Lecture notes on Critical Perspectives on Eating Disorders

Lecture 1

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Welcome all to the lecture series on eating disorders. I have prepared three lectures in this series. However, a fourth lecture is reserved for consolidation of all the material covered during this lecture series on Critical Perspectives on Eating Disorders. Additionally, it will present an opportunity for you to clarify any points with questions. The classification of eating disorders, historical perspectives on anorexia nervosa, and psychodynamic ideas on the etiology of anorexia nervosa will all be covered in the first lecture. The aetiology of anorexia nervosa will be covered in the second session from the standpoint of feminist perspectives. After that, a poststructuralist critique of feminist theories will be presented. The third session will concentrate on how discourse influences our knowledge of eating disorders in men, including anorexia nervosa and bulimia nervosa.

Even though these diseases had been mentioned in literature prior to 1980, anorexia nervosa and bulimia nervosa (commonly known as anorexia and bulimia) were first listed as disorders in the DSM-III. Our consideration of historical viewpoints and early psychoanalytic theories only concentrates on anorexia because that is where the majority of past research has concentrated. The DSM-III defined anorexia and bulimia as a subgroup of illnesses that are often identified for the first-time during infancy, youth, or adolescence. A new diagnostic category for eating disorders was established with the release of the DSM-IV. The DSM-IV acknowledged that eating disorders were distinct from other kinds of childhood disorders and that they can also manifest in adults. In 2013, the DSM 5 included binge-eating disorder as a new eating disorder and modified one of the diagnostic standards for anorexia. This was because the absence of menstruation, or amenorrhea, was no longer necessary for diagnosis. According to research, amenorrhea is not a clinically significant criterion that prevents men from receiving an anorexia diagnosis.

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Restricting calories intake leading to a severely low body weight, is the first DSM 5 symptom of anorexia. So, a person with anorexia consumes little food each day, makes an effort to limit their calorie intake, and usually steers clear of items that are heavy in sugar and carbohydrates. So the person might only consume water throughout the day and consume an apple in the morning and a dish of broccoli and carrots in the evening. A person with anorexia has a severely low body weight as a result of their calorie intake restrictions. Extreme anxiety over putting on weight, getting obese, or recurrent behaviors that prevent weight growth are other symptoms. The person's fear of gaining weight is the main reason why they restrict their energy intake. If the person does eat something high in calories, perhaps as they felt pressured to eat when out with friends, then they will feel intense anxiety about this as they are afraid of gaining weight. The person may then engage in activities such as exercising excessively, using laxatives or fasting to ensure that they don't gain weight or that they lose any weight that they may have gained. The person may also weigh themselves frequently to ensure that they are not gaining weight and will feel anxious if they have put on even a small amount of weight.

A person with anorexia exhibits a disturbance in the way in which their body weight or shape is experienced. Thus, the person may be very thin but when they look in the mirror they actually see an image of themselves that large or overweight (even though in reality they are underweight). Thus, this is a type of body dysmorphia and may be one of the reasons why a person with this disorder doesn't

recognise the seriousness of their low body weight. The person also experiences undue influence of body weight or shape on self-evaluation. Thus, how they look affects how they feel about themselves as a person. Even though they may have many good attributes such as being a good friend and doing well academically, it is their body weight or shape that influences what they think about themselves rather than these other attributes. Lastly, the level of severity of anorexia is determined by the person's BMI or Body Mass Index, with a BMI of below 17 indicating mild anorexia, a BMI below 16 indicating severe anorexia and a BMI below 15 indicating extreme anorexia. The criterion of having a BMI below 17 is controversial. BMI isn't a very accurate measure as it doesn't take muscle mass and bone density into account. In addition, a person with a BMI of 18 may need treatment and it could be difficult for them to access it until their weight drops low enough. Men might not reach this low body weight even though they exhibit the other symptoms of anorexia as men with anorexia have been found to place more emphasis on their body shape (such as body building to increase muscle mass) than on losing weight. Anorexia is diagnosed in about 0.4% of the population and the prevalence rates are 10 times higher in women than in men. When we discuss eating disorders in males in Lecture 3 it will become evident that the actual prevalence rates of eating disorders in men may be higher than reported for several reasons.

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With bulimia, a person's self-evaluation is also unduly influenced by their body shape and weight. They are usually dissatisfied with their weight and don't want to put on weight, but their fear of gaining weight isn't as extreme as a person with anorexia and they don't have a disturbance in the way in which their body weight or shape is experienced. A person with bulimia engages in episodes of binge-eating. This is where the person eats a large amount of food in a period of 2-hours and they are unable to control their eating during the binge-eating episode as they either can't stop eating or control how much they are eating. Thus, the person may consume a large pizza, a big bag of crisps, half a chocolate cake and 2 litres of Coke. After binge-eating the person engages in inappropriate compensatory behaviours to prevent weight gain such as self-induced vomiting, taking laxatives or diuretics, fasting or exercising excessively. The person would want to make sure that all of the high calorie food is out of their body after binge-eating so they may eat something orange like a carrot before binge-eating and then vomit until they see the carrot and know that they've gotten rid of all the food they've eaten. Even though the person is ridding their body of the high calorie food they have eaten they don't usually end up losing weight as their body absorbs about 30% of the calories taken in and their metabolism is affected. To be diagnosed with bulimia, the episodes of binge-eating and using inappropriate compensatory behaviours to prevent weight gain need to occur at least once a week for 3 months. In extreme cases the person engages in these behaviours twice a day. This disorder is diagnosed in about 1 to 1.5% of women and the prevalence rates are 10 times higher in women than in men.

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A person with binge-eating disorder engages in episodes of binge-eating where they eat a large amount of food in a period of 2-hours and have a sense of lack of control over their eating. However, they don't engage in inappropriate compensatory behaviours or base their self-evaluation upon their body shape or weight. The binge-eating episodes are associated with three or more of the following symptoms: Eating rapidly, feeling uncomfortably full, eating when not hungry, eating alone (as the person feels embarrassed about binge-eating and doesn't want other people to know that they are doing this), feeling disgusted and feeling depressed or guilty. Thus, a person with binge-eating disorder usually feels bad about themselves for giving in to their urge to binge-eat and would prefer to have more control over their eating. To be diagnosed with this disorder the episodes of binge-eating need

to occur at least once a week for 3 months and they need to cause the person distress. In extreme cases the person binge-eats twice a day. Binge-eating disorder is diagnosed in about 1.6% of females and in about 0.8% of males. Thus, the gender gap in prevalence rates between men and women is smaller for this disorder than for anorexia and bulimia.

One of the criticisms of the DSM 5's diagnostic criteria for bulimia and binge-eating disorder is that they don't adequately consider the reason why a person may be binge-eating. Research has found that these disorders are frequently comorbid with depression and binge-eating may a coping mechanism to manage the feelings of depression that the person is experiencing (in the same way that another person may drink alcohol, take sedatives or self-harm as a way to regulate and manage overwhelming feelings of depression). Studies have found that, in people where depression is comorbid, treating depression leads to a decrease in binge-eating and/or compensatory behaviours such as self-induced vomiting. The person may also be stuck in a cycle where binge-eating leads to feelings of depression which in turn triggers episodes of binge-eating. Thus, it's important for clinicians to assess a person with bulimia and binge-eating disorder for symptoms of depression to determine which of these is the primary disorder how the symptoms of these two disorders intersect.

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Although the term anorexia wasn't in existence in the 12th Century, food refusal in woman has been discussed in literature throughout history and the explanations for why a woman refuses to eat has changed over time. You will notice that I am not referring to why men refuse to eat as the issue of men and eating disorders has been largely absent in the literature up until about the 1990s. In the 12th Century, food refusal was viewed as something positive. It was linked to fasting and denying one's needs at a time in which religion played an influential role in society. A person who was able to deny their needs, such as not eating, was revered and this denial of needs was viewed as a means to achieve sainthood which is what is meant by the term 'holy anorexia'. Thus, food refusal wasn't viewed as pathological or deviant. From the 15th Century, many women were accused of practicing witchcraft. It was believed that these women had voluntarily made a pact with the devil and as a result many women were put on trial and executed. Many of the women accused of witchcraft engaged in behaviours that deviated from the social norms of the time such as wanting to study, practicing alternative medicine and working as a midwife. Thus, persecuting women for these behaviours may have been a form of social control. Food refusal was another behaviour seen as a sign of deviance. As it isn't possible to survive without nutrition, a person who refused to eat for a long period of time was thought to be a witch as this seemed to be the only explanation for their ability to survive without eating. In later years, food refusal as well as other types of behaviours that deviated from social norms were viewed as a sign of insanity or madness. The fact that a person was refusing to eat seemed inexplicable thus, the person was labelled as insane or mad. With the emergence of the medical model, physicians examined women to try to find a physiological reason, such as problems with the gastric system, that could account for why they were refusing to eat. However, no physical cause for food refusal could be found. In the early 19th Century, the medical model of mental disorders started to emerge. In line with other disorders such as hysteria, where no physical cause could be found for a person's symptoms, food refusal was seen as a symptom of a mental disorder such as hysteria. Thus, refusing food was seen as a pathological behaviour. This explanation will be discussed in more detail in the subsequent slides.

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In 18 74, a British physician Sir William Gull was interested in the scientific study of dysfunction of the gastric system, first referred to food refusal as anorexia nervosa. Following difficulties to find a physical

cause in his patients' loss of appetite and associated emaciation (extreme weight loss) he concluded that the person was suffering from anorexia nervosa which is a psychiatric phenomenon resulting from psychopathology or mental illness.

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In the late 1800s, anorexia was viewed as a mental disorder and as a condition affecting women. An analysis of the discourse in texts on anorexia during this time highlights the ways in which this disorder was socially constructed. When talking about discourse, I am referring to the language used to describe a phenomenon such as anorexia and how the language used influences and reproduces meanings associated with that disorder. For example, some therapists refer to the person in therapy as their patient, while others refer to them as their client. The word patient and client have very different meanings and can influence the type of relationship that is constructed between the therapist and the person in therapy. Using the word patient implies that the person is ill; whereas client refers to a person who is receiving a service. These words are also associated with power dynamics. In relation to the word patient, the doctor would be perceived as having more power in the relationship and the patient is expected to listen to and follow the advice of the doctor without questioning it; whereas the relationship that a person has with a client is more equal and collaborative with both parties being involved in decisions about therapy. Thus, discourse or language used can have a powerful influence on the construction of a phenomenon. For example, as you progress through university into postgraduate study, you will start to produce knowledge through research. Thus, it's important to be aware of the kind of language you use when talking or writing about the object of your research.

When analysing the discourse in texts written by people researching or working with people with anorexia, it's evident that this disorder was socially constructed as a condition affecting women as men were largely absent in the literature on anorexia and accounts of the disorder are linked to discourses of femininity, such as the personality traits that are perceived as being female traits and references to the person's sexuality being uninhibited during a time in which women were expected to inhibit their sexual desires. Medical discourse such as patient, treatment and illness were the predominant words used when describing women with anorexia which implied that they were in some way ill. Other types of language used to describe women with anorexia in these texts were deviant, deficient, inherently irrational, emotionally unstable and mentally perverse. Mentally perverse wasn't referring to a sexual perversion but rather that the person was stubborn and couldn't be persuaded to eat. These types of discourse reproduced oppressive social conditions for women with anorexia. Because they were viewed as ill, irrational and emotionally unstable it was believed that they were in need of treatment, not able to make decisions for themselves and that they needed to be restricted from doing anything that made their illness worse. Thus, confinement was one of the treatments and a woman was expected to remain confined to her room and not to engage in tasks that exerted them physically or mentally such as going for walks, socialising and reading. In terms of discourse, discourse analysis (which is an analysis of the type of language used to describe phenomenon), reveals the ways in which disorders such as anorexia are socially constructed and kept women with this disorder in a subordinate position. Invasive treatments such as force feeding a person, hospitalising them and using electroconvulsive therapy were used.

Changing the way in which anorexia is socially constructed changes the way in which other people view the person with this disorder and the types of treatments recommended. For example, if anorexia is viewed as a disorder that arises due to dysfunctional family relationships, then the disorder

is perceived as being caused by family dynamics rather than something being inherently wrong with the individual and treatment focuses on changing family dynamics rather than changing the individual.

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In the early 1900s, psychoanalytic theories on the causes of anorexia emerged, the most prominent theories of that time being Sigmund Freud's theories. According to Freud, impairment in the nutritional instinct (which is the person's biological instinct to eat in order to obtain the required nutrition to survive) was related to the person's inability to come to terms with sexual excitation. Thus, the refusal to eat was viewed as a symptom of hysteria and a reaction to experiencing feelings of sexual excitation. The person would feel anxiety and distress about experiencing feelings of sexual excitation as they were living in an era when it was taboo for women to experience these types of sexual feelings. Thus, Freud didn't consider anorexia as a distinct disorder, but rather viewed food refusal as a symptoms of hysteria in the same way that a person's arm going lame or a person losing their hearing (when there is no physical cause underlying these symptoms) is a symptom of hysteria.

Many of Freud's clients with hysteria and symptoms of anorexia reported experiencing sexual abuse. However, Freud wrote that the memories of sexual abuse reported weren't actual memories of abuse but were fantasies. As we discussed in the lecture on Borderline PD, this meant that women's reports of sexual abuse weren't believed and issue of sexual abuse wasn't addressed in literature on eating disorders and other psychological disorders for decades. Freud's view of the aetiology of anorexia pathologised the individual and the problem of anorexia became located in women's attitudes towards sexuality, reducing the analysis to a dichotomy about the rejection or acceptance of heterosexual femininity. In addition, women's ideas about sexuality were excluded, and so-called non-normative sexualities, such as bisexuality and homosexuality are pathologised, reproducing a normative discourse about sexuality, women and relationships within the family and broader society.

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Another psychoanalyst, Arthur Crisp, also linked the symptoms of anorexia to female sexuality. When a young person starts going through puberty and developing physically, they start moving towards womanhood. This is associated with being the object of the male gaze and needing to take on the role of wife and caregiver. Crisp theorised that people with anorexia experienced severe anxiety or a phobic avoidance of maturing into womanhood and food refusal and associated weight loss was a way for the person to avoid womanhood. When a person eats very little and is extremely underweight they usually feel fatigued and don't have much energy to do anything. In addition, they stop menstruating and being able to reproduce and their body shape takes on a more male appearance as their body is no longer curvaceous. Thus, the symptoms of anorexia result in psychobiological regression which is adaptive as it protects the person from moving into womanhood and their body shape will no longer be threatening. Similar to Freud's theory, the symptoms of anorexia are linked to female sexuality, the disorder is located within the individual and the person is perceived as deviant in some way as they should want to mature, move into womanhood and take on the roles that society expects them to fulfil.

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The last psychoanalytic theory we will be discussing is Hilda Bruch's theory on the aetiology of anorexia. Bruch theorised that anorexia is caused by abnormal family patterns of interaction as well as the influence that the media has on a person's desire to be thin. The enmeshment hypothesis extends our understanding of anorexia. It still focuses on psychological factors underlying this disorder, but extends its focus to include family dynamics or patterns of family interactions. According

to the enmeshment hypothesis, a person with anorexia is over-compliant and they have parents who are controlling. Thus, the person faces a struggle for independence in the face of parental control. For example, the person may not be allowed to make decisions about what to wear, who to be friends with and what activities to participate in after school. Their parents may also be very intrusive by checking up on their child's whereabouts frequently, going through their possessions and generally not allowing them much privacy. Thus, it's difficult for a person with overcontrolling and intrusive parents to become independent, have control over their lives and develop a sense of themselves as separate from their parents. Thus, food refusal was viewed a way for the person to cope with struggles around control and identity and to gain a sense of control as food, and their body, is the only thing that they can control as their parents cannot force them to eat and gain weight.

Bruch also focused on the role that the media plays in the development of eating disorders and argued that the changing cultural trends in the female body shape explained why women strive to be thin and contributed to the onset of eating disorders. Thinness and fragility became feminine attributes of the middle classes of the late 19th Century. During the late 1960s and early 1970s the rise in mass media created a representation of the ideal feminine body as one that was characterised by thinness. For example, high profile clothing models such as Twiggy, became part of popular culture and women felt pressured to conform to these cultural icons of femininity. In addition, the multi-million-dollar slimming industry reinforced the culture of thinness by encouraging practices of calorie-counting, weight-watching and dieting so that women could regulate their body size. Slimming food supplements became commonly used as a means to lose weight during the 1980s even though media reports warned consumers about the dangers associated with their usage. Research on eating disorders has found that the prevalence rates of these disorders rose in relation to the decreasing BMIs of women portrayed in the media.

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The anti-psychiatry movement arose in the 1960s and consisted of researchers, academics and clinicians who were disenchanted with psychiatry. They argued that mental illness was intrinsically related to the social conditions of an individual's life and that theories on underlying disease causation couldn't be proven and weren't desirable in terms of developing effective treatments. As a result, social theories that recognised that social factors play an important role in the development of psychological disorders began to emerge and a few key writers became associated with the anti-psychiatry movement. R.D. Laing, a British psychiatrist, was a major proponent of the social origins of schizophrenia. Laing co-authored a book with Esterson in 1964 entitled Sanity, Madness and the family. This book was the first major consideration of family and its role in the onset of psychological disturbance and the authors argued that families, particularly parents' relationships, created patterns of dysfunctional behaviours in family members through inconsistent and contradictory actions.

Erving Goffman published an ethnographic analysis of psychiatric institutions in 1961 entitled Asylums. It gave a compelling account of the lives of the inpatients of St Elizabeth's Psychiatric Hospital in Washington, D.C. In this ethnography he described a series of dehumanising and humiliating practices that depersonalised patients and constructed their 'non-identities'. These processes also encouraged patient compliance with institutional regimes. These critiques of psychiatry included a focus on therapeutic alternatives to invasive procedures by restructuring therapy for mental illness. The foundation of the Arbours Association in London is an example of an attempt to restructure therapy for mental illness. The association established several therapeutic communities based on a philosophy that encouraged respectfulness between its residents and residents' participation in the running and workings of the community. Notice that here people receiving therapy are referred to as

residents rather than patients. This this approach was not entirely successful with all its residents but the majority significantly improved their emotional lives and returned to their homes.

Even though early social theories focused on family dynamics, these theories focused more on the significance of the relationship with the mother than the father. For example, early work on infant feeding examined maternal emotional hostility as the main precipitating factor in the onset of a child's reluctance to accept nourishment and the subsequent development of 'infantile dwarfism'. The term schizophrenogenic mother (also known as the refrigerator mother) emerged in the 1950s from research on the relationship between a person with schizophrenia and their mother. The stereotypical mother of a person with schizophrenia was theorised to be emotionally disturbed, cold, rejecting, dominating, perfectionistic and insensitive as well as overprotective and fostering dependence. Thus, one of the outcomes of these social theories was that it led to mother-blaming.

In the 1970s, feminist perspectives on the aetiology of eating disorders emerged. The next lecture is going to focus on discussing and critiquing these perspectives and theories.