. Two anorexic girls indicated that food is anything digestible, while non-food, as one of them pointed out, is "the not edible stuff". One bulimic girl classified everything as food, except broccoli and meat, which she dislikes. A dance school interviewee thought of food as everything, which gives the body energy. However, she perceived liquids and sweets as not belonging to this specific group. Yet another dancer had quite an interesting theory as well: "Food is everything one can swallow". This can then be divided into two different kinds of food: The first group consists of food which gives pleasure, like sweets, chocolates and junk food. The second group consists of health

foods such as vegetables and meat." Non-food to this specific girl was non-digestible items, which the body cannot use at all.

With most of the participants' perception that food includes everything that can be considered healthy for the human body, and non-food being the so-called 'pleasure foods' like sweets, chocolates and junk food, it became apparent that the health beliefs among some of the participants were responsible for the divisions concerning food and non-food. At the same time, when the girls were asked whether they perceived their families as having a healthy lifestyle, many mentioned that they would say so because of healthy eating habits. This was usually underlined with examples like: "We eat little meat, but lots of veggies and salads." Furthermore, cooked meals were often considered to be very 'healthy', due to the way they were prepared. Preparation of food, excluding the use of excessive amounts of oil, butter or fat was the reason for cooked meals being classified as healthy. Families joining the 'Weigh-less' programmes were perceived by their participating daughters as living an extraordinarily healthy lifestyle. In addition, to be healthy also often implied not living on junk food. One model stated that: "Usually we really eat very healthy. My mum cooks and we eat little meat and lots of salads and vegetables. Only sometimes, on weekends, we cheat and go and buy a burger." Here, unhealthy eating habits are equated with cheating, which implies that this specific girl feels that, in the case of eating a burger, she is doing something wrong. Further, drinking a lot of water was also often considered 'healthy', even though, as indicated above, many interviewees did not perceive liquids to be foods. From this discussion, it became evident that food and non-food were often considered to be closely related with 'healthy' and 'unhealthy' respectively. This, in turn was perceived to be closely interrelated with many of the girls' perceptions concerning 'good' and 'bad' food.

For the discussion concerning the participants' perceived distinction concerning 'good' and 'bad' food, it was found, that overall, 'good' meant 'healthy', while 'bad' was used to describe foods which have been socially stigmatised by Western people as fattening or unhealthy. The good/bad dualism in terms of food became apparent from statements such as the following: "Good foods are the ones which are freshly prepared, steamed, without fat or sugar. Otherwise raw vegetables or fruits." An anorexic girl explained: "Bad foods are deep-fried in oil or in butter. Chocolate, cake and bread are

very unhealthy as well". One bulimic girl gave a short and concise answer: "Good food is healthy and bad food is fattening".

Food/non-food, good/bad food as well as healthy/unhealthy food are closely connected with foods the participants always avoid. Besides the food the girls dislike, usually it was the 'bad' and unhealthy nutrients the girls said should be avoided on a regular basis. Again, the girls' answers were very consistent with sweets, chocolates, junk food and in an oily manner prepared meals being avoided most often. "I can tell you exactly what I don't eat. I avoid chocolates, cookies, sweets, pies, burgers, chips and junk food. I just feel healthier and have more energy if I don't eat that stuff", a dance school girl explained. Avoiding fattening foods had nothing to do with not liking them or not craving for them. Many girls explained that they do not eat the unhealthy food because: "it makes me fat" or they feel guilty if they have not followed a healthy diet. "I spare myself that nagging feeling of guilt after every sweet I eat. It's not worth it", or, "Even though I crave for a big steak, I don't eat it because I know the miserable feeling afterwards", were common answers by many of the participants. Avoiding food as well as ignoring cravings for food that was considered fattening, was experienced by almost all of the participants.

Further, reducing food intake after having overindulged was also apparent amongst many of the interviewees. One participant suffering from anorexia indicated that: "I always eat very healthy foods like veggies and fruits. Plus I try to stop eating before I'm full, it's better for the body. But if I eat too much for lunch, for example, then I will definitely miss out on dinner. I always try to eat around about the same amount of food every day." This finding was especially interesting, since according to Garfinkel and Garner (1982 : 4) this behaviour is usually found among anorexic individuals. The eating disorder specialists indicate that for anorexics foods are generally always to be avoided, with high carbohydrate foods becoming feared especially and totally rejected. Exceeding the daily 'allotment' of any food will induce extreme feelings of guilt and a desire to cut back the food intake on the next day (Garfinkel and Garner 1982 : 4). It seems as if the so-called weight and food phobias are not only common among individuals with serious eating problems, but also among the 'normal', average adolescent girl.

Besides the bad foods, which the girls avoided, some of the eating disordered participants had different reasons for not eating some foods: "I can't eat the food we got stuffed with in Tara. If I just smell eggs, battered fish, French toast or red meat and pork, I feel nauseous. Oh yes, and *Yogi Sip*[3]. When I was sick[4] that was the only thing I drank for days. I definitely can't drink that anymore." A bulimic girl pointed out that at a stage of her illness: "I avoided all food but muesli, fruits and milk. This went on for days. Then I couldn't be strong anymore and so I would binge on the most fattening and unhealthy food available in our house. Today I hate muesli. I know it is healthy and one should eat it, but I can't get myself to eat it."

It became apparent that with this dualism of good/bad and healthy/unhealthy is accompanied by a thorough and sophisticated knowledge of nutrition. According to answers on a question from the EAT-questionnaire, more than half of the participants were *always* or *often* aware of the calorie content of foods they ate. Furthermore, the participants knew a lot about calories and which foods are for slimming and healthy or are fattening and unhealthy. One girl said, for example: "The Weigh-less programme tells you which food you can eat and how much calories it contains. I would say good foods are, for example, broccoli, carrots, beans, meat, and so on. One can say all the foods which fill you and give you energy without making you fat." Often, a similar division in eating behaviour parallels this division in types of food considered good/bad, healthy/unhealthy.

Most interviewees indicated that they pass through 'good' and 'bad' phases in the course of time. This is usually determined by specific life situations the girls find themselves in. Many of the dancers and models indicated that they eat less when stressed, depressed, very busy, or during competitions and photo shoots. Some indicated to eat more experiencing premenstrual syndrome (PMS), when in the company of friends, or in times of tests and exams. In the case of the eating disordered girls, however, especially the anorexic girls never allowed themselves to eat more. An anorexic girl answered the question "In which life situations do you eat more than usual?" in a very simple manner: "Never". Therefore, eating less was an everyday 'must' for the anorexics, with eating more being totally out of the question. On the other hand, bulimic girls perceived themselves as going through different phases every

[3] A brand name for a drinking-yoghurt in South Africa.
[4] The girl refers to being sick when talking about her eating disorder.

day. Even though they indicated that they try to eat as little as possible around people, when alone they would usually binge on the 'bad' foods. The following quote illustrates this divided world of eating: "Around people I eat almost nothing, and if I do eat, then only very healthy stuff. But as soon as I am alone and miserable, I eat huge amounts of the most fattening food I can find."

According to their own interpretations, some of the eating disordered interviewees regarded themselves, in accordance with their views of food as either 'good' or 'bad', as being a 'good' or a 'bad' person. It became apparent that in the case of having overindulged in 'bad' foods, the person would consider herself to be 'bad'. The 'good' and 'bad' self is directly related to the 'good' and 'bad' food consumed, with a bulimic girl explaining this perception in detail: "When I binge, then the demon in me takes over. I think it's the bad part of me. I don't know. I always term it 'the demon'. Usually after a bingeing and purging session, I tell myself that this was the last time and that I will have to kill that energy robbing demon within me." Yet another bulimic girl expressed similar feelings when overindulging. She explains that during the day, when she tries to eat as little as possible, she always has to tell her 'bad' side to stop thinking about food. This 'bad' self can only be controlled sometimes. Usually, it is this self which takes over when the girl vomits, takes laxatives, or simply eats too much 'bad' food. To explain it more plainly, the 'bad' self is blamed when 'bad' food is eaten, or when 'bad' behaviour is allowed to occur, otherwise the person considers herself to be 'good'.

Living throughout the year with society's pressures to display the required "prim and proper" figure, some of the girls decide at least once a year that their eating behaviour deserves a holiday. It seems that for many, not only was the body allowed to rest from the stresses of the year, but so too was the eating behaviour. As one dance school girl reasoned: "I just take a break from my usual eating patterns and dieting and let go." Whether the strictly controlled food intake of the year was allowed to slip into a care-less, eat-more holiday mode depended on two factors. Firstly, whether the girls were on holiday with friends or their families, and secondly, whether the holiday was taken in the summer or winter season. Most girls who went to the seaside with friends, indicated that they eat less because: "We are very busy at the sea. We swim, play volleyball on the beach, and run around. Food is not so important then. Actually I

sometimes even forget about eating." In the case of spending a relaxed time with their families, many participants indicated that there is always a lot of food around, especially food one would not eat at home. "There is no routine on holidays and it's the same with eating. It's ice cream, sweets, chocolates, and in the evening we usually braai." Another participant indicated that: "You are in a different environment, with no stress. There is no routine and one relaxes and socialises around food." Even 2 of the eating disordered girls pointed out that holiday means relaxing, and, "you can let go and don't think about health for a while".

Concerning the difference between the seasons, some of the girls thought of the summer season as the 'bikini season' and therefore eating more of the so-called 'good' foods was required. As one bulimic girl indicated: "As soon as the summer starts I am even more body conscious. I just have to imagine myself in a bikini and I get goose bumps. Then I usually try to eat very little and very healthily." Another bulimic girl also indicated a distinction between summer and winter seasons. She explained that in the winter season she relaxes more around food (i.e. eat more) but in the summer it is impossible to do so. "Especially before the summer holidays, I start to diet and I usually only stop after we have been on holiday. I think I would not put on my bikini if I cannot lose at least a couple of kilos before we leave."

Therefore, while for many of the girls a holiday meant a break from dieting, calorie counting and being relaxed about food, others perceived this to be the time when particularly strict measures concerning weight and body have to be taken. Only one girl – a model – indicated little change in eating behaviour: "I eat relatively healthily during the year, and so too when on holiday. I do go for ice cream and chocolates, but I don't eat more than at home. I eat what I like and what I am in the mood for. There is no pressure on eating more simply because I am on holiday and I am allowed to." This quote emphasises most of the participating girls' weight and body conscious lifestyles. Only one in 22 girls had no apparent issue with eating and food, while all of the others perceived food – the substance that sustains life – as something one has to control almost a whole year around.

This obsession with food is also apparent in the amount of time the participants spend thinking about food during the course of a day. In this regard, a difference could be

detected among the more weight-conscious and eating disordered girls. The anorexic and bulimic girls indicated that they perceive themselves to giving too much time and thought to food on a regular basis. Some of the dance school participants, as well as some of the models, indicated only thinking about food when hungry. However, many participants of Group 1 and weight-conscious participants from Group 2 and 3 gave answers ranging from 24 hours a day to a couple of hours a day. "I think about food 24 hours a day. Usually I plan ahead what I can eat and what doesn't make me fat. Thinking about food sometimes helps me not to binge and purge", a bulimic girl explained. An anorexic participant explained that: "I think about food 22 hours a day, the rest of the time I sleep. I think about what I can eat next and plan carefully so that it is not too much and not too fattening." Preoccupation with food was also expressed by one of the dancers, who indicated that she thinks about food quite a lot. The reason she mentioned for doing so was that she always has to count the calories already eaten and only then can she decide whether or not she may eat more. "This takes quite some time", the girl explained. On the other hand, the minimum amount spent on thinking about food also came from an eating disordered girl. The anorexic participant explained that: "I think about food every third day for about 3 minutes. Food doesn't make me happy." This girl was busy starving her body at the time of the interview and her relationship with food seemed to be rather bizarre, as she ate almost nothing in the course of a day. However, whether this specific girl really almost never thought about food, or whether she only said so in order to justify the starvation process was not clear from her statements.

3.4 WEIGHT CONTROL METHODS USED BY RESEARCH PARTICIPANTS

Overall, the most widely reported weight control behaviour of the eating disordered girls (Group 1) was *starvation*. Nine of the 10 girls reported that they had, at some stage of their lives, voluntarily deprived themselves of food, while 3 girls admitted to currently being engaged in starvation behaviour, not eating at all for at least two to three consecutive days. In order to indicate the process of starvation more clearly, excerpts of one of the anorexic girls' dietary intake schedule are presented below:

- Monday: Eleven sugarless, black coffees were consumed in the period from eight o'clock in the morning to four o'clock in the afternoon. Thereafter, one *Bernini*, one *Fanta* as well as one "Brandy and Coke" were consumed in succession.
- Tuesday: Nine coffees were consumed in the period from eight o'clock in the morning to four o'clock in the afternoon. At five pm, the girl drank one *Bernini*, and half an hour later one glass of *Coca-Cola*. With the *Coca-Cola*, one small piece (she indicated that herself) of a lamb chop was eaten. More cold drinks were consumed later that night.
- Wednesday: Seven coffees were consumed during the course of the day. Again, at about five o'clock in the afternoon she drank one *Bernini*, followed by a *Coca-Cola* two hours later. At around eight o'clock that evening, she enjoyed one glass of *Coca-Cola* and some boiled vegetables with margarine and salt.
- Thursday: The girl drank 6 coffees during the day, followed by 3 *Bernini's* after work. At night, 3 "Brandy and Coke" were consumed followed by a glass of milk at midnight.

The ensuing days were almost identical to the ones presented above. Furthermore, this anorexic girl mentioned that when she does eat she regularly has the impulse to vomit right afterwards. It has to be mentioned that even though starvation was extremely common amongst the Group 1 participants, the weekly food schedule presented above was the most extreme case of starvation encountered. Some of the girls did, at the time of the interview, at least eat every day, even if it was only 2 apples and 4 *Provita*[5] biscuits. A very interesting finding was that in most of these extreme cases of starvation, the girls never ate by themselves. In the rare instances when they did take in nutrients, it was mostly with members of their families present. In the case indicated above, the minimum amount of food consumed was in the company of the grandmother. "When I am in my own apartment I never eat. The only time I eat something is when I am with my family and friends. They think there is something wrong with me, and in order to stop them from worrying, I eat. But I hate it – food makes me fat and is disgusting. I am never hungry." More information concerning the starving girls' relationships with their bodies, as well as the influence of peers and boyfriends will be given in sections to follow.

[5] A brand name for a savoury biscuit in South Africa.

Binge eating was the second widely reported behaviour among the eating disordered participants. One question included in the Eating Attitudes Test (EAT 40) was whether the person had "gone on binges where I feel that I may not be able to stop". Of the 10 eating disordered girls, 3 participants indicated *always*, while 2 circled the answer *often*. Two interviewees felt they *sometimes* cannot control the amount of food they take in, while one indicated she only 'rarely' binges on food. Two girls reported *never* to have the urge to binge on food. It has to be mentioned that the girls' own definition of a binge was relative. According to Van Zyl (1996 : 4), bingeing is the accepted term for the periodic bouts of overeating. However, Van Zyl (1996 : 4) states that some people refer to a binge as a state of loss of control, while for others it signifies quantity eaten in one session. The caloric value of a true binge is open to interpretation because some binges consist of 4000 – 6000 calories but other reported binges go as high as 20000 calories. One of the bulimic girls related her experience of a binge in this way: feeling guilty because of extreme bouts of overeating the day before, that day – as on so many days – she decided not to eat at all. After having investigated everything eatable in the family kitchen for a couple of times already, the feeling of hunger became unbearable and she decided only to eat half a slice of bread. However, as soon as she started eating, the overwhelming feeling of not being able to stop overcame her, and so she opened the fridge: "I knew exactly what was in there and the first thing I took out was the pasta of the previous day. I did not even close the fridge door or heat the food. I just grabbed a fork and started eating. When I had finished the whole pot, I grabbed the butter and some cheese." After a couple of lavishly buttered slices and cheese, the girl decided to eat something "more healthy". Two bananas and one yoghurt later, it was time for desert. Ice cream was taken from the freezer and: "after I had eaten a couple of bowls of the strawberry ice-cream I wanted some chocolates. I took one slab of chocolate to my room and finished it as well. Then, the extreme feeling of guilt started to come back." Only 3 of the participants indicated to binge as described in the medical classification of Van Zyl (1996). What was more common was a form of compulsive eating where little bits were eaten continuously during the day. Most interviewees were also extremely concerned with the amount of 'bad' foods eaten. Bingeing was often equivalent to eating more 'bad' (unhealthy) than 'good' (healthy) food.

At the time of the interview, 4 members of Group 1 seriously practised *purging* as a method of weight control. One interviewee practised self-induced vomiting after every meal, sometimes as often as 5 – 7 times a day. She reported that: "All energy I have turns into bulimia. Every time I eat something I feel so guilty and so I drink a lot of water. After a couple of minutes I go to the toilet and vomit the eaten food." Two girls reported purging only after having eaten too much, round about once or twice a week. One of the eating disordered girls practised the behaviour very infrequently, inducing vomiting only when bored and dissatisfied with her body shape. Further, one of the interviewees considered herself to be cured of bulimia, while one anorexic participant reported vomiting after every meal, not voluntarily however (she indicated that she felt nauseous after meals and vomiting was a reflex to this feeling) and therefore, according to her, she was not suffering from bulimia. Seven out of the 10 participants indicated that the feelings of guilt they experienced after eating as well as the obsessive fear of gaining weight and getting fat were the main reasons for this weight controlling behaviour.

One participant practised extreme *laxative* abuse, taking up to 4 – 5 pills per day. Three other girls had used laxatives with some frequency during a slimming phase. For weight loss 2 of the girls frequently used *diuretics*. In addition to dieting, 3 of the girls regularly swallowed appetite suppressants as well as diet pills. Two interviewees described themselves as having been addicted to the diet pills but fortunately managed to stop taking large quantities thereof. Furthermore, all eating disordered participants followed *strict diets* at some stage of their illness. An indication of their conscious and unconscious dieting became clear through their answers to the EAT question "I am aware of the calorie content of foods that I eat". Four of the anorexic girls answered by circling the word *always*. Two girls indicated that they are *often* aware of the calories they take in. The rest were only *sometimes* conscious of the caloric content.

When being asked to indicate further weight control methods, all of the eating disordered girls mentioned *exercise*. Five of the anorexic girls undertook strenuous exercise after meals in order to burn the maximum amount of calories they had taken in that day. To indicate the severity of this obsession with exercising, one participant described her experiences regarding exercising. The girl explained that she gets up every day at 03.00 am to fit in an extra session of exercise. She pointed out that she

goes to the fitness centre at 05.00 am but that the two hours spent there are not enough. Therefore she exercises at home as well. The girl also said that while she was hospitalised in the eating disorder unit, she was not allowed to exercise at all. The only time of the day when she was alone was during the half an hour during which the eating disordered girls could take a bath. "While the water was running into the bath, I exercised as much as possible. Usually I would run on the stand or do sit-ups for about 25 minutes. Afterwards I bathed very quickly."

In Group 2, the girls from the modelling agency, only one participant was perceived by the researcher to show behaviour which could be classified as *starvation*. The girl indicated not eating at all, and was living only on bottles of *Coca-Cola* for a couple of consecutive days. Her colleagues viewed this specific girl as *the* model, with great international modelling potential. As one friend of hers indicated: "If one wants to compete in the international arena, one has to meet their standards. Overseas agencies are very different to those here in Bloemfontein. One cannot afford to have half a kilogram too much on your body, but rather a couple of kilograms too little." *Bingeing* behaviour was described to occur rarely among most of the girls, while one model explained that she sometimes engaged in periodic bouts of overeating. *Self-induced vomiting* after meals was as rare, with one participant indicating similar pattern than the Group 1 individuals. "Sometimes, mostly on weekends, when I stuff myself with highly fattening food, I try to get rid of it by sticking my finger down my throat." Here again, the feeling of guilt from overeating was emphasised. Two of the models infrequently used *laxatives*, while none had ever swallowed *diuretics* in order to control their weight. According to their answers from the EAT, the girls very rarely engaged in *dieting behaviour*, with most of them explaining to the researcher that they always eat what they wanted. However, when going through their diary intake schedules, it was clear that most of them followed a very healthy, non-fattening diet. Of the 7 models who completed EAT, 4 interviewees indicated to strenuously *exercise* in order to lose weight. Two of the models reported that they do not take strict measures to control their weight.

In the case of Group 3, the dance school girls, total starvation could not be detected in any of the interviewees. Three participants on a fairly regular basis practised *bingeing* behaviour, while none of the dancers have *purged* after eating in order to control

weight. Five girls indicated *dieting* on a regular basis, with one having used fat absorbers as well as *diuretics* at some stage. *Laxatives* were infrequently used by 2 of the girls. Out of the 7 girls who completed the EAT, 6 *exercised* in order to control their weight. Before the interviews, the dancing instructor mentioned concerns about one girl who was overly weight-conscious. When her responses were analysed, this specific girl showed unhealthy behaviour concerning eating and exercising. The girl strenuously exercised every day, on some days dancing for more than 5 consecutive hours. She admitted to being weight-conscious, eating only a minimum of, as she termed it "fatless health food". Knowing the exact number of calories consumed per meal, she always reflected on what she was eating in order to know whether she was 'allowed' to eat more without experiencing the usual feelings of guilt. If ever she exceeded her personal caloric intake level, she would immediately exercise it off.

At this stage it has to be mentioned that even though most of the Group 2 and 3 girls were relatively familiar with concepts like bingeing, purging, the use of laxatives and diuretics, the significance these terms presented by the Group 1 interviewees, was perceived to differ from those of the other participants. With most of the eating disordered girls having received professional treatment for their eating problems, these concepts in their extreme forms were connected to personal, actual behaviour. It seemed that most of the interviewees of Group 2 and 3 had, for example, when indicating purging, a somewhat different picture in their heads. However, their degree of familiarity with the concepts did not change their equally strong wish to conform to the Western beauty ideal. Preferred body images of the interviewees will be discussed in detail in paragraph 3.6.3, the media as influencing factor.

3.5 PERCEPTIONS CONCERNING THE BODY

3.5.1 The concept of beauty

As indicated in Chapter 2 (paragraph 2.5), people at all times and in all places used the concept of beauty to evaluate the human body. One of the basic characteristics of anorexia nervosa is that it involves "a disturbance in the way in which one's body weight or shape is experienced" (American Psychiatric Association 1994 : 544). Therefore, one could say that the same people also have a disturbed perception of

beauty. In general, it is frequently the problem of adolescent females to be over-concerned with their bodies, but in the case of anorexia nervosa this indulgence has become distorted. Unfortunately there are no 'fixed' norms of beauty, but it is still an acceptable criterion to determine the extent to which anorexics and young females in general have disturbed perceptions of their bodies.

Some of the girls only focused on physical appearance and explained that: "A perfect body is beautiful"; "no fat, no pimples"; "like a model"; "beauty is when someone has a pretty, clean face, healthy hair, a toned body", and "the person must also be well groomed and well dressed." Most of the participating girls divided beauty into two different concepts: outer and inner beauty. Outer beauty was generally considered to be similar to the looks of famous fashion models. The following quotes are examples of perceived outer beauty: "If someone looks like a model, nice legs, nice hair, healthy skin, firm butt – that's beautiful."
"Cindy Crawford is beautiful. She is tall and has a toned, feminine but thin body. She also has nice hair and a pretty face."
"People who are skinny are beautiful. It's their thin tummy, their toned legs, their nice face, the pretty smile, the full hair and their shiny eyes which makes them beautiful."

Inner beauty was often perceived as, like one bulimic girl termed it, "the spark which comes from within", or as "the thing inside that shines outside". The interviewees equated this spark or inner quality with positive personality traits like a good sense of humour, friendliness, happiness, loyalty, responsibility, and the ability to handle situations and people in a fair and honest manner: "I would say inner beauty is the nice personality a person has. If she is friendly, happy, positive, honest, loyal, gets along with everyone and can listen to people, then I would say she is beautiful from the inside." This combination of inner and outer beauty was perceived to be the ultimate picture concerning a beautiful person. However, many of the participants gave more importance to the inner traits: "Beauty lies in the eye of the beholder, but the inside says everything. Nobody likes a grumpy and angry person who never smiles." "Inner beauty is the real beauty. You can be beautiful from the outside and maybe draw a lot of attention because of the nice first impression, but when you open your mouth and no sense comes out of you, then people stop thinking that you are beautiful. That's where the dumb blonde comes in."

With regard to the concept of beauty, the girls seemed to have a very mature perspective. Taking people for who they are, and following a philosophy which is sensitive to inner personality traits, were found to present a very positive outlook on life. However, this perspective was somewhat shaken when the question "Do you consider yourself to be beautiful?" was added. The eating disordered participants, as well as the dance school girls, answered this question with a definite *no.* Referring to outer beauty these girls would state: "I am ugly and fat." "No, I'm not beautiful. The mirror definitely doesn't say so!" Some girls even answered in a sarcastic tone, not really wanting to talk about the issue mentioned: "I have stretch marks, pimples, and I am fat. What was the question again?" When questioned further as to whether at least inside beauty (according to them the more valuable aspect of beauty) was present, negativity and a disbelief in the importance of the inner beauty was detected: "I am a bitchy person, pessimistic and negative. I hate people who sit on my head. I am too honest with people. ... No, I have no inner beauty." A bulimic girl explained that she 'had' the spark, but: "I lost it. The demon steals my spark. Now I am ugly from the outside and inside. That's what bulimia does to me."

Thinking more about the topic concerning inner and outer beauty confused some of the girls, with one changing her mind and denying the existence of inner beauty all together. "I think I am a nice person but I don't think people see me as beautiful. I am not so sure anymore about whether the inside really counts anyway. That's not what it's about. When you sit together with guys and a fat lady passes they immediately laugh and say something negative. To them, and I think to me too, she is not beautiful. So obviously they would not give her a chance. I have actually just now changed my mind. Beauty is really just what is on the outside. Can you change my last answer?"

It was evident that the participating models more often classified themselves as beautiful. Even though they were quite modest with their answers, the negativity expressed by Group 1 and 3 interviewees was missing: "I know I am not Miss World, but I think I am quite okay. Especially with make-up I look quite nice sometimes. I think my personality is not so bad either. I'm average." "It depends on my mood and whether I had a hectic day. When I am relaxed and spent time on my body, I usually feel quite beautiful." Yet another model had quite an interesting view concerning being beautiful: "I think I am beautiful. Everyone is beautiful. It just depends on one's self-

confidence and whether, in the presence of others, one presents oneself as a beautiful person. If I think I am beautiful others will think so too."

From the answers concerning the participants' conceptualisation of beauty in others and themselves it is clear that they have rather opposing views. External to themselves they have a relative balanced view between outer and inner beauty, although they reiterate the general beauty standard. In evaluating themselves they have, with the exception of the models, a very negative outlook with regard to both outer and inner beauty.

3.5.2 Perceptions concerning body shape

The body and its appearance seemed to be of great value to most of the interviewees. Whether it is to impress male counterparts; beating same-gendered peers in the 'I have the better-body-competition'; trying to reach an out-of-reach beauty ideal presented by the media, or whether the family socialised their daughters to be 'feminine', an extraordinary dissatisfaction with the body could be detected among almost all of the girls. For some of them, this dislike or dissatisfaction with the body was experienced as so bad that depressed feelings concerning body shape were indicated. Especially the eating disordered girls answered the BSQ question, "Have you felt so bad about your shape that you have cried?" with a definite *always*. Further, the questionnaire also pointed out that many of the girls' thoughts about their body shape impacted negatively on their ability to concentrate. For some, the dislike went as far as imagining cutting off fleshy areas of the body in order to be more satisfied with their appearance. One anorexic girl underlined the great discontent with her body: "I just hate my body. It's ugly and fat." The eating disordered participants more often expressed this total rejection of the body. A bulimic girl was of the opinion that: "Nothing fits together. My body parts are totally out of proportion. It's disgusting." For others the body is not as extremely rejected, but it is fragmented with certain parts causing offence. In fact, none of the participating girls were totally and completely satisfied with their appearances. "It's my butt. It is fat and has stretch marks"; "It has always been my stomach. I just hate the fat rolls. It's especially bad when I sit down."; "The parts I really dislike are my upper legs, which are too big for my body, and my big and round butt." While some of the girls mentioned that they are not happy with

the way their nose, toes, etcetera looked they were usually more dissatisfied with certain body parts they perceived as too 'fat'. Most of the eating disordered girls indicated that even though there was absolutely no fat on their bodies anymore they were still highly dissatisfied with their bodies: "I was never satisfied with my body. Not when I weighed 50 kg, 40 kg or 30 kg. There was always something, which bothered me, and I never felt okay and happy about my body." It became apparent that even when they reach their previously set goal regarding slimness, it never brings them satisfaction. The following quote of a bulimic girl explains this further: "I think one is unhappy inside and then one tries to change the outside. You change and change but in the end you are never happy, no matter how skinny you are."

Yet another interesting finding concerning the participants' perception of their bodies was the skewed images many of the girls had in connection with their physical structure. Eating disorder specialists (Bruch 1973; Garfinkel and Garner 1982; Lelwica 1999) have acknowledged the disturbances in body-size awareness, especially among anorexic individuals. The vigorous defence of the emaciated body as not too thin but as just right, as normal, was already indicated by Lasègue in 1873 (as quoted by Garfinkel and Garner 1982 : 3): "The patient when told that she cannot live upon an amount of food that would not support a young infant, replies that it furnishes sufficient nourishment for her, *adding that she is neither changed nor thinner.*"

Results of this research project show similar distorted images amongst almost all of the participants. Furnham and Alibhai's table of "Culture preferences for body shapes" (1983 : 831) was shown to the interviewees with the request to describe the table. The table consists of 12 female shapes, ranging from extremely anorexic to extremely obese, which were labelled alphabetically A to L, so that A was the extremely anorexic figure and L the very obese. A 13th figure, labelled M, had the words "Me as I am now" printed on it. The figures the girls pointed out as "Me as I am now" were compared to the girls' indicated body weight in the Cultural Background Questionnaire. It was found that almost every single participant perceived herself as significantly larger than she actually was. However, one of the anorexic girls showed the most disturbed body image. While starving her body to a current body weight of 40 kilograms, the girl indicated that she looked like the female figure presented under the letter G. Shocking findings were also obtained regarding the participants' view of an

ideal body image. For many girls, and especially the eating disordered participants, figures B and C were preferred standards of slenderness. In the case of the models and dancers, figures between C and D were mostly shown. Therefore, only the anorexic figures, as well as the figures indicating a very slender feminine physique, were desired. Only 5 out of the 22 participants highlighted being satisfied with an E or F figure, a more realistic female body shape.

Regarding the results of the table, one can conclude that misconceptions about body size appear to be rather common among the participants, with many having an exaggerated interpretation of any curve and many perceiving excess weight as grotesquely fat. Therefore, the goal of thinness was central to many of the interviewees, and the associated fear of becoming fat overwhelmingly strong.

3.5.3 The fear of obesity

Save the whales, harpoon a fat chick
(Car sticker, quoted by Shefer 1986 : 247).

The fear of becoming fat haunted almost every interviewee. BSQ results indicated that almost all of the participants, no matter which group they belonged to, were afraid of becoming fat or fatter. The fear of fat seems to stem from the negative perception the interviewees attached to the concept of "being overweight". It seemed as if the eating disordered girls had the most negative comments when asked to describe the concept of overweight. The following statements were made by some of the Group 1 participants: "The only thing I can say is 'elephant', 'house', and 'disgusting'." "When I think of overweight I see a very fat, not beautifully built person". "I see a woman who wears tight clothes and her stomach hangs over. Her butt is too big and she has big legs and fat cheeks". A dance school girl was equally harsh in her decision concerning overweight individuals: "To me, overweight is a person who wears pants larger than size 32. She has a chubby face, wide hips and cellulite." These perceptions are usually deeply internalised among many of the participants, and strong feelings were expressed concerning people living with excess body weight. "I feel very sorry for them – most have family problems or it's genetically determined." Besides feelings of pity, some expressed anger at their lack of self-control. "It's disgusting – people

should prevent that. It really puts me off", a bulimic girl indicated, while an anorexic girl was of the opinion that: "They always bitch about their weight but never do something. I have no respect for these people, nor do I like them." Overweight, therefore, seemed to be strongly associated with eating too much or eating the wrong things. Furthermore, obese people were perceived as being out of control around food. A bulimic participant perceived 'fat' people as having an eating problem and she explained this via the following statement: "I really relate to them. I feel I am one of them because of my bingeing behaviour. I know exactly how horrible they feel." Even though this girl considered herself to be "one of them", she associated bingeing on masses of food with obese people's ways of eating.

Many of the participating girls equated fat with personality traits or moral flaws, and this can be underlined with statements like: "They are lazy, untidy, and have no self-discipline." "They are big, chubby, cuddly and sometimes friendly and very hard working." "They can be friendly and nice but also unhappy, frustrated and angry." Besides viewing obesity as a kind of personality 'defect', something one is disgusted with and afraid of, many of the interviewees were of the opinion that it is "not healthy". "They are fat, unhealthy and grumpy", a model argued, and "They are fat, unhealthy, uncomfortable and not beautiful", was the opinion of a dance school girl. It became apparent that most interviewees felt that the habit of fat people to eat large quantities of food as well "bad" foods is especially unhealthy. However, the participants reacted to obesity more on an emotional level, almost as if it was contagious. For example, one of the bulimic girls mentioned that when sitting next to obese people she feels the urge to leave the restaurant, or at least to move to another table where she cannot see them "stuffing their faces". It was astonishing that only 5 out of the 22 interviewees regarded obese people as "normal people like you and me". "I don't judge people according to their weight. Still, I think everybody should look after themselves." However, the girl, quickly added that: "I personally definitely don't want to be overweight."

It is clear from the above that fatness in others is associated with negativity on different levels. The majority of the participants equated fat with big objects, negative personality traits, negative emotional states, unhappiness, unattractiveness, and

unhealthy eating behaviour. On the other hand, being thin is equated with being physically attractive, healthy and happy.

It quickly became apparent that almost every participant perceived the issue of being overweight for herself to be an unbearable situation, and most of the girls had pre-planned drastic measures which they would implement in the case of "getting fat". While one dance school girl indicated: "I would definitely kill myself. Really, I am not joking", an anorexic girl stated that: "My mum would kill me. She always tells me that I am fat. Anyway, I would hate it as well. I would get depressed and miserable. I would definitely do something about it." Further, many of the participants regarded the emotional feeling of hatred as being closely related to larger body size. The following quote indicates the perceived self-hatred in the case of being obese in combination with the weight control methods which would then be used: "I would hate it. I would do everything in my power to lose the excess weight. I would exercise, diet, drink water, eat less, starve, everything, but I would not stay fat". Some of the participants indicated that they would lose their sense of self: "I would be shy, insecure and have little self-confidence. It would break me. I would really hate that."

All participants stated that they would be miserable because they would not be able to take part in their leisure time activities. "I would not be able to dance, walk or run, it would be a disaster – dancing is my life", a dancer indicated. A model was of the opinion that, "doing sports and my modelling would be finished if I was fat. I would never be happy then." A Group 1 participant felt the same and said that: "I am an excellent swimmer and people who swim can't be fat. So I can't." Besides this aspect of losing the ability to perform in their leisure time activities, many participants expressed the inability to wear "nice clothes" as one of reasons why being overweight was out of the question. "One can't wear nice clothes. This would really make me extremely self-conscious." "Nothing would fit me nicely. I definitely wouldn't mix with people then." Being able to wear nice clothes and present oneself as pretty in public was therefore closely related to one's self-confidence. Answers on the BSQ concerning "Have you not gone out to social occasions because you felt bad about your shape?" confirmed these findings with many of the participants answering in the range of *always, often,* and *sometimes*. This correlates with the perceptions of eating disorder specialists (Garfinkel and Garner 1982; Gordon 1990; Williamson 1998) that

women are, and perceive themselves to be, constantly under surveillance and that it is their societal duty to be decorative.

From the above it is clear that the 22 participants have a severe aversion for obesity or even a slight excess of weight in themselves. This intensely negative feeling towards fat might be interpreted as the idiosyncratic attitudes of a few individuals or it could also be ascribed to a hypersensitivity to societal pressures. In their answers to the question "If you were to be stranded on a faraway island, with the knowledge that nobody will ever rescue you, would you mind being overweight?", the majority of the girls confirmed the influence of society on them. Out of the total number of participants, only 4 girls (1 bulimic girl, 1 dancer and 2 models) replied that it would not bother them to be fat when removed from society: "To be overweight doesn't matter then. One wants to look nice for other people. People judge others from their first impressions, but if there is nobody who can judge me, then it is okay, then I can be fat." For this model, being removed from society implied that she would not be judged by others concerning her looks. Therefore being fat would not be a problem anymore because there is nobody one has to impress with one's looks. The bulimic girl presented a similar opinion, and she pointed out that: "On the island there would not be any shops and clothes. Here everything is about others and what they think about the way I look. There it would only be me, so it wouldn't matter to be fat."

For 18 participants however, the negative issue of gaining weight and being fat was socialised so deeply into their belief system, that not even in total solitude would they allow their bodies to expand. A participating dancer pointed out that, "It is the way I grew up. My mum would say, 'Stop eating sweets because you get fat'. And the more she said that the more I realised that fat is not beautiful." Yet another dance school participant argued that, "It makes me feel good to be thin. I was told thin means to feel good, and so it is." As already mentioned above, feelings concerning a fat body were very internalised, and some of the interviewees explained that: "I see myself as a slender person. Fat is not part of my identity." "It is something inside of me – how I want to look. So it wouldn't matter whether I am stationed on the moon or on a far away island. I would still hate to be fat." Other girls mentioned the health factor to be the reason for not wanting to gain weight and be obese. "I don't even watch them (obese people) on TV. I always change channels because I can't handle them. They are

so unhealthy and, no matter where I am, I wouldn't like to be so unhealthy." "I just don't like to be fat and have an unhealthy body. Not here and not on the island."

3.5.4 Eating attitudes 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'.
(Coward 1984 : 105).

How the participants felt about their bodies and the behaviour they expressed concerning eating were closely associated. For many of the eating disordered interviewees, their eating behaviour was understood to have developed as a result of concerns about their body size. Participants from Group 1 explained that they were unhappy with their bodies, felt fat and ugly and therefore decided to "do something". "Doing something" usually implied reducing food intake. This unsatisfactory perception of one's own body and the resulting restriction of food intake, however, were also often strongly expressed by the Group 2 and Group 3 participants. BSQ results concerning the question "Have you been so worried about your shape that you have been feeling you ought to diet?" showed that reducing one's food intake due to body shape dissatisfaction was common among almost all of the participants. The effect body consciousness had on some of the eating disordered participants' eating behaviour can be illustrated by the following accounts:
"I started to exercise, but that didn't really help. Then I stopped eating meat. That helped a bit. I decided to eat less as well, I thought a radical diet still works the best. And so I stopped eating solids. And believe me, the extra kilo's came off. In the end, I only drank hot water and lemon juice. Sometimes I would still treat myself with watered custard, but that I stopped as well. I can tell you, I really looked good in the beginning."
"I just felt really fat and ugly and so I decided to start dieting. But it didn't really work. ... I wanted to have a fat-free body and I thought bingeing and purging was the easy way out. I must say it worked okay, until my hair started falling out. That was really bad because at last I had an acceptable body, but now I was getting bold. I wondered if I could ever have everything in order."

"I wanted to wear the same clothes as my sister but she was thinner and skinnier than me. I decided I had to lose weight. You know, I like it when the bones stick out on a body; it looks really sexy and attractive. I lost a bit but every time I looked in the mirror I still was fat. Especially when I squeezed my stomach together there were still masses of fat. And so I decided to stop eating."

While not all participants engaged in as severe forms of weight reducing behaviours as the eating disordered girls, many of the Group 2 and 3 interviewees changed their ways of eating in pursuit of a thin body. Often, the body is seen as a reflection of the eating behaviour and negative feelings about one's shape dominate what and when one is allowed to eat: "As soon as my jeans sit more tightly on me I know it is time to diet. Usually I just drink more water, eat less fat, ... well, I eat less overall." "I diet about every second month. I actually lose my weight quickly but then when I stop, I unfortunately gain it as quickly again. It's a real yoyo effect."

Many interviewees indicated a direct relationship between food and gaining weight. The feeling of eating and immediately feeling different (fat) about their bodies was often described, whereas not eating or dieting was perceived to be in an immediate and direct relationship to losing weight. The BSQ question "Has feeling full (e.g. after eating a large meal) made you feel fat?" was answered positively by many of the participating girls. Some even indicated *always* feeling fat after having eaten even a small amount of food. Further, feeling bloated immediately after meals, an EAT question, was equally positively confirmed, with especially the eating disordered girls indicating *always* experiencing the physical sensation of fullness. "I feel so fat and guilty after eating. It's really a horrible feeling. One is helpless against it," a bulimic girl stated.

Feeling bloated, fat, full and guilty after meals often leads to the need to display self-control around food. Participants of all 3 groups indicated trying to be in control around food. This was also confirmed by the answers the EAT questions concerning this topic. In-depth investigations concerning the self-control some of the participants displayed around food elicited the following quotes: "When me and my friends eat out I would always order from the kiddies menu. It is enough for me and I don't like stuffing my face like they do. Then they bitch again how fat they are. I'm rather safe

than sorry." "I always have to control my appetite. Otherwise I would be eating day and night and look like an elephant. I think everybody who wants to stay skinny is doing that."

What makes the pursuit of thinness so powerful are the rewards it promises and often, at least temporarily, delivers. Most interviewees indicated that rituals aimed at slenderising the body created the sensation of being immediately rewarded. Eating disorders specialist Lelwica (1999) argues that these rewards are sought and achieved on many different levels: through social norms and physical sensations, through moral codes and cultural identities, and through the promise of self-determination. This was confirmed by most of the participants who felt that eating is in a direct but negative relationship to the body. By reducing food intake, many of the interviewees felt rewarded in the sense of acting in a socially approved manner, by a feeling of 'fitting in' (whether into one's clothes or into society) and by gaining immediate satisfaction when being able to resist the temptation of eating. However, in order to understand the rewards of punishment and the saving promises of being thin, the agents of socialisation – the family, the peers and the media – and their influence on the individual, have to be examined more closely.

3.6 SOCIALISATION OF THE THIN IDEAL

3.6.1 The family as influencing factor

The family represents the first and most significant force in adapting the growing child to a culture. From this, the question arises as to whether particular families magnify certain aspects of culture and whether this may be a forerunner of anorexia nervosa and bulimia nervosa. In the following paragraphs it is the objective to present results regarding certain key aspects concerning the family as an influencing factor, such as demographic characteristics, family relationships, child-rearing practices and the family as a cultural agent of the thin ideal. It is important to note that these key aspects were selected according to indications found in the literature on eating disorders and are thus not a complete discussion of the nature of the families involved.

3.6.1.1 Demographic characteristics of families

Concerning the indicated socio-economic status of the participants' parents (Chapter 1, paragraph 1.3.4), it was found that more of the Group 1 girls' parents belonged to the upper-middle class than did those of the interviewees from the other groups. This was based on some of the eating disordered girls' indicating that their parents lived in the well-to-do areas of Bloemfontein with both mother and father in high-income employment. Further, it was found that most of the Group 2 and 3 participants came from typical middle class homes. With most of these interviewees indicating that their parents' worked in medium-income positions and lived in middle class areas of the town, the middle class was accepted to be the families' status. For those individuals who had already established their own living environments and careers, none was considered as have an extremely high or extremely low living standard. Overall, most participants could be considered belonging to the upper-middle class with some of the eating disordered girls coming from higher social classes than their counterparts.

It was evident that all of the participants had grown up in what is considered a traditional nuclear family. All participants had been raised by both parents, as were their siblings. Apart from one dance school girl, all of the interviewees had siblings, with the average number of children per family being between 2 and 3. Of the 10 eating disordered participants, 7 had a brother/brothers and the same number of interviewees had a sister/sisters, while in the case of the 6 models, only 3 girls had brother(s) and 5 of them had grown up with same-sex siblings. Group 3 – the dance school girls – was the group with the smallest number of siblings, where only 3 interviewees had a sister/sisters and 2 had a brother/brothers. The influence of family size and birth order of children on the development of eating disorders is still uncertain. Eating disorder specialists (Garfinkel and Garner 1982) however, indicate that there has not been an over-representation of any particular family size influencing the development of eating disorders. Similarly, Garfinkel and Garner (1982) report that the specific birth order of females born within a family did not make some more prone to becoming anorexic or bulimic.

Most of the participants considered themselves as growing up in a relatively stable family home. Despite the increasing divorce rate in Western countries, which often

exceeds 50 percent, only 3 of the eating disordered girls' parents were divorced, and the parents of one of the dance school girls had separated recently. This finding correlates with the observation of Ushakov (as quoted by Garfinkel and Garner 1982 : 169), who observed a high frequency of traditional family life among anorexia nervosa patients. Further, the literature (Bruch 1973; Garfinkel and Garner 1982) usually describes a negative correlation between anorexia and the separation of the parents. Whether the low number of divorces and separations of the participants' parents is influenced by their traditional family values and persisting religious precepts concerning the annulment of marriages, or whether the families could really be termed stable, was not clear from the collected data. Most girls from all groups, however, perceived their parents' relationships as satisfactory.

3.6.1.2 Family relationships

Major eating disorder specialists (Bailey 1991; Bruch 1973; DiNicola 1990; Garfinkel and Garner 1982; Wallin and Hansson 1999) have postulated that certain family relationships – especially the ones formed by mother and daughter – are closely related to the development and maintenance of anorexia nervosa as well as bulimia nervosa.

While 5 of the models and 4 of the dance school girls indicated having either *excellent* or *good* relationships with their mothers, only 2 of the eating disordered girls stated that they have an *excellent* relationship with their mothers. Two girls from Group 1 perceived the relationship to be *good*, while 4 thought that a *medium* connection exists. Further, 2 of the interviewees from Group 1 rated the relationship to be *not so good*, and *bad*. In the case of the last 2 participants mentioned, some of the negativity towards their mothers can be illustrated by statements like: "My mum is conservative and narrow-minded. The only thing she worries about is what other people think." "I definitely don't want to be like her. She is a hateful person who always thinks she is right. She only criticises me about how I look. We definitely don't have anything to say to each other." This strong negative feeling towards mothers was, however, toned down when, through further interviewing, it became clear that the relationship was not as bad as first indicated. According to results from the in-depth interview, a love-hate relationship was the case rather than total hatred towards the mothers. "Sometimes we are actually quite okay. Then we can talk like friends and we tell each other

everything. Other days, we just fight about every little issue, and then I cannot believe that just a couple of days ago we felt so close." Therefore, out of the 10 participants of Group 1, only 2 had positive relationships with their mothers. In terms of the above-mentioned research on mother-daughter relationships, this information could be interpreted as a confirmation of the tendencies of anorexics and bulimics to have problems in their relationships with their mothers.

With reference to the existing relationship the girls have with their fathers, no real patterns could be established. As with the Group 1 girls, 5 Group 2 and Group 3 participants perceived their connection to their fathers as either *excellent* or *good*. They considered the reason for their mutual understanding to be either because they shared the same type of personality, or due to being "exact opposites". Two interviewees from Group 1 stated that their relationship could be considered *medium*, with one of them indicating that her answer was due to her father's "lack of culture": "He absolutely has no style, and more than once a day he would say to my mum that she is fat and she should lose weight. Such behaviour makes me really mad!" While 2 interviewees thought of the relationship as being *not so good*, only one of the eating disordered participants considered her relationship with her father as *bad*.

With regard to the Group 2 and 3 participants, the majority indicated having either an *excellent* or *good* relationship with their fathers. The reasons were mostly common interests, trust in each other or the excellent communication father and daughter shared. From both groups, only one model and one dance school girl considered the relationship *medium*, with both girls' reasons being the little time spent with their fathers.

It has to be mentioned that in the context of research on eating disorders, the parent-child relationship has been increasingly studied in the last couple of years (Haworth-Hoeppner 2000; Leung *et al.* 1995; Wallin and Hansson 1999). Haworth-Hoeppner (2000 : 217) found that, inter alia, a parent-child relationship characterised as unloving is an important factor in the production of eating disorders. In retrospect one could not say that the participants in this research had "unloving" relationships with their parents. Even though the majority of the girls in Group 1 felt that they had less satisfactory relationships with especially their mothers, there could also be other

reasons for their negative evaluation. For example, the wide variety of sometimes good, sometimes bad feelings some girls expressed in connection to their mothers, could be due to the different moods they experienced in the course of their illness. Furthermore, this conclusion is based on the fact that almost all of the girls admitted having shared a positive relationship with their mothers when they were younger.

However, a final conclusion concerning this topic cannot be made. The fact that especially the anorexic and bulimic girls experienced problems in their relationships with their mothers and some even with their fathers, cannot be ignored. It might be the result of their physical and mental conditions, but it could also be one of the possible influencing factors causing the disorder. On the one hand, the numbers of participants representing the negative view on parent-child relationships are too few to be conclusive, and on the other hand, other possible reasons for the negative evaluation by the participants were not explored in more detail in this research project.

3.6.1.3 Child-rearing practices

In connection with child-rearing practices, it became apparent that the participants were raised in an individualistic manner. However, the radical individualistic trend preferred in Europe and United States of America was perceived to be counter-balanced by relatively strong family ties, as well as possibly by strong religious beliefs. Most of the interviewees belonged to the Dutch Reformed Church, but the strength of their faith as a motivating force in their attitudes towards eating and weight control was not investigated.

Further, almost all of the participants indicated having been raised in a rather strict and disciplined manner, however, the parents were mostly perceived by the interviewees to be very caring, protective as well as understanding. What was interesting to notice, however, was the degree in disciplined socialisation the girls received. Four of Group 1's eating disordered participants, 2 of the models and 2 of the dance school girls indicated that they had been raised in an extremely strict manner, with their parents applying excessively conservative rules in the child-rearing process. While most of the other participants also experienced their upbringing to have been strict and disciplined, the degree of coerciveness practised by the parents was indicated as lower.

Bailey (1991 : 253) indicates that either over-involvement or under-involvement in the child-rearing process is a contributory risk to eating disorders. The over-involvement leading to a lack of individuation was described in the paragraph above. Under-involvement was also perceived to exist among some of the Group 1 participants. When questioned concerning the degree of interest the parents showed in the children and their activities, 4 participants of Group 1 were of the opinion that their parents had raised them without any real interest or parental involvement. One of the Group 1 interviewees explained that: "We kids were always alone. My mum and dad worked from morning to night in the shop, only being interested in making money. They just didn't care what happened at home. My siblings and I always had to take care of ourselves." None of the other groups' participants shared this feeling of the 4 Group 1 participants.

The majority of the participants perceived the way they had been raised as very strict and disciplined, and therefore also over-involved. A small number (4) of participants of Group 1 have indicated that their parents raised them with little parental interest and under-involvement. However, according to the literature (Garfinkel and Garner 1982), the exact role of child-rearing practices in the predisposition and perpetuation of anorexia nervosa and bulimia nervosa is not clearly determined. Nonetheless, child-rearing practices may be viewed as important because they represent and magnify aspects of a culture.

3.6.1.4 The family as a cultural agent

Proponents of the family perspective on the study of eating disorders contend that individuals either develop a normal or distorted body image in the context of family life (Bruch 1978; Garfinkel and Garner 1982; Haworth-Hoeppner 2000; Leung *et al.* 1995; Wallin and Hansson 1999). It is widely accepted that the family operates as a formidable influence on identity, contributing to the development of the self and the formation of the self-image. Therefore, the extent to which the family transmits cultural messages about thinness and body shape, and the manner in which the family conveys these messages to family members are viewed as crucial in the development of eating disorders. The following section will investigate preoccupations with weight

within the family, the socialisation of the thin ideal within the family and gender socialisation.

a) Preoccupation with weight within the family

It was evident that almost 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 mostly from within the family, especially from mothers being supportive of dieting behaviour.

Most interviewees were brought up in weight conscious families. Out of the 22 participants, 16 girls indicated that their mothers were constantly dieting. While some mothers only restricted their food intake, others were on "formal diets", with many of them using laxatives, diet pills and appetite suppressants. One bulimic girl stated that: "My mum is always on a diet. Either she eats almost nothing and drinks only water, or she uses fat absorbers to lose weight. I rather prefer it if she uses the pills, because then we get normal food in the house." Three of the participants' mothers were on a "Weigh-less" programme, cooking the prescribed health meals for the whole family. It was interesting to notice that the dieting behaviour of the mother left many of the girls with a perception of the family living a healthy lifestyle. While many of the dance school girls associated healthy living not only with eating fat-free, sugar-free, oil-free foods, but also with regular exercise, positive family relationships and the lack of alcohol and cigarette use, many eating disordered girls as well as models associated a healthy lifestyle with healthy eating. "We are all very healthy", indicated one of the anorexic girls, "the whole family eats 'Weigh-less' food, and my mother makes us all drink a lot of water."

Even though exercise was important to most of the families, it was found that it was usually the children and the fathers who exercised regularly. There appeared to be a difference between the exercise level of the bulimic girls' mothers and the anorexic girls' mothers. Four of the anorexic girls indicated that their family members were "sport fanatics", with even the mothers being very active. Mothers of bulimic girls seemed to be generally more overweight, and their daughters

perceived them to be "typical housewives". One bulimic girl said: "My mum is a real mum and housewife. She is a bit overweight, not doing much sport. When I see her, it is in the kitchen being busy preparing food. Yes, that's her." Overall, the apparent universal responsibility of females being in charge of the food preparation and consumption was the rule rather than the exception amongst the participants' families. It seemed that most of the girls appreciated their mothers for their effort put in the preparation of meals. However, when questioned as to whether they wanted to look like their mums, when they are their age, 14 out of the total number of participants answered with a definite "*no*". Except for the 4 eating disordered girls whose mothers were very active, the Group 1 participants as well as the models (Group 2) were especially against looking like their mothers. Concerning the dancers (Group 3), the girls were more willing to look like their mothers when older. The reason seemed to be that the mothers of the dance school girls were less overweight and more active than the Group 1 and 2 participants' mothers. Statements like: "My mum still looks very good for her age. She is also a dancer, and I would be very happy to look like her when I am her age", were common.

The influence mothers have on their daughters concerning a weight-conscious lifestyle became especially apparent regarding their modelling themselves on mother's way of "looking after herself". Even though many girls did not want to look like their mothers, they were prepared to use the same methods of controlling their weight. "I have been eating the prescribed meals for so long now, I will definitely stay on the 'Weigh-less' programme. It is healthy and doesn't make fat." One eating disordered girl explained that: "My mum always keeps herself fit and healthy. I will have to exercise as much to look like her one day."

Copying their mothers' weight-conscious behaviour also became apparent when the question of "Do women eat smaller portions than men?" was asked. The overall positive answers ranged from, "Girls don't use that much energy as guys", or "Men work harder and their metabolisms works faster, they need to eat more", to "Women eat less because they want to look lady-like and impress guys." The different opinions concerning this topic will be discussed in depth at a later stage, in the section on gender socialisation. For this discussion on the imitating of

behaviour, it was very interesting to note that most of the girls indicated that their mothers usually eat the smallest portions. "If there are four pieces of meat, my dad always gets the biggest. Then, my mum gives the second biggest piece to my brother. In the end it is up to me which of the two smallest pieces I want." As a result, the behaviour practised by most of the girls was always to eat smaller pieces than especially their male counterparts. This can be underlined with statements like: "I always eat less than men. Otherwise they will think, 'No wonder she is such a fat pig, she eats so much'", or "It's more feminine to eat less. It's just the proper thing to do".

b) Socialisation of the thin ideal within the family

Assumptions that woman should eat less than men and watch their weight, were rooted in the family experience of most participants. In order to underline the seriousness of their attitudes towards restricted eating, the statement of a bulimic girl went as follows: "I hate overweight women who eat too much. If I am in a restaurant and I see some fat ladies eating so much, I have to get up and leave, or at least sit somewhere else, where I can't see them. It really disgusts me." The perception that women should eat less was so intense, that it hampered many social occasions. One extremely weight-conscious dance school girl, whose daily life, according to her written account, consisted of counting calories and exercising off the possible excess eaten, was asked if she uses any weight-control measures. Regarding this interview, the mother of the girl was reluctant to let the researcher conduct the interview with her daughter alone. Without giving her daughter a chance to answer, she replied in response to the question: "No, my daughter is so extremely lucky. She doesn't have my build but her dad's. She eats healthily, yes, but she really doesn't have to watch her figure. She is naturally beautifully built." Despite the worries of the dancing instructor about the girl developing an eating disorder, the mother kept on bragging about her daughter's looks being genetically determined without the girl being involved in any way.

Out of the 22 participants, 15 have been continually urged to eat less by their mothers. Special mention was made by most of the interviewees that this request/demand mostly came from their mothers. Usually, the girls indicated that

they were asked to eat fewer chocolates and sweets, but some participants stated that their mothers were very particular when it came to getting second helpings at the dinner table. In the case of the eating disordered girls, the mothers were simply worried about the girls' figures. Common remarks given were, for example, "We don't want you fat", or "It's enough already". Participants from the dance school and of the model agency indicated that their mothers were worried that if they overate, the girls would not perform properly regarding their leisure time activity. One model stated that her mother, especially before big competitions, would ask her to eat less, while a dance school girl pointed out that her mother would remind her that she was not that thin anymore, and that overeating might influence her dancing negatively.

However, the pressures to eat less or to restrain their food intake did not only emanate from the participants' mothers. It appeared as if fathers also had a strong influence, but from a different angle. Regarding the fathers, there seemed to be a difference between the various groups. The fathers especially of the eating disordered girls seemed to socialise their daughters by focusing on being disparaging about overweight women, with special attention being given to their wives' weights. Only one girl indicated that her father would remind her to eat less because, as she mentioned: "He would tell me that 'You are going to be as fat as your mother'. So his opinion started to count a lot. I thought that if he thinks I am fat, then everyone else will". However, most of the girls remembered their fathers commenting negatively not about their weight, but about their wives'. Two bulimic girls' fathers were really against overweight women, and the girls underlined this with statements like: "My dad always says to my mother that she is fat and that she should lose weight", and "When we are sitting at the dinner table, and my mum wants seconds, he always grins stupidly and says: 'Eat, so that you become big and strong'." Statements like these were described by many of the eating disordered interviewees, while members of Group 2 and 3 did not mentioned such behaviours by their fathers.

One bulimic girl's dad never criticised the mother. In her case, the girl explained that she always felt inferior to her older sister, who was, as indicated by the father, more beautiful, slimmer, had better marks at school, etcetera. This specific

interviewee explained that she always wanted to be like her sister. "It was not that I wanted to be like my sister because she looked so nice; I only thought that if I am like her, my dad will love me as much." In this case, the pressure to have a slim and slender body did not come from the siblings per se. Rather, the sister was perceived as an idol only because the participant's father idolised the girl. However, siblings can sometimes put pressure on the individual to lose weight.

Only the Group 1 participants in fact remembered negative remarks from their siblings concerning their weight and body shape. "When we were smaller, my brother and I would wrestle a lot. Whenever I got the upper hand and I sat on him, he would say: 'You are very heavy, I think you have gained weight again.' Even though I did not show it to him, I was very hurt and his words stuck in my head for days." Again, it was with the bulimic girls that this behaviour was more apparent than with any other interviewees: "My brother used to tell me that my ass got fat", or "My sister is so much prettier than me. She is 3 years older than me but I was wearing bigger sizes of clothes than she was. We laughed a lot about that but actually it was not funny to me at all. I was devastated".

From the above-mentioned statements it becomes apparent that the research participants hate fat. The family, which is the main transmitter of cultural standards and values, appears to be rather radical in socialising the children to conform to the beauty ideal of their culture. The necessity of the pursuit of a slim and slender body, which today is equated with self-control, elegance, sexual attractiveness and youth, is hammered into the girls' heads from a very early age. Little boys are sometimes socialised with preferences for a particular form, learning to evaluate negatively everything not conforming to the cultural standard of attractiveness. The different aspects of socialisation with regard to gender will be discussed hereafter.

c) Gender socialisation

In many cultures, children are socialised according to their gender. As already indicated, girls are often socialised into being more weight-conscious, with many

of them having learned to appear "prim and proper" when filling their plates. However, this was not the only emphasis in gender socialisation.

The relatively strict gender differentiation mentioned above often left the girls feeling stigmatised for being plump or overweight, while a lot of girls experienced their brothers as "being lucky" and in no need to bother about their weight. It has to be mentioned that the dance school girls as well as the models experienced fewer problems concerning this aspect. Whether this was due to many of them never having had weight problems, or whether there has been a difference in upbringing was not completely clear from the girls' answers. However, it seemed as if the first mentioned option was the more realistic one, since especially the models termed themselves as "slightly underweight children".

Concerning the eating disordered girls, it was mostly the bulimics who were, in their opinion, slightly overweight when they were children. As they recalled their childhood experiences relative to weight, one interviewee stated that: "It never mattered whether my brother picked up a couple of kilo's. Usually my dad would say: 'That's my boy, becoming big and strong'. With me it was a different story. Whenever I needed new clothes because I had grown out of my old ones, my parents would tell me to cut down on food because 'It is not lady-like to be fat'. That was about the time when I started eating less than my brother." Yet another eating disordered girl indicated that there was no difference between her and her brother. Both were forced to watch their weight from a very early age, with the brother being put on a "Weight-watchers" programme when he was seven years old. "We were both fairly chubby kids. My parents, and especially my mother, hated it. Even though she was overweight herself, she did not want us children to be obese. As soon as one of us picked up a kilo or two, drastic measures were taken by her."

Even though the last example did not indicate a difference in gender socialisation with regard to weight and body consciousness, the majority of the girls were raised distinctively. One anorexic girl indicated that her mum was "on her case" the whole time. "Sit up straight, eat less, drink slowly, behave, ... It was always

the same between her and me. My brother, on the other hand, could not do anything wrong. He could chew with his mouth wide open and it didn't matter."

Further, the pursuit of a slim and slender body also seems to originate from a dichotomy concerning the interviewees' perception of "why women eat less than men". Even though it became apparent that the participants' parents never used food as a source of punishment, a deep-seated belief in restraining women could be detected. The first reason usually given by the participants was that: "men are stronger, more active and therefore use more energy". However, most of the girls did not leave this statement unquestioned. Usually, after thinking for a while, they would add: "*and* women learn to eat less." When further questioned, many interesting opinions concerning the socialisation of the thin-ideal were presented. "It's more feminine to eat less", was one of the common explanations. "It's like an etiquette a woman has; if she eats less it shows she cares about her looks and she is well groomed." Femininity paired with a sense of 'women have to look nice and fragile in order to attract men' indicated that some of the participants' beliefs were based on the opinion that women have to inhibit themselves for their male counterparts. This can further be highlighted via the following quotes: "Guys don't like girls who eat so much. Therefore they don't eat – they want to impress them." "Women think more about their figure ... they do it to impress men and to make their girlfriends jealous." "Men don't care what they eat but girls worry about their weight. They are really obsessed with food and the body. I think we do it for the guys."

From the above-mentioned quotes it became apparent that the participants' weight and body conscious behaviour, their perceptions concerning what is healthy/unhealthy and what is food and what not boiled down to one single aspect: impress men and remove any potential competitor by having the most feminine and slender body. This acquired behaviour was so 'normal' for the girls that many had to think about the issue for quite a while. One of the dancers explained after a long period of reflection: "It's a society thing. I grew up that way. It's automatic. You do it to impress men ... Now that I think about it, it's pathetic".

It seems that in order to become a thoroughly feminine woman, constant efforts have to be made to measure up to the family's, and ultimately the Western, standard of beauty. Women need to appear as pleasing as well as exciting visual objects for men. The question arises as to whether the preferred looks for women can ever be achieved or whether they are totally unattainable to women. This will be discussed in the paragraph 3.6.3 on the role of the mass media regarding body image.

Concerning gender socialisation in the Western world, one can conclude that the socialisation of women would be unlikely to have such widespread and devastating effects on women's attitudes towards themselves, were men not also brought up to treat women in ways that promote the objectification of women.

3.6.2 Peers as an influencing factor

Especially in adolescence, the peer group is one of the most important sources of social approval. Girls often seek advice and support from friends about personal issues, such as attractiveness and self-control. In order to conform to the societal pressure to be thin, girls encourage each other to lose weight by suggesting dieting behaviour.

For most eating disordered interviewees (Group 1), the beginnings of the eating problem can be traced back to an increasing weight consciousness as well as dieting behaviour. For many, this was during their adolescent phase, which was normally articulated through a growing awareness of their physical appearance as a female and directed towards male attention: "It all started with the matric farewell. I wanted to look my best. I had the perfect dress and the perfect date. The only thing I still had to do was lose weight." The peer pressure to diet and be slim was strongly associated with the importance of being desirable to boys or men. The role men and boyfriends play concerning body attitudes in women will be discussed later in this section. To begin with, the influence of same-gendered friends will be examined.

It seemed as if the above-mentioned high school farewell was a reason for many of the girls to start dieting. Many of the participants explained that the formal occasion was taken very seriously by them as well as by most of their female classmates. Dieting

was the norm rather than the exception, with everyone wanting to be as pretty as possible. Even though the dieting behaviour seems to be practised excessively during the last couple of months of high school, many girls explained that they experienced a persisting pressure at school to be attractive and beautiful. This often led to competition between the various circles of girl friends.

The models (Group 2) were more self-confident about their bodies and their appearances, with most of them pointing out that they were not in competition with their friends concerning looks and body weight. "I think some of the girls in my class want my body", was a typical answer of Group 2. One very weight-conscious dance school girl indicated that her friends were all fatter than her and that she thought they envied her for her slim body. "When we relax around the swimming pool, I often feel very uncomfortable wearing a swimsuit. My friends are all fat and they stare at my body all the time and tell me I am too skinny. They are just jealous."

This competitive-jealous behaviour was especially apparent among the eating disordered interviewees. One girl said that she would do anything to have her friend's body, but she never told the friend so. This feeling of jealousy was termed by one of the Group 1 participants as "silent competition". "You always compare yourself to your friends, but you never tell them. All you want to do is lose more than them." One of the girls of Group 1, when asked whether she was in competition with her friends concerning the attractiveness of their bodies, answered emotionlessly: "Well, what a question? Tell me who isn't? We all want to change some aspects of our own body with somebody else's. That's normal". This answer indicated the seriousness of dissatisfaction of young teenagers with their bodies. It seemed as if it was a totally normal feeling for a young female adolescent to be unhappy about body shape and weight, and just as normal to go on diets and exercise strenuously to lose weight. Among the eating disordered girls of Group 1, the body image disturbance could be detected when two of them indicated that, despite their actual weight being far below their ideal weight for their height, they thought that they were the fattest amongst their circle of friends and that they definitely had to lose weight in order to have bodies like them. Even though these girls pointed out that they compare themselves with any female body, it was their peers with whom they were in direct competition.

Peer pressure to have a slim and slender body was so strong and so much a part of the norm that those who were not succeeding in the pursuit of a 'perfect' body were treated with great disrespect. One model explained that they had a festive occasion in the school hall with all of the scholars being present. A classmate of hers had to give a lecture concerning the festivity. Her fellow students did not perceive her as attractive, and they made her feel their disrespect for her body. "Everybody started laughing and gossiping about her. It was really embarrassing and I actually felt sorry for her. Nobody listened to a word she had to say but made fun of her body." Other girls expressed the peer pressures they encountered as follows: "If you are not thin and beautiful, you are not part of the cool girls' group. People ignore you. This is when I started dieting. I did not want to be perceived as fat and ugly anymore." Consequently she had tried dieting as well as the use of diet pills, but without any success. "I was desperate to lose weight, but I didn't know how to." This leads to yet another important aspect of the negative influence peers can exert on each other.

Not every girl in early adolescence is familiar with eating disorders. Many of the eating disordered participants indicated that they had learned of the illnesses only after having been diagnosed with it. Concerning the model and dance school girls, most of them had heard of the disorders at some stage, but the illnesses were viewed as something alien. Vomiting after meals or engaging in starving behaviour was therefore not thought of as being directly connected with anorexia and bulimia. With this in mind, the following statement might indicate the naivety of some of the girls. "I had heard from a friend that one of her friends is losing a lot of weight by sticking her finger down her throat after eating. This seemed to me the ideal way out." Learning about ways to reduce one's weight was also indicated by one of the models. Her modelling career sometimes took her overseas to compete with international girls, and according to her, all that is talked about is the most effective way to control one's weight. Most effective, however, does not mean most healthy, and it was a shock to hear which methods her peers suggested. To give a brief account of the conversations these models have, she related as follows: "You don't know anybody there. The only thing that is binding is the modelling and the methods used to control weight. It was horrific. Many of them told me that the best and easiest way for me to lose weight was to take drugs. When one takes the drug one never feels hungry but has all the energy in the world – it makes the starving easier, they said." From statements like these it

became apparent that peers were an important source for transmitting dieting behaviour.

These extreme suggestions to control weight were also encountered in another sphere of peer influence. According to one anorexic girl, who was hospitalised for her illness, the most effective ways to continue with starvation behaviour inside the institution was by listening to peers. During the three months the girl was hospitalised, everything, according to her, revolved around how to discover 'tricks' to break the cycle of 'forced feeding'. One of the examples she mentioned was: "It was actually really funny in there. In the beginning, when I got there I ate everything I had to. I hated it but I did not know better. But the longer one is there, and the more contact one has with the girls, the more you learn. Every time we had cookies and tea in the dining hall, we tried our best to make them disappear. Even though there were a lot of nurses around checking up on us, we always knew what to do: eat, blow your nose and in the process spit them into the tissue, or crumble little pieces of the cookie in your hand and then dump them unnoticed into the pot plant. My favourite trick was as quickly as possible, to stuff little bits into my trousers. After tea-time, we would usually discuss which ways to get rid of the cookies were the best and most effective." In spite of not being in favour of the forced feeding process, it was shocking to learn that even in institutions where eating disordered girls are supposed to support each other to get better, all they did was assist one another in increasing the severity of the illness. Since this was the only anorexic girl being institutionalised over a very long period of time, no comparison could be made with other girls' perceptions concerning this topic. However, with the details this girl gave about her stay in hospital, it was clear that many girls who are going through the same feeding process shared her experience of "we will starve together".

Peers, however, did not necessarily need to be a direct source of information on how to successfully control their weight. Sometimes it was not necessary to be told in detail what kind of weight-reducing method was to be used. Some girls were simply inspired by the ineffectiveness of their friends' behaviour to lose weight. Two bulimic girls who indicated that vomiting after having eaten seemed to be the ideal way to meet the standard of attractiveness, pointed out that none of their friends had told them to engage in such behaviour. Rather, it seemed as if the constant "diet-talk" at school

concerning what is successful and what not became too much and so other, more effective methods were thought of: "The girls starve and diet all the time. I was sick of it. So I thought I had the best solution. Eat as much as you want and then you throw up. I was so delighted with my 'new' discovery for losing weight, I did not tell anyone. I wanted to impress them." It seemed that especially the bulimic girls were, directly or indirectly, influenced by their peers' opinions concerning the 'right' weight control method. In the case of anorexia, it was found that most of them, like any other 'normal' girl, started dieting by reducing the food intake. The influence of peers in this case lies within the positive remarks some of them received from, among others, their peers. Even though more information concerning this topic of positive and negative remarks with regard to body shape was presented in paragraph 3.6.1.4, the role peers play in this regard needs to be elaborated here. At the time of the interview, many of the participants – except for the anorexics who were trying to beat the starvation process – mentioned receiving positive remarks for losing weight and negative ones for gaining. These remarks, according to the girls, came most often from either peers or boyfriends. A dance school girl indicated that: "Of course my friends make positive remarks when they see that I have lost some weight. Usually they also ask me how I did it." This was also confirmed by especially the anorexic girls. "I dieted and so I lost a bit of weight. Especially my friends at school and my boyfriend complimented me on how nice I looked. It simply stuck in my mind and I wanted to lose more and more. And then it got out of hand – I could not stop anymore, it was a downward spiral I could not stop." Yet another girl explained that: "It was so nice to be one of the skinny girls in school and for the first time to get positive remarks about my body. And so I wanted to lose more and more. ... To myself, I still looked fat in the mirror."

It is not proposed that anorexia, or even bulimia, are simply produced by positive remarks concerning a girl's body leading to dieting getting out of hand. However, it has to be acknowledged that many of the girls enjoyed the positive remarks when losing weight and wanted to avoid the negative remarks when gaining a couple of kilograms. This in turn sometimes triggered behaviours, which led to obsessive dieting behaviour and eventually to eating disorders like anorexia nervosa and bulimia nervosa.

Another important aspect mentioned by many girls as being influential in their decision on whether to diet or not was teasing. As indicated in the literature, (Chapter

2, paragraph 2.7.4), teasing influences body image dissatisfaction, heightens shape consciousness, and increases a desire to be slender. Out of the 22 participants who were asked the question "Why do you think girls suffer from eating disorders like anorexia nervosa and bulimia nervosa?", 10 girls – 4 from Group 1, and 3 from Groups 2 and 3 respectively – perceived "teasing by peers" as one of the most important determinants in the production of eating disorders. Unfortunately, it was not investigated in depth whether the teasing emanated more from either their male or female counterparts. Further, the impact teasing behaviour had on the different interviewees could not have been established either. Only one eating disordered girl explained in a more detailed way that, when friends make jokes about her weight ("You grew nicely into your jeans") she feels very hurt and this in turn negatively influences the degree of her bingeing and purging. From the rest of the girls it did not become clear whether they had been teased and therefore started to reduce weight. What seemed to be evident from some of the girls' perceptions concerning the negative impact teasing can have on the production on eating disorders, however, was that they acknowledged the positive correlation between making fun of someone's weight and a low self-esteem concerning the body.

Yet another peer influence, which seems to reinforce the glorification of slenderness, was the girls' opinions concerning the importance of being desirable to males. Everybody, without any exception, pointed out that their male friends' opinions concerning their bodies were very important. "One wants to look nice for the guys, that's normal", or "I feel good if I get complimented by my male friends on how I look", were common remarks made by the girls. Looking good for their male counterparts, however, could not have been an easy task for the participants. The reason therefore is that the standard of attractiveness perceived desirable for males was a rather unattainable one. By explaining their perceptions concerning which physique males prefer it became evident that all interviewees considered the typical Western 'supermodel look' as most desirable. Answers ranged from: tall, skinny, blonde, long legs, toned body, sexy behind, small breasts, to no fat, no cellulite, no pimples. One eating disordered girl stated that: "I know what guys want because I have a lot of male friends. The girl must be skinny. She doesn't have to be too tall, but should definitely not weigh more than 45 – 50 kilograms. Her legs have to be toned; she needs to have big breasts and long hair. The face doesn't really matter." Many models referred to the

"Coke-bottle build" as the most desirable physique for women. Overall, even though there were differences in perception concerning the preferred sizes of breasts, height, as well as eye and hair colour, the features most outstanding and mentioned by everyone were thin and toned with no body fat being acceptable.

A follow-up question asking whether it matters to the participants what guys think about them was answered by many with a definite "Yes". Here it was interesting to notice that most dancers were of this opinion. Answers ranged from, "That's why I am preoccupied with food and my body, one wants to look sexy for the boys", and "It's not nice to hear nasty comments about one's body from them", to "Not anymore, but as a teenager it was a big issue". Many models indicated that it did not matter what males thought of their body, with only one girl indicating, "First impressions are very important. I like to look good and attract the attention of guys". Five eating disordered girls found it important to have their male counterparts being attracted to them. The other half indicated that it was not an issue what the males thought but rather what they thought of themselves. "I don't care what they say about me. I, for myself, want to look attractive."

It is accepted that the one sex wants to attract the other. Further, people look for recognition, whether in their work or private life. However, with the current societal standard of thinness being what it is, it seems as if being recognised as a beautiful woman is unattainable to many. From the above it was clear that the girls' perception of beauty was influenced by the thin ideal. Therefore, if one does not comply with the ideal, changes need to be made. This became apparent with some of the participants going on strict diets in order to be attractive to the opposite sex. For this discussion regarding peers it is noteworthy that for some girls an unattainable beauty standard can cause body dissatisfaction, which in turn might lead to the taking of drastic measures in order to change the body.

The perceptions of male friends concerning the thin ideal could also be established because many of the interviewees had boyfriends. Thirteen participants were involved in a relationship, with 4 of the eating disordered participants, 4 girls of the models and 5 dancers being able to answer the question on whether their boyfriends preferred a slim and slender body. Answers differed amongst the participants, with especially the

ones coming from the anorexic girls being distinguishable. These girls indicated that their boyfriends definitely did not want a skeleton as a partner, with two girls stating that their partner would rather prefer an overweight girl to someone suffering from anorexia. "He always preferred skinny girls, but since I have been sick he often tells me that it is very ugly to be so thin." It seems as if the whole illness experience of this anorexic girl's boyfriend changed his perception concerning beauty, with the thin ideal not being as important anymore. The rest of the girls explained that their boyfriends prefer slim and slender females, with some of them being complimented when losing weight. "He is not fat", an eating disordered explained, "so he doesn't want me fat either. When I lose a couple of kilos he really likes it."

For other participants, the question as to whether their boyfriends prefer slim and slender females was perceived as rather ridiculous. Answers like "Obviously, he likes skinny girls – which man doesn't?" or "What a question – of course!" were common here. To conclude in this regard, the girls' opinions concerning their same gendered friends' unhealthy preoccupation with food and eating has to be mentioned. Many interviewees' girlfriends were perceived to have an unhealthy preoccupation with weight and excessive dieting behaviour was mentioned to be the reason thereof. Constant dieting, the use of diet pills, as well as starvation, were mentioned by 15 girls to be a rule rather than an exception regarding their peers. 'Girl talk' of "Gee, I ate too much over the weekend. I'll have to go to gym immediately after school", or "I definitely picked up weight. No more food for me", was indicated by many of the participants' girlfriends. It seemed as if they wanted to be acknowledged and liked by their male counterparts and that is why the weight issue was so important. "Girls want to be liked by guys and guys like skinny girls. That's why we all want to be thin", was one of the dancer's opinions.

This last statement seemed to be exactly the reason for many girls' weight conscious behaviour. It was evident that the opinion of others, especially one's peers, was very important for a positive self-image. Influenced by the prevailing cultural standard of beauty, the pursuit of a thin body seemed unavoidable with the female peers encouraging one another with weight conscious behaviours. The camaraderie developed teaches them new tricks, with more effective methods being tested all the time. However, one question remains: "Why did some of the girls indicate that they do

not care what anybody else thinks, they want to have a slim and slender body for their own sake?" With this question in mind, the media as influential socialising agent, which promotes contemporary body ideals by transmitting them almost unconsciously into people's belief and behaviour needs to be explored in depth.

3.6.3 The media as an influencing factor

Behavioural modelling, which is enhanced by the mass media, according to Thompson and Heinberg (1999 : 340), is one of the most potent and pervasive communicators of socio-cultural standards. Indeed, the media, its image of the ideal woman and its emphasis on dieting, seem to play a significant role in the production of body and weight dissatisfactions among women.

Even though some of the girls did not perceive television as an important part of their leisure time, 12 out of the 22 girls spent more than two hours a day watching television programs, with some of them indicating more than three hours daily. It was interesting to find that some of the eating disordered girls preferred programes like *Beverly Hills* or *Melrose Place* because like one girl stated: "Its so nice because there are all these young, beautiful people, who never work and never have stress. They just party and enjoy life. And they don't have to eat either. Its just a perfect world." A bulimic girl was very interested in watching the food channel. She explained that she loves food but that she always feels so guilty when eating. Therefore, she rather watches other people prepare and eat food. "It's them who get fat, not me!"

Furthermore, all of the eating disordered girls, the whole group of models and half of the dance school participants indicated that they frequently read female fashion magazines like *Femina, Cosmopolitan,* and *Vogue*, with *Cosmopolitan* being the most often read magazine. While half of all the participants confessed reading these magazines in order to know what the Hollywood stars are up to, others were most interested in the fashion and clothes section.

The strong influence of the media became especially apparent when the girls were answering the question: "If you could exchange your body for somebody else's, whose would it be?" Even though this question was supposed to underline the body

satisfaction/dissatisfaction among the different participants, it became a strong indicator of the importance of the role of the media in the girls' lives. Only one dance school interviewee pointed out that she had never come across the perfect body she would like to change her own to. Rather, she would like to undergo some changes on her own body to feel comfortable with it. Here it was not clear whether the girl was referring to plastic surgery or whether she only thought of changing her appearance by dieting. However, 21 out of the 22 girls answered that they would love to exchange their body for that of a 'perfect' model. Cindy Crawford, Claudia Schiffer, Naomi Campell, Elle McPherson and Kelly McGregor were just some of the models the girls indicated. One anorexic girl thought of the skeletal Calista Flockhart (TV star of the sitcom *Ally McBeal*) to be the beauty ideal she would like to emulate. Answers to the SATAQ confirmed this dissatisfaction with their own bodies, with more than half of the participants indicated that they *always* wish to look like a swimsuit model. Of the three groups, the eating disordered girls were the most eager to compare themselves to models: "Everything is so perfect about them, and even if they wear the ugliest clothes, they are still beautiful". The specific answer of one girl indicated the ever-present struggle of accepting one's own body while idolising out-of-reach beauty ideals: "Oh, they are so beautiful and I would really like to look like them. But I know as well that every body is precious. So eventually I will have to accept how I look and who I am." Especially regarding the older participants, it became apparent that they were trying to appreciate their own bodies. However, as illustrated in the statement presented above, concerns about not complying with the beauty ideal persisted.

With so many girls dreaming of having the bodies of the rich and famous, it was strange to find that many of the same girls mentioned that these beautiful women live a relatively unhealthy lifestyle. They have anorexia, they starve, they use drugs, they smoke too many cigarettes, they sleep too little, they don't exercise, and they are generally unhappy, were some of the opinions of the participants. Only one Group 2 interviewee indicated that "the models themselves could actually be healthy, but the model agencies force them to lose more and more and then it gets out of hand." It was astonishing that the beauty divas were idolised with such passion even though the participants thought of them living totally unhealthy lifestyles. Therefore, it became apparent how important the thin ideal was to most of the participants. It seemed as if they would rather live a totally self-destructive and unhealthy lifestyle than not have

the preferred 'perfect' body. One girl highlighted this by stating: "I know that they are leading very unhealthy lifestyles but it still looks nice. I really enjoy the way their bodies look."

With this in mind, some of the girls' answers concerning whether they perceived themselves as being influenced by the media seemed to be rather contradictory. While most of the models and dance school girls were aware of the influence the media had on them, 3 of the eating disordered participants thought of the media as not affecting them at all. Answers like "I decide for myself what is beautiful and what not. I am not easily influenced", or "Well, the models are pretty but the biggest enemy is myself – I perceive myself as being too fat", underlined their opinions. Whether this was due to their being too caught up by the disorder, and therefore really not perceptive of any environmental influences being possible triggers, or whether they really thought the media was not influencing them could not be established. However, in comparing their different answers on various occasions concerning the beauty ideal, it seemed as if, despite their disbelief, they too were influenced by the mass media. One further example of the definite relationship between media influence and idealisation of a slender shape could be established with the girls' responses to the statement: "Most people believe that the thinner you are, the better you look in clothes". All of the participants unanimously answered this statement with *always*, *often* or *sometimes*, with nobody believing that this was not the case.

Further, it was found that the eating disordered girls, who realised they had been influenced by the media, glorified the slender ideals with far greater passion than did the other participants: "Models are so beautiful – if I only could be like them", was an overall opinion. One of the Group 1 participants explained that she knows that the media influences her because: "While I was very anorexic, Kate Moss was my ultimate goal regarding how I want to look. When I got better, I saw that she actually looks ill and anorexic herself. At the moment I prefer the bodies of models like Cindy Crawford."

The awareness of the media as an influencing factor in the pursuit of a slim and slender body was especially presented by the Group 2 and 3 interviewees. One Group 2 model indicated: "Obviously I am influenced by the models on TV. I want to look like them.

Every model dreams being on a magazine cover or on TV presenting fashion." A dancer indicated that people are actually very easily influenced. She underlined this statement with the following: "When I was in England, the fashions did not appeal to me at all. The sizes were so small and everything had to be tight fitting. When I came back to South Africa the same clothes became fashionable here, and the longer I was exposed to them by TV or magazine ads, the more I liked them. Eventually I bought the trendy clothes. That's the media at its best." Yet another dance school girl stated that: "The media shows you how you should look. But they are very clever, they immediately show you how you can change yourself to look like this as well."

This leads to yet another strategy the media uses to create body dissatisfaction and weight preoccupation among women. TV and magazines do not only present a thin ideal unattainable to many, but also evoke guilt and shame about women's appetites and body size. "Every time I sit in front of the TV eating something and they show a beautiful and thin women I have to stop eating because immediately I feel guilty and fat", one of the eating disordered girls indicated. Further, the media presents overweight people as lazy and dissatisfied with life. According to answers gained from the SATAQ, almost all of the participants regarded fat people in our society as unattractive. The perceptions concerning too much body weight as well as overweight people were discussed in paragraph 3.5.3. However, the need for a slim and slender body in order to be an accepted member of society became apparent when most of the interviewees agreed on the importance of working hard on one's physique in order to succeed in today's culture.

To combat the guilt experienced from overeating and from not looking as one is supposed to, the media has the right answer: diet products. The fear as well as anxieties some women experience in incidences of unrestrained eating can be conquered by the use of the diet products advertised on TV and in magazines. Some of the girls indicated not only dreaming of being as thin as the people presented in the media but also going for the products presented in order to control weight. "Every second add on TV is about how to lose weight. And if I am unhappy with my weight I obviously listen more closely and maybe even try the product out", one dance school girl stated. A Group 1 participant pointed out that: "Everyone wants to be thin like the people on TV and in magazines. Not everyone, however, has the self-discipline to eat healthy.

And so one buys the pills which they suggest." "Do you know the presenter of 5FM, Darren Scott?" a Group 2 interviewee asked, "He was really fat and now, with the help of diet pills he has lost so much weight. He really looks good. And if this worked for him, it will work for me." Even though most participants indicated being rather irritated with the amount of diet products advertised in magazines and on TV, the same girls, when asked where they get the information regarding which diet product to buy, mentioned these very advertisements. Again, this indicated the strong and pervasive influence the media has on the participants.

Concerning the participants' perception regarding whether behaviours like starving, bingeing, purging, and the use of diet pills are becoming a normal part of every day life, many girls answered "yes", and blamed the media as one of the strong influencing factors in the production of eating disorders. "If I tell my friends that I am using a new diet product seen on TV, nobody thinks it is funny. It's actually very normal. I am always dieting", one of the dancers commented. And yet another dance school girl summarised the complex circle of influences as follows: "The media tells us how we all have to look. Clothes and everything are made only for skinny people. Because they know we don't look like that anyway, they immediately give us the right methods to lose weight as well. Have you seen that? It's one diet product ad and then a fashion ad, and so on. They show this over and over till we believe there is something wrong with us, and so we use diet pills. We buy the brand they tell us we should and then it gets out of hand. We can't stop anymore and want to be skinnier and skinnier like the fashion models. Yes, and then you have anorexia or bulimia, and everybody asks 'How could that have happened?' Funny, isn't it?"

The ironic way in which this girl presented the problem does not seem to be far from the truth at all. As the girl indicated, the media bombards people with images of a generally unattainable ideal. The importance of looking like this ideal is underlined by unacceptable body images as well as by the solutions on how to change the unwanted body form. The message of "Real women's bodies are inadequate and in need of work, but we can help you," is communicated to the masses. The guilt and shame experienced by many who do not conform to the ideal can then be conquered by using what is presented and suggested in magazines and on TV. A pill here, laxatives there, or maybe equipment to tone the muscles underneath the fat, and as seen above, young

women will go to extreme lengths to reach the 'perfect' body. For some, however, this preoccupation with weight and the underlying body dissatisfaction turns into a lifelong obsession, which might even turn out to be fatal.

However, the media cannot be blamed as being the sole trigger in the production of eating disorders. Rather, all three socialising agents are perceived as equally potent in this process. Why the participants thought that so many girls world wide suffer from eating disorders like anorexia and bulimia will be dealt with in the following section.

3.7 PARTICIPANTS' VIEWS CONCERNING THE TRIGGERS OF EATING DISORDERS

Almost all of the interviewees were of the opinion that behaviours like starving, bingeing, purging, use of laxatives, diuretics and diet pills, were becoming too normal a part of everyday life. The participants often mentioned that the media markets a body image which is desired but difficult to attain. Further, most of the participants indicated that diet products dominate the media. "That's all the magazines advertise, diet products and clothes for skinny people." "No wonder people diet and starve. That's all one sees on TV. Diet products during commercials and skinny beautiful people, who live happy and perfect lives in the movies." The negative effects of the free accessibility of diet products were pointed out by many, with one anorexic girl explaining: "It doesn't matter how old you are. You can buy diet pills, appetite suppressants or laxatives over the counter everywhere and nobody asks you why or for whom." Not only did the interviewees criticize the media for over-presenting diet products and the market for distributing the products to everybody who wants them, some participants were of the opinion that lifestyles per se changed over time. "It's the easy way out. Nobody has to go to any effort and exercise or eat right. Just buy some pills and you will lose weight. Every child knows that already." "Appetite suppressants are so easy to use", an anorexic girl explained, "one can get the pills and they then replace meals. It's easier, faster and more convenient because one doesn't need to cook and one loses weight in the process."

It became apparent that the girls were aware of the Western lifestyle and its extreme focus on the thin ideal. They expressed their perceptions concerning the

inappropriateness of the societal standard of thinness with quotes like: "It's really getting out of hand. People are obsessed with their body and weight. Everyone is on a diet. It's a bad example for kids." "People don't know where to stop anymore. It is an issue, not a way of life." "People forget that everybody is built differently. Not everyone can look like a model. Fat people are judged according to the way they look and they are so unhappy that the only way to a happy life is through dieting. It is sad." "It's a disgrace. Guys only like the skinny girls like models or actresses. What about us? Do we all have to look like them?" With most of the girls perceiving the problem to be "out of hand" – a disgrace for the Western standard of life – one model was of the opinion that: "It's just fine. One has to look after oneself. That's just how it is."

Concerning the development of eating disorders, many different opinions were presented. One of three socialising agents was usually presented, sometimes all three simultaneously, with peers and the media being the two indicated most often by Group 2 and 3 participants. The eating disordered girls often saw the problem to be an interrelated one. "It's everything: my family which has so many problems. The friends who are on constant diets and with whom one is often in competition regarding who has the better body. It's the guys whom one wants to attract. It's the TV which always shows these sexy women; the magazines, which show you how to lose weight; my low self esteem and lack of self-respect; and of course my perfectionism. I want everything in life to be perfect, my body included. Well, if one starts dieting with this potent combination then one can easily end up having anorexia, don't you think?"

Further, while the family, peers and the media were often seen as triggering eating disorders, it was always dieting behaviour which had got out of hand which the girls saw as the ultimate mechanism causing starvation, bingeing and purging. "Friends are thinner and then they maybe tell you that you are fat. Yes, and then you start dieting and you get so many positive remarks. You go on and on and on with it; till it's too late", an anorexic girl indicated. A bulimic girl thought that: "It's society. One wants to fit in. You see beautiful skinny girls on TV and you know men prefer their bodies. So it's a sexual thing as well. You diet so you can attract men. And then you overstep the fine line between being on a diet and being sick." A model argued like this: "I think anorexia starts when people tell you that you look bad. You give in and start dieting. Your body changes and you are so happy that you go on eating less and less. Bulimia I

think is just extremely stupid behaviour." The eating disordered girls had a somewhat different opinion concerning their eating behaviour. To many, it was an obsession that one cannot break: "You start dieting and it becomes an obsession. Your body and losing weight are all you think about. Nothing else is interesting. Only how much you ate and how much you lost," an anorexic girl explained. A dancer also thought of it that way: "One is obsessed with losing weight. I can really imagine how it goes. Last year I was too strict with myself in what I allowed myself to eat. I restricted myself to only one or two sweets, and that only over weekends. I lost a fair amount of weight, and if it had not been for my dancing, for which I need my strength, I would have liked to lose more."

Whether eating disorders were seen as uncontrolled dieting, obsessions or just "extremely stupid behaviour", solutions presented by the participants were characterised with great uniformity. "What is important is a supportive Christian home for the proper development of the child's self-esteem. It all starts with negativity coming from the inside, that's why the girls need to change something. They just change the wrong thing – the outside," a dance school girl explained. Yet another dancer argued that: "The girls of today are insecure, too emotional and unhappy. They dislike themselves and are in great need of attention. They want power as well. Dieting and changing one's body is the only way they think they can get what they want and need." A participating model mentioned: "The girls get teased at school by friends telling them that they are fat. From this they lose self-confidence and they start being unhappy. And then they start to change. One has to learn to be happy with oneself."

3.8 SUMMARY

This chapter starts out with a narrative of one of the research participants concerning her experiences of anorexia nervosa. This story presents the views and behaviour of an extreme case of a person suffering from an eating disorder. The story brings, even when the clinical information on eating disorders is relatively known, any reader under the impression of the real experience of the illness. However, the most important message of this tale is in the closing sentences, where the girl confirms her belief in the Western ideal of thinness. This gives a deeper understanding concerning the almost impossible task therapists have in curing anorexia and bulimia patients and it

strengthens the viewpoint of scientists (and this study), that cultural beliefs are at the root of the problem of eating disorders.

The rest of the discussions in Chapter 3 verify this statement. In the presentation of the perceptions of participants concerning food and eating, participants make a distinction between food and non-food, based on whether the substances are healthy (good) or unhealthy (bad). An important result, which shows the obsession with food, is the amount of time the participants spend thinking on food. This is even more distorted in the information on weight control methods used by the participants. All the participants are familiar with methods such as laxatives, diuretics, diet pills, strict diets and exercise, but only the eating disordered girls and a few of the models and dance school girls make use of the typical methods of starvation, bingeing and purging. In the discussion on the perceptions concerning beauty and body shape, the participants present, to a greater or lesser extent, distorted images of their bodies. The fear of obesity is deeply internalised and the majority of the participants admit to having a severe aversion for obesity in others and themselves.

In the second part of the chapter, the influences of the prominent socialisation agents of the thin ideal are discussed. The research findings provide further confirmation of the fact that eating disorders are cultural bound. Within the family and the peer group there exists a preoccupation with weight and eating healthily: Most of the mothers are constantly on a diet; children are expected to eat healthily and to be careful in order not to gain weight; and girls are continually urged to eat less. Concerning the peer group it was found that a competitive attitude and a need for social approval put pressure on the young female to conform to the thin ideal. Further, the peer group acts as an important source of information on dieting and other methods of weight control, whilst being desirable for males provides additional reinforcement in the achievement of the slender female physique. Finally, the media as influencing factor is discussed. In line with females all over the world, the participants idealise famous fashion models and film- and television stars. The participants also confirm the potent influence of the media as agent of change when they admit to acting on the invitation of advertisements to use slimming products.

In an effort to determine which one of the socialising agents could possibly have the biggest influence on young female, the research participants were asked to give their views on the triggers of eating disorders. They are unanimous in their understanding of the problem that all three agents play a major role in causing anorexia nervosa and bulimia nervosa, but it became apparent that they perceive the individual as also having a responsibility to be more accepting of her body and being secure in her identity.

CHAPTER 4: CONCLUSION

4.1 OVERVIEW

This study starts with the research question concerning the relationship between culture and anorexia nervosa and bulimia nervosa. The question is formulated after a thorough literature study that shows that eating disorders can be regarded as an epidemic in the Western world. An anthropological approach to eating disorders implies inter alia that the research participants are cultural beings who live in specific cultural contexts with relative culture-bound ideas and perceptions regarding their illness aetiologies and experiences. The approach also entails an emphasis on the emic and holistic perspectives of culture.

The overall objective of the research project is to conduct an exploratory, empirically based investigation into the connection between culture and anorexia nervosa and bulimia nervosa among three selected female groups in Bloemfontein. The specific objectives are to:

- Scrutinise the relevant literature on anorexia nervosa and bulimia nervosa;
- Obtain perceptual-conceptual information concerning the individual's self and body image;
- Investigate the influence of familial factors such as the family environment, parent-child relationship, parental styles, discourse on weight, food consumption, and lifestyle present in the household;
- Examine popular cultural influences, like the pressure for thinness expressed by peer groups and the visual as well as the printed media.

As will be indicated in this chapter, these goals set for the study are met.

As discussed in Chapter 1, the research participants comprises of three selected groups: Group 1 consisting of persons who, at the time of the research (or previously) suffered from anorexia nervosa and/or bulimia nervosa; Group 2 consisting of individuals from a model agency, and Group 3 consisting of members of a dance school. It is important

to understand that Groups 2 and 3 are not control groups in the normal sense of social science research. They are in effect risk groups, which implies that they can easily fall into Group 1 if they cross the boundaries and become anorexic or bulimic. In a sense the three groups have the same perceptions, values, worldviews and behaviours concerning, for instance, their bodies, food, obesity, and experience as well as more or less the same socio-cultural influences concerning the ideal of thinness. In that sense they can be seen as representing Western cultural standards, which often emphasise a healthy lifestyle with exercise and health food as prominent characteristics.

In this research, questionnaires and in-depth interviews are used to collect the relevant data in order to obtain insight into the cognitive thinking, beliefs and behavioural patterns of the participants. Structured questionnaires, such as the BSQ, SATAQ, EAT 40 as well as a Cultural Background Questionnaire (CBQ) were used. The first three questionnaires are standardised questionnaires used in the social and medical sciences, while the Cultural Background Questionnaire was compiled by the researcher. For practical reasons it was not possible to use traditional participant observation techniques in this study. An extensive literature study (Chapter 2) is undertaken to develop a theoretical frame of reference of anorexia nervosa and bulimia nervosa as phenomena in Western society. The empirical research findings are presented in Chapter 3. The purpose of this chapter (Chapter 4) is to present a number of general conclusions pertaining to the study and its objectives.

4.2 BEING FEMALE AND BEAUTIFUL IN WESTERN SOCIETIES

One of the prominent conceptualisations regarding being female and beautiful in contemporary Western societies over the last few decades could be summed up as: being physically attractive equals being desirable to men; equals being a successful member of society; equals being a valuable individual; equals being happy. Eating disorder specialists (Dally and Gomez 1980; Furnham and Alibhai 1983; Osvold and Sodowsky 1993) have shown that a feminine appearance is indispensable to personal worth. Therefore, in order to be a happy, confident and valuable human being, Western women need to conform to the standards of physical attractiveness set for them.

The females participating in the research process range from normal dieters and exercisers to very ill eating disordered individuals. The ideology equation presented above seems to be internalised by all of the interviewees, with almost all of the participants fearing fat and admiring slimness. This fear of obesity, which is a relatively new preoccupation within Western societies, and which originated from a fear of being unhealthy at the beginning of the 20th century, shifted its significance to fat being considered déclassé, hated and despised (cf. Gordon 1990). Information gained from the empirical research confirms this conceptualisation, with many of the participants being of the opinion that slim equals everything that is positive, while fat is perceived to be negative on many different levels. Some of the interviewees equate obese people as having a personality 'defect', lack of self-control, and moral flaws, while others perceive overweight people to be unhappy, unattractive and out of control regarding their eating behaviour. The socially constructed ideology sees fat and thin as diametrically opposed to each other and while being fat is negative, being thin is the dream of every Western woman, with a fat-free and toned body being the ultimate goal (cf. Lelwica 1999). This obsessive goal of thinness found among Western women, as described in the literature, is confirmed by the participants when expressing their ideal body image. Many of the interviewees highlight anorexic-like physiques to be desirable and skeleton-figured models as beauty ideals.

Because beauty is a woman's principle in life and slenderness crucial for success and goodness, Western women are in constant need to change. Women know that this ideal can only be attained, if possible, by constantly working hard and relentlessly on their bodies. 'Working' on one's body is in direct relationship with eating because women learn from an early age that what you eat is what you will look like and feel like. These socially constructed equations between food and fat and between overeating and immediately gaining weight as described by Coward (1984), is experienced by many of the participants, irrespective the group they belong to. Further, feeling bloated, fat, full and guilty after meals is described by the participants of all three groups as leading to the need to display self-control around food.

4.3 GROWING UP IN A WESTERN CULTURE

a) The family

Growing up female in contemporary Western societies means that the child learns at an early stage how to behave in a gender specific manner. Often, a double standard is inherent in traditional gender norms: Men are encouraged to develop their minds, women are rewarded for refining their bodies; men are supposed to be sexually attracted (to women) while women are supposed to be sexually attractive (to men); men are encouraged to satisfy their physical appetites, and women are taught to deny their own needs for the sake of others (cf. Lelwica 1999).

The family, which is a mediator of culture and operates as a formidable influence on identity, is one of the major contributors in the development of the self and the formation of the self-image. According to the literature (cf. Dally and Gomez 1980; Osvold and Sodowsky 1993) girls are socialised from a very young age to get a sense of their self-esteem from their physical appearance rather than from what they do, while little boys are socialised to have a preference for a particular female form, learning to evaluate negatively everything not conforming to the cultural standard of attractiveness. A differentiation concerning gender socialisation with regard to eating and the body can be detected in all the homes of participants, with some of the girls feeling stigmatised for being plump or overweight. In addition, many of the participating girls reveal an extremely deep-seated belief in the restraint of women, with some of them believing that they eat less because they are less active and need less energy than their male counterparts. Despite having been socialised to be moderate eaters, more than half of the 22 participants have been urged to eat less throughout their lives.

According to the literature (cf. Haworth-Hoeppner 2000), talk about weight that occurs routinely and that is a central organising principle in family dynamics predisposes offspring – male and female – to value thinness in women. In the case of a female member not being able to comply with this inherent value of being ultra-slim, pejorative remarks about overweight family members tell her directly

and indirectly that being fat is not acceptable. Many participants remember being criticised by family members for being overweight or eating too much and such remarks are deeply internalised. This is apparent as many of the participating girls indicate being dissatisfied with their own bodies and mention using drastic measures in order to change their female physique to a more societally appreciated body size.

In the research, the influence of parents as good role models for the proper development of eating and exercise habits is a rather negative one. Seemingly not being able to reach the idealised beauty ideal, many of the participants' mothers are – in spite of being excessively weight-conscious and dieting – not able to possess a fat-less, muscular female body. As a result, many of the mothers are supportive of dieting behaviour, with some even using laxatives, diet pills, and appetite suppressants. The participating girls, growing up believing that the pursuit of a slim and slender body is equated with self-control, elegance, sexual attractiveness and youth, therefore do not want to turn out like their mothers and be overweight. Therefore, the weight-conscious behaviour practised in many households is seen as appropriate by most of the participants and copying this behaviour comes naturally.

Moreover, overeating, in the form of taking in as large, or larger portions of food than male counterparts do, is considered by almost all of the participants as inappropriate and it seems as if most of them are socialised to believe that being a beautiful and socially acceptable woman is in a direct relationship with eating moderately. Watching one's weight and being constantly working on one's feminine appearance is so internalised by many, that by the time the girls enter school, they are very receptive of the perceptions and practices of their peers.

b) Peers

As indicated in the theoretical framework, Western children are not only socialised by family members, but peers spend a great deal of time together, influencing each other with regard to persisting cultural norms (cf. Arnett 1995). It is found that peers reinforce the already existing cultural ideology of the slim

ideal. Further, it seems that when girls enter adolescence, physical appearance and an interest in more mature social concerns – such as the ability to attract popular boys – turn out to be the most important issues (cf. Henslin 1996). This is confirmed by the interviewees when the girls describe the typical Western 'supermodel look' to be the most preferred one amongst their male peers. In order to look attractive to the opposite sex the girls perceive themselves to be in need of possessing the sought-after model look. Most of the participants point out that their male friends' opinions concerning their bodies are very important.

This ideal, however, can only be attained when engaging in strict dieting behaviour. By suggesting different methods of dieting behaviour, the girls encourage each other to conform to the societal pressure to be thin. Positive remarks from friends for losing excess weight often encourages the use of more drastic weight control methods. Some eating disordered girls even indicate having learned their disturbed way of dieting from their female friends.

Peers, however, do not only encourage dieting behaviour by exchanging 'successful' methods on how to lose weight, but the 'silent competition' with each other is also found to encourage the girls to diet. In the case of not being able to win the competition and possess the most perfect female body, yet another phenomenon within peer behaviour comes to the fore. It is shown in the literature (cf. Levine and Smolak 1994) that teasing others who are not conforming to the desired body image is a common phenomenon among peers. This behaviour in turn is said to influence body image dissatisfaction, heighten shape consciousness, and increase a desire to be slender. The participants confirm the positive correlation between making fun of someone's weight and a low self-esteem concerning the body, with some even believing that the production of eating disorders is influenced by being teased about one's weight by peers.

Overall, it seems as if it is a totally normal feeling for a young female adolescent to be unhappy about body shape and weight, and just as normal to go on diets and exercise strenuously to lose weight. The influence of both male and female peers positively reinforces body dissatisfaction and weight conscious behaviour and

sometimes even leads to behaviour associated with eating disorders like anorexia nervosa and bulimia nervosa.

c) Media

However, the process of socialisation takes place within a larger cultural context. Media images, produced primarily for young females, bear the imprint of the Western culture's ruling ideologies, and many women are bombarded with it from a very young age.

Magazines are available to most young women because they are relatively affordable as well as portable and unlike the shifting images of women on TV, readers can study a magazine photo an infinite number of times, for as long as they want. The convenience of affordability and portability makes them seen everywhere: at the newsstand, in a doctor's waiting room, and in most family homes. Most interviewees participating in the research project indicate frequently reading female magazines in order to be informed about Hollywood stars, fashion and clothes. In this process, females are bombarded with bodily appearances and model's bodies that are esteemed not so much for their creative talents as for their bodies. Being advocates and promoters of unrealistic and dangerously thin ideals, women's magazines are often viewed as the most potent form of mass media (cf. Wolf 1990). However, eating disorder specialists (Garner and Garfinkel 1982; Thompson and Heinberg 1999) do not underestimate the powerful influence of television. More than half of the interviewees watch television for more than two hours a day, and many of especially the eating disordered participants (Group 1) prefer programmes they cannot relate to. Series presenting images of the 'perfect' young woman who lives the 'perfect' life are idealised. As a result, many girls recognise the presented feminine ideal as a norm, as the ideal, as the ultimate. Even though some of the participants are of the opinion that they are not influenced by images the media presents, it is apparent that all of the girls would do anything to possess the 'perfect' body. Whether being anorexic, bulimic, or a member of the risk groups, 21 out of 22 participants even know the name of the model they would love to exchange bodies with. However, realising that they

never will be Cindy Crawford or Claudia Schiffer in person, many have to use drastic measures to come closer to the idealised ideal.

(Un)fortunately, the media, apart from presenting this ideal, tells females in the same breath how to make the most of their own bodies. While overweight people are presented as lazy and dissatisfied with life, the media aims to help people get their life in order and to stop the misery of being overweight. Two very different but seemingly equally potent strategies are used: the weight-loss and fitness campaigns. Even though many participants indicate being rather irritated by being constantly bombarded with the amount of fitness and diet products presented daily by the media, the fear as well as anxieties experienced after incidences of unrestrained eating are conquered by the use of the diet products advertised on TV and in magazines.

From the above it becomes apparent that growing up as a female and being bombarded with Western beauty standards is not an easy task. In a culture where the female anatomy is evaluated largely according to its size and contours, it makes sense that ritualistic practices aimed to regulate the body's weight and appetites figure prominently in this quest.

4.4 'CULTURE-LITE' AS A WAY OF LIFE

It is proposed that the preoccupations with eating and the body are sometimes "normal" for women in so far as they are often socially constructed as part and parcel of femininity. From the data collected during the fieldwork, it becomes clear that a wide range of eating/body problems prevail among the individuals who participated in the research process. Some of these are diagnosed as clinical eating disorders, some come close to the descriptions of the DSM-IV but do not fit the total criteria, and others are perceived to be "normal dieters".

It is the overall objective to investigate the role of culture in the development of eating disorders. Based on the literature, the fact that culture plays a major role in the development of eating disorders is already established. The more complex questions are about what the nature of the culture involved is and how culture might contribute to

the development of eating disorders. It is suggested that two main factors dominate the development, namely, the belief in the Western ideal of thinness, and the process of socialisation through three agents: the family, peer group and the media. Through the functioning of both these main factors a specific Western sub-cultural lifestyle (which one could term 'Culture-lite') came into existence, which provides an ever-present source of ideas and behaviour regarding food, eating habits and weight control. This lifestyle could also be presented as a continuum with the absolute healthy lifestyle on the one pole, and eating disorders at the other end of cultural behaviour and beliefs. This idea was confirmed by Berkman (as quoted by Garfinkel and Garner 1982 : 31), who argues that dieting behaviour is indeed the trigger of a continuum leading to eating disorders like anorexia nervosa and bulimia nervosa. He states "...no sharp line separates simple malnutrition from anorexia nervosa and the minimal requirements for the making of the diagnosis of the latter are to a certain extent only a matter of personal opinion." Does this imply that anorexia nervosa and bulimia are "dieting gone mad"? According to the participating girls, this is exactly what happens. While the family, peers and the media are often seen as triggering eating disorders, it is always dieting behaviour gone out of hand which the girls see as the ultimate mechanism setting off starvation, bingeing and purging. Not implying that this is totally wrong, it should be added that the problem of eating disorders is much more severe in terms of the drastic anatomical, physiological and psychological changes it brings about.

It is assumed that each woman's unique experience (also with reference to the research participants) determines where on the continuum of strong Westernised feminine beliefs and associated eating practices she will be positioned. Her position will be determined, for example, by her relationship with her mother, her gender socialisation, and the extent of the influence of the media on her beliefs, etcetera. In this process, the individual will be under external pressure to conform, but most importantly, she also has to make choices herself. However, in the case of young females, society should share this burden of making choices. What is often not recognised by many eating disorder specialists is the fact that if aspects of Western culture did not place such strains on women to conform to an unattainable beauty image, there would be no problem in the first place. Certain aspects of Western culture – the family, the peers, the media and a combination of all three agents of socialisation – have shifted the abnormal/normal perceptions concerning women and beauty in a direction where

eating/body problems are considered normal, and where disordered eating is only considered by clinicians to be severe when a dangerously low body weight is involved.

Therefore, in conquering eating/body problems among young females, Western ideologies have to be challenged and the shift of "abnormal" to "normal" has to be balanced again. As mentioned in the theoretical framework, behavioural modelling is radically enhanced by the mass media (cf. Gordon 1990), and it has been suggested that the mass media are the most potent and pervasive communicators of socio-cultural standards (cf. Thompson and Heinberg 1999). However, it is accepted that the media has at its ultimate goal the maximisation of profit and this would change if they change their strategies. Therefore, as long as these standards prevail, it will be the ultimate goal of young women to desire an anorexic-like physique.

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APPENDIX A

Name and Age:	Date:	Time:	Number:

BSQ-34

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER NEXT TO YOUR CHOSEN RESPONSE.

1. Has feeling bored made you brood about your shape?

   1)always 2)often 3)sometimes 4)rarely 5)never

2. Have you been so worried about your shape that you have been feeling you ought to diet?

   1)always 2)often 3)sometimes 4)rarely 5)never

3. Have you thought that your thighs, hips or bottom are too large for the rest of you?

   1)always 2)often 3)sometimes 4)rarely 5)never

4. Have you been afraid that you might become fat (or fatter)?

   1)always 2)often 3)sometimes 4)rarely 5)never

5. Have you worried about your flesh being not firm enough?

   1)always 2)often 3)sometimes 4)rarely 5)never

6. Has feeling full (e.g. after eating a large meal) made you feel fat?

1)always 2)often 3)sometimes 4)rarely 5)never

7. Have you felt so bad about your shape that you have cried?

1)always 2)often 3)sometimes 4)rarely 5)never

8. Have you avoided running because your flesh might wobble?

1)always 2)often 3)sometimes 4)rarely 5)never

9. Has being with thin women made you feel self-conscious about your shape?

1)always 2)often 3)sometimes 4)rarely 5)never

10. Have you worried about your thighs spreading out when sitting down?

1)always 2)often 3)sometimes 4)rarely 5)never

11. Has eating even a small amount of food made you feel fat?

1)always 2)often 3)sometimes 4)rarely 5)never

12. Have you noticed the shape of other women and felt that your own shape compared unfavourably?

1)always 2)often 3)sometimes 4)rarely 5)never

13. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching television, reading, listening to conversations)?

1)always 2)often 3)sometimes 4)rarely 5)never

14. Has being naked, such as when taking a bath, made you feel fat? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

15. Have you avoided wearing clothes which make you particularly aware of the shape of your body? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

16. Have you imagined cutting off fleshy areas of your body? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

17. Has eating sweets, cakes, or other high calorie food make you fat? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

18. Have you not gone out to social occasions (e.g. parties) because you felt bad about your shape? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

19. Have you felt excessively large and rounded? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

20. Have you felt ashamed of your body? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

21. Has worry about your shape make you diet? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

22. Have you felt happiest about your shape when your stomach has been empty (e.g. in the morning)? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

23. Have you thought that you are in the shape you are because you lack self-control? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

24. Have you worried about other people seeing rolls of fat around your waist or stomach? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

25. Have you felt that it is not fair that other women are thinner than you? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

26. Have you vomited in order to feel thinner? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

27. When in company have you worried about taking up too much room (e.g. sitting on a sofa, or a bus seat)? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

28. Have you worried about your flesh being dimply? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

29. Has seeing your reflection (e.g. in a mirror or shop window) made you feel bad about your shape? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

30. Have you pinched areas of your body to see how much fat there is? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

31. Have you avoided situations where people could see your body (e.g. communal changing rooms or swimming baths)? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

32. Have you taken laxatives in order to feel thinner? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

33. Have you been particularly self-conscious about your shape when in the company of other people? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

34. Has worry about your shape make you fell you ought to exercise? ☐

1)always 2)often 3)sometimes 4)rarely 5)never

Name and Age:	Date:	Time:	Number:

SATAQ

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER NEXT TO YOUR CHOSEN RESPONSE.

1. Women who appear in TV shows and movies project the type of appearance that I see as my goal. ☐

   1)always 2)often 3)sometimes 4)rarely 5)never

2. I believe that clothes look better on thin models. ☐

   1)always 2)often 3)sometimes 4)rarely 5)never

3. Music videos that show thin women make me wish that I were thin. ☐

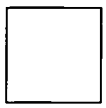
   1)always 2)often 3)sometimes 4)rarely 5)never

4. I wish to look like the models in the magazines. ☐

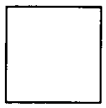
   1)always 2)often 3)sometimes 4)rarely 5)never

5. I tend to compare my body to people in magazines and on TV. ☐

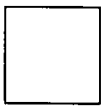
   1)always 2)often 3)sometimes 4)rarely 5)never

6. In our society, fat people are regarded as unattractive. 

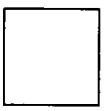
1)always 2)often 3)sometimes 4)rarely 5)never

7. Photographs of thin women make me wish that I were thin. 

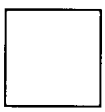
1)always 2)often 3)sometimes 4)rarely 5)never

8. Attractiveness is very important if you want to get ahead in our culture. 

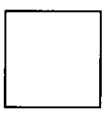
1)always 2)often 3)sometimes 4)rarely 5)never

9. It's important for people to work hard on their figures/ physiques if they want to succeed in today's culture. 

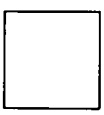
1)always 2)often 3)sometimes 4)rarely 5)never

10. Most people believe that the thinner you are, the better you look. 

1)always 2)often 3)sometimes 4)rarely 5)never

11. People think that the thinner you are, the better you look in clothes. 

1)always 2)often 3)sometimes 4)rarely 5)never

12. In today's society, it is important to always look attractive. 

1)always 2)often 3)sometimes 4)rarely 5)never

13. I wish I looked like a swimsuit model.

1)always 2)often 3)sometimes 4)rarely 5)never

14. I often read magazines like *Cosmopolitan*, *Vogue*, and *Glamour* and compare my appearance to the models.

1)always 2)often 3)sometimes 4)rarely 5)never

Name and Age:	Date:	Time:	Number:

EAT-40

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER NEXT TO YOUR CHOSEN RESPONSE.

1. Like eating with other people.

   1)always 2)often 3)sometimes 4)rarely 5)never

2. Prepare foods for others but do not eat what I cook.

   1)always 2)often 3)sometimes 4)rarely 5)never

3. Become anxious prior to eating.

   1)always 2)often 3)sometimes 4)rarely 5)never

4. Am terrified about being overweight.

   1)always 2)often 3)sometimes 4)rarely 5)never

5. Avoid eating when I am hungry.

   1)always 2)often 3)sometimes 4)rarely 5)never

6. Find myself preoccupied with food.

   1)always 2)often 3)sometimes 4)rarely 5)never

7. Have gone on eating binges where I feel that I may not be able to stop. ☐

1)always 2)often 3)sometimes 4)rarely 5)never

8. Cut my food into small pieces. ☐

1)always 2)often 3)sometimes 4)rarely 5)never

9. Aware of the calorie content of foods that I eat. ☐

1)always 2)often 3)sometimes 4)rarely 5)never

10. Particularly avoid foods with a high carbohydrate contents (e.g. bread, potatoes, rice, etc.). ☐

1)always 2)often 3)sometimes 4)rarely 5)never

11. Feel bloated after meals. ☐

1)always 2)often 3)sometimes 4)rarely 5)never

12. Feel that others would prefer if I ate more. ☐

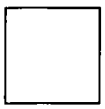
1)always 2)often 3)sometimes 4)rarely 5)never

13. Vomit after I have eaten. ☐

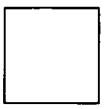
1)always 2)often 3)sometimes 4)rarely 5)never

14. Feel extremely guilty after eating. ☐

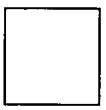
1)always 2)often 3)sometimes 4)rarely 5)never

15. Am preoccupied with a desire to be thinner. 

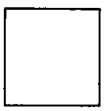
1)always 2)often 3)sometimes 4)rarely 5)never

16. Exercise strenuously to burn off calories. 

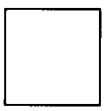
1)always 2)often 3)sometimes 4)rarely 5)never

17. Weigh myself several times a day. 

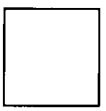
1)always 2)often 3)sometimes 4)rarely 5)never

18. Like my clothes to fit tightly. 

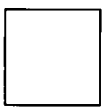
1)always 2)often 3)sometimes 4)rarely 5)never

19. Enjoy eating meat. 

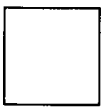
1)always 2)often 3)sometimes 4)rarely 5)never

20. Wake up early in the morning. 

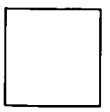
1)always 2)often 3)sometimes 4)rarely 5)never

21. Eat the same food day after day. 

1)always 2)often 3)sometimes 4)rarely 5)never

22. Think about burning up calories when I exercise. 

1)always 2)often 3)sometimes 4)rarely 5)never

23. Have regular menstrual periods. 

1)always 2)often 3)sometimes 4)rarely 5)never

24. Other people think that I am too thin.

1)always 2)often 3)sometimes 4)rarely 5)never

25. Am preoccupied with the thought of having fat on my body.

1)always 2)often 3)sometimes 4)rarely 5)never

26. Take longer than others to eat my meals.

1)always 2)often 3)sometimes 4)rarely 5)never

27. Enjoy eating at restaurants.

1)always 2)often 3)sometimes 4)rarely 5)never

28. Take laxatives.

1)always 2)often 3)sometimes 4)rarely 5)never

29. Avoid foods with sugar in them.

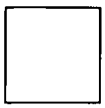
1)always 2)often 3)sometimes 4)rarely 5)never

30. Eat diet foods.

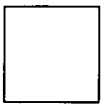
1)always 2)often 3)sometimes 4)rarely 5)never

31. Feel that food controls my life.

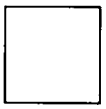
1)always 2)often 3)sometimes 4)rarely 5)never

32. Display self control around food. 

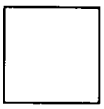
1)always 2)often 3)sometimes 4)rarely 5)never

33. Feel that others pressure me to eat. 

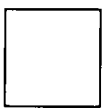
1)always 2)often 3)sometimes 4)rarely 5)never

34. Give too much time and thought to food. 

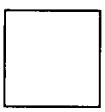
1)always 2)often 3)sometimes 4)rarely 5)never

35. Suffer from constipation. 

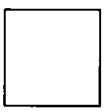
1)always 2)often 3)sometimes 4)rarely 5)never

36. Feel uncomfortable after eating sweets. 

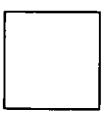
1)always 2)often 3)sometimes 4)rarely 5)never

37. Engage in dieting behaviour. 

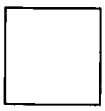
1)always 2)often 3)sometimes 4)rarely 5)never

38. Like my stomach to be empty. 

1)always 2)often 3)sometimes 4)rarely 5)never

39. Enjoy trying new rich foods. 

1)always 2)often 3)sometimes 4)rarely 5)never

40. Have the impulse to vomit after meals. 

1)always 2)often 3)sometimes 4)rarely 5)never

APPENDIX B

THE CULTURAL BACKGROUND QUESTIONNAIRE:

I am an Anthropology student at the University of the Free State investigating the connection between culture on the one hand and eating disorders (anorexia nervosa and bulimia nervosa) on the other. The following structured questionnaire aims at collecting cultural background information concerning yourself, your family and your social environment. The confidentiality of the data obtained will be maintained, meaning that your autonomy and privacy will be respected at all times.

Please answer the following questions as carefully and honestly as possible. Your co-operation is highly appreciated.

Thank you.

Iris Bauchinger

Name:	Date:	Time:	Number:

PLEASE GIVE THE FOLLOWING DETAILS ABOUT YOURSELF

1.) Please state your age ..... years ..... months

2.) Are you:

a)married b) single c) divorced/separated d) engaged

3.) Where were you mainly raised?

Name of place: .....

a) rural area/farming area b) urban/city region

4.) What is your current living arrangement?

a) family home

b) university residence

c) commune/digs

d) on my own

e) with partner/spouse

f) other: please specify .....

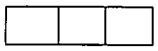
5.) Name the people currently living with you (include age and occupation):

.....

.....

.....

.....

6.) Who are the people you consider part of your family? (Genealogical Table) 

7.) How old are your parents?

a) father b) mother

8.) What is your father's occupation? .....

9.) What is your mother's occupation? .....

10.) How old are your siblings?

a) brother(s)

b) sisters(s)

11.) What is the occupation of your siblings?

a) brother(s)

b) sister(s)

12.) What is your home language(s)? .....

.....

.....

13.) Do you have a religious affiliation? (Are you a member of a specific church?)

yes no

If yes, please specify .....

14.) Occupation:

a) scholar — type of school: ..... | | | |

grade: ..... | | | |

b) student — tertiary education at: ..... | | | |

year: ..... | | | |

c) employed — your occupation: ..... | | | |

employed at: ..... | | | |

d) unemployed — for how long: ..... | | | |

reason: ..... | | | |

15.) How would you describe your performance at school/university/work? (e.g. very hard working, just do what is asked, am laid back, etc.) | | | |

.....

.....

16.) Which social clubs/associations do you belong to?

a) sportclubs..... | | | |

b) church organisation..... | | | |

c) crafts ..... | | | |

d) culture (e.g. scout, choir, etc.)..... | | | |

e) other ..... | | | |

17.) What is your most favourite leisure time activity?

.....

.....

18.) Is the television an important part of your leisure time activity?

yes no

19.) Approximately how much time per day do you spend watching TV?

a) +/- an hour

b) +/- two hours

c) more than three hours

20.) Do you read female magazines like *Femina, Cosmopolitan, Vogue,..*etc.?

yes no

If yes, please name the three you read most often .....

.....

.....

21.) Do you participate in any sport activities? .....

.....

.....

.....

22.) How often do you exercise at present? ☐☐☐

a) every day

b) two to three times a week

c) once a week

d) a couple of times a month

e) very seldom

f) never

23.) What is your favourite type of food? ☐☐☐

.....

24.) Would you say you normally eat quite healthy food? ☐☐☐

Yes no

Please explain why you think you are eating healthy/not healthy: ..... ☐☐☐

.....

.....

.....

25.) Which kind of snacks do you like most? ☐☐☐

a) Fruits

b) Sandwiches

c) Chips

d) Cookies/Sweets

e) Other, please specify ..... ☐☐☐

26.) Do you enjoy eating with people, or do you rather eat alone?

a) enjoy it

b) don't care

c) avoid it

If your answer is c), explain why you avoid eating with people .....

.....

.....

27.) How would you describe your personality?

.....

.....

.....

28.) How would you describe your relationship with your father?

a) excellent

b) good

c) sometimes good/sometimes not so good

d) not so good

e) bad

Please explain your answer (give examples).....

.....

.....

.....

29.) How would you describe your relationship with your mother?

a) excellent

b) good

c) sometimes good/sometimes not so good

d) not so good

e) bad

Pease explain your answer (give examples).....

.....

.....

30.) How would you describe the way in which your parents raised you?

a) very strict and disciplined

b) caring but very protective

c) without much interest in me

d) understanding

e) little interference

31.) How much time do you spend with ....

father

mother

a) a lot

b) a couple of hours a week

c) very little

32.) How do you perceive your relationship with your sibling(s)?

brother(s)

sister(s)

a) excellent

b) good

c) sometimes good/sometimes not so good

d) not so good

e) bad

33.) Which sibling influences you the most and why would you say so?

.....

.....

.....

.....

34.) Do you think your family lives a healthy lifestyle? Explain your answer

(How do you know this?).....

.....

.....

.....

35.) Is exercise important to your family?

Yes no

If yes, please explain the type of exercise they do .....

.....

.....

36.) Are any of your family members occupied with constant dieting?

Yes no

If yes, please indicate who .....

.....

37.) Name all your close friends who are playing an important role in your life at the moment.

	Gender (M/F)	Residence	Since when do you know each other	Mutual interests Nature of contact (friendship, sport church, etc.)
1.				
2.				
3.				
4.				
5.				
6.				
7.				

38.) Would you say your friends talk/think much about food?

yes no

How do you know this? (Give an example).....

.....

.....

39.) Do you think any of your friends have an unhealthy preoccupation with food?

yes no

If yes, explain .....

.....

.....

40.) Do you have a boyfriend?

yes no

41.) Since when do you have a steady relationship?

years ..... months .....

42.) How would you describe your relationship with your boyfriend? (e.g. very close, intimate, loving, friends,....)

.....

.....

43.) Do you think your boyfriend prefers a slim and slender body?

yes no

If yes, why do you think he prefers a slim body built .....

.....

.....

44.) Explain the body built you think most guys in your age group would

prefer.....

.....

45.) Does it matter to you what the boys of your age think/say about your body?

yes no

If yes, why do you think their opinion matters to you .....

.....

.....

.....

46.) How would you describe somebody who is overweight?

.....

.....

.....

47.) How do you feel about people who are overweight?

.....

.....

.....

48.) Do you think anyone from your family/circle of friends is overweight?

yes no

if yes, who is this person and why do you consider him/her as being overweight .....

.....

.....

49.) Would being overweight pose a problem to you?

yes no

If yes, explain why .....

.....

.....

.....

50.) If you look in the mirror, do you think you have to loose weight in order to reach your personal ideal weight?

yes no

If yes, how many kilograms do you think you should loose

.....kilograms

51.) Please state your height ..... centimetres

52.) Is your menstrual cycle regular?

yes no

If not, explain why you think your menstrual cycle is irregular .....

.....

.....

53.) As child, before puberty, were you

a) overweight

b) normal weight

c) underweight

54.) Please state your present weight

a) ..... kilograms

b) If you are unaware, please estimate ..... kilograms

55.) What is the most you ever weighed? ..... kilograms

56.) What is the least you have ever weighed? ..... kilograms

57.) What would you consider to be your ideal weight?

..... kilograms

58.) Do you consider yourself to be presently:

a) very overweight

b) quite overweight

c) slightly overweight

d) the correct weight

e) slightly underweight

f) quite underweight

g) very underweight

59.) In order to control your weight, do you use any of the following methods? ☐☐☐

a) Self induced vomiting

b) Laxatives (facilitating evacuation of the bowels)

c) Diuretics (causing increased output of urine)

d) Strict diets

e) Chewing or spitting out food

f) Exercise

g) Fasting

h) Other ..... ☐☐☐

.....

60.) Do you consider yourself to have an eating problem? ☐☐☐

Yes no

Please specify why you believe so ..... ☐☐☐

.....

.....

.....

61.) Have you ever heard of the eating disorders anorexia nervosa and bulimia nervosa? ☐☐☐

yes no

If yes, please explain both eating disorders and their symptoms

a) anorexia nervosa: ..... ☐☐☐

.....

.....

.....

b) bulimia nervosa: .....

.....

.....

.....

62.) Have you ever been <u>treated</u> for any of the following? (You may tick more than one)

a) loss of weight/ underweight
b) obesity
c) bulimia nervosa

d) being overweight
e) anorexia nervosa
f) compulsive eating

other, please specify .....

63.) If so, what forms of treatment did you receive? (You may tick more than one)

a) hospitalisation

b) doctor (G.P.)

c) psychiatrist

d) psychologist

e) dietician

d) other, please specify .....

.....

64.) In your opinion, was the received treatment effective?

yes no

If no, why do you think it did not help you .....

.....

.....

.....

65.) Do you think eating disorders like anorexia nervosa and bulimia nervosa are a serious problem in South Africa.

Yes no

Explain your answer .....

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