Lecture 3

Slide 2

Today we will analyse how discourse on eating disorders has impacted our knowledge of anorexia and bulimia and how discourse implicitly portrays these disorders as hierarchically opposed to one another in the final lesson on eating disorders. Additionally, we'll talk about eating issues in men.

For the intention of deconstructing the hierarchies they imply, Maree Burns looked at descriptions of anorexia and bulimia in her journal article Eating like an Ox. Analysis was done of the language used by women with eating disorders, medical experts, psychological literature, and popular culture when discussing anorexia and bulimia. It was discovered that the discourse utilized affects how these disorders are classified and how women who have these problems are classified and governed. Instead of questioning whether bulimia and anorexia are or are not distinct from one another, Burns was more interested in how we perceive them to be distinct and how this understanding is intimately linked to presumptions about typical femininities. The hierarchical oppositions that were latent in the discourse were destroyed through analysis. For example, anorexia was viewed as being opposite to bulimia in that a person with anorexia is viewed as having self-control; whereas a person with bulimia is viewed as lacking self-control. A hierarchy was evident in the ways in which anorexia was viewed as being superior to or better than to bulimia. An analysis of the discourse also found that understandings of these disorders as different to one another were tied to assumptions about normative femininities. In other words, what it means to be a women and how people with these disorders do or don't deviate from ideas about femininity.

Slide 3

This slide looks at how discourse has shaped our understanding of anorexia and bulimia and at the different ways in which these disorders are viewed by people with the disorders, health professionals, psychological literature and in popular culture. The behaviours that typify anorexia and bulimia do, at first glance, seem to be radically opposed. One is characterised by self-starving and the other by binge-eating and purging. However, even though the diagnostic criteria for these two disorders share many features such as desire for thinness, body dissatisfaction, and fear of weight gain, they are (in line with that first glance) organised into distinct and separate pathologies. Despite the diagnostic overlaps, the practices of starving and binge/purging are considered incongruent and invite oppositional constructions of the phenomena and of the women who are diagnosed, or who identify, as bulimic or anorexic. Discourse analysis found that people with anorexia were viewed as having total control, total denial, perfectionism and a sense of achievement. On the other hand, people with bulimia were viewed as being out of control and indulgent, being a failure and being shameful. In addition, in the same way that I have placed anorexia nervosa above bulimia nervosa on this lecture slide, people with anorexia are viewed as being superior to and better than people with bulimia. For example a person with anorexia is seen as successful in controlling their eating; whereas a person with bulimia is seen as failing to control their eating. Both want to lose weight but a person with bulimia is repeatedly referred to as a 'failed anorexic'. An example of this hierarchical representation of anorexia and bulimia can be found in Extract 3 where a psychiatrist talking about people with these eating disorders says that "*They're [women with anorexia] overachievers – are often – well they're high achievers and (long pause) they're quite driven a lot of them, they have a certain um (long pause) they have a persistence that allows them to be anorexic. You've actually gotta be . . . quite good at . . . controlling yourself to be anorexic. Most people can't manage it . . . ah, there's a certain persistence about them*

that ah, most people don't have and – so they do have certain personality qualities – you know quite obsessional and . . . driven that allow them to succeed at anorexic – if you can succeed as an anorexic whereas I think a bulimic, you know, you could consider a bulimic as a failed anorexic" (Burns, 2004. p.277). Another example is from an account by Fran, a woman diagnosed with bulimia. She says, "*I almost feel that anorexics are the . . . are the successes*". When asked by Burns why she thinks this and if she would prefer to be anorexic she says, "*Well, anorexics can do it, I can't I mean, I sort of feel like I've even failed at being an anorexic*" and "*Oh yeah. Mm I would love it. I would really, really love it", and when expressing her views on bulimia she says, "Well, it's sort of like, having given in. You know like having let your appetite control you. You know whereas, anorexia's a wonderful feeling of being in control. Of, you know – not letting um, your hunger or anything else take charge of you*" (Burns, 2004. p.276-277). These quotes illustrate the theme of total control with anorexia and being out of control with bulimia that was found in discourse on these disorders. Total control and total denial was found to stimulate feelings of pride and a sense of achievement, perfectionism and being different, perhaps even better, than other people. For example, in an interview with Lynn, who is describing her past experience of eating disorders she says, "*I don't know how the atmosphere had been created but I know that it felt right away that there was some kind of hierarchy between those labelled with anorexia and those labelled with bulimia and that anorexia represented this more kind of achievement of perfection and it was a cleaner disorder because you weren't throwing up and there were just all of these things that um made – made that category. I mean that's the ultimate achievement of anorexia is to kind of have it perfectly*" (Burns, 2004, p.287-288). In comparison, a person with bulimia is perceived as being indulgent, a failure and shameful. This indulgence is evident in Rosie's description of people with bulimia when she says that "*I used to think that bulimics were um . . . were greedier and I used to think that it was really bad to be bulimic but it was OK to be anorexic, because it was um bulimia was like a greedy type of behaviour like you'd eat and then you'd be sick whereas anorexia they just didn't eat at all. I always wanted to be like that…*" (Burns, 2004, p. 278). These quotes highlight the ways in which anorexia is viewed as preferable or superior to bulimia and these views are internalised by people with the disorder which leads to a person with bulimia feeling like a failure.

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This slide looks the four themes that emerged through discourse analysis in relation to the ways in which the characteristics of anorexia and bulimia, and people with these disorders, are positioned as opposites. The four themes are control and lack of control, success and failure, abstinence vs. greed and sexuality. The quotes on the previous slide illustrate how anorexia is positioned opposite to and above bulimia in relation to the first three themes. These oppositions are also evident in Hilda Bruch's (the psychoanalyst's theory we discussed in the first lecture) account of women with bulimia in the Handbook of Psychotherapy for Anorexia Nervosa and Bulimia that was published in 1985. In this account Bruch writes that "*They [women with bulimia] make an exhibitionistic display of their lack of control or discipline, in contrast to the adherence to discipline of the true anorexics . . . The modern bulimic is impressive by what looks like a deficit in the sense of responsibility. Bulimics blame their symptoms on others; they may name the person from whom they 'learned' to binge, in particular those who introduced them to vomiting . . . from then on, they behave as completely helpless victims. Though relatively uninvolved, they expect to share in the prestige of anorexia nervosa. Some complain about the expense of their consumption and will take food without paying for it. They explain this as due to 'kleptomania', which indicates, like bulimia, an irresistible compulsion that determines their behaviour*" (Bruch, 1985, p.12).

People with anorexia and bulimia were also portrayed in opposite ways in popular cultural and representations of women's deviant appetites are not confined to prescriptions about appropriate eating but are also infused with sexual themes whereby women's desire for food is often conflated with, and substituted for, desire for sex in relation to notions of femininity and their sexuality, and this is also evident in psychological discourse. Mainstream psychology also reproduces value-laden notions of what constitutes 'appropriate' feminine sexuality, which is heterosexuality that is structured around male desire and engaging in traditional heterosexual sexual acts. Women with anorexia are described as '*having difficulty negotiating heterosexual relationships, ultimately retreating from, or rejecting, the inevitably of becoming a sexually mature woman'*. Thus, they are portrayed as deviating from the social norm by not wanting to engaging in heterosexual relationships or to become a sexually mature woman. This was evident in the discussion on aetiology in the previous lectures where it was proposed that people with anorexia have a phobic avoidance of entering the male sphere of development and that they transform their bodies in reaction to feelings of guilt about transforming their lives and personalities and that they struggle to separate from their mothers and become independent, adult women.

In contrast, women with bulimia are described as more likely to have '*impulse-control problems, to abuse alcohol or other drugs, to exhibit more mood lability, to be sexually active and to have difficulty developing age-appropriate sexual identities'*. This is evident in an extract from a book published by Abraham and Llewellyn in 1995 entitled Sexual Reproductive Function in Eating Disorders and Obesity where the authors describe people with bulimia in the following way. "*Bulimia nervosa patients are frequently sexually assertive, their sexual behaviour mirroring their eating behaviour. Their level of sexual activity is associated with an increased risk of pregnancy and a higher rate of induced abortion. More bulimic women than age-matched women masturbate to orgasm, have orogenital sex or anal intercourse and reach orgasm regularly*". (Abraham & Llewellyn, 1995, p. 283). This description conflates eating with sexual activity and indicates the negative way in which women who indulge either of these appetites in non-prescriptive way, are portrayed. Another example of this conflation is evident in a quote from a psychologist who Burns interviewed. Sue, the psychologist says that "*She [friend with bulimia] just loved to eat. She was a very sensual person and she loved to eat and she liked to to sleep with strange guys (laughs) and you know I mean she she she / MB: yeah / she um she she really lived and and she couldn't bear putting on weight so she used to vomit*" (Burns, 2004, p.280). This 'bad girl' sexuality of people with bulimia portrayed in these quotes is in direct contrast with the 'good girl' sexuality exemplified by the figure of the 'anorexic' woman who is constructed as having limited sexual experience and desire.

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An analysis of the discourse found that, at the point where a person with anorexia becomes emaciated, anorexia is no longer privileged over bulimia. Rather it is viewed as deviant and dangerous as the person is no longer the object of the male, heterosexual gaze. Thus, once a person's body has become so thin that they are no longer attractive, they are no longer perceived as having the positive attributes of success, perfectionism and achievement and their practices are viewed as deviant and no longer preferable to the practices of people with bulimia. This is evident in the following quotes. Firstly, Becca who previously portrayed anorexia in a positive light in comparison to bulimia says "*Anorexia . . . I think the real reason it's considered – with – more with distaste is because, you really, really do see the results of it, and it's just so horrifying to see these skinny, skeletal, you know, skeletal figures, and it's, it's more like the shock value where – with anorexia, and I think, more, more, more people would consider anorexia . . . as, as a worse . . . as a worse thing than bulimia*" (Burns, 2004, p.281) and Pip, a doctor, describes both anorexia and bulimia as serious disorders when she says, "*I*

think they're [anorexia and bulimia] both severe – they both have enormous implications. If you regard death as the ultimate then the anorexics [sic] the one that is terrifying". Thus, the consequences of anorexia, rather than the practices themselves are constructed as deviant and pathological.

Slide 6

According to Burns, the way in which discourse positions women with anorexia has several implications. Firstly the disorder is located within the individual and the discourse reproduces dominant psychological theories and popular representations that posits these behaviours as arising in part from personal characteristics originating within individuals. For example, restricting food intake is described in terms of personal characteristics such as control and strength and binging and purging are described in terms of personal characteristics such as weakness and vulnerability. By locating pathology within the individual, the social and discursive contexts of women's lives are denied. It also positions anorexia as the more acceptable or desirable eating behaviour that reflects inner strength and resolve; whereas bulimia represents the opposite of this. In addition, by viewing the person as responsible for their eating pathology, the person effectively becomes their diagnosis and their identity and behaviour become defined by their illness. For example, Kay, a young women with bulimia, concludes that her real self is a bulimic self and that when she is bulimic she is vulnerable and weak and she feels like this is her real self. Thus, she is internalising the ways in which society views people with this disorder and this informs her identity or how she perceives herself as a person. The fact that anorexia is viewed as desirable and acceptable in comparison to bulimia which is viewed as deviant and shameful, means that people with bulimia are more likely to experience feelings of guilt and shame in relation to their eating behaviours and may become isolated; which could partially worsen the person's binge-eating and purging behaviours and the development of self-starving. Viewing anorexia as desirable and acceptable, particularly if this idea is reproduced by people in the profession of psychology, could reinforce a person's restriction of food intake and weight loss as it is viewed as positive, an achievement and associated with qualities that people aspire to have. Pro-Anorexia websites, forums and social networking groups also reinforce these eating behaviours through the discourse used on these sites and practically by providing advice how to lose weight, decrease your appetite, induce vomiting, reduce the side-effects of eating disorders, hide weight loss from your parents and doctor etc. It is important for people and professionals, particularly in the field of psychology to interrogate discourse and to be aware of how they are constructing eating disorders and the implications that this can have on society's understanding of these disorders and on the lives of people who engage in behaviours associated with eating disorders.

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I am moving on to a discussion of eating disorders in men. In this discussion I am going to be focusing on the reasons why the prevalence rates of eating disorders, particularly anorexia and bulimia, are higher in men than in women, on differences in clinical presentation and reasons for dieting, on the aetiology of eating disorders in men and the implications of anorexia being socially constructed as a disorder than only affects females. The prevalence rates of anorexia are 10 times higher in women than in men which means that the majority of people diagnosed with this disorder are women. However, the actual prevalence rates of anorexia in men may be higher than what is reported. Anorexia as well as other eating disorders in men may be underreported, may go undetected or the person may be misdiagnosed with a different disorder. One of the reasons why the prevalence rates of anorexia may be lower in men is due to diagnostic bias. It was only in 2013, when the DSM 5 was published that the diagnostic criterion of amenorrhea, where a person stops menstruating, was

removed from the diagnostic criteria for anorexia. Thus, as men don't menstruate, it is unlikely that they would have been diagnosed with anorexia.

Anorexia is also viewed as a female disorder by some professionals and society. As a result, there is stigma and shame attached to men being diagnosed with an eating disorder which may make them reluctant to seek treatment. Thus, fewer men are likely to be diagnosed with eating disorders if they are less likely to discuss their symptoms of eating disorders with a clinician such as a doctor or a psychologist. The fact that some professionals also view eating disorders as a female disorder means that they are less likely to assess for the presence of these disorders in their male clients. The literature on eating disorders focuses predominantly on women both with respect to research on people with eating disorders and research on the aetiology of these disorders. When entering the search terms anorexia nervosa and women into Primo on the UCT Library site, I got 34 940 results and 23 754 results for bulimia nervosa and women and 20 645 results for binge-eating disorder and women. In comparison, I got 19 961 results for anorexia nervosa and men, 11 986 results for bulimia nervosa and men and 11 678 results for binge-eating disorder and men. Even though not all of these articles will be related to the terms searched for, it highlights the difference in the volume of literature that has been published on eating disorders in men and women; with similar results found for binge-eating disorder in which the prevalence rates of the disorder are twice as high in women in comparison to 10 times as high for anorexia and bulimia.

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Research has found that the clinical presentation of anorexia in men varies from women in a few ways. Both men and women experience a fear of gaining weight and the onset of the disorder is in late adolescence or early adulthood which is the same for both sexes. Men also experience body dissatisfaction but this tends to be linked to their upper body. This may be due to social pressures conform to the ideal of having a body that is lean and muscular. Thus, men place more emphasis on obtaining a particular body shape than on achieving a low body weight. This could also account for the lower prevalence rates of anorexia as men are less likely to reach a BMI below 17. Binge-eating and exercising excessively has also been found to be more common in men than restricting food intake. Thus, the person still has a fear of gaining weight, is dissatisfied with their body and evaluates themselves according to their body shape and weight, but they are more likely to engage in behaviours such as binge-eating and exercising excessively than restricting their food intake. This could also account for the lower prevalence rates of anorexia in men as restricting food intake is one of the diagnostic criteria for anorexia. Thus, the DSM's diagnostic criteria doesn't take these variations in clinical presentation into account which results in a gender bias in the diagnostic criteria.

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Research into the reasons that men diet have found a wider range of reasons for dieting in men. These include actually being overweight rather than feeling or believing that you're overweight, wanting to attain goals in sport. For example, a jockey needs to maintain a minimum weight and for many other sports a person needs to be slim and agile to perform well. This is supported by the fact that the prevalence rates of eating disorders are higher in athletes. Another reason for dieting is wanting to feel more masculine and wanting to gain respect from others which is linked to social norms around the ideal male body. These norms are also promoted in the media, in the same way that thinness is promoted as a body ideal for women. Magazine covers and advertisements tend to portray men as strong, lean and muscular. These ideal body images are also evident in children's toys such as barbie dolls and action figures.

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Studies on the aetiology of anorexia in men have found that similar family dynamics seem to play a role for both men and women. For example, Bruch's enmeshment hypothesis that states that a person with anorexia is over-compliant and has parents, usually a mother, who is controlling. Thus, the person struggles to become independent in the face of parental control and begins to control their body by controlling what they eat as this is the only area of their lives that they are able to control. In addition, having a distant or absent father, parental conflict and divorce have been found to be linked to the onset of anorexia in men. These factors weren't discussed in relation to the aetiology of anorexia women as fathers are largely absent in the research on the aetiology of anorexia in women. More recently, this research has focused on the father-daughter relationship although there is still a dearth of research focusing on this relationship.

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Anorexia has been socially constructed as a female disorder. This influences society's views of this disorder in men as well as the ways in which professionals and lay people view the disorder. Our understanding of these disorders also influences the type of research questions academics ask and the type of knowledge that is produced. For example, in the 1970s gender scales were developed to assess for the presence of so-called feminine and masculine traits. Several early studies on eating disorders in men assessed the personality traits of men and the results of the study provided scientific proof (in inverted commas) that femininity is a risk factor for anorexia and that masculinity is a protective factor, as the participants in the studies who exhibited the symptoms of eating disorders tended to score higher on feminine traits and lower on masculine traits than those who didn't exhibit the symptoms of eating disorders. This led to the stereotype that men with eating disorders don't conform to the notion of hegemonic masculinity and that they are either homosexual, asexual or effeminate. Men who didn't display more feminine traits were labelled as more severely disordered as this didn't challenge the idea that an eating disorder is a female disorder. Interestingly, research on women with eating disorders didn't assess personality traits in this way in order to determine how feminine or masculine they were. Thus, the social construction of eating disorders as a female disorder influenced research questions and as a result the knowledge produced and this reproduced the belief that eating disorders are a female disorder. On the next slides I will be discussing research that looks at the ways in which these stereotypes about men with eating disorders have filtered into discourse used by men when discussing eating disorders.

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Studies conducted by Benveniste and colleagues in 1999 and Mc Ville and colleagues in 2003 analysed the discourse used in lay accounts of men with anorexia. Participants were asked to explain anorexia in relation to which men are likely to have anorexia and what the causes of the disorder are likely to be. Overall, the language used by the participants served to distance anorexia from hegemonic masculinities. Thus, when speaking about anorexia the participants spoke about it as a female disorder and didn't attribute hegemonic masculine traits such as courage, aggression, rationality and toughness of body and mind to men with anorexia. Thus, their discourse served to sustain both the dominant masculine identities and the gender-specific construction of anorexia as, if the participants changed the way that they perceived anorexia (for example by acknowledging that so-called strong men can have this disorder), this would challenge their beliefs about this disorder being a female disorder.

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When discussing men with anorexia the participants referred to men with this disorder as new age men and used terms such as more feminine, more emotional and more focused on their appearance to describe men with anorexia. The men were also perceived to have been raised differently and socialised to be more feminine, in other words, not raised to be typical man. Thus, there was a perception that their childhood and the way they were raised and socialised from a young age swayed them from the norm. All of these accounts indicate the participants viewed men with anorexia as being different from other men. Alternatively, if a man with anorexia doesn't have effeminate qualities and they don't fit into the category of a new age man, then the participants expressed the belief that there must be something wrong with the man. Either a man with anorexia was mentally weak as a result of psychopathology or the person must be engaging in eating disordered behaviours because they're depressed. If the participants didn't adopt this viewpoint then it would challenge their belief that so-called manly men could exhibit symptoms of an eating disorder. Thus, men with anorexia were either portrayed as effeminate in some way or there was something inherently wrong with them. One of the limitations of both of these studies is that there was a small sample size. Thus, the findings of these studies may not be generalisable. In addition, it is possible that being asked specific questions about men with anorexia may have elicited more stereotyped answers than if the participants were asked to discuss eating disorders in general, in relation to both men and women.

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Mc Ville recommended that future research focuses on exploring the unique features of eating disorders in men to get a better and more accurate understanding of symptom presentation which can aid diagnosis and treatment. It is also important to explore issues relating to the social construction of masculinities as these influence the way in which men with eating disorders are perceived and perpetuate the stigma associated with eating disorders in men. It's also important to address the gender bias inherent in the conceptualisation and diagnosis of eating disorders. If academics and clinicians continue to view eating disorders as female disorders and the diagnostic criteria for these disorders don't capture the clinical presentation of eating disorders in men, then these disorders will continue to be stigmatised, men will be reluctant to seek treatment and eating disorders in men are likely to go undetected, undiagnosed or be misdiagnosed. It is also important to look at the issue of developing treatments specifically for men with eating disorders. Most people receiving treatment for eating disorders are women and research into the efficacy of these treatments has predominantly been conducted with female participants. The treatment needs of men with eating disorders may or may not be different but more research is needed on this topic to determine what types of treatments are likely to be effective. Another criticism not discussed in these articles is the underlying assumption of heteronormativity in the research and literature on eating disorders in men and women. There is an underlying assumption that men and women are the only two genders that exist and, when homosexuality it discussed in research, it is usually discussed in relation to men with eating disorders and linked to the stereotype that men with eating disorders are more feminine. In addition, the issue of sexual orientation is explored in research on eating disorders in men but not on eating disorders in women.

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