Mental Health and Society week 24
Final year lecture on eating disorders

I shall be focusing on eating disorders and culture. Previously it was assumed that eating disorders were unique to the 'culture of slimness' in Western Europe and North America. However there is growing evidence that people have the same kinds of symptoms in developing countries too. In addition to the handout. I have provided a list of links to articles and other material, which can be accessed from my web page http://www.brown.uk.com/eatingdisorders/bodlist.htm. Of the various items there perhaps one of the most useful is a review piece by Miller & Pumariega (2001) about culture and eating disorders.

There is a tendency in the literature to consider eating disorders to be part of a clinical syndrome but there are indications that eating disorder symptoms are a part of normal life for many women. E.g. Dolan & Gitzinger (1991: 3) say that 20% of normal women binge at least once a month, 90% have been on slimming diets and 10% have used vomiting and laxative abuse at some time as a way of controlling weight.

Thinness and culture: Garner et al (1980) documented how models were getting thinner in Miss America Pageants and Playboy from 1961 to 1978. Maybe there are other antecedents elsewhere in Western culture - religion (Joughlin et al 1992) highlight asceticism in Anglican Christianity. Treasure et al (2008) comment on the present day focus on ‘size zero’ models and the presumed relationship between this and eating disorders.
Arondeus & Weeda-Mannak (1991 in Dolan and Gitzinger 1991) identify and review tendencies in culture and society that predispose eating disorders. For example, the value attached to thinness in terms of beauty, sexual attractiveness, and success. Weight control is seen as synonymous with personal success, discipline, personal strength and will-power. At the same time the average weight of women has increased in the last few decades.
Orbach (1986) identifies the 1960s as the time when thinness became more strongly fashionable, Twiggy, Jean Shrimpton. Bennet and Gurin (1982 in Arondeus & Weeda-Mannak, 1991) say 'the central expression of the new liberated woman was her thin body which came to symbolise athleticism, non-reproductive sexuality and a kind of androgynous independence.' Beck et al (1976 in Arondeus & Weeda-Mannak, 1991) Boskind-Lohdal (1976 in Arondeus & Weeda-Mannak, 1991) say that clinical evidence suggests that women with eating disorders had internalised the cultural standards of successful femininity in an attempt to avoid rejection. Weeda-Mannack & Arondeus (1990) say that anorexic women have lower self esteem than non eating-disordered controls and lack of self esteem seemed to be associated with greater traditional femininity.

Beauticians may be at higher risk of eating disorders (Wong,2003). So are dancers (Hieland et al, 2008). Diet, fitness and weight loss products and services have become important sectors of developed nations’ economies (Hesse-Biber et al, 2006).

Malson (1999) sees eating disorders as arising out of the late 20th century destabilisation of identity: In a sense people aren't really sure about gender roles, identities and social and familial roles any more and this radical uncertainty is implicated in the creation of anorexic identities. She draws on a corpus of interview material where her participants claim to be experiencing identity difficulties and lacking a strong sense of who they are. Anorexia may be a way of refusing or avoiding identity; at the same time it might be an identity one can claim or own oneself, in a way which cannot be said of more conventional identities any more. Another idea, in a paper about models by Mears and Finlay (2005) is that losing weight is a kind of 'work' or effort to acquire a kind of bodily capital.

Different kinds of feminist explanation (From Hepworth, 1999)

1) The mother daughter relationship in feminist thinking

The mother daughter relationship has been of considerable interest to feminist thinkers and therapists (e.g. Lawrence, 1984, p. 67) 'I can say with certainty that I have never worked with an anorexic woman who has had a straightforward relationship with her mother.' To Orbach (1986) the key feature was the problem of separation between mother and daughter and the ambiguous social role that the daughter is unprepared to take on. Thus the development of anorexic symptoms is a way for the daughter to recapture the safety of the mother-daughter bond. In Hilde Bruch's work (1974) she argued that women who became anorexic in later life were subject to meticulous care in earlier childhood, where the mother anticipated the child's needs. Thus the child does not develop self worth and independence. To Chernin (1986) the problems of separation and differentiation were particularly important when the daughter became aware of her mother's life of subordination 'the anguished concern about the mother is hidden just beneath the surface of the eating problem.' (Chernin, 1986, p. 43).

2) Anorexia as a problem of identity

Some authors (e.g. Chernin, 1986; McLeod, 1981; Orbach, 1986) have interpreted anorexia as a problem of identity and role conflict, where role conflicts have become internalised. The social identity which women are encouraged towards is itself confusing, particularly the conflicting demands of e.g. school success, careers and motherhood and conventional femininity. These constraints and expectations are believed by McLeod (1981) to make it difficult to develop an autonomous, 'authentic' identity.

3) Feminist psychoanalytical ideas about the nature of eating disorders (Lawrence and Lowenstein, 1979; Orbach, 1986)

The concept of socialisation was a major focus here. Women are socialised to attach unconscious meanings to food, including guilt, the idea of comfort eating and the self denial of nutritional needs. In addition, the patterns of consumption, media and advertising serve to create women as commodities, which alienated them from themselves and reinforced their inferior social status and enhanced their definition in terms of physical appearance. Orbach's therapy involved psychoanalysis and critique of social structure. However, Hepworth charges this approach with being overly individualistic in focus. It has very little to say about men, either as (occasional) sufferers or as participants in patriarchy.

Assessing people's problems with food.
Often done with questionnaires. E.g. Restraint scale (Herman, 1978) Eating Attitudes Test (Garner and Garfinkel, 1980) Eating Disorder Inventory (Garner et al, 1983) Eating Disorder Examination (Cooper and Fairburn, 1987) Body Shape Questionnaire (Cooper et al, 1982). Problem with questionnaires is that they make assumptions about the nature of restraint, dieting, body shape attitudes. E.g. 'restraint' not quite like the situation you get with people who assign different values to different foods chocolate naughty, wholemeal stuff good etc. BSQ not entirely relevant when there are specific regions of the body that are considered revolting, e.g. thighs, buttocks, nose etc.

Cross cultural perspectives.
Anorexia and bulimia seem to exist largely in Northern Europe and North America but what happens to ethnic groups who arrive in this culture? There's some stuff on my website that might help you with this, including Littlewood (2004) and Soh et al (2006). Edquist (2008) points to the way that eating disorders and related behaviour and experience appear to be increasing even in countries where they were historically low.

Mumford et al (1991) studied Asian and Caucasian girls in Bradford. 2 questionnaires (Body Shape Questionnaire and Eating Attitudes Test [EAT]). Are people from an 'Asian' ethnic background prone to worry about weight, food and so forth as much as white British?
Asian girls had higher scores on the EAT scale indicating greater concern about food and body weight.
The 'factors' revealed through factor analysis of the questionnaire responses suggested a similar structure in 'Asian' and white subgroups. Does this mean that the attitudes to food and bodies have some conceptual equivalence between 'Asian' and white people? Maybe true but also it might arise through the questionnaires - e.g. the factors are based on intercorrelating items like 'Give too much thought to food' and 'Find myself preoccupied with food': 'Aware of the calorie content of foods' and 'Eat diet foods'. So it's not clear (to me anyway) whether they're measuring the competence in Western language and culture or some underlying psychological features. Interestingly, the study also found that the more traditionally orientated people (in terms of their greater use of 'Asian' language and dress) were more likely to be concerned about eating and more likely to be concerned about their body shape and eating patterns. There was some evidence to suggest greater proneness to psychiatric symptoms where there is greater difference in cultural attitudes between parents and children (El Islam et al, 1988). Bryant-Waugh and Lask (1991) echo this point from their case histories. 'It is interesting that we have not yet seen a child with anorexia nervosa from a family who seem to have exchanged their traditional culture for a more typical western lifestyle' (p. 232). DiNicola (1990) proposes that anorexia nervosa can be viewed as a 'culture change syndrome' whose onset may be triggered under conditions of socio-cultural flux. Notice how this tends to focus the cause of eating disorders in the families and in the individuals, not in the possibility of racism in British culture which might have something to do with the problems. Cross cultural work involving other countries Dolan & Ford (1991) are doing some work towards using standard questionnaires in different countries, e.g. they

applied a binge scale and a restraint scale to male & female students in an English speaking university in Egypt. Binge eating was common in Egyptian students and a positive correlation was found between binge eating and restraint. Some problems exist with the representativeness of the Egyptian group. The factor structures which emerged from the factor analysis were not comparable with those typically found in UK or American samples. Mumford et al (1992) surveyed 396 schoolgirls in Lahore, Pakistan with the Eating Attitudes Test and Body Shape Questionnaire. None appeared to have anorexia and one met the criteria for bulimia. There was some indication that most 'westernised' girls appeared to be more 'at risk' for eating disorders. The effect of westernisation seemed to occur in the form of greater dissatisfaction with body shape. Choudry & Mumford (1992) translated the Eating Attitudes Test into Urdu and administered it to 271 schoolgirls in Mirpur, Pakistan. Some terms were not easy to translate – for example there were difficulties with the way e.g. 'calories' are understood. EAT seems to perform 'adequately' (Choudry & Mumford, 1992: 249). There were more eating disorders in Asian girls living in Bradford (3.4%) than in those in Mirpur (0.4%).

Thompson (1992) analysed the syndrome in African-American, Latina and White women, and proposed that eating problems were a strategy for coping with conditions such as sexual abuse, racism, low socioeconomic status, sexual orientation and poverty. There were fewer mentions of issues of appearance, and eating was more to do with the ways in which women take care of themselves.

Ethnic differences in concern over weight shape and food have been found more recently by Wildes et al (2001) who concluded that whites were more likely to display eating pathology than other ethnic groups on the basis of an extensive review of published studies. These differences are especially pronounced when looking at people with sub-clinical eating concerns, especially where dietary restraint and body image are concerned, and in samples of college students in the US, where whites tend to be more concerned than African Americans.

Chisuwa and O'Dea (2010) described the rising level of eating disorders in Japan, which, whilst still less than is typically found in 'western' cultures, appears to be rising, as does the presence of behaviour that falls short of an eating disorder but involves similar behaviour – restricting calorific intake, exercising, skipping meals & purging.

Gunewardene et al (2001) compared Chinese adolescent girls living in Australia with a comparable group living in China and a group of Australians with no Chinese heritage and discovered that the non-Chinese Australians dieted significantly more than the Chinese groups. However the Chinese group in China dieted more than the Chinese group in Australia.

Explanations from sufferers themselves

Here is a table of causes identified by sufferers taken from Tozzi et al (2003)

Table 1. Examples of causes identified by sufferers

Causes

Self-esteem

‘No self confidence’’; ‘‘low self-esteem, lack of confidence’’
Perfectionism
‘Perfectionist’’; ‘‘wanted to be seen to be perfect’’; ‘‘perfectionist— didn’t look the way I wanted to’’
Achievement
‘‘Extreme goals and ideals’’; ‘‘high achiever’’; ‘‘wanting to achieve something, be excellent at something’’; ‘‘has always set very high standards’’
Parental expectation
‘‘Parents never satisfied’’; ‘‘parents strict, high expectation’’; ‘‘high expectation from father—pressure to achieve at school and university’’
Family dysfunction
‘‘Family always very controlling’’; ‘‘a lot of fights and problems’’; ‘‘issues with mother’’; ‘‘mother dominant, overpowering, negative’’; ‘‘parents constantly bickering’’; ‘‘parents’ messy divorce’’
Family weight and food issues
‘‘Lived with obese aunt, always dieting; mother fat. . .’’; ‘‘food always a big issue in the family, used as reward’’; ‘‘family stress on slim, healthy eating, exercise ’’
Weight loss/dieting
‘‘Diet got out of control’’; ‘‘a bit overweight, started dieting, got out of hand’’
Sexual abuse
‘‘Raped by older boyfriend’’; ‘‘sexual abuse by an uncle’’
Inappropriate comments
‘‘Everyone teasing’’; ‘‘comments at school’’; ‘‘teacher at school constant put-down’’
Mood
‘‘Depression’’; ‘‘low mood’’; ‘‘unhappy kid’’
Adolescence
‘‘Puberty’’ ‘‘adolescence—unprepared for changes’’; ‘‘hated puberty’’; ‘‘not accepting maturing body, wanting to be child-like in appearance’’
Control
‘‘Eating was one thing that could be controlled’’; ‘‘felt it gave me some control over my life’’
Pressure/stress/frustration
‘‘Stress, part of a bad time in life’’; ‘‘pressures: exams, boyfriend pressured to get married, father very ill’’; ‘‘stressful time’’; ‘‘stress at work—losing job—pressure at home’’
Loss
‘‘Grief at boyfriend’s death’’; ‘‘father’s sudden death’’

Here are a few of the factors which were helpful in ‘curing’ them, again from Tozzi et al (2003).

Table 2. Examples of recovery factors
Recovery
Maturation
‘‘Time, maturity. . .’’; ‘‘growing up’’; ‘‘older, more mature’’
Supportive relationship

‘‘Met husband’’; ‘‘good, healthy relationship with husband, unconditional love and acceptance’’; ‘‘supportive husband—treated her normally all the way through it’’; ‘‘being valued by husband’’
Supportive friendship
‘‘Good, really close friends’’; ‘‘two excellent friends who treated me the same all the time, no matter what’’
Support from other patients
‘‘Knowing other patients, support/discussion’’
Therapy
‘‘Therapy, group sessions’’; ‘‘good therapy: people listening, understanding’’; ‘‘Gestalt therapy’’
Medications
‘‘Medications to deal with mood problems’’; ‘‘medications probably lowered anxiety’’
Leaving home
‘‘Leaving home: distance from parents’’; ‘‘left home, reduction in pressure’’
Religion
‘‘Prayer, faith in God’’; ‘‘Christianity’’
Children/pregnancy
‘‘Kids growing up, wanted to be there for them’’; ‘‘wanting to be OK for the kids’’; ‘‘pregnancy—totally refocused life’’
‘‘Waking up’’
‘‘Realized seriousness of situation and snapped out of it’’; ‘‘realized I had to stop’’; ‘‘just know it was time to get better’’
Increased self-esteem
‘‘Feeling better about self’’
Willpower
‘‘Determination to get out of it’’; ‘‘strength of character, determination to get it out of my life’’; ‘‘strong personality’’
‘‘Good loss’’
‘‘Leaving husband’’; ‘‘splitting up’’
Job
‘‘Getting job’’; ‘‘work place—being valued in jobs’’; ‘‘broad range of experiences through number of different jobs’’

Therapy:
Themes in therapy which is undertaken voluntarily often emphasise education and self development on the part of the sufferer. For example, a feminist therapist quoted by Hepworth (1999, p. 87) stated:
“So in a very subtle way, I think women's power is thought of by the whole society I think as very frightening in the image of this huge devouring mother, where and which everyone comes from and somehow everyone is scared of that and wants to push that image away, so that it would get reduced in size, they want to reduce their power, feel bad about their power, feel bad about their needs, feel bad about depending. And how that then ties into the mother-daughter relationship and working with that on a very personal basis in therapy.

I understand it as being passed down, generation to generation, and that I, as a therapist and as a feminist therapist, it is my job to somehow try and enable that woman through my relationship with her to understand how she is re-enacting this with her mother to somehow try and get her out of that a bit, but also to put it in a context in a very subtle way of the society to help her to understand that she is not this isolated being."

In another context, feminist-informed educational style therapy has been described by some other workers, for example Van Vreckem and Vandereycken (1991 in Dolan and Gitzinger 1991) describe a therapeutic and educative programme concerned with enhancing the sexual and body awareness development of young women with eating disorders. Dealt with issues like falling in love, body experience and images, menstruation, sexuality, contraception and choice of partner. in a group setting and/or in pairs.
i) Falling in love - recollect early romantic experiences, nice feelings come out but also disappointments, tensions and anxieties. Impression of being out of control when falling in love is very disturbing to some of these women. Parents often reported as denigrating, ridiculing or overcontrolling.
ii) Body experiences and feelings. Done in pairs, dress in bathing suit and look at self in mirror and at each other, expressing feelings about changing bodies, commenting on them etc. Maybe as a result people can develop a stable, cohesive, integrated mental representation of their bodies. many clients have not looked at themselves for months or years. Verbalise their feelings to each other and replace critical feelings with more self-approving ones. Focus on internal sensations and images. Anorexics and bulimics lack internal or evocative images of their body self and tend to rely on actual or conjectured reactions of others to their body. Notice distortions and generalisations in other people's thoughts more easily than their own.
iii) Menstruation - sometimes there are ideas like menstruating women are unclean, contaminated, sick, unable to have sex. Menstruation sometimes remembered as painful, humiliating, negative, didn't know what was happening to them. Maybe group work and shared experience can help to make feelings about bodily functions more positive.
iv) Other forms of sexuality - remember past sexual experiences, sex play with peers, abusive sexuality in the past, how this might link with eating and body feelings at the time and subsequently. Often Lesbian fantasies and feelings are revealed in this aspect of the programme. Sometimes conflict over feeling that one is 'homosexual' or 'not normal'.
v) Contraception - fears doubts, experiences with different methods
vi) Choice of partner. What's attraction all about? Why do we feel attracted to certain people? Is sexual attraction the same as emotional closeness? Fear of infidelity and rejection, boredom, lack of control and lack of freedom and individuality in relationships.

Coercive and antagonistic themes in therapy:

Some of the mental health workers in the psychiatric services interviewed by Hepworth (1999) highlighted the way that staff see their roles in a hospital setting:

“Well, when they come in they're usually assessed for the first few days to take a baseline really, . . . all their behaviour, their eating behaviour especially, to see how much they eat, *when* they eat, and things like moods and sleep. Then, after that .. . we usually draw up a menu. .~. . I mean food is a central part of their treatment and they draw up menus of things that they like and dislike. Then, they're usually isolated in a room . . . the bathroom doors are locked, someone sits with them 24 hours a day . . . special nursing it's called ... and they start off with small portions and the portions get bigger. It starts off with three light dinners, then the portions and the meals themselves get more substantial as they improve.
Basically it revolves around getting them to eat and getting them to keep the food down because apparently they... the consultants' main worry is the *deviousness* of them.... Because they claim that they're devious and somebody needs to sit with them after they've eaten at least for one hour afterwards. . because they will regurgitate this food or they take laxatives or they'll exercise, you know, burn off this, all this food. The main emphasis in the treatment really is to get them to keep food down, to get them to put on weight and weight gain is a measure of success of treatment really.” (Hepworth, 1999, p 91)

“with the anorexic patient, or a patient with an eating disorder, we tend to find that even though we do work on the primary nurse system we have to keep the other staff totally informed of *every* development because we found that manipulation is a particularly difficult aspect. There was a lot of manipulation, hence we found one girl to have kidney beans at the bottom of her locker, raw kidney beans which she fed herself on, 'cause it's a good, you know, laxative. Also, sending other patients down the shops for laxatives. having loads and loads and loads of fruit and bread, bingeing at night in order that she could be weighed the next day so that she would gain the weight she'd have a bottle of Perrier water plus a loaf of bread the night before a weigh. Hence we had to make sure that we had different weight days. We could never tell her when she was going to be weighed. So you always come across these conditions which you're never really prepared for as a nurse, you just can't think ahead of them so you've always got to think, come across them and then have to eradicate the problem like we do.... You would have to sit her down, ask her why, if she'd got any more - . . search her room with her and another nurse,.. . with her permission, if, you know, it's . . . it's very difficult. especially as that time. sort of, building up a relationship with her and then you've got to do that.” (Hepworth, 1999, p. 92).
‘Patients’ on the other hand emphasise the value of control and involvement (Reid et al, 2008).

Men and eating disorders:
Rare but may be increasing. Small numbers limit what we can tell about them, but there are some patterns. E.g. adult men with eating disorders reported poor relationships with their fathers Hartley (1991 in Dolan and Gitzinger 1991) and 2 people who had severed connection with their fathers had made most progress. Maybe also explainable in terms of similar social pressures as women. Often the symptoms can be the same (apart from amenorrhoea!). In younger children (8-12 yrs old) the sex difference in incidence is less

marked. Refusal of food is more often rationalised in boys as being to do with health and fitness rather than being about an ideal body shape.

Body shape and young men: Pope et al (1999) have looked at the evolving ideals of male body shape through the changing shape of toys. Action hero type toys are evolving to sow more developed musculature around the shoulders and upper torso. Young men, especially if they are not in a romantic relationship, may be preoccupied with attaining a socially desirable body shape (Giles & Close, 2008).

References.

Andersen, A.E., & DiDomencio, L. (1992) 'Diet vs. Shape content of popular male and female magazines: A dose response relationship to the incidence of eating disorders?' International Journal of Eating Disorders, 11 (3) 283-287.
Bryant-Waugh, R. & Lask, B. (1991). 'Anorexia nervosa in a group of Asian children living in Britain' British Journal of Psychiatry, 158, 229-233.
Chernin, K. (1986) The hungry self: Daughters and mothers, eating and identity, London: Virago.
Chisuwa, N. & O'Dea, J.A. (2010) Body image and eating disorders amongst Japanese adolescents. A review of the literature, Appetite 54: 5–15.
Choudry, I.Y. (1992) 'A pilot study of eating disorders in Mirpur (Pakistan) using an Urdu version of the Eating Attitudes Test' International Journal of Eating Disorders, 11, (3), 243-251.
Cooper, Z. & Fairburn, C.G. (1987) 'The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders' International Journal of Eating Disorders, 6, 1-8.
Cooper, P.J., Taylor, M.J. & Cooper, Z. (1987) 'The development and validation of the Body Shape Questionnaire' International Journal of Eating Disorders, 4, 485-494.
DiNicola, V. (1990). 'Anorexia Multiforme: Self starvation in historical and cultural context. Part II: Anorexia nervosa as a culture reactive syndrome' Transcultural Psychiatric Research Review, 27, (4)
Dolan, B. & Ford, K. (1991) 'Binge eating and dietary restraint: A cross cultural analysis' International Journal of Eating Disorders, (10), (3), 345-353.
Dolan, B., Leiberman, S., Lacey, J.H. & Evans, C. (1990). 'Family features associated with normal body weight bulimia. International journal of eating disorders, 9, (6), 638-647.
Dolan, B. & Gitzinger, I. (1991) 'Why women: Gender issues and eating disorders' London: European council on eating disorders.
Edquist, K. (2008) Globalizing Pathologies: Mental Health Assemblage and Spreading Diagnoses of Eating Disorders, International Political Sociology, 2: 375–391
El Islam, M.F., Abu-Dagga, S.I. & Malasi, T.H. (1986) 'Intergenerational conflict and psychiatric symptoms' British Journal of Psychiatry, 149, 300-306.
El Islam, M.F., Malasi, T.H. & Abu-Dagga, S.I. (1988) 'Inter parental differences in attitudes to cultural changes in Kuwait' Social Psychiatry and Psychiatric Epidemiology, 23, 109-113
Garner, D.M. & Garfinkel, P.E. (1980) 'Socio-cultural factors in the development of anorexia nervosa' Psychological Medicine, 10, 647-656.

Garner, D.M., Garfinkel, P.E., Schwartz, D. & Thompson, M. (1980) 'Cultural expectations of thinness in women' Psychological Reports, 47, 483-491.
Garner, D.M., Olmstead, M. & Polivy, J. (1983) 'Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia' International Journal of Eating Disorders, 2, 15-34.
Giles, D.C., & Close, J. (2008). Exposure to 'lad magazines', drive for muscularity in dating and non-dating young men. Personality and Individual Differences, 44, 1610-1616.
Gunewardene, A., Huon, G.F., & Zheng, R. (2001) Exposure to Westernization and Dieting: A Cross-Cultural Study International Journal of Eating Disorders, 29, 289-293.
Heiland, T.L., Murray, D.S. and Edley, P.P. (2008) Body image of dancers in Los Angeles: the cult of slenderness and media influence among dance students, Research in Dance Education, 9, (3): 257–275.
Hepworth, J. (1999) The social construction of anorexia nervosa, London: Sage.
Hesse-Biber, S., Leavy, P., Quinn, C.E. & Zoino, J. (2006) The mass marketing of disordered eating and Eating Disorders: The social psychology of women, thinness and culture, Women's Studies International Forum, 29: 208–224
Herman, C.P. (1978) 'Restrained eating' The Psychiatric Clinics of North America, 1, 593-607.
Joughlin, N., Crisp, A.H., Halek, C. & Humphrey, H. (1992) 'Religious belief and Anorexia Nervosa' International Journal of Eating Disorders, 12, (4), 397-406.
Kog, E. & Vandereyecken, W. (1985) 'Family characteristics of anorexia nervosa and bulimia: A review of the research literature' Clinical Psychology Review, 5, 159-180.
Lawrence, M. (Ed.) (1984) The anorexic experience, London: The Women's Press.
Lawrence, M. (Ed.) (1987) Fed up and hungry, London: The Women's Press
Lawrence, M. & Lowenstein, C. (1979) Self starvation, Spare Rib, no 83.
MacLeod, S. (1981) The art of starvation: London: Virago.
Malson , H. (1999) Women under Erasure: Anorexic Bodies in Post-modern Context, Journal of Community & Applied Social Psychology, 9, 137-153.
Mears, A. and Finlay, W. (2005) Not Just a Paper Doll: How Models Manage Bodily Capital and Why They Perform Emotional Labor, Journal of Contemporary Ethnography, 34: 317-343
Miller, M.N & Pumariega, A.S.G. (2001) Culture and Eating Disorders: A Historical and Cross-Cultural Review, Psychiatry 64, (2), 93-110.
Mumford, D.B., Whitehouse, A.M. & Choudry, I.Y. (1992) 'Survey of eating disorders in English- medium schools in Lahore, Pakistan' International Journal of Eating Disorders, 11, (2), 173-184.
Littlewood, R. (2004) Commentary: Globalization, culture, body image and eating disorders, Culture, Medicine and Psychiatry, 28: 597–602.
Mumford, D.B., Whitehouse, A.M. & Platts, M. (1991) 'Sociocultural correlates of eating disorders among Asian schoolgirls in Bradford' British Journal of Psychiatry, 158, 222-228.
Murray, S. (1999) Eating Disorders and Criticism of Cultural Ideals, European Eating Disorders Review, 7, 204-212

Myers, P.N. & Biocca, F.A. (1992) 'The elastic body image: The effect of television advertising and programming on body image distortions in young women' Journal of Communication, 42, 108-133.
Orbach, S. (1978) Fat is a feminist issue, London: Hamlyn
Orbach, S. (1986) Hunger strike: The anorexic's struggle as a metaphor for our age, London: Faber & Faber.
Pope, H.G., Olivardia, R., Gruber, A. Borowiecki, J. (1999) Evolving Ideals of Male Body Image as Seen Through Action Toys, .International Journal of Eating Disorders, 26, 65–72.
Reid, M., Burr, J., Williams S. and Hammersley, R. (2008) Eating Disorders Patients' Views on Their Disorders and on an Outpatient Service: A Qualitative Study, Journal of Health Psychology, 13, (7): 956–960.
Soh, N.L., Touyz, S.W. and Surgenor, L.J. (2006) Eating and Body Image Disturbances Across Cultures: A Review, European Eating Disorders Review, 14, 54–65.
Steiner-Adair, C. (1986). The body politic: normal female adolescent development and the development of eating disorders. Journal of the American Academy of Psychoanalysis, 14, 95-114.
Thompson, B.W. (1992) '"A way outa no way": Eating problems among African American, Latina and White women' Gender and Society, 6, (4), 546-561
Tozzi, F., Sullivan, P.F., Fear, J.C., McKenzie, J. & Bulik, C.M. (2003) Causes and recovery in Anorexia Nervosa: The Patients' perspective, International Journal of Eating Disorders, 33, 143-154.
Treasure, J.L., Wack, E.R. and Roberts, M.E. (2008) Models as a high-risk group: the health implications of a size zero culture, The British Journal of Psychiatry, 192: 243–244.
Weeda-Mannak, W.L. Arondeus, J.M. & Takens, R.J. (1990) 'Sex role identity and anorexia nervosa' In Drenth, J.D., Sergeant, J.A. & Takens, R.J. (Eds.) European perspectives in Psychology' Chichester: John Wiley.
Waller, G., Hamilton, K. & Shaw, J. (1992) 'Media influences on body size estimation in eating disordered and comparison subjects' British Review of Bulimia and Anorexia Nervosa, 6, (2), 81-87.
Wildes, J.E., Emery, R.E. & Simons, A.D. (2001) The role of ethnicity and culture in the development of eating disturbance and body dissatisfaction: A meta-analytic review, Clinical Psychology Review, 21, (4), 521-551
Wolf, N. (1990) 'The Beauty Myth' New York: Vintage Books.
Wong, Y. (2003) Female beauticians may be a high risk group for developing eating disorders, Nutrition Research, 23: 1297–1302.