November 2017

Diagnostic Divisions of Eating Disorders: A Critical Analysis

Channah A. Leff
University of South Florida, cleff1@mail.usf.edu

Follow this and additional works at: http://scholarcommons.usf.edu/etd
Part of the Psychiatric and Mental Health Commons

Scholar Commons Citation
Diagnostic Divisions of Eating Disorders: A Critical Analysis

by

Channah A. Leff

A thesis submitted in partial fulfillment of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts and Sciences
University of South Florida

Major Professor: Daniel Lende Ph.D.
David Himmelgreen, Ph.D.
Tara Deubel, Ph.D.

Date of Approval:
November 1st, 2017

Keywords: medical anthropology, psychology, history, eating disorders

Copyright © 2017, Channah Leff
# TABLE OF CONTENTS

ABSTRACT iii

CHAPTER 1 – Introduction 1

CHAPTER 2 – The Invention of Eating Disorders: A Historical Overview of the Literature 7
Earliest Historical Records 8
Medical Transition 10

CHAPTER 3 – Diagnostic and Statistical Manual of Mental Disorders: A Brief History 15

CHAPTER 4 – A Review of the Anthropological Literature 20
Cross-cultural Relativity of the Thin Ideal 20
Experience and Narrative 22
Redefining Disorder 24
Biocultural Approach 25

CHAPTER 5 – Methods 28
Site and Sample 28
Recruitment 30
Person-Centered Ethnographic Interviews 31
Focus Groups 32
Participant Observation 32
Autoethnography 33

CHAPTER 6 – Results 35
Amanda’s Story 36
Will’s Story 41
Jolene’s Story 45
Kat’s Story 47
Maxine’s Story 49
Mabel’s Story 55
Mariel’s Story 56
Molly’s Story 57
Rhonda’s Story 67
Sharon’s Story 70
My Story 73
Results Summary 78
CHAPTER 7 – Analysis

Historical-comparative Method 79
Social Construction of Human Categories 80
Race Tangent 82
Social Construction of Mental Illness 83
Basic Inductive Approach 86
Loose Categories 87
Cyclical Behavior 92
‘Real’ Effects of Socially Constructed Categories 96

CHAPTER 8 – Conclusion 102

References 107

Appendix A: Study Flyer 113

Appendix B: Script for Obtaining Verbal Informed Consent 114

Appendix C: Person-centered Ethnographic Interview Questions 116

Appendix D: Focus Group Questions 117

Appendix E: Letter of IRB Approval 118
ABSTRACT

The objective of this thesis is to critically examine the diagnostic divisions of eating disorders as proposed within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). I focus on Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and Other Specified Feeding or Eating Disorder (OSFED), although there were several new categories issued in 2013. Using person-centered ethnographic interviews, focus groups, participant observation, and autoethnography, I collected qualitative data to highlight how disordered eaters perceive themselves and their behaviors in relation to their diagnoses. I recruited participants in Boston, MA from Eating Disorders Anonymous (EDA), a decentralized network of support groups for disordered eaters. Subjects in my study, as well as from EDA at large, have a wide variety of diagnoses. Building off anthropologies of the pathological body, embodiment, medicalization and neuroanthropology, I highlight how predominant scripts of mental illness in both popular media and science shape the ways that disordered eaters understand their pathological behaviors. I also examine the historical and contemporary evolution of eating disorder theory within the psychological literature, offering a reflexive approach to the theoretical foundations within the field. Interweaving psychological literature reviews with ethnographic data, I demonstrate that disordered eaters do not fit as straightforwardly into diagnostic categories as presumed. Instead, findings indicate that individuals express different combinations of symptoms that range across diagnostic divisions.
CHAPTER 1

Introduction

Disordered eating was only accepted as a medical condition a century and a half ago, although many of the symptoms were documented long before. Medical professionals brought particular symptoms into the spotlight one by one, systematically organizing them into their own diagnostic divisions. An overview of the historical background can be used to place disordered eating into a type of social context that is otherwise forgotten. The sequential steps leading up to contemporary models for understanding eating disorders are crucial for understanding how we arrived here.

Self-induced starvation was the first form to be recognized in the medical community, and anorexia nervosa made it into the very first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. According to the latest edition, the DSM-5 (2013), anorexia nervosa is defined by three major criteria: (A) the restriction of “energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health,” (B) an intense fear of weight gain or fat, and (C) distorted perception of one’s body or poor self-esteem due to poor body image. Anorexic patients were first treated and recognized by medical physicians in the late 19th century, and, since then, the predominant method to identify the condition has been body mass index (BMI). Thus, the main criterion for identifying a case of anorexia nervosa is a BMI that falls within the underweight range (BMI less than 18.5), and the level of severity depends on just how
underweight the individual is.

In some of the earliest studies of anorexia nervosa in the early 20th century, binging (consuming very large amounts of food in short periods of time) and self-induced purging (vomiting up food or using other methods to rid oneself of nutrients) were documented as comorbid symptoms in some anorexic patients. Bulimia nervosa was adopted into the third edition of the DSM (1980). According to the DSM-5 (2013), bulimia nervosa involves: (A) Persistent binge episodes (“eating in a discrete amount of time an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances” and a “sense of lack of control over eating during an episode”), (B) “recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise,” (C) the occurrence of these episodes at a minimum of once per week for at least three months, (D) poor self-esteem due to poor body image and (E) the occurrence of episodes outside periods of anorexia nervosa. As opposed to anorexia, which uses BMI to determine level of severity, bulimia nervosa cases are judged based on the number of binge and purge episodes per week.

Binge eating disorder (BED) was only outlined in the latest version of the DSM in 2013. According to the DSM-5 (2013), BED involves (A) reoccurring episodes of binge eating, (B) the same definition for binges as bulimic binges, but more specifically must include three or more of “1. Eating much more rapidly than normal. 2. Eating until feeling uncomfortably full. 3. Eating large amounts of food when not feeling physically hungry. 4. Eating alone because of feeling embarrassed by how much one is eating. 5. Feeling disgusted with oneself, depressed, or very guilty afterward,” (C) significant shame around the subject of binging, (D) the occurrence of binge episodes at a minimum of once per week for at least three months and (E) the occurrence
of binges in the absence of bulimic or anorexic episodes. Like bulimia nervosa, the level of severity is determined by the frequency of binge episodes.

In addition to anorexia, bulimia and BED, there is an “other” category also featured in the DSM. Atypical eating disorder was first introduced into the DSM-III (1980). Its name was later changed to eating disorder not otherwise specified (EDNOS) in the DSM-IV (1994) and finally other specified feeding or eating disorder (OSFED) in the DSM-5 (2013). This disorder was created to incorporate clinical presentations of disordered eating, in which the patient does not fit into another diagnosis or the clinician is unable or does not wish to provide a more specific diagnosis. The DSM-5 (2013) includes examples for presentations of OSFED, including mild forms of anorexia nervosa, bulimia nervosa or BED, purging disorder (persistent purging behavior in the absence of binging) and night eating syndrome (excessive consumption of food in the night hours). OSFED characterized as mild forms of anorexia, bulimia, and BED is evaluated according to the same standards as mentioned previously (i.e. BMI equal to or above 18.5, binge/purge episodes less frequent than standards for bulimia or binge episodes less frequent than standards for BED).

Although OSFED is defined as a subclinical form of disordered eating, research has indicated otherwise. A meta-analysis of the available data indicated that EDNOS patients line up to their anorexic, bulimic and BED counterparts in regards to general health problems and psychopathology – even rates of suicide (Thomas, Vartanian & Brownall 2010). Additionally, the majority of eating disorder cases fall under OSFED. With every new edition of the DSM, disorders and diagnostic criteria are added, removed and adjusted. Since the first inclusion of atypical eating disorder in the DSM-III, there has been a trend towards slightly more liberal eating disorder criteria. Amenorrhea (absence of menstruation) was once considered a defining
symptom of anorexia nervosa, but it is no longer included in the DSM. Similarly, bulimia nervosa and BED went from two or more episodes per week to one or more. These changes have subsequently lowered the prevalence of the “other” category, but not by much. Before these changes, approximately 60% of the total eating disorder diagnoses were EDNOS diagnoses (Fairburn & Bohn 2005), whereas after the DSM-5, approximately 53% of diagnoses would be considered OSFED (Keel, Brown, Holm-Denoma & Bodell 2013).

Despite findings that more than half of recorded cases of disordered eaters are diagnosed with OSFED and that OSFED is likely no less problematic than other eating disorders, research on eating disorders almost never focuses on this topic. OSFED as a disorder has subclinical status, and most people have never even heard of it, so it is no surprise that researchers would rather focus on the big three. Furthermore, OSFED is more complicated to study with traditional methods, as it is fuzzier in definition. In order to produce results that are regarded as credible, diagnostic criteria outlined in the DSM are generally utilized to operationally define study samples. The DSM is commonly used because it is revered as a standardized approach to the study of mental health (which is more or less the reason it was established in the first place, which I will discuss later). In a classic psychological study, the use of strict operational definitions for study samples promotes validity and reliability of the results. However, it also means that the results pertain to a very limited group on individuals. This type of experimental design leads to a sort of chicken or the egg paradox: researchers use disorder definitions to study disorder, yet researchers created the boundaries around disorder in the first place. Selecting for participants that fit into given diagnostic criteria means that the participants are used to represent their disorder. In this way, the disorder becomes some sort of entity, and the only way to grasp it is to round up people that fit into its boundaries; the only way to understand it is then to find
similarities among its members, or to find what separated them from the “normal” population.

With the acceptance of socially constructed eating disorder categories, researchers are presented with ample opportunity for comparative studies. The search for differences among disorder categories in regards to hormones, neurotransmitters, etc. is endless. Just like any area of research, sometimes are differences found at levels of statistical significance, and sometimes they are not. When differences are significantly different – whether it be between anorexics and bulimics, anorexics and normal eaters, etc. – the existence of these categories are validated further. To put simply, rigid measures are used to solidify the fluid boundaries around disorder. Disordered eaters have been examined with all sorts of lenses: psychopathology, neurophysiology, endocrinology, and so on. Researchers have identified diverse commonalities among those afflicted, and these findings have been and are used to further refine diagnostic definitions. Similar family histories and personality traits, for example, have shaped the quintessential disordered characters (Hurst & Zimmer-Gembeck 2015). Stories of the overachieving, hairsplitting anorexic and emotionally turbulent bulimic schoolgirls have become so prevalent that these clichéd roles can be found throughout popular films – Center Stage, Dying to Dance, The Secret Life of Mary Margaret – the list goes on. Both individuals are painted as emotionally deep, introverted, and highly intelligent, and both are young girls. Anorexics, however, seem like they have everything figured out on the outside, whereas bulimics are impulsive and erratic in their behavior. On the other end, binge eaters are often portrayed as lazy and stupid – traits commonly associated with heavier body types. These depictions may influence not only how the general public perceives eating disorders, but also the ways in which disordered eater understand themselves.
This can be problematic on multiple levels. First and foremost, people do not fit into neat categories. We are complicated and multifaceted beings and cannot be successfully mapped out like elements on the period table. As I have already mentioned, scientific studies select for individuals that fit the diagnostic criteria, and leave out those that do not. In this way, we simultaneously ignore apparently sub threshold and peculiar cases, while producing questionable results. The breadth of our knowledge on eating disorders only spans the margins that we created in the first place. If the purpose of psychology is to properly identify and treat disorder, then we need reevaluate whether our definitions for disorder serve their purpose.
CHAPTER 2

The Invention of Eating Disorders: A Historical Overview of the Literature

Christianity was integral to the development of many branches of academia – medicine included – as early universities grew out of Cathedral schools in medieval Europe. Although higher education eventually separated from the Church, religious residuals are still very much apparent within Western ideologies (Futuyma 1982). The scientific method has since replaced Christianity as the “gold standard” (Adams 2013) for knowledge production, and religious explanations are often relegated to folktale (Good 1994). But religious undertones persist in the ways we perceive the world around us. Rene Descartes’s Cartesian dualism is one example, which involves the idea that the spiritual mind exists separately from the physical body. Descartes, a philosopher and a devout Catholic, was influenced by the Christian conviction that the carnal body is sinful and animalistic in nature, while the soul has the potential for holiness, morality, and repression against instincts of the flesh. Nancy Schepet-Hughes and Margaret Lock (1987) deconstruct the mind/body concept, emphasizing the profound influences of dualism that lurk beneath virtually every conceptual surface of Western thought. The division between physical form and abstract mind has been a powerful guide to our understanding of sickness. The development of biomedicine and psychiatry as separate fields is a testament to Cartesian dualism, in that we view physical and mental sickesses as dichotomous.
Earliest Historical Records

Similar trends apply to eating disorders, which were pigeonholed as religious phenomena long before medical or psychological. Anorexia nervosa was predated by anorexia mirabilis, a condition spanning from the Hellenistic era up through the medieval period. Written records from this time describe instances of women starving themselves in pursuit of purity and sanctity (Wiley & Allen 2013). This form of early anorexia was linked to the very same religious ethics that influenced Cartesian dualism. Restricting the bodily urge for food was respected as a form of asceticism, and extreme fasting was used to get closer to God. Binging, on the other hand, was seen as surrendering to hedonic temptations so evil that gluttony was included in the Seven Deadly Sins (Brynum 1984). There are many different theories as to how these beliefs came to be, such as the probable explanation that overindulgence threatened lives during periods of famine (Bemporad 1997). Nevertheless, these standards were forced much more heavily upon women, which is evidenced by the extreme bias towards female characters in food-related Christian tales. Connections among the female body, motherhood, and food were entangled to the point where a woman’s piousness was judged in accordance to both her sexuality and eating habits. A willingly starving woman was a metaphor for righteousness because what she gave up could be used for nurturing others (Brynum 1984). Although anorexia mirabilis and anorexia nervosa are equal in terms of behavioral and physical symptoms, each is understood with the predominant discourses of its time – the former to religion and the latter to science.

Parallel to restrictive eating, evidence of binging and purging (both separately and together) predates the invention of bulimia nervosa as a disorder by centuries. Some of the earliest documentation of purging behavior also comes from the Hellenistic period, in which emetics and enemas gained popularity for medicinal purposes in Greece, Rome, Egypt and
Arabia. Since at least that time, various methods of purgation have been utilized throughout Europe and the Middle East to rid the body of toxic or seemingly toxic substances, and in the Middle Ages they were among the most common remedies (Nasser 1993). There is also the well-known case of the vomitoria in ancient Rome, in which members of the elite class would induce vomiting in order to eat more during feasts (Russell 1997). Many scholars, however, argue that this is merely a well-preserved myth.

There is also documentation of bulimic symptoms in Catholic saints with anorexic mirabilis between the 14th and 18th centuries. Numerous saints that dedicated themselves to an ascetic lifestyle were also known to binge and purge in between fasting periods. Saint Veronica (1660-1727), for example, was known to restrict and overindulge at different times. In her own writing, as well as and observational accounts, “the sisters sometimes found Sister Veronica in the kitchen, the refectory, or the dispensary, where she ate everything there was” (Russell 1997, 13). This occurred throughout the many years that she practiced fasting. Saint Mary Magdalen de Pazzi (1566-1607) was also known for practicing self-starvation and other forms of self-torture in pursuit of holiness. She lived on only bread and water for long stretches of time, broken by spells of binging and purging: “she was observed by other sisters in the cloister to break her strict diet… when she was tormented by cravings for food and gobbled it down” (13). At the time, these behaviors were recognized as evil and brought on by the mischievous work of Lucifer (Russell 1997). Anorexia mirabilis is sometimes argued as the earliest identification of restrictive eating as a disorder, but at that time binging and/or purging had not been recognized as a crucial component to the phenomenon.
Medical Transition

In regards to the timeline, anorexia mirabilis transformed into anorexia nervosa once the disorder was recognized within the medical field. That first known medical record of anorexia was in 1689, when Dr. Richard Morton of Britain described the physical symptoms of a woman practicing self-starvation. Over the next couple centuries, the condition gained recognition in the medical community (Pearce 2004). Apepsia hysterica (“hysterical cessation of digestion”) was one of the early medical terms popularized. For several centuries, female hysteria was seen as a common driving force behind a variety of conditions of the female sex. From sexual desire to loss of sexual desire, hysteria was a catchall diagnosis. Up until the 20th century, anorexia was also seen as a component to female hysteria. Apepsia hysterica was gradually replaced by anorexia hysterica (“hysterical loss of appetite”) and then anorexia nervosa (“nervous loss of appetite”) towards the end of the 19th century, once it was accepted that the self-starvation was induced by a lack of interest in food and not gastric malady. Dr. William Gull of Britain, one of the pioneers to study and treat patients with anorexia, coined the name that we still use today (i.e. anorexia nervosa). He argued (1873) that the disorder was more than just a physical disruption of hunger:

The want of appetite is, I believe, due to a morbid mental state. I have not observed in these cases any gastric disorder to which the want of appetite could be referred. I believe, therefore, that its origin is central and not peripheral. That mental states may destroy appetite is notorious, and it will be admitted that young women at the ages named [16-23] are [e]specially obnoxious to mental perversity. (24-25)

Early descriptions of anorexia nervosa, involving case studies of young starving women, focused on the physical symptoms of the disorder. Doctors detailed how women were brought back to life with careful medical treatment, asserting that nutritional intervention served as the cure. Although the transition from “hysterical cessation of digestion” to “nervous loss of
appetite” represented a step towards recognizing the psychological influence to anorexia, the mental component of the disorder was generally reduced to female hysteria (Bemporad 1997). Ernest Lasegue, another pioneering physician of anorexia nervosa, was in line with predominant theory of the time that anorexia was a symptomatic expression of female hysteria. In order to systematically tackle the issue of hysteria, he suggested (1873) deconstructing the “disease” into its symptomatic components:

   In my opinion we shall never succeed in composing the history of hysterical affections but by the separate study of each symptomatic group. After this preliminary analytical labour, we may collect the fragments, and from there reproduce the whole disease. Regarded in its entirety, hysteria has too many individual phenomena and hazardous incidents to allow of the particular being found in general. (265)

Lasegue’s approach, which was characteristic of the time, reveals the complex entanglement between medicine and psychology in Western discourse. Even before the treatment of anorexia as a psychological condition and the institutionalization of the field of psychology in the 20th century (which I will discuss later), we see that clinicians have attempted to compartmentalize symptom categories in order to piece together overarching disorder. Throughout history, self-starvation has consistently gained greater attention than binging and purging, whether it be medieval saints or hysterical housewives of the 19th century. In both examples, however, there is documentation of restriction, binging and purging. In Dr. Gull’s early case studies of anorexia nervosa, he wrote of his patients: “Occasionally for a day or two, the appetite was voracious” (Gull, 1874, 23). For the most part, however, early clinical observations mention this aspect “in passing” (Russell 1997, 14).

   In the first few decades after Gull coined anorexia nervosa, many specialists viewed anorexia as a subset of endocrine disease, since the two overlapped in symptoms. In 1914, German pathologist Morris Simmonds discovered the connection between a damaged pituitary
gland and cachexia – eventually termed Simmond’s disease. Advancements in the understanding and detection of endocrine diseases eventually allowed for the distinct differentiation between anorexia and Simmond’s disease (Hempworth 1999). Emphasis of the physical nature of anorexia remained popular, however, and, in 1952, anorexia nervosa was listed in the first publication of the DSM-I as a psycho-physiological disorder (APA 1952).

Following the formal recognition of anorexia nervosa as a distinct psychological disorder, different theories and perspectives arose to explain for its origins. Proponents of Freudian psychoanalysis framed the disorder as rejection of sex by preventing oneself from developing the physical curves associated with female sexuality. Others argued similarly that the disorder was caused by fear of pregnancy and motherhood. The psychodynamic approach, which branched off psychoanalysis, portrayed anorexia as a result of ineffective parenting. German psychoanalyst Hilda Bruch published her pivotal work *Eating Disorders* (1973) after several decades of treating patients with both restrictive and binging tendencies. She viewed anorexia and bulimia as inherently connected, stemming from similar issues with food and learning in early childhood. Bruch highlighted the importance of control in disordered eating, a concept that is nearly universal in contemporary eating disorder literature. Stressing early mother-child bonding, Bruch suggested that disordered eating could result in individuals whose mothers neglected their hunger signals in infancy. In this way, children may learn a sense of helplessness around food, thereby developing control issues when they are old enough to gain autonomy over their eating choices. She also argued that the use of food for positive reinforcement and/or negative punishment could disturb the process in which children learn to interpret feelings of hunger, fullness and satisfaction (Bruch 1973). For example, a child that is given a treat to quiet a
tantrum or withheld food for misbehaving may learn to associate food with emotions unrelated to physical hunger cues.

Bruch (1973) recognized that restricting and binging behaviors often coexist. This was not uncommon at the time, as bulimia nervosa was not yet classified as its own disorder. Binging and purging behaviors gained wider recognition by specialists during the early 20th century. A couple of the earliest cases in contemporary Western medicine include two separate accounts by French psychologist Pierre Janet and Swiss psychiatrist Ludwig Binswanger. Janet documented in 1903 that Nadia, an anorexic patient of his, exhibited a fear of fat and food restriction but would also sometimes eat large amounts in short periods of time. Around the same time, Binswanger oversaw the treatment of an anorexic patient named Ellen West. Like Nadia, Ellen was extremely afraid of becoming fat and would limit her consumption to stay thin. She experimented with weight loss methods, and for a long period of time she consumed excessive doses of laxatives daily. She also would eat large amounts of food and then throw them up afterwards. Ellen killed herself in 1921 at age 33 (Gordon 2000).

Binging and purging behaviors continued to expand in recognition after several studies reported considerable percentages of anorexic patients to engage in vomiting and/or binging at least some of the time. These studies brought greater attention to the subject of binge/purge behaviors, while recognizing the symptoms as part of anorexia nervosa (Waller, Kaufman & Duetsch 1940; Nemiah 1950; Bliss & Branch 1960). One researcher even declared, “anorexia nervosa should be considered, then, as not just the loss of appetite, but rather as a disturbance in eating” (Nemiah 1950, 266). British psychiatrist Gerald Russell also recognized binging and purging behaviors in anorexic patients, yet he advocated for a separate diagnostic classification of the symptoms. In 1979, he published his paper “Bulimia nervosa: an ominous variant of
anorexia nervosa,” coining the term bulimia. The very next year, bulimia was cataloged as its own disorder in the DSM-III (1980). In 1987, the term bulimia was extended to bulimia nervosa in the revised DSM-III (DSM-III-R) (Gordon 2000). The DSM-III was the first edition to incorporate a separate section for eating disorders.

In 1994, the fourth edition of the DSM was released with many more psychological disorders, including Eating Disorders Not Otherwise Specified (EDNOS). EDNOS was first established to integrate a separate category for those that didn’t quite fit anorexia or bulimia. This could pertain to both outlier and sub threshold cases. Binge eating in the absence of purging fell under EDNOS until the latest DSM-V published binge-eating disorder (BED) as a separate disorder in 2013.

Placing eating disorders into historical context demonstrates that the distinct diagnostic categories do not necessarily exist separately. Instead, they simply reflect the order of when specific behaviors were recognized. From the historical perspective, eating disorders can be mapped onto a metaphorical phylogenetic tree, in which they all stem from the same condition and each branch represents the point when newly discovered symptoms were classified into new disorders.

The timeline can explain for the superficial branching of disordered eating categories, but the underlying method guiding the disorder mapping process is a deeper reflection of biomedicine and Western ideology at large. The field of psychology in the US and Europe, in many ways, followed in the footsteps of its biomedical counterpart. By providing historical background of the institutionalization of psychology in the last one and a half centuries, I will now demonstrate that the “medicalization” of mental health was evident since its early stages.
CHAPTER 3

Diagnostic and Statistical Manual of Mental Disorders: A Brief History

There are countless different illness classification systems that have been developed throughout time and place; the DSM is but one of them. Aside from the tremendous variation that exists in how mental illness is recognized, defined and categorized, the intent behind the systems vary as well. The original purpose for labeling mental disorder in the United States was for statistical collection. The frequency of “insanity” was recorded for the first time in the 1840 census. Four years later, the first professional psychological organization was founded under the name Association of Medical Superintendents of American Institutions for the Insane (Grob 1985). (The organization went through a series of name changes and today is known as the American Psychiatric Association (APA).) By 1880, there were seven distinguished categories collected in census data, including dementia, dipsomania, epilepsy, mania, melancholia, monomania and paresis (National Committee for Mental Hygiene 1918). Towards the end of World War I, the APA began collecting numbers from psychiatric wards (Gorwitz 1974).

In the 1920s, the APA began developing a classification system that could be used to standardize the diagnosis of severely ill patients in psychiatric wards. Until then, the main activity of the APA remained to collect and analyze statistical data, but, at this time, its role expanded to clinical practice. The American Medical Association (AMA) had been leading the way towards a systematic approach at classification and diagnostic practices, and the APA intended for its mental disorders to be incorporated into the International Statistical
Classification of Diseases and Related Health Problems (ICD). The ICD-6 (1949) was the first edition to include a segment for mental illness. This was pushed heavily by the US Army, Navy and Veterans Administration, which had developed additional mental disorder categories to describe issues faced by returning World War II soldiers and veterans (Houts 2000).

The APA further modified the ICD-6’s mental illness section and, in 1952, published the first official manual of mental disorders for clinical practice: the DSM. A total of 106 mental disorders were included in the DSM-I. The manual totaled to 130 pages, of which included a glossary with short descriptions of each diagnostic category (APA 1952). The APA published the DSM-II in 1968, in coordination with the ICD-8. There were not many changes per say, but rather additions. The second edition of the DSM included 182 disorders. Although it added on 76 diagnostic categories, the manual was only four pages longer than the first edition (APA 1968).

Predominant psychiatric approaches of the time are apparent in the first two editions of the DSM, which were heavily influenced by psychodynamic and biological theory (Mayes & Horwitz 2005).

The DSM received a great deal of criticism for having very poor reliability as a diagnostic tool. The APA responded with an effort to expand diagnostic descriptions, using the ICD (by now maintained by the World Health Organization) as a measuring stick. The publishing of the DSM-III (1980) was again coordinated with the new edition of the ICD-9 (1979), and this time the language and structure was much more aligned with biomedicine (Rogler 1997). Similarly to the ICD, the DSM’s “categorical approach assumed each particular pattern of symptoms in a category reflected a particular underlying pathology” (Fadul 2015:140). The DSM-III was also designed, however, for target audiences of political and administrative background. The purpose behind this was to appeal (once again) to those in charge of gathering
statistical census data. Terminology borrowed psychodynamic psychotherapy was thereby omitted, and a new multiaxial scheme emerged, which would consider multiple modes of causality in the development of mental illness (Williams 1985). In this way, the underlying dogma of mental disorder classification became to outline diagnostic criteria that would (1) allow for the labeling, grouping and counting of the mentally ill, and (2) reflect underlying causation specific to each diagnostic division (Decker 2007).

After several years of drafting and testing, the third edition of the DSM was published in 1980. This version contained a whopping 265 number of diagnostic categories and stretched to 494 pages (APA 1980). The DSM-III elicited a polarized reaction, one that continues to permeate discussion on mental illness today. The manual effectively adopted a more scientific rigor that it was initially criticized for lacking, which quickly led to its pervasive use across the globe (Mayes & Horwitz 2005). On the other hand, however, the DSM-III advanced and solidified the trend towards biomedicalization of mental illness. APA members themselves have even expressed these opposing views. Robert Spitzer, chair of the APA during the development of the DSM-III, stated that “mental disorders are a subset of medical disorders” (Spitzer, Sheechy & Endicott 1997:4). In a 2007 interview, however, he famously recognized the issue of biomedicalization, saying: “What happened is that we made estimates of prevalence of mental disorders totally descriptively, without considering that many of these conditions might be normal reactions which are not really disorders. And that’s the problem. Because we were not looking at the context in which those conditions developed” (quoted in Davies 2016:3).

Efforts continued to standardize and medicalize mental illness with the drafting of the DSM-IV. It took six years and the combined work of over 1000 individuals. Teams were assigned to each diagnostic category, which worked together to conduct exhaustive literature
reviews and consulted with both clinical researchers and clinical practitioners. The developers again worked in conjunction with those of the ICD, assuring that the manual remain in line with medicine. The DSM-IV was finally published in 1994 with 297 disorders and 886 pages (APA 1994). Some disorders were omitted in the fourth edition, but many more were added. Diagnostic descriptions became lengthier, with greater detail and generally more conservative criteria (First 2010). The APA (1994) also included a formal definition of mental disorder:

Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. (1994)

In response to criticism, it also included a statement of the limitations:

Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder.’ The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations… There is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries. (1994)

Although these statements attempt to address the issue of medicalization, the system of classification remains the same. Each version of the DSM builds off of its predecessor, expanding the system without much change to its foundation. The development resembles a phylogenic tree: the original beliefs remain largely untouched, while new categories, greater in number, branch off the old ones. In response to complaints about the ever-increasing number of disorders, the David Kupfer, head of the DSM-5 planning committee, stated that the DSM-5 would not include more than the DSM-IV. The DSM-5 was published in 2013 with 947 pages (APA 2013). Although the number of listed disorders was strategically lowered, modifications in
diagnostic criteria expand lifetime mental illness prevalence to an estimated half of all Americans (Kessler et al. 2005).
CHAPTER 4

Review of the Anthropological Literature

Cross-cultural Relativity of the Thin Ideal

Past anthropological literature regarding EDs has generally focused on the cultural relativity of beauty standards and the diffusion of the Western thin ideal, as well as national ED prevalence in relation to patterns of globalization. Some scholars argue that attractiveness is relative and varies cross culturally (Dike 2009; Becker 2004; Brink 1995). Others presume that there are innate mechanisms that guide our perceptions of attractiveness (Rhodes 2006), which reflect inherited behaviors of intersexual selection (Rhodes, Simmons, & Peters 2005). The answer most likely falls between the two. There are similarities across cultures in how attractiveness is determined – universal traits that signal health and reproductive fitness. However, signaling traits vary widely depending on environmental pressures (e.g. higher body fat where there is substantial risk to starvation; lower body fat where there is substantial risk to obesity). Taking this into account, it is important to understand attractiveness as a dynamic conception that varies greatly between populations, rather than a collective measure that can be objectively quantified. Pamela Brink’s (1995) classic study on the fattening rooms of Nigeria, for example, demonstrated the range of body ideals around the world, in addition to the interplay of macro-level phenomena that contribute to these said ideals. This research provides a grounded base to ED inquiry, reminding us that the drive to lose weight is neither innately human nor culturally universal.
Arjun Appadurai (1990) traces the extent to which patterns of globalization affect the modern world. He suggests multiple routes of cultural diffusion, including mediascapes, which are dominated by hegemonic world powers. With the advent of Internet, mediascapes can now deliver graphic messages to the farthest corners of the earth. Cross-cultural studies have demonstrated the connection between increased rates of eating disorders and media. Anne Becker’s (2004) work in Fiji is a quintessential example, taking us one step further in understanding the influence of society and culture on disordered eating. She explored disordered eating among schoolgirls from the Nadroga province of Fiji, indicating that the skyrocketing rates directly followed the initial introduction of television to the region. Her site of interest is noteworthy because of its late introduction to television in 1995. Becker’s (2002) early ethnographic accounts suggest that beauty had been traditionally embodied by voluptuous curvatures. Dieting had been virtually nonexistent, and, prior to 1995, there was only one case of anorexia ever recorded. Becker and colleagues (2002) designed questionnaires on body image and eating habits, which they distributed to female adolescents in two separate waves: (1) within a month of initial TV use and (2) three years later in 1998. The most striking difference was that none of the participants reported purging behavior in 1995, but, in the second wave, 11.3% admitted purging and 69% had tried dieting to lose weight. Many girls even said that they wished to look more like actresses from their favorite TV shows (e.g. Beverly Hills, 90210). This study is foundational in establishing a direct link between media and body image. Heavy exposure to pop culture facilitates learned associations among slenderness, light skin and status. Almost every recorded case of an eating disorder reportedly coincides with low self-esteem, body image and dieting, so these factors cannot be ignored. Not only did this study successfully link the role of Western media with poor body image and disordered eating, but it also exemplified the extent
to which external hegemonic forces can alter such deeply rooted facets of culture.

Eileen Anderson-Fye (2004) has studied body image and overall mental health from a global perspective, notably in Belizean schoolgirls. After finding recurrent patterns, in which disorders have appeared in developing regions undergoing Westernization, Anderson-Fye focused on regions that demonstrated greater resistance. Relying on person-centered ethnography, she looks into the cultural mindset common amongst Belizean youth that protect against Western ideals and pressures. While Belizeans show outward appreciation for the female figure, they do not associate beauty with wealth or ethnicity. Furthermore, rather than focusing on size, they tend to value shape instead. These together have likely prevented a surge of eating disorders, common in regions like that of Fiji and other developing nations. When compared aside Becker’s (2004) work, we are reminded of the vast complexities of a disorder that lies across social and biological arrows of influence. Thus, it is often inadequate to determine any one causal factor or pattern, but, instead, we must accept that abstract cultural symbols are embodied behaviorally and therefore physically.

*Experience and Narrative*

Another way that culture is embodied is in the ways that cultural understandings of illness are implanted in individuals’ expressions of symptoms. Although most of Sigmund Freud’s work has by now been harshly scrutinized, it is still highly influential on contemporary discourse of mental health. João Biehl and Amy Moran-Thomas (2009) outline Freud’s take on symptoms, including (1) symptoms that are experienced similarly by patients with the same illness and (2) symptoms that are difficult to pinpoint – ones that are inexplicable, seemingly unrelated to the patient’s life history and misunderstood by psychoanalysis. He saw them as “another level of experience, reflecting, perhaps, a kind of universal culture” (Biehl & Moran-
Thomas 2009:268) – the “culture” of what it means to be human. The systematic study of abnormal psychology is rooted in the understanding that humans experience certain symptoms in response to specific ailments of the brain. Mark Nichter (2008) argues that this type of universal culture of human experience may in fact be a product of mimesis, in which inner expressions are paralleled with predominant cultural expressions. In other words, symptoms are not only conveyed as outcomes of pathological processes, but also as interactions with socially constructed modes of expression. The ways in which we communicate sickness are socially learned to a large degree, not to mention the very notion of sickness itself. Biehl and Moran-Thomas argue that Freud’s interpretation is overly simplistic for today’s standards because of his lack of attention to historical and cultural context.

The notion of experience is often employed because it more neutral than further-reaching concepts such as mind or self, but Robert Desjarlais (1994) argues that its use can also evade its underlying intricacy. It offers a base to which we can discuss other aspects of human life, yet the term itself is often overlooked and assumed as universal. The etymology of experience demonstrates that the definition has evolved to incorporate not only the examination of external phenomena, but also the subjective inner processes that occur in response to them.

Other anthropologists share similar viewpoints for examining the use of common terms in studying mental illness. Nichter (2008) explains narrative as an attempt to define oneself as the sum of experiences along the temporal range of one’s life. Although narratives are useful for telling stories, Nichter points out that they can also distort reality as just that: stories. He argues that narratives of specific illnesses are often pre-constructed within a cultural context and then incorporated into individual experience as building blocks for identity formation. Using Foucauldian discourse analysis, Elizabeth Eckermann (1997) suggests that psychological
treatment can actually reinforce disordered behaviors by altering patients’ understanding of themselves and embedding the diagnosis into their assembled identities. Susan Bordo (1988), among others, demonstrated the vast complexities, contradictions, and transformative qualities that exist within ED accounts, further suggesting that psychological treatment may trim down patients’ self-conceptualizations and realign them towards biomedical models of disease. Power dynamics between therapist and patient are certainly an essential piece of this discussion, but I argue that ED characters have become so prevalent in popular culture, that this phenomenon occurs both in and outside the therapeutic setting. The dissemination of ED models from psychology into everyday life is one area on which I focus my research. ED caricatures have not only reinforced biomedical definitions in a sort of positive feedback loop, but they have also contributed to modern-day subcultures of anorexia and bulimia.

**Redefining Disorder**

More recent literature has extended these types of critiques and opened up space for redefining EDs, sometimes attempting to forget past claims and look for new patterns. Megan Warin (2010), for example, interviewed individuals struggling with anorexia and searched for subjective meanings and interpretations of the label. She emphasized the surreptitious aspect of restrictive-related behaviors, demonstrating their ties to deeply personal, profoundly private features of self-identity. Richard O’Connor (2015) took a similar approach, interviewing ED participants and subsequently dividing them into relevant personality types. His three categories (performative disposition, ascetic disposition, and virtuous disposition) are evidently influenced by the historical symbolism of self-starvation and deprivation. O’Connor stressed the importance of contextualizing anorexia, suggesting that nesting it under pathology has contributed to a long history of misunderstanding. He argued that biomedicine’s application of Cartesian dualism in
differentiating mind from body, as well as individual from society, justifies the framing of anorexia as mental illness, as well as portraying the anorexic as abnormal. O’Connor’s work builds off Nancy Scheper-Hughes and Margaret Lock’s (1987) deconstruction of Cartesian dualism. They explain how viewing the body as a machine that functions independently and according to natural laws, biomedicine simultaneously simplifies disease as malfunction, dismisses emotion as peripheral, and disregards cultural context as irrelevant. Applying these concepts to the medicalization of mental health, it becomes clear how eating disorders have, in contemporary medicine, been similarly attributed to neurological dysfunction.

Rebecca Lester (2007) used a cross-cultural approach to critique the ways in which we define eating disordered. She interviewed and observed patients and practitioners in one eating disorder treatment center in Mexico City and one located in a small city in the American Midwest. Lester warns that countries outside the U.S. do not necessarily use the DSM in the ways expected of American professionals. While the biomedicine aims to standardize illness into comprehensive manuals, it is dangerous to assume that these devices will translate across borders. Lester reasons for a more ethnographic approach to diagnosis and treatment, thus bringing an open mind to every individual patient without the influence of predetermined “prototypes” (382). Taking a step back and focusing solely on American participants, I argue that similar issues apply within our own borders as well. In my own research I continue in this line of contextualizing and redefining disordered eating, but instead demonstrate how conventional definitions affect patients in a multitude of hidden ways.

**Biocultural Approach**

Rebecca Lester (1997) has similarly critiqued the medicalization of disordered eating, but she also identifies the fallbacks of critical feminist theory in re-contextualizing eating disorders,
arguing that it creates parallel dichotomies and limitations. Lester recognizes the feminist approach as a reaction towards the extreme and sometimes offensive views of biomedicine. Feminist theory objects to the biomedical view that disordered eating represents pathology within the individual, ignoring any context in which the individual is situated. It poses that the problem is with the context instead, in that the disordered eater is made sick by merely existing in a society that expects her to look and act a certain way. Although feminist scholars add worthy consideration to the understanding of the disorder, Lester points out that they leave us with an incomplete picture of the problem. Biomedicine points inward, while feminism points outward; it remains unclear how the inward and outward connect.

Daniel Lende and Greg Downey (2012) write about this gap between inner and outer—between biological and social—and the importance of this piece in understanding either. From a biocultural or, more specifically, neuroanthropological perspective, cultural practices that guide groups of individuals to behave in particular ways can lead to changes on the chemical level. Roepstorff, Niewohner and Beck (2010) similarly describe culture as “patterned practices,” embedded in neurological pathways. One example that Lende (2012) demonstrates is how poverty, quite literally, “poisons the brain” (183). For example, a child that grows up in an environment in which he or she faces chronic physical danger can lead to chronic elevated levels of stress hormones that hinder language skills and cognitive memory. Highlighting the ways in which limited access to basic commodities are expressed neurologically, he demonstrates how culture and human biology become intertwined.

The same can be said about Western ideals and eating disorders. Theoretical models from the field of psychology do underline the effect of “environmental effects,” but they identify these as separate from genes, hormones and neurotransmitters. Furthermore, the vast complexity that
exists among sociocultural influences is often lumped together into simply “media.” I argue that
the major reason psychology tends to shy away from deeper analysis is because it lacks the tools
to study abstract concepts that are challenging to quantify. Using Lende’s “poverty poisons the
brain” (183) model, I aim to provide the needed attention to sociocultural issues that are both
shared and varied among disordered eaters.
CHAPTER 5

Methods

Site and Sample

When I first started brainstorming how to get access to a population of disordered eaters, I thought the simplest way would be to volunteer or intern at a clinic, connect with the professionals and then propose my idea. I quickly found out, however, that it would be much more difficult than I expected. Options were limited to start out, as there were not many centers with a large staff or patient population. One office informed me that they had only two working practitioners, and several turned me down because they said they simply didn’t have enough work to create a volunteer position. After contacting every center in Tampa Bay that specialized in eating disorder treatment, I received a total of two volunteers. Both of these positions, however, would be in assisting with clinical studies, and I was told that I would not be allowed to interact with patients. I considered going down that path and figuring out how to get access later, but then I stumbled upon eating disorder support groups.

An online search informed me of Eating Disorders Anonymous (EDA), a network of anonymous support groups for disordered eaters with locations across the country (in addition to Europe, Australia and Africa). EDA is not a business, nor is it even an organization – in the traditional sense of the word. According to their website, EDA is a “fellowship of individuals who share their experience, strength and hope with each other that they may solve their common problems and help others to recover from their eating disorders” (Eating Disorders Anonymous 2017). The reason I say that EDA is not an organization is because the individual groups are only
connected via the website in order to provide meeting information for interested individuals. Those who are involved in running the site or starting new groups do not get paid and keep their identities anonymous. Attending meetings is completely free, and no registration is required. As the website states, the “only requirement for EDA membership is a desire to recover from an eating disorder” (2017). EDA was originally modeled after alcoholics anonymous (AA), and the structural dynamics and model of recovery are very similar. Like AA, EDA follows a 12-step program. Meetings are generally based on the EDA book, called *EDA Big Book*, and there is access to each chapter on the website. The basic premise of the book is admitting powerlessness over one’s disorder and thereby working towards balance, rather than abstinence.

Because the EDA welcomes sharing and open discussion, it aligned well with my research and there was no conflict of interest. The support groups were valuable for collecting data because they (1) offer free, non-committal resources and are therefore open to an array of disordered eaters regardless of medical insurance, socioeconomic status, etc., (2) do not have economic incentive and focus entirely on recovery without uneven power dynamics, (3) and they are loosely regulated and therefore did not present legal obstacles. This first point allowed me to use targeted sampling across a diverse range of diagnostic divisions. Rather than focusing on a specific group defined by diagnostic divisions, my target was broad. The individuals I encountered at support groups were unconfined by the wide range of barriers preventing them from clinical treatment, such as high or low clinical severity, financial issues or even stigma. This meant that I could access a group much more representative of the overall population of disordered eaters and not just the limited sample that make it to the clinic.

The total sample size for the study was 38 individuals, comprising of 34 individuals for participant observation (from five meetings), 8 individuals for focus groups and 10 individuals
for ethnographic interviews. The study sample included only adult participants from support groups for eating disorders in Boston, MA and Tampa, FL and excluded any individuals under the age of 18. I did not collect data pertaining to race or ethnicity, but I did record age and gender because of the potential biological significance. The study was not considered to be greater than minimal risk, and the only potential harm identified was potentially feeling uncomfortable or embarrassed at times. Although I did not provide monetary compensation, I offered a written summary of participants’ interviews in exchange for their time.

Recruitment

My methods included person-centered ethnographic interviews, focus groups, participant observation and autoethnography. Because the support groups are inherently anonymous, it was easy and simple to keep the data anonymous. I attended separate support groups for participant observation from those where I recruited interview and focus group participants. I found meeting times and locations for different groups listed on the EDA website (Eating Disorders Anonymous 2017). There was not much other information included, although there was contact information (either phone number or email) for each location. I contacted the listed information prior to attending in order to confirm – a good idea on my part, since I found out that one group listed online was no longer meeting in person. Most groups met at public or semipublic locations, such as churches or library meeting rooms.

For interview and focus group recruitment, I created flyers (see Appendix A) and left them in the support group locations prior to group meetings. The flyers provided brief details on the study, including a short blurb about the purpose, requirements for participation, my contact information (i.e. university email and personal phone number) and the IRB number. As shown in the flyer, I informed attendees that I am a researcher from the University of South Florida,
looking for willing participants to discuss their eating disorders. The flyer clearly stated that they could contact me at their will if they were interested in participating or simply wanted more information about the study. It also included the incentive, in which participants would receive a written narrative in exchange for participating in an interview.

Six individuals reached out to me (four via email and two via text) in response to my flyer. I briefly explained to them the purpose of my study and what participation would entail, in addition to answering any questions they had for me (e.g. privacy concerns). Four out of the six individuals that contacted me proceeded to participate. I arranged to meet with each at times and locations convenient for them – public locations, such as coffee shops and parks. I prepared a script for obtaining verbal informed consent (Appendix B), which I presented to participants upon meeting them. I made it clear that participation was completely optional and that they could withdraw at any point during the study. I also provided details about how I would keep all information confidential, such as replacing their real names with codes and pseudonyms. Each consented to both participation and recording, for which I used a free application on my tablet.

I also used snowball sampling to recruit more participants, in which I asked my participants to let other support group attendees know about my study. From this I was able to obtain six more participants. I followed the exact same procedure to explain the details of my study. The only difference was that two of these individuals were located farther away and opted to participate remotely. One I spoke with via telephone and one via Skype.

**Person-centered Ethnographic Interviews**

The majority of my data came from the one-on-one interviews. Person-centered ethnographic interviews, which are fundamental to the study of anthropology, aim to shift attention to the interviewees’ mindsets (Levy & Hollan 1998). I used a prepared set of six
questions to ask participants about their eating patterns, underlying thought processes and life
history (see Appendix C), and I followed up with probing inquiries to get deeper into matters of
relevance. Data collection was aimed at obtaining experiential evidence compatible for
comparison to top-down theoretical models from the field of psychology. The time frame of each
interview ranged anywhere from thirty minutes to an hour and thirty minutes. I asked for
permission to tape interviews with an audio-recorder application on my tablet, so that I could use
the recordings later on for data analysis. I used the audio recordings as my main source of data,
in addition to written notes that I took throughout the study. In order to keep confidentially, I
never asked for participants’ full names. I kept a password-locked Excel sheet with their first
names and contact information. I assigned identification numbers for each person and replaced
them with a pseudonym when writing up the results and analysis.

Focus Groups

I conducted a total of two focus groups, which lasted for approximately forty-five
minutes to an hour. Eight out of the ten total interviewees participated – three at the first group
and five at the second. Using a prepared set of three questions (Appendix D), I asked participants
how they defined disordered eating and how they fit into those definitions. The subject matter
was aimed at establishing the frameworks and discourses from which the participants perceive
disordered eating. This portion of the data collection was useful for getting participants to talk
about their perceptions of eating disorders in general, as opposed to their personal experiences.

Participant Observation

I attended five EDA meetings for participant observation, at three different locations.
Two locations I attended twice (although there were different attendees each time I joined). I
obtained a waiver of informed consent during the IRB process for support groups that I selected
for participant observation. I did not use an audio-recorder during meetings or collect anyone’s names. I did not introduce my study or myself as a researcher, rather I attended as an EDA-goer. Participant observation at group meetings involved no more than minimal risk to subjects, as it did not alter their experiences at the meetings in any way. Since they attend meetings to discuss their thoughts freely, my participation and observation constituted as normal. There were a few reasons for collecting this data without informed consent. First off, it allowed me to observe authentic support groups’ conversations. Secondly, it kept me from interrupting or intruding on the meetings. There may have been a number of participants, for example, that would not have felt comfortable otherwise, and it would have been unfair for me to take away from their EDA experience. Lastly, I wanted to participate in the groups as an insider attendee and not an outsider researcher. Actively observing and participating during EDA meetings was a significant component of my study. During this portion, I listened to individuals share intimate details of their disorders, actively discuss facets of ED behaviors, and learned firsthand about the atmosphere of anonymous support groups. Interacting with participants in a more natural setting added greater depth. It also gave me a chance to witness a form of alternative therapy, as opposed to what I would have seen in a clinic. It is important to note, however, that some participants had received some form of treatment during or prior to their attendance.

*Autoethnography*

Part of my autoethnographic data comes from my participation at EDA meetings, but I also set aside time to write about my own experiences with disordered eating. Similarly to the procedure I followed for focus group and interview questions, I touched upon the same topics that I covered with participants. Autoethnography was an important part of my study, as I could not ignore the fact that my personal experiences brought me to this subject in the first place. As
an anthropologist, it is essential to discuss positionality in relation to one’s work.

Acknowledging that my perspective is inherently intertwined with this literature is part of creating an honest and thoughtful piece of work.
CHAPTER 6

Results

Ethnographic evidence “consistently dies within the dominant conceptual paradigms of global health” (Biehl & Moran-Thomas 2009, 16). In biomedical discourse, ethnography is underscored as anecdotal and “has nowhere to live in the numerical counting of drugs delivered, in the recording of dire mortality statistics, and in the biased selectivity of randomized experiments” (16). Along those same lines, sociocultural factors are often dismissed within the biomedical literature because culture is thought to exist outside of the individual, as an intangible, unscientific presence. While there has been a shift to including more qualitative methods and data within the biomedical literature, a greater focus is still needed in many areas of research. Honing in on the connective channels between culture and biology will complement existing psychological literature. Validating how society and culture infiltrates human processes of learning, thinking, and behaving will demonstrate the importance of understanding these effects. Traditionally, anthropology has viewed culture as a byproduct of people coming together and developing their own systems of beliefs, behaviors and norms. In this way, culture can be described as some sort of abstract presence that exists at a level greater than the individual. It is for this very reason that the culture concept within anthropology is often incompatible with psychology, a field devoted to studying the human mind. In order to understand the effects of culture on human psychology, we need to reframe the concept of culture in a way that is compatible with psychological models. I offer that culture can be equated to the absorption and accumulation of external stimuli and incoming information to which a person is exposed. Under
this definition, culture is in need of analysis when it comes to understanding risk, development, and recovery of disordered eating. With the use of narrative telling, I hope to emphasize how much we can learn from individual experience. We all come to disordered eating habits from diverse paths, and we make sense of our disorders in ways that let them fit into our larger life stories. How we find meaning in our behavior is as significant as the behavior itself.

I found that people were very open to talking about personal issues during the interviews. Everyone that volunteered consented to being recorded, which was extremely helpful for collecting and analyzing data. All 10 interviewees opted for summaries of their interviews, which serve as the majority of the results chapter. The summaries are nearly identical to those that I gave to participants, except for the use of pseudonyms and the omission of some superfluous detail.

Amanda’s Story

It started in seventh grade. Her mom threatened to take her to a treatment program, so at that point she “pulled [her] act together” without being hospitalized. She later relapsed several times, including a couple times in high school, this past year, as well as this past summer: “I thought it was gone, but I’ve been fighting it still.” Back in seventh grade, Amanda was in the “kind of nerdy group.” She had the same group of friends all the way from preschool to seventh grade, when she decided to branch off and join the popular circle. She explains: “in the process of trying to fit in with different people who were hotter than I was, maybe I tried to sacrifice too much of myself.” She also felt that her new group of friends was skinnier than she was (even though they weren’t), so she had to change herself to measure up to them. One girl, in particular, Amanda found to be stunning. This girl knew it, and she spent a lot of energy making sure she
looked perfect: “she would, like, re-tie her sweatpants string if the bow wasn’t perfect, and she would always, like, spend 20 minutes re-straightening her already straight hair. And I guess I might have internalized some aspects of that… I felt people’s gaze on me more, so I felt more pressure because of that.”

Her mom has tried every approach possible to help Amanda: “she tried a gentle approach, she tried scaring me out of it by reading me the facts about, like, how I would die if this went on too long. And I don’t know, hearing those facts didn’t make me want to stop, it just made me upset about what I was doing because it wasn’t fully in my control. I mean, I don’t think that eating disorders are.” Amanda thinks her mom could tell from the very beginning: “I remember trying on shorts in the dressing room with her and then asking her for a smaller size because the size that always fit me was too big. And then she started bawling in the changing room – I’ll always remember that. I also remember my parents getting really upset if they ever heard me throwing up in the bathroom.”

She has noticed that the cycle is similar every time. It usually begins with restriction, and then the binging and purging come when she doesn’t restrict as much as she’d like. The disordered behaviors start out slowly and become increasingly severe until she has “negativity associated with 100%” of what she eats and drinks. She feels ok with drinking water to a certain extent, but even too much of that is off limits: “I’d to cut myself off from sustenance… It was definitely a self-harm thing. I mean, it was comparable to cutting or something because I thought ‘if I stop eating, I’ll literally wither away in to nothing. So, that was, like, my logic.” Amanda feels that her relapses are sparked by depressive periods, in which something or someone brings her down. This past semester, in particular, was the worst she’s ever been. “I feel in love with someone who was a physics grad student, and I’m a physics undergrad, and he was my TA, and
he had a girlfriend, but he still flirted with me. And I’ve never loved like I loved him. I kind of still love him. And he left to go to Maryland. And then from Maryland he’s gonna go across the country to, like, Oregon or something to go live with his girlfriend. And he gave me so much hope. Like, he really made me think that he was gonna choose me… When things were good I was fine, and then when things got bad, I got really bad. I had to go to the hospital – a psychiatric hospital for a while, and that was against my will.” She had been seeing a psychologist at the time, and Amanda told her she wanted to kill herself. Her psychologist subsequently forced her to be hospitalized against her will: “I’ve heard that having an eating disorder might link to a lack of control, and I’ve never had my autonomy stripped from me as it was at that time. And the whole time I was in the hospital, I was literally trapped.”

During her time in the hospital, they never addressed the eating disorder. Amanda doesn’t think they noticed much of her eating habits because the focus was on her depression. Additionally, Amanda told them she was vegan and wasn’t able to eat most of what was given to her. She explains that being vegan is unrelated to her eating disorder: “the guy who broke my heart – he was vegan. And the director of the observatory I teach at – because I’m doing astrophysics – they’re both vegan, and they’re the strongest influences in my life. And so I became vegan. And I’m also a human rights major, so it’s very much so for political reasons and my own personal wellbeing and animal rights.” Amanda also likes being vegan because it allows her to be more adventurous with her food choices. Instead of the regular pizza, burger, omelet, she gets creative with cooking. She likes cooking, and she especially loves baking.

Amanda has a boyfriend now. She’s not doing too much better though. Last week she threw up most days, but this week she has been able to cut it back. Although she recognizes that the onset of her disordered periods are in response to major negative events, she doesn’t
understand what causes these changes on a smaller scale. She notices when the relapse is over because she stops thinking about food constantly. “I think about food all the time,” she explains about her disordered eating phases. Sometimes she knows a binge is coming on, but other times she starts eating and can’t stop. The perceived health-value doesn’t matter when it comes to Amanda’s preferred foods for binging. She’ll even indulge on a whole bag of carrots or grapes – really anything, as long as it tastes good.

During restrictive periods, it’s a different story. When she lived in the dorms, it was much easier to restrict because she would often allow herself to visit the dining halls once or twice per day. On those days she would have no more than a few hundred calories. Not having easily accessible food in her dorm, as well as eating in front of a large group of students, was usually enough to keep Amanda from binging during that time. Amanda has been embarrassed to eat in front of others since long before her disordered eating first developed. “I never liked the word ‘chew’ or ‘taste’ or, like, ‘tongue,’ ‘savor.’ Like, those words just grossed me out, and I never liked cooking shows or the shows where people would critique the cooking. Just like, watching people eat on TV kinda grossed me out… then yesterday I got food at Clover with, um, someone who’s in my research group, and I was very nervous the entire time, and when I got there I got like, a chickpea falafel. Pretty good. But, it was like pretty wide and I, like, didn’t know what to do. I didn’t eat for almost five minutes, and then I just ate around it… If I’m interested in a boy, if I just start talking to someone, I always eat so much less, not even just when they’re there, but like, in general, and I don’t know why. Definitely, I’ll make sure to make it a point that they know that I’m only gonna eat, like, a piece of bread or something like that.” When asked if she associates eating with being fat, she hesitated at first and then responded that it depends on the food. “Healthy” foods, ones that she “would probably poop everything out,” could be ok, but the
foods that “stick with you” make her think about getting fat. “And I definitely associate, 100 percent, non-vegan foods with being fat… Like, if I see a hamburger, it just screams to me ‘clogged arteries and heart attack.’” Amanda likes how she looks the most when she’s at her thinnest – even when she’s “very underweight and [her] face looks sallow… It looked so beautiful to me. I got more attention, but I also wasn’t doing it just for the attention. I got more attention from everyone – people I was friends with, people I wasn’t friends with. People would comment on my pictures and be like ‘oh my god, you’re so skinny.’” She hasn’t been at her lowest in quite some time however: “I always feel my body, like, I always feel my hipbones to see if it’s back at that point and it never is.”

The only other person in Amanda’s family with disordered eating is her grandma, a vivacious woman in her mid-70s. She had health complications at birth, including fetal alcohol syndrome, which limited her growth significantly. For a long time, she wasn’t able to stomach much. Amanda’s mother told her that her grandmother had anorexia later in life. Amanda was the first grandchild born, and she helped her grandmother become happier. Now, in old age she seems to eat more, but she still has a weird relationship with food and “talks about food all the time. She’ll, like, reach for a third slice of pizza and give me a look like she’s a kid reaching for the candy jar. And it’s like – it’s, like, good for her that she’s eating, but she puts so much stress on food. She writes me weekly letters, and it’s like ‘I fed the boys this blah, blah, blah. I went out to eat with Lou, and I got this and I ate this much – can you believe it?’ She always wants to make it a point that she is not eating that much.”

“At many points in my life, I’ve been done with it. But then it’s only come back, and that’s made me think about it is a big part of my life and who I am. And definitely in social situations, I’m aware of what and how much everyone else is eating. I notice a lot of food-related
things that I think go over everyone else’s heads. It actively shapes – even if I’m not actively restricting – it actively shapes how I see the world… In a fucked up way, I kind of like that a little bit… A large part of me wishes I could stick with it, but another large part of me wishes that I could just go be 100 percent healthy and wholesome.”

Will’s Story

Will is 32 years old, and he started binge eating in his early teens: “It started from a pretty young age. When I would be upset or anything, I would choose food, and I would just find a lot of comfort in that, and I still do… it’s kind of like a feel-good for me. At times, I eat way, way, way more than I should – to the point of discomfort.” He’s has had a big appetite for as long as he can remember: “I feel like I’ve always eaten a lot, and I’ve always been a little – not fat, but a little chunky. And I can’t really remember when the binging started. Maybe it was a little gradual, but it’s really always up and down. Like, I notice that my weight is always up and down. I’ll have different size clothes – like, I have to have them at all times.”

He has always turned to food during stressful periods. His teenage years came with their own set of problems: “I think school was always really difficult for me. And then, like, coming out as gay was also a thing that played a role.” Will never liked school very much. He had some trouble with learning in the classroom environment, and he always felt as though he was trapped there. Because of this, Will developed a rebellious streak that lasted throughout his teen years and on. His parents sent him to a therapeutic boarding school, which was one of the major dark periods of his life. They thought it would be beneficial for him, but, unfortunately, he had the opposite experience: “They actually recently shut it down for child abuse, but, umm, it was in Oregon… It’s really solely based on therapy, and, I mean, you’re really young. I think the
earliest grade is like eighth or ninth grade, and you have intensive therapy – you have this thing called ‘life stuff,’ and you – it’s kind of confusing to explain – but it’s kind of like a series of group activities where you kind of go through your childhood and try to figure out when things started to get crazy. Picture like an hour-therapy session, but you live there full-time. They had a small academic part, but most of it was definitely therapy.” Will had a tough time there and found that the school’s motives were not at all aligned with the wellbeing of the students: “It was just a complete waste of money and time.” He believes that was when his eating habits started getting really bad: “I think that’s probably when it started because they had meal times and you could just eat as much as you wanted. I think a lot of those kids had eating problems. It’s just really weird thinking back on it. I think that’s when a lot of people – ‘cause I still talk to a lot of these people – and I think that’s where they developed a lot more issues. The school really messed people up. There are kids that even sued the school… The school was in the middle of – like, the closet town to the school was this town with like 50 people, and that was an hour away. Seriously, somebody needs to make a movie about this place. It was really crazy – it’s in, like, the middle of the forest, and we were way out there.” After graduating at 18, Will never went on to college. Because high school was a traumatic experience for him, he “didn’t want anything to do with school after that.”

In more recent years, his binge-eating has arisen from more adult stresses: “I used to work in Boston, and I live in Andover now, so when I would take the train there would be all sorts of food things in the train station. So, I would – if work was really difficult that day – I would always stop and just get, like, tons of food and then go home and then eat again. Usually if I’m working, I’ll eat a lot just because it’s really stressful.” Binging is generally a private event. He still eats a lot when he’s with company, but when Will engages in “full-out binging,” it isn’t
planned and he is generally alone. He knows it’s going to happen when he starts having the urges: “I remember the feelings, like on the subway on the way to North Station, and I would just be thinking about the food that I could get when I was there, and that was helping me, like, not feel like crap about my day… I’ve tried things to stop it, but it’s more like I just do it. There are times when I’ve tried not to, but if I have it in my mind it’s gonna happen.” Will can binge on pretty much anything, but he usually goes for foods that taste good and are easy to access: “I would say ice cream is huge for me. And really just like fast food – like McDonald’s-type stuff. I think because you can order a bunch of stuff and it’s fast.” Will normally eats regular meals at home with his family, so the binge episodes are on top of that. The frequency of his binges ranges, but at the worst times, he binges multiple times in a day. “At times I definitely feel like it’s out of my control. I feel like it’s almost like I’m addicted to drugs or something. I get a high off of it. It’s 100 percent about the full feeling… It depends on what the reasoning is that I’m eating it. Like, if I’m eating it just for – like, just for actual pleasure and to have a nice time, I can eat a small amount of it. But if I’m going for a different intention, like if I don’t feel well, then I’m going for the biggest thing that I can find.”

Will feels that he fits into the BED category. He has tried to restrict, but, for the most part, he is solely a binge eater. With regard to purging: “I’ve thought a lot about doing that, but I never did because I just don’t like throwing up. But, like, it’s weird – sometimes I do eat so much that it just happens naturally.” Being a binge eater is a big part of how Will sees himself, at least during the lower points in his life. “The thing that’s unfortunate is that when I’m working, I’m stressed out. So then I eat a lot, and then I gain, like, a ton of weight and then I feel uncomfortable even, like, working at all. And it just gets – and I just get either fired or I quit or whatever.” After gaining significant amounts of weight, he feels embarrassed going to work
because he doesn’t want to be judged. Currently, he’s in a somewhat “low place, but it’s been worse. I feel like, when I’m in my normal space – when I’m who I am regularly, I’m more active and I don’t eat as much. But it’s been a really long time; it’s been, like, years since I’ve felt like that… I recently moved back to Massachusetts, like, a few years ago, and I think since I left the place where I was – where I felt more comfortable being myself, now I just have a lot more anxiety.” When he is in a happy place, his eating habits follow suit, he sheds pounds and feels altogether better about himself. In that way, his eating behavior propels him forward. This goes for both high and low points.

Body image is definitely a big part as well: “If I’m not feeling good about the way that I look, I usually just eat until I can make myself feel better. Like, I don’t do it the other way around. Like, an anorexic would just stop eating, but I need – it’s almost like I’m addicted so I need food. And when I would start to get thinner, I would get kind of scared to eat – like I would freak out a little bit more about what I was eating. I remember that was more what I was like in Miami, but here I haven’t really been like that. If I’m active and I’m outside it’s a lot better. That’s why when winter comes around, it’s so bad for me. If I’m just stuck in the house or if it’s winter and I can’t go out, it’s really depressing.”

“In my opinion I think [the pressure] is on anybody, but I have a feeling that it’s probably more for women, just because I would assume that it’s really difficult to have to live up to all those standards. And I think guys have the same thing, but they just work out. Like, if they have that issue, they’ll be like those guys that are always in the gym.” In other words, there is pressure on both men and women, but the behaviors in which men engage to ease those pressures do not raise red flags.
Jolene’s Story

Jolene danced ballet for many years as a child. There was a lot of pressure to stay thin, and she suspects now that a lot of the girls had eating disorders. They never talked about that, but there was always an underlying competitive tone. At times, she recalls, they would compare with one another how many bones they could see. Jolene resorted to disordered eating sometime during middle school. “I happened to go through this, ya know, growth spurt, and all of a sudden I thought I was this huge cow. So I started, like, purging because I just wanted to be smaller.”

Growing up, Jolene recalls thinking that being thin was “just what you had to look like.” Seeing stick-thin models and celebrities on TV and being surrounded by tiny ballet dancers taught her to “get used to seeing those images makes you think that that’s what normal people look like. Although the dance teachers never told the girls to stay thin, the message was carried through in other ways. Auditions, for example, often had height and weight limits. Jolene explains a few possible reasons, particularly the issue with lifting partners that weighed too much. Additionally, the leotards were always tight and showed every bulge and fold. Once Jolene had her growth spurt, she was even more determined to lose weight so that she could compensate for her height.

Coming from a Chinese family, in which food was a central component, Jolene had to eat regularly with her parents. To get around this, she resorted to purging after meals. Jolene kept this up for several years. She describes herself then as “very unhealthy,” and often bloated with stomach pain from the purging. When she was 16, her secret got out when she collapsed due to dehydration. She went to the hospital and was diagnosed with bulimia. Jolene remembers that the doctor had to really push her to get treatment, “I don’t think I believed him. I was really angry, and I was just kind of like, ‘no, like, I don’t have a problem.’ Like, it’s not wrong to want to look
a certain way.” For two or three years following that incident, Jolene went to mandatory therapy sessions and saw a nutritionist that designed her meal plans. The first two or three months were the hardest because she to eat and keep it down, but at that point she couldn’t stomach much. When people tried to give her more, she would “either refuse or full out start crying... It got to the point where, obviously I don’t think it was really happening, but in my head I could feel myself getting fatter the more I ate. I felt like I was losing a huge part of my life and control of my body.” She went through a period at that time where she didn’t want to go outside because she knew her number on the scale was going up: “during that time, I genuinely thought that I was the ugliest person on the planet and that no one would want to talk to me… I thought food was the most evil thing on the planet.”

Although it’s been several years since Jolene went through treatment, she still feels that there are ups and downs. Some days she thinks about how easy it would be to eliminate food from her routine, whether it be through restriction or purging, but now she consciously recognizes that she can’t do that. She believes that the media and society at large is starting to expand the definition of what a normal female looks like, but unfortunately the earliest lessons from childhood never seem to go away. In college, she transitioned from fat-fear to health-consciousness. During that time, “everyone was going through health crazes, with, like, juice cleanses and stuff, so I was like, oh being healthy and eating all these lean foods are a big thing now and I wanted to do it too because it was, like, trendy. I was like maybe it won’t help me be stick-skinny, but it’ll get me to be, like, slim and toned.” Because this was shortly after Jolene went through recovery, she fell right into this other extreme: “exercise all the time and only eat, like, chicken breast and protein.” Looking back, she thinks she still had an unhealthy relationship
with food and that it was more of an obsession. She believes the problem isn’t simply that thin is the goal, but the wanting to be something that society says you have to be.

**Kat’s Story**

Kat is 24 years old. Her life seems to be going really well. She is in a happy marriage, she just bought a house, and she’s doing great in her career. She is doing life right. However, she’s also had disordered eating for almost 11 years. The last two years, in particular, have been worse than she could have ever predicted.

Her mother is also bulimic and was always open with Kat about her eating habits to an unwarranted degree. Kat is the oldest of five girls, and her mom exposed her to bulimia at the age of 9. In some ways, her mom used her as a therapist, but in other ways she used Kat because she liked to brag about it. She could “eat whatever she wanted and still be thin,” and she was proud of that. Her mom taught her that being thin is everything, drilling that into her head over and over again. Kat didn’t understand why her mom was “constantly making herself starve or puke,” except that she wanted to be thin. Kat was always a normal size – the most she ever weighed was 130 pounds at 5’4” – yet she was raised to always be concerned with her size.

Kat developed a cutting habit early on to deal with the emotional pain. She didn’t want anyone to know about the cutting, but she got caught once after wearing a bathing suit that exposed the scarring on her upper thighs. None of it is ever for attention. Her struggle is internal; her thoughts are kept hidden. Her best friend and her husband are the only people in the world that know about her eating disorder, and she doesn’t talk to her mom anymore because of how terrible she was.
Kat and her husband want to have a child, but she stopped menstruating and can’t get her situation under control. She’s afraid that her husband will leave her at some point because he so badly wants kids. But her eating is out of her control. She goes through periodic stretches of restriction and binge purging. Often it depends on how her day went. If she had a stressful day, she doesn’t want to eat at all. Sometimes she’ll even go a few days at a time. “If I can skip breakfast, I can go up to a week without eating barely anything. But I go to work at 4 in the morning, so there is breakfast usually there.” During binge trips, she’ll eat anything and everything – even healthy food. She’ll eat an entire watermelon. It’s about being filled to the brim with nourishment. Then it’s gone quicker than it entered, “I don’t wait. The last thing I eat, I’m in the bathroom eating it. Sometimes I’ll make an entire box of pasta and just put salt and pepper on it, and eat the entire thing... it doesn’t matter what it is but I want a large quantity of it... the more there is, the easier it is to come up again, so you can get all of it, as sick as that sounds.”

Previously binging and purging was just for the weekends, “It was like an occasion, it was exciting: oh, it’s Sunday and I can eat whatever I want, and eat a whole Domino’s pizza and not feel bad about it.” During the week she didn’t necessarily eat only healthy, but she would exercise excessively. In terms of Saturday and Sunday, she would want to sit on the couch and eat all day.

On the weekends she bartends and models part time, so being around a lot of other young people makes her want to be thin. At the bar she has to wear less clothing, and she is around other pretty girls, so she’s always questioning whether she looks good. She feels physically and mentally sick if she goes to the bar after she’s eaten anything. Even at her government job on the
weekdays, however, she’s still thinking about how the older men see her. In reality, she doesn’t think they actually care, but in her head they do.

She’s surprised sometimes that more people don’t notice. She gets really embarrassed if anyone makes a comment and does whatever she can to hide it. She works with all men, and no one really thinks anything of it. Her husband and her friend know they’re not allowed to talk about it or ask about it or give her any looks when she goes to the bathroom. It’s embarrassing. She does it because she “has to do it.” She tells them eventually she’ll figure out a way to control it, but for now if they bring it up, they’ll lose her trust and she’ll never be able to talk about it again.

In regards to her family and social life, Kat is the strong one. Kat wants to be like a mom for her sisters, so she hates the idea of having them check up on her or talk about her behind her back. She is selfless. She has let this secret take over her life for the last decade, trying to stay put together.

Maxine’s Story

Maxine has BED. The binging started November of 2014. Maxine explains, “I’ve always kind of been an over-eater because I like food, and I’ve always had a ravenous appetite, but that’s when I noticed that it was for reasons other than being hungry… I think I was really depressed, because, umm, about six months prior I had been diagnosed with epilepsy. Yeah, so, umm, I had been having lots of seizures, and I think it was partly the fact that I was not in school, I didn’t have a support group, I was isolated, I was spending lots of time with my grandmother who cooks a lot, and then that became a crutch for me – was to eat when I didn’t have that interaction or was depressed, and I just made a habit out of it. So, I can really pinpoint that –
going to live with my grandmother was the starting point.” It’s been a little over a year now since Maxine has had a seizure, and her epilepsy is under control. After moving in with her grandmother, Maxine started eating too much of the food she cooked: “She’s excellent at cooking. She cooked great food, and I loved it!” And then it progressed to getting or making her own food and secretly binging on that. It’s out in the open now, in that Maxine’s family and friends pretty much all know. This is because they’ve witnessed her over-eating. She tries not to showcase her disorder in front of others, but sometimes she can’t help it. If she doesn’t know a person very well, she generally won’t over-eat in front of them; but when it comes to her closest connections, they have all noticed it at some point or another.

Her eating habits are “a little worse when [she’s] alone.” Maxine believes that it’s the social interaction that keeps her from going into binging mode: “I don’t think it’s because I’m self-conscious about it. I think it’s because I have that interaction, and I’m – ya know – I’m maybe eating a little bit slower because I eat really, really quickly. But when you’re talking to someone and having lunch, it’s different… I live by myself now, and it’s a little bit harder. I have to really – it’s kind of a catch-22 – I don’t wanna have too much food in the house, but then if I don’t have something that I want, I’ll order out.” Her binges are generally unplanned, in that she starts eating and can’t stop: “I tell myself that I won’t – I try to tell myself that I’m not gonna eat, like, all of this, or I’m just gonna eat a normal portion. And then I start, and I kind of lose control a little bit.”

Since Maxine uses food to make her feel good, she mostly binges on comfort foods: “it’s especially Italian food. It’s probably just the starches, and sauce with all the sugar, and the cheese – breadsticks, lasagnas, spaghetti.” She’ll even eat a lot of salad if it tastes good, but generally her problem foods are salty and starchy: “I’m not a dessert person. I’m a salt person. I
have, like, low salt levels for some reason, and I crave it constantly. And I’ve tried, you know, even taking salt tablets just to get it up, but my salt levels are still low. I don’t know why but I do. My mom – I remember – when I was like seven, took me to the doctor because I kept craving salt. I would just want salt on everything, and she was afraid I was going to have an extremely high sodium level, but it was really low.” Maxine takes salt supplements now, but she still loves salty foods. She has also been diagnosed with Hashimoto’s thyroiditis, which runs in her family: “that’s when the doctor told me that I needed to cut my portions down because I can’t eat as much as normal people and still – even with the thyroid replacement – still maintain my weight. So they put me on a really restrictive diet at 700 calories a day when I was 11 years old, and that was probably needed but it really wasn’t by my own choice. I wanted to follow it – it wasn’t like my mom was like ‘you can’t eat this, you can’t eat that.’ But if I was going to eat something that had a lot of calories, she’d be like ‘oh, remember what Dr. Foley said.’ So, I followed that for about a year, and then I just couldn’t take it anymore – I was hungry all the time, I was grumpy.”

In the following years, Maxine was treated with hormones and eventually her levels were normalized. Although the disease can increase hunger, Maxine doesn’t think that it’s the culprit for her binges: “it can make you hungrier, I’m not sure if it does for me. Some people it does. I notice that sometimes if my thyroid levels get a little low – you can also take some other medications to help – sometimes, yeah, I won’t feel as full as quickly. That might have a tiny bit to do with it, but I don’t think that’s at the root of my binging.”

Maxine was ok with her body until that point when she started gaining weight at around age 11: “I started getting really puffy, and I remember this like it was yesterday – it was around the time – I was actually 12, and I, ya know, started my diet and was losing a little bit of weight, went to go visit my great grandfather, and he just kept telling me how fat I was and how bad I
looked. I mean, I know I was overweight, but I wasn’t, like, obese. So yeah, I felt really bad about myself then. And then when I was 13 – those were horrible years – umm, I don’t know, for some reason I lost lot of friends. I, like, wasn’t cool, or something like that. And so I started thinking, ‘oh it’s because I’m ugly or because I’m fat.’ I didn’t really – I didn’t, ya know, act on it – didn’t binge, wasn’t anorexic or anything like that. I just wasn’t happy with myself. It stayed the same until about, like, junior year of high school, when I think then I started feeling better about myself. My body kind of filled out a little bit more, I was curvier, and ya know I just naturally lost weight. I didn’t change anything, but I lost some weight, like baby fat kind of, and my hair turned lighter, so suddenly I was kind of pretty at that point, so I felt better about myself.” Up through college, Maxine’s confidence increased, her eating habits “were totally normal,” and she stayed in shape with exercise: “Especially my sophomore and junior year of college, I remember, I had, like, guys all thought I was attractive or whatever, and I had – I still have – the same boyfriend for four years. And, ya know, it was nice having people think you’re attractive, when eight years ago, people thought you were hideous.” She felt good about herself, she liked the way she looked, and she ate when she was hungry.

Maxine says, “Being a binge eater is part of who I am. I didn’t think of myself that way until – you know – until I kept telling myself ‘oh, I’m gonna change. I’m not gonna binge eat this, or I’m not gonna – I’m gonna stay away from this food.’ And I think it was about a year ago, I realized I’m – yeah, I’m like out of control. And that’s, like, when I started thinking that’s part of me. I don’t think it was a sudden realization. I think it was more like a gradual process, realizing that I’ve told myself so many times that I wasn’t gonna do this anymore.”

When Maxine binges, she normally eats “like six slices of pizza” or “a couple frozen single-serve lasagnas,” until she feels bad about what she’s doing and stops. Up until that point,
she feels like she can’t control herself: “when I’m eating like that I’ll feel horrible about myself, and eventually I’ll have to stop, and I’ll just, like, throw it all away.” The frequency varies, but currently Maxine binges once a day on most days. For the most part, Maxine fits into the BED category, but she has also experimented with compensating behaviors: “about a year ago – about that same time that I realized I was really out of control – I dabbled with making myself throw up, but I was like I can’t do this. I hate vomiting. It did make me feel better, like, less guilty, like ‘oh, ok. It’s only like I ate four slices.’ But I really couldn’t stand the throwing up ‘cause, like, I’d be on the floor, like, sobbing and sweating.” A short time before she “dabbled” with bulimia, she went through a short “anorexia phase.” During that period, she limited herself to 300 calories a day. She went on to Pro-Ana websites, where she learned tips and tricks: “I drank, like, a lot of water, and that’s what people suggested. A lot of people also suggested, ya know, having a picture of yourself. One of the things was to have a picture of yourself and to write on the back of it how disgusted you were with yourself and keep it with you. So I did that. I did not feel good about myself and I felt really sick, so I stopped. With the vomiting, it made me feel a little better afterwards, but not eating did not.”

Maxine’s mom has issues with eating as well. She’s clinically obese, and her weight has gone up and down a lot. Maxine sees a lot of similarities between their behaviors: “My mom is kinda like me – if she gets something, she needs to finish it. She doesn’t actively seek to binge, but her problem is if she gets food or she makes food, she can’t help but eat it.” From what Maxine’s grandmother has told her, her mom wasn’t like that until Maxine was a child. Her mom was always very petite – at 4’8” she used to weigh less than 90 pounds, but now she’s around 170.
Stress sparks binges often: “Mostly it’s stress. If I had a really bad day at work, and a lot of people were calling me and I go to lunch, then I’ll really binge because of that stress… and it’s counterintuitive. When I’m not feeling good about my body, or myself I eat more… You feel bad about yourself for not fitting into that, umm that thin type. But, umm I think the difference is you just give up on it, and you’re like ‘I can never be thin because I have this disorder, so why not make it worse?’ Why not just go ahead and eat if you’re never going to be thin?”

Out of her own volition, Maxine started seeing a therapist in January 2015: “I was seeing her once a week. I was going really regularly for about six months. Umm, she didn’t wanna talk about the eating a lot. She kinda wanted to go more into what was at the root of my anxiety, the roots of my depression. And then the eating, which is also really one of the roots of my anxiety and depression, we didn’t talk about so much. She acted like it was the anxiety and depression that was causing my eating, and that if we figured out what was causing the anxiety and depression then it would help with the binge eating. It really didn’t work for me, and I think – well maybe I didn’t go into it with as much of an open mind as I should have, like I was really concerned about the eating, which she didn’t seem to take, like, that seriously. ‘Cause I was a little bit thinner then too, and so she was like ‘oh, you look fine. Ya know, you don’t look overweight,’ and I’m like, ‘well, I’m gonna be soon!’ I do think that some of it [binging] comes from the anxiety and depression, but I also think that some of it is just, like, a habit. Like, a real, kinda, like, addiction. It’s still falling under a mental health, like, psychological problem, but I think a lot of it is the same problems that a lot of people, ya know, have with alcohol, but mine is with food. I think sometimes it is exacerbated by anxiety and depression, but I think it’s an addiction.”
Mabel’s Story

Mabel practiced gymnastics for many years. From a young age, she felt pressure to stay slim in order to succeed at the sport. At the ripe age of 12, her coach began limiting her caloric intake: “I was pretty much forced into anorexia because she, uh, wouldn’t let me eat anything, so I was basically dehydrated and malnourished. In that sport, you’re expecting to be really skinny all the time, so she would just tell me that I’m fat and wouldn’t let me eat anything. I think I ate probably a piece of dry toast for a whole day.” That was her last coach, whom she only stayed with for four months.

Mabel was the top gymnast in her group, so she had the most pressure upon her. The coach had recently moved to the US and was looking to make a name for herself, which is why Mabel believes the coach was so severe. At the time, Mabel was too young to fully recognize the faults in the coach’s behavior. It wasn’t until she fell ill a few months in that the situation was brought to light. Severely anemic, dehydrated, and deficient in several vitamins, Mabel received medical care and was told to stop gymnastics.

Mabel absorbed her coach’s words and believed them for many years. Mabel’s self-confidence was depleted, and she continued to restrict her eating long after quitting gymnastics: “I always looked at food as the enemy basically.” She believes that disordered eating is something that sticks with you: “I mean, I still struggle with normal eating habits, so I can’t say that it ever went back to normal. I’ll just go without eating. Like, I can go the whole day without eating almost anything, like not remember to eat or I’ll eat very tiny amounts. And I’m super conscious about, like, what I’m eating. Like, making sure I’m not eating anything too fattening. Or like, if I eat a little too much, I feel like I need to go exercise that second and make sure I don’t get fat from it.”
Mabel no longer does competitive gymnastics, but she coaches. “I’m always really supportive and never ever, ever, tell the girls that they’re fat or need to change anything like that.” She has seen a few therapists over the years and feels that “it helps to just talk about it.”

Mariel’s Story

Mariel was diagnosed with anorexia when she was about 10 years old. It was most severe throughout middle school, and she came close to being hospitalized a few times. At that point, she had to have weekly weigh-ins at the doctor’s and was supervised during school lunch, in which she had to eat at the nurse’s office. Mariel never received in-patient treatment; rather, she agreed with her doctor that if she lost more than a half-pound in one week, they would hospitalize her. That was a huge motivator for her. “I was definitely anorexic, but, like, I also had really severe anxiety, and so that played a big role, and that has, like, carried past the eating disorder. I’d say I’m a pretty type-A kind of person; like, I like to control things, and definitely worry a lot. But, like, I was first diagnosed around my eating disorder.” Mariel doesn’t consider her anxiety to lie at the root of her disordered eating, however. Instead, she believes that the culprit was medication: “this was around the time that I was diagnosed with Crohn’s disease, and so I was being hospitalized because of that, and part of the medication with severe autoimmune diseases is, um, Prednisone. Prednisone is a type of steroid that mimics cortisol, and so what happens with that is you get – when you’re on it for a long time at high doses, you can get symptoms similar to Cushing’s, so you tend to put on a lot of weight around the face, around the figure, and it’s a lot of stuff that was kind of stressful to see these sudden changes as someone who was only 10.” Because her medication made her initially gain weight, she responded by restricting her food intake.
The beginning is very fuzzy, as she was only 10 years old. She remembers that she stopped eating breakfast early on, since she never liked breakfast that much anyways. Then she would distract herself chatting with friends, so she soon started skipping lunches as well. She started looking at nutrition facts and stopped eating all foods with high fat content. “I was 10. I was unhappy with my appearance, and [restricting food] was, like, the only way I knew how to. I guess it’s like, when you’re, like, that young it’s kind of like the common thought processes that make sense. But when you’re older, it’s not quite the same, like, driving behaviors.” Because Mariel was so young at the time, she didn’t put much thought into her strategies for losing weight. Restricting any and all foods was her mode of choice.

“I kind of blacked out a lot of that time period. Like, I was also pretty depressed, and I had a lot of anxiety, so I just don’t remember those couple years very well. “I don’t really think that thing ever really goes away, but afterwards I wasn’t in danger anymore. Now, I definitely – probably – use food as, like, stress breaks. I don’t usually study while I’m eating, so I’ve kind of forced myself into a weird reward pattern with food, which I’m trying to break.”

Molly’s Story

“It started when – it was – it started slightly after I started getting into this routine and started to like, train myself on how to exercise and what form of exercise I liked and going to the gym regularly. Because it took me a while to get used exercising regularly cause I didn’t do that before, and uh, to use a gym and stuff. And it was also very like, weird because you had to be with people in the same place and exercise with them and like, not socialize with them. So, it took me a while to get used to going to the gym. And then a year after that – it was September and I had the wedding in December – I was like, ‘ok, now that I have gotten into this routine of
going to the gym and I know what to do,’ umm, I was like ‘ok, let’s set a goal. Because I have the wedding in December let’s set a goal that this is the weight and the measurements I have now, let’s have this by end of November.’ So when I set that goal I was like, really adamant about reaching that goal, and I was doing everything right. I was eating the right amount of food. And mind you, I used to do everything in the most healthiest way ‘cause I – before that I heard about people going on, like not eating anything, like restricting themselves to a point where they’re not eating, cleanses and stuff like that, and that’s not something I personally – and also with the fact that I studied so much biology, and like I was so much into health in general – that I knew it was bad for me, so I didn’t wanna subject myself to that ‘cause I knew it was just brainless. So, I started eating healthy, healthy, healthy, but, at some point – like, it was slightly before the end of November when I was like, really desperate that I was like, ‘ok, I’m almost there, but I’m not yet there so I’m very desperate to reach the goal’ and I’m like, ‘hmmm.’ And, I don’t know when exactly that seed was planted in my head, but I did hear something on TV or some person that oh, there’s like this – oh, I think there was some joke on some comedy that models throw up because they need to be of a certain weight and you could just eat, eat, eat and then eliminate it.”

Molly hadn’t heard of that anorexia or bulimia beforehand, as they are more well known in the States, “a lot of self-harming things that I have done in the past have mostly been because somewhere on television or through one friend – somebody mentioning it somewhere – and I think ‘oh my god, that’s the most fucked up thing and I’ll never do it,’ but that seed is still planted in my head and somewhere in my life after that I have found myself doing that… After my sister’s wedding, I gain half of that weight back because I stop throwing up. I feel like, the wedding’s over. Umm, I can – not that I want to at that point – ‘cause I went into the exercise
thing keeping in mind that this is not a short-term solution. It’s something that I have to make a lifestyle of. So, umm, exercising is not something that you are doing to keep weight off, but you’re keeping yourself healthy, umm, ’cause at that point I had read so much like when I got started with all of that I did research on it, so I did research on—oh, how much weight lifting helps women stay off osteoporosis? Umm, keeps their joints healthy, bone density, dadadadada. I used to take supplements and oh my god, I was – I was like, pretty much – not obsessed, but a good thing I gained was awareness of what I was doing and why I was doing it and how it was affecting my body. So, all of that. But then after that, I feel like the restriction thing became a little low, and that no, no, no voice in my head became a little less frequent after my sister’s wedding because I was like, ‘ok, let’s just be a little less restrictive but continue exercising, continue being healthy. So I gained – I think – one third of the weight back, which was fine with me. I was fine. But at some point, I was like, ‘ok, no I’m pretty much being very irregular with my gym-ing, so I’m not – I’m not trying to reverse this, so I have to get back to the gym. So it’s been like – the whole journey that I’ve been through up until this has been kind of this up and down thing, sort of realizing the fact that it’s not just the exercising, it’s also the food. And now I realize that it’s not just exercising, not just food, it’s also about your mental state. It’s also about how happy you feel about your body, how, like, emotionally connected and good you feel about your body in general. When I feel good about my body, I do it less, I eat better, and, at that point, I’m exercising, but I’m not doing it to lose weight – I’m doing it because I feel stronger. It’s more of an emotional need. At this point, it’s definitely as much of an emotional need as much as it is, umm, to keep my weight steady or to lower my weight. It’s – it’s the emotional thing to keep myself working well, studying well, getting good grades, being – still being socialize-able,
still being social enough to have friends, being in relationships, going out, and do good in other parts of life.”

The span before her sister’s wedding was the initial period of Molly’s disordered eating, and she’s had many ups and downs since then: “I don’t know if I’ve had a worst time, but I’ve had, like, cycles. Like, you know, cycles of being very good and then being very bad, and then when I’m being really bad I realize that ‘oh, all this time, I didn’t realize that this was also a thing that I didn’t know was really important to understand. So, slowly, slowly, slowly, every time I’ve gone down the path of self destruction, I have realized that – I have picked myself up and I’ve thought that, ‘ok, fine, whatever. I have harmed myself,’ but I think of what else do you have to do to have this be less frequent. And that’s when I realize that, ‘ok, I need to know more about nutrition.’ So I add that part and do more research, not just about exercise, but about food and what helps me where, and then at some point, when I go back down, I realize that ok, this is more of an actual need as well in order to work well. So it’s like a very – my whole life has been like a self-help book sort of a thing, as boring as that sounds, I feel very like, good even if it’s been shitty small sessions, but I think overall the result of it has made me be more aware, more self-aware and knowing my needs.”

The cycles that Molly goes through generally last about three days: “Then I start to look really bad, so I’m like ok – you know how your face starts to look really bad after a while, like you – ‘cause I like to look a certain way and if I’m looking – I hate looking tired. That’s something that I hate looking. I feel like I always try to look awake and sharp, and if I’m not up to that standard then I feel like, no, I need to get more sleep or I need to eat better, I need to do things that will help me to look that way, and it’s more of like a self-image sort of a thing, which I feel like anybody has. Umm, but yeah so when that starts to get affected – when I start to look
tired in general and I start to like – and I’ve realized that when it’s like the third day or something I start to water more often and I just feel bad and my skin gets dry, because like, the minerals in your body and your electrolytes are really imbalanced because you’re throwing up and you’re losing water, so yeah. That’s when I’m like ok, no. No more. I like, come to my senses at that point… It usually starts with once a day. Very rarely, it’s been twice. But, it’s also physiologically impossible to throw up one after the other, like I feel like it doesn’t happen… I feel like the trigger is not actually the food. It’s been sometimes like, oh my god I want wings, but that’s actually not the real reason I want the wings. The real reason I want the wings is because I feel like I want to be in this little hole where I’m doing nothing and thinking about nothing but eating yummy wings, so that’s – it’s usually been an emotional trigger. And I feel like my anxiety has usually been the trigger. Umm, depression leads to the anxiety and then the anxiety is what leads to me thinking I want to be in a hole, I want to not think about anything else because I am literally not able to breathe right now because so many things are overwhelming me, and so I need to be thinking about eating something while I’m eating it.”

Molly is very close with her older sister, and she spent the summer living at her home. At her sister’s house, Molly was very careful to keep her disordered eating hidden. She believes her sister doesn’t know, or, if she does not, doesn’t want to bring it up. Her sister tends to push serious things aside, while Molly has a very different approach: “I cannot ignore my messy stuff. I need to go through it, understand it, have a whole sit-down session with it, and then come out the other way completely – I don’t know – completely or partially somehow healed. Umm, and somehow knowing what happened to me… Afterwards I have this whole emotional breakdown because I feel that I did something bad to myself, ‘cause otherwise I do things to keep myself healthy. Because, I feel like – because of the fact that as a teenager I had bad self-esteem, after a
certain point with the whole transition thing when I was 18, I was like, at that point, I sort of made this deal with myself that ok, I cannot do things that will – that are insulting to my body because my body doesn’t like – my body doesn’t deserve it. It doesn’t deserve it. ‘Cause my body compared to so many other people who are disabled, who are like, disabled without them doing anything, I am born a healthy person, I am able to do so many things successfully. I am able to achieve goals that I want to set for myself, and if I am able to do that, and if my body can do that, I need to respect my body… So when I don’t do that for that small amount of time, I feel guilty for myself. So that emotional breakdown session – when I’m just bad because of the fact that I did those things – for like a night, and then the next day I’m like a new person. Like, almost, like something you’d see in a movie, when you come out like, wearing really good clothes and going for a workout and having a good workout and finishing your work on time, so it’s like very ‘woo,’ you’re back on track sort of a thing, which is good, but I feel like over time I need to make sure that my frequency goes down. And the rest of the time I don’t think about it at all, I’m just thinking about what’s healthy.”

Having an eating disorder has made Molly much more aware of what she eats: “I would say it’s changed my relationship with food in a good way. It’s changed in a way that I know what’s healthy for me, and I can make decisions according to umm – not that much connected to my relationship with food, but I would if anything it’s made it better because I know what’s good for me and what’s not and umm, I’m more aware of things and have done more research. I know at any time that I have roughly this much more to eat today, so I should have this one good meal right now, like usually I don’t end up eating lunch a lot of days and so I go back home and eat a good full meal that I feel satisfies all my nutritional needs. I am still within my calorie limit, so I’m fine. So, one of the gyms that I was at had this whole thing of calculating my BMI, my
metabolic rate and everything, and amount of exercise, amount I burn, and my muscle mass, and, according to that, how much I should be eating. So, according to that, and according to the heaviness of my exercise, and frequency of my exercise, I should be eating 1,200 or 1,300 calories. It has to do with the quantity I eat, because I try to keep my portion sizes in a certain way, so I don’t – ‘cause that’s what I have noticed, like earlier, as a kid, I was conditioned to eating to larger portion sizes. Umm, and my parents would be happy to feed me because her first kid, my sister, was one of those kids who wouldn’t eat at all, because I ate, my parents would feed me more and eventually my portion size became huge and I wanted to eat and eat, so that’s when I realized it was bad, and I needed to understand that – and it’s more of like, a body thing, like you have to train your body to feel full after a certain amount.”

“I wasn’t overweight as a kid. I’ve, in fact, never been overweight in any way, I’ve just been – pretty much almost if I gained five more kg’s or 10 more kg’s I’ll become overweight, so almost there. The one good thing is I realized – came to a good realization at a good point in my life – if I would have continued on the same path, it would have been much more destructive. Like, people you see now that are much older and very obese and have like, heart problems, ya know… My body has changed a lot since I have started to regularly exercise, it’s changed a lot in terms of stamina, in terms of shape, the way I feel, I look, my skin – like, I had dermatitis issues. My dermatitis has – touch wood – gone. Like, I think that was one of the reasons, it was stress that had no release and was coming out in my skin. When I started exercising, that helped my stress.”

“It’s almost like having an alcohol addiction, right – it’s like you count the days that you are not drinking anymore, but there will be one day that like, you are just out of control, and you...
just tell the world to fuck off, and you drink, and then you’re able to get that [AA token], and then you lose it, so it’s almost like that. It’s very much like that.”

What is an addiction, really? It’s something that is triggered by some other need, isn’t it? It’s why do you want to overdrink alcohol? Because you are – one reason could be you are too overwhelmed and you want to numb your senses, so you feel that’s a solution. So you drink, drink, drink until you become numb and then slowly your threshold becomes higher, and you drink more, more, more and eventually you become an addict. So I feel that’s addiction for some people. For me, it’s more of a triggered thing than a thing I’m doing to help myself. It’s also a thing I’m doing to help myself, but that comes after the fact that it’s more bodily triggered. It’s more something that I’m not – I would feel differently if I was like, smoking ‘cause for smoking I can get the money to go buy it, go buy it and then smoke, smoke, smoke until my lungs are collapsing, but for bulimia, it’s more of a bodily response because I’m anxious, anxious, anxious, and then I can’t – I feel like oh my god the world’s gonna explode if I don’t get this food out of myself right now because I feel like this is not right. Or maybe there’s part of me that doesn’t want to call it an addiction. I think that might be part of it too.” Molly feels that she would never rely on substances, other than food, as she believes that is like “saying fuck you to your body.” At the same time, it seems simple to just stay away from unnatural and unhealthy substances – “It’s harder to stay away from it when it’s just me and that is like, so easy to do. Also when you like, from inside – when you feel that your stomach cannot be holding this food, that’s when it’s like, maddening. It’s like – it, I mean—it’s gets that bad. It doesn’t get that bad that much – the way I’m describing it, but there have been times.”

Molly has thought about seeking help, but she has never gone through with it. A big part of the reason is because she feels like she needs to figure it out herself, “even with exercising, I
hate having somebody give me instructions. I feel like when I learn something on my own, I’m able to schedule it better with the rest of my life. If I have a personal trainer training me on how to exercise, I will not do it. ‘Cause I hate someone standing on my head and instructing me on how to do it. That’s when my ego kicks in. ‘Cause like, there’s also like this – yes, I feel like a therapist will help you with an issue, but that person can help you only to a certain point, also, umm, for example, if I’m seeking a therapist’s help for depression, a lot of times the stuff I’m verbalizing – yes, they’re true, but there are a lot of other things in your head that a lot of the times you cannot verbalize, so, in a way I feel like it’s pointless because the therapist is not in my brain to actually know what’s in my brain. I feel like even if I’m verbalizing, that therapist may not actually be able to help me the right way. Yes, 99.9 percent of the way, that therapist can help me and knows what that person is doing because that person has studied and has a degree, but I feel like, not everybody can. Like, I feel like very few people are that good, umm, from personal experiences, like, I just know that ok, you can – also, like, the way that I know the education system works, you can get a degree and be a therapist and you can be a counselor and you can have a PhD and multiple PhD’s, but not everybody’s as good and I feel like – also, I don’t wanna like, spend money on that because I don’t have the capacity to. So, I always try to find ways and things that I can learn through material and do it myself. So, I think I can get over it myself over time – trial and error. ‘Cause if I have someone telling me what to do, I’ll mostly spend time thinking that person is stupid or just wrong or doesn’t know me enough… Focus groups seem like a thing that I could potentially do, but right now, I feel like I just don’t have the time. Like, I feel like I could go, but, at the same time, I can also spend that time like, actually working, studying, and I can help myself – ya know, on my own time. Like, when I am not – when I am in a bad place, I give myself time. Like, I – I take time out and I stay at home or I just,
I do something that’s only with me. I don’t talk to anybody, just watch a movie by myself, or I cry. But whatever – I know what I need to do.

Molly believes that she would have developed bulimia regardless of her sister’s wedding: “Mm, I think it would have still developed eventually. That was a trigger that put pressure on me to act that way, but at some point, I would definitely I think [develop bulimia] because I’m growing more – I’m growing up more, I’m looking at more like, pop-culture, I’m trying to like – I’m hearing about more bulimia, and now that the world’s becoming more open mental health and eating disorders I’m hearing more about it so I’ll eventually do it.” She believes that the thin ideal is at the root of her disorder, however: “it started out with the need to be thin. That’s the original cause. Now it’s turned out to be more of an emotional trigger, anxiety trigger, but yeah.”

Molly believes that in order to recover from disordered eating, one must understand the disorder. She feels she is already on the path to recovery: “I understand it better now. And, like I said, to have a solution to a problem, I’ve usually seen that I need to understand and label it, read more about it, understand what it does to my body, both biologically, emotionally, in all ways. So, because I am in that phase – understanding phase, I feel that I am already towards finding the solution, and I’ve sort of done trial and error on solutions, so I already have certain solutions that work for me. Umm, like I said, like the working out thing I feel like, ok, now it’s going to do bad things to my stomach so let’s just wait, get up early, go work out, and feel good about that. So yes, solutions are there. So if I use those solutions more often, then the frequency will become less and the solution is on its way.”
**Ronda’s Story**

Ronda is not exactly sure when she developed disordered eating, but she thinks it started getting really severe when she was in middle school. She had leg surgery and wasn’t able to exercise for a long period of time, so she started worrying more about the possibility of gaining weight. Then she went on the South Beach diet with her mom (cutting off carbs), and they competed about who could be the better eater. From there, it continued to get worse.

At the same time, however, Ronda believes she would have developed disordered eating either way. Even before her leg surgery, she started skipping lunch at school. She recalls when she really young, “maybe like 8 or 9 or something, I was always afraid of, like, fat people, and I didn’t want them to touch me and I didn’t want to eat what they were eating, just out of fear of being, like, fat.” She believes this feeling started at a very young age because, even by first grade, girls at school would engage in ‘fat talk.’ It was “common knowledge that girls didn’t wanna be fat.” She thinks it started even before girls were trying to impress the boys, and that it was more about competition. To Ronda, it was about being “proud of yourself. To be the girl that other girls would say had the nice body.” She was always very observant of what other people ate, making she was always ate less than they did. Additionally, there is an extreme preoccupation with weight and appearance in the women on her mom’s side of the family. She never knew her eating habits were unhealthy until her diagnosis. Her mom started noticing that she seemed down, so she sent her to a psychologist; it was then that she was diagnosed with anorexia. She remembers blushing at the time, feeling strange being told that she had a serious problem: “I kind of felt stupid for, umm, letting that happen.” Although Ronda didn’t quite know that her eating was disordered, she wasn’t very surprised either.
On a normal day Ronda would try to not eat anything until 3 o’clock, when she got home from school. Her friends didn’t notice, or at least didn’t say anything, because Ronda hadn’t eaten lunch at school for a long time. When she did eat, Ronda would have kosher meat – turkey, chicken, roast beef, eggs, and certain vegetables. She wouldn’t eat fruit because of the high sugar content, or certain starchy vegetables – peas, carrots, corn, etc. She ate a lot of soup, but she would pick out all the noodles first, of course. She also drank a lot of coffee to curb her appetite.

At times, Ronda also engaged in binge-purge behaviors. Her first major bout of anorexia included small spurts of bulimia/BED, and the second time they were a little more frequent. During the second time, when she relapsed, she would eat an entire just of honey or entire jar of peanut butter. She remembers: “one time I bought a cake from Shaw’s, and I ate the whole thing. But when these events would happen, it was almost like, kind of fun or something. I didn’t feel guilty when this happened because I knew I had really good self-control all other times, and I felt good that I could eat an entire cake and still be skinny.” During another “cake incident,” she was with two other friends, and they were all eating cake: “normally I would have never eaten that, but I was doing it just to show that I could – I knew that I could. I felt like it wasn’t going to affect my body the way that it was going to affect their bodies. I could restrict the next day.” This is why she never felt guilty after eating during the first anorexia phase: “I was really good at restricting.” At that time, the binges were always a type of reward, when she was celebrating or feeling carefree.

During the second phase it was a little different. She relapsed when she was 21 years of age, almost eight years later. In between she gained back the weight necessary to keep her doctors happy, but she “never went back to normal eating thoughts.” She believes that recovery
is learning that you have to eat to live, and that eating should be enjoyable. She has come a long way but still has fear of getting fat.

For treatment the first time, she saw a therapist, a nutritionist, and had an inpatient stay at a hospital for a week. “I didn’t really consider any of that helpful. Like, I would not really listen to them, or I might lie to them. I thought it was boring. I did so I wouldn’t be difficult for my mom, but I didn’t really consider it helpful. During the second time, she only saw a therapist. It had started getting bad the summer before she went back to college, but once she returned to her normal school routine, “it naturally got a little better.” Seeing the therapist during this time was more helpful: “I don’t think I give her enough credit, but I do think it helped.” She felt that focusing on the negative thoughts, instead of just the unhealthy eating behaviors was beneficial to her recovery path. She didn’t like following diet plans or keeping a food diary, especially, because it made her think even more about the food. What she found to work was getting rid of the fear of fat, being realistic about what would and wouldn’t make her fat, and building up her confidence in other areas of life. She thinks that the negative thoughts always stick with you to some degree, but she also knows that she’s at a weight with which she would have never previously been satisfied and she likes it. She likes her body now, despite not being able to fit into any of her old clothes. She has learned to accept it, especially because she “still restricts. But it just doesn’t work as well as it used to.”

“I do not think it relates to guys directly. Maybe indirectly, I mean back then I would consider myself pretty vain, ya know, I wanted to be attractive and I wanted to attract guys, but I didn’t directly think that I wanted to be skinny so that I was attractive to guys. Also, being in a relationship when I was dating a guy that was an asshole didn’t really affect my eating at all, but my current boyfriend makes sure that I eat, and I do eat more with him.” Her relationship with
food is a work in progress. Learning to cook has helped. It’s not 100 percent, but she now considers herself a healthy eater.

She doesn’t believe the media is fully to blame because “it’s hard to be thin, and it takes a lot of effort. So, naturally there is always competition among girls.” If it wasn’t considered beautiful to be thin, she thinks eating disorders would be rare or nonexistent. If that were the case, she doesn’t think she would have developed an eating disorder. She still thinks, however, that there is something “unfriendly in [her] brain” that would have made it “come out somehow,” through depression or something related.

Sharon’s Story

“I think I’m mostly bulimic. Binging has been more of an issue in the last couple years. I think sometimes you fall in either category, and sometimes you fall all over the place.”

“It started when I was 14. I lost my dad, and that was the only thing that I could control. You know, the thing with binging is you skip over the enjoyment. It goes straight to the compulsive. Like, I don’t even enjoy what I’m doing or what I’m eating.

Sharon started dancing at a very young age, and by the time she was in fifth grade she was a professional ballerina. When she began dancing professionally, it got worse: “It was always in private. It was always, like, the water running. No one knew. Because, ya know, when you’re anorexic you’re skin and bones, but when you’re bulimic, you’re – you can pass for health. It was always, like, when my parents were at my brother’s hockey games or something, and that was when I would order a bunch of food.”

She got severe with binging again when she went to college at Florida State University, when she was “partying a lot and not eating.” She would try to restrict, but end up binging in
between stretches of not eating: “It started out maybe once a day and then went up to three times. But nothing was in my system – I mean, I’d go to class and have, like, a coffee and a Snickers bar.”

Sharon is 31 years old now and has relapses all the time. Sharon believes that triggers may be both inner (emotion) and outer (food). As she gets older, however, it seems to be more about the habit than the food itself. Striving to be thin has always been the biggest driver for Sharon to restrict her caloric intake. And ballet only made things worse: “everyone talked about [being skinny]. It’s mostly the teachers. They weigh you and stuff… There were some teachers that would give out pills… It shouldn’t be like that. They don’t know what they’re doing – they’re destroying their self-esteem, and these little girls just wanna dance.” When Sharon was at her lowest weight, her family members intervened: “My aunt was watching. When I had dinner with her family, she wouldn’t even let me go to the bathroom without watching me.” Her aunt’s skeptical eyes didn’t make a difference to Sharon’s eating disorder: “once you get that mindset, you’re gonna do it.”

Sharon describes her eating patterns as “all over the place… I don’t eat meals. Umm, I don’t eat breakfast, I’ll maybe eat lunch, but then, like, and I won’t eat dinner. It’s not, like, restricting – it’s just like, I’m maybe just not feeling it.” She explains that she doesn’t necessarily refrain from food all day, but instead will eat sporadically without set meal times. Although she is not opposed against the structured component of meals, she prefers to eat by herself and on her own time: “I don’t like sitting down and eating with people. I just feel like people are watching me. I don’t like it. I usually bring it to my room – isn’t that sad?”

Many of her friends and family know about it, but they don’t discuss it much. Her fiancé knows as well, but he’s “grossed out. He’s like ‘I don’t understand,’ and I’m like, ‘ok, well
people put needles in their arms, ya know? And stuff things up their noses [chuckles] – you know what I mean?”

“I can’t be like 40 and be bulimic.” Being a disordered eater is part of Sharon’s personal identity: “I won’t say I’m bulimic, but I say I have eating issues, and I’ve always had eating issues… I feel like a freak. I mean if you tell someone you have an eating disorder, they’re not gonna be like ‘oh that sucks.’ They’re gonna wanna know more and more. Ya know? I really don’t open up. I see it as an addiction… It’s like an impulse. That’s the best word to describe it. It’s totally out of my control. I have resisted, but only once or twice [successfully]… It’s almost as if my mind isn’t thinking. It’s not thinking this is so bad for you – it’s just like ‘get this out.’”

There have been periods when Sharon has had milder disordered eating. These periods have usually occurred after more severe periods, in which she’s been able to “scare” herself into healthier eating habits. Another effective mode has been “hearing stories. My mom has colleagues at work who – one woman – her daughter’s in a really bad place, and they spent like 20 grand on her teeth. Stuff like that just really freaks me out and resonates with me.” After listening to her mom’s story about this girl, Sharon went from binging and purging to just binging. Her mom also makes lots of passive-aggressive comments about Sharon’s eating habits, even in front of her siblings: “She’s just trying to be a bitch [laughs]. Ya know, like, if she’s mad at me, she’ll be like ‘why don’t you just go binge – go binge on a bunch of crap.’ She’ll just make comments, like ‘the room smells like vomit.’ She’s like all organic and crap, and I don’t think she means it, but that’s, like, all she has on me, ya know. So, I don’t know. She’s never offered to get me help or treatment. She’s more concerned about, like drinking, and, like, I almost never drink.”
Even if Sharon had never been a ballet dancer or her father hadn’t died of cancer, she believes she would have developed an eating disorder eventually: “I think it’s just programmed inside of me.”

Sharon doesn’t easily enjoy eating. When she has “regular meals” she has to make a conscious effort: “I have to really sit down and change my mindset. And just like, it’s almost just like I have to really be, like, enjoying it, I have to be with people. I can’t be in my room alone eating because I will binge. It’s a lot of effort.”

Sharon doesn’t dance anymore, but she now teaches instead: “I’m trying to give the kids that I teach just a positive – it’s so important – a positive, ya know, outlook and reinforce that you don’t need to be, ya know – you don’t need to resort to those types of things.”

“I could be restricting for weeks and weeks, but does that label me as an anorexic? You know? Or you could be doing it for the last 10 years and you’re not doing it now or last year – does that mean you’re still anorexic?”

My Story

When I was little everything was normal. When I really started going down the wrong path, I was in my sophomore year of high school. That year I switched to the public high school in my town, after years of attending Jewish day school. As the new kid in a huge class of strangers, I felt very unsure of myself and stopped my involvement in all sports and afterschool activities. I would come home to an empty house everyday around 2:30 in the afternoon. This was a big adjustment for me, after getting home from volleyball practice at 7pm the year before. My dad worked late, and my mom no longer lived there. She was diagnosed with early-onset Alzheimer’s when I was in middle school, and since then, she had declined to the point where we
decided to put her in an assisted living facility. As I mourned for my living mother, watching her slowly deteriorate, I was enveloped by a deep sadness. The year I switched to public school, I disconnected from things that once made me happy. I made friends with a great group of girls, but I never spoke to any of them about my mom. I spent time with friends on weekends, but most weekdays I walked home and stayed there. I had no idea what to do with all that free time, so usually I sat and watched TV with a big bag of potato chips. I wasn’t binging at that point – it was mostly out of boredom – but slowly I started using food as a break from reality. To no surprise, I put on a little weight. Up until that point in my life, I pretty much ate whatever I wanted. I stopped when I was full, and I didn’t think about food constantly. When I began noticing that I had gotten a little chubby, I tried to restrict myself. I had never done that before, however, and I had no clue where to start. From what I remember, my eating habits didn’t change much except for switching out regular brand items for the “reduced fat” versions. I ate just as much as before, but I started associating food with guilt. At some point I came up with the idea to throw up after I ate too much. That way, I justified, I didn’t have to feel guilty because the food would simply be gone. Once I tried it and realized it wasn’t so bad, I was overwhelmed with the illusion that I could do anything without consequence. From there, binging and purging became part of my weekly routine. I would have a stressful day at school and daydream until the moment I got home and could stuff my face. At first, I would binge on whatever yummy things were in the house – Oreos were my favorite. Later on when I got my license, however, I would occasionally make trips to the grocery store to purchase goodies. I relied on sweets as my predominant source of feel-good entertainment – cupcakes, cookie dough, frosting, cinnamon buns, and so on. I would buy one or two packages, depending on the size, go home, drink lots of water (to help the purging process), and then stuff as much dessert into my mouth in as little time
as possible. During that 5-or-so-minute period of euphoria, I could sometimes consume up to 2000 calories. I would eat until I physically could not fit another bite, and then I would crouch over the toilet with a towel and a bottle of seltzer water. Throwing it up was the ultimate release, and I learned to love the feeling of an empty tummy.

The first several times I did this, I felt like I was just experimenting and having fun. Eventually, although I can’t pinpoint exactly when, I developed what I would call a disorder. Usually the binge/purges were planned in a ritualistic sequence of events. But the spark initiated the sequence was out of my control. I’d have stressful day or moment, and this intense urge would come over me to gorge myself with sugary treats. It could come at any time. I would be sitting in class, and all of a sudden I knew I was going to binge as soon as I could be alone with food. It was almost like the feeling when you need to pee: the longer you wait, the more intense the sensation becomes, until you ultimately release it. Once I binged to my heart’s desire, I felt an instantaneous need to expel everything I had consumed. And so I did. I stuck my finger down my throat and induced vomiting over and over again until I felt sufficiently hollow. At the end of this cycle, I felt clean once again, and I returned back to my normal state and wouldn’t think about sweets until the next time.

At certain times the binge-purge episodes grew closer together in time, and at others they subsided for a while. At peaks, I would also restrict more severely in between. I dabbled with different patterns. In high school I usually refrained from eating the rest of the day following a binge, but sometimes I would get so hungry that I would eat anyway. I continued to gain weight until my senior year of high school, when I weighed around 180 pounds.

When I got to college, things changed. I lived in a dorm, and my days were structured. I would go to the dining hall at set times to eat with my new friends from my floor. I no longer ate alone,
and I no longer had a kitchen to myself. When I ate with friends, I was only forced to conform to social norms. I made the revolutionary discovery that if I ate a good-sized meal three times per day, I wouldn’t obsess about food as much in between. The urges went away for a while, although I still occasionally enjoyed giving in when I returned home from a drunken night.

Eventually I began to see the pounds coming off, and I was motivated by how easy it was. I started going to the gym regularly, and before I knew it I had lost 15 pounds. I started reading books and online articles about healthy eating and weight loss, and I adjusted my diet and workout routine accordingly. Over time, my eating became more and more strict. I began counting calories obsessively. I would count measuring sizes and look up every item’s nutritional value online. Even if I had a 5-calorie stick of gum, it would go into the tally. I limited myself to 1200 calories, but I overestimated most things just to be safe. I was hungry most of the time, but my motivation to lose weight powered me through. I also allowed myself one cheat meal per week. Every Friday night, my friends and I would go to the Jewish Chabad center to celebrate the start of Shabbat. We ate dinner in a large room with 200 other students and limitless plates of home cooked food. I ate whatever I wanted, and lots of it. I ate first, second and third helpings, of Challah, pasta, chicken and potato kugel, followed by endless brownies, cookies, rugelach and pastries. This too, became a weekly ritual, and it was enough to keep the urges at bay during the school week. And I felt no guilt because I was still losing weight even with overindulging every Friday night.

I didn’t know how much I needed to lose because I hadn’t been at a size that I liked in several years. I decided to keep going until I was happy. I never wanted to look or be emaciated, but I wanted more than anything to know what it felt like to be thin. I eventually lost 50 pounds and had reached my lowest weight since I was 12 years old. At 5’9” and 130 pounds, I had a
BMI of 19.2 and felt great about it. I still wasn’t completely satisfied though. I wanted to be able to wear anything and not be self-conscious about any part of my body. If I lost five more pounds I would fall into the underweight category, so I figured it would be safe to hover just above the line. Five more pounds, I told myself.

I never lost any more weight, however, because my family started making comments. My sister and aunts would tell me I was too skinny, and they would watch what I ate like hawks at family get-togethers. My binging habits would also return when I went home on vacations. I never went back to the extremes of high school, but I would often find myself uncontrollably snacking throughout the day. I gained a little of the weight back, but I closely monitored the scale so as not to let it get too out of hand.

Over the next few years, I became a much happier person. I accepted the loss of my mom, and out of that, I found new appreciation for my dad. I made great friends. I interned at a neuroscience lab. I started getting more enthusiastic about psychology, and earned straight A’s during the last two years of college. Everything was coming together, which was also apparent in my eating habits. I continued learning about health and wellness, but I also added in reading about recovery. In my own personal journey, I found that aiming to cure myself of my eating disorder was actually counterproductive. Trying to eliminate any kind of food or behavior 100% of the time always ended up in a parallel restrict-binge-purge cycle. Instead I learned to manage myself by focusing on softening the sharp highs and lows. If I slipped up and ate too much, I did not punish myself by skipping the next meals, but instead I forgave myself and started fresh the next day. I also stopped throwing up after eating too much, because I wanted to feel the real consequences of overeating instead of tricking myself that I could erase it. I still thought about
Results Summary

After speaking in depth with many people about their experiences with disordered eating, I started to notice some of the similarities that tie us together and the differences that make each of us unique. There are endless paths that lead individuals to engage in disordered eating habits, but there are similar messages to which we are exposed that spark the desire to be thin in the first place. Disordered eating is a serious issue, and I believe it should be considered a mental illness. My results indicate, however, that the subclasses, with which the DSM divides the illness, are not representative of real people. While my participants varied widely in eating habits, almost every single one exhibited behaviors across diagnostic divisions. I argue that historical development, rather than advancement of science, explains for the divisions in DSM, and I will discuss more of this in the analysis chapter.
CHAPTER 7

Analysis

_Historical-comparative Method_

In addition to my qualitative approach to data collection, the data analysis will be entirely qualitative as well. I am using a combination of the historical-comparative method (Luker 2008) and the basic inductive approach (Thomas 2006). The purpose of the historical-comparative method is to generate or test social theories from historical data. This method makes comparisons across time periods, allowing for the development of causational relationships among identified variables. The historical-comparative method can also be used to examine existing theories by analyzing cases in search of either consistency or contradiction. Luker (2008) explains that this method pushes researchers to produce “big think” questions (192) that force us to place variables into broad context: Instead of asking, ‘how does bark relate to trees, roots or leaves,’ ask, ‘how does bark relate to the ecosystem?’

In regards to the historical-comparative method, I emphasize the importance of historical context to various components of disordered eating. I have already mapped out the timelines for the invention of eating disorders, as well as the development of psychology as a social institution. Throughout my analysis, I will point out pieces of information that relate to these chronological events. Later on, I will explain more about the basic inductive approach and how I use it. I will now outline some of the historical background behind social construction theory and how it relates to eating disorders. This will be my way of answering ‘how the bark relates to the ecosystem.’
Scala naturae ("ladder of being") is a concept that views Earth’s life forms as a hierarchal system. Derived from Ancient Greek philosophy, scala naturae positions God at the top, followed by angels, then people, then animals and, finally, plants. This hierarchical view of the world is rooted in the very birth of Western civilization and induced a similar outlook on human diversity. Humans were eventually divided into sub-rankings, in which socially constructed categories of class, gender, and race were used to categorize people by social value (Futuyma 1982). The notion that animals and humans could be distributed into stratified tiers permeated the sciences. In the early 18th century, Swedish biologist and physician Carolus Linneaus created an official taxonomical system for mapping out all known species. Linneaus believed that by studying the Earth’s creatures, he was looking into the mind of God. The infiltration of Christian belief into scientific theory sparked a functionalist paradigm within the study of biology: if God created everything the way it was meant to be, then everything found in nature serves a purpose. Other philosophers and scientists of the time, such as Descartes, Kant and Buffon, rejected the Creationist explanation and advocated for the study of natural phenomena only by natural laws. Although this divide between science and religion has grown exponentially in the last few centuries, the early influences of Christianity are still present. Linnaeus’s work, for example, has been widely criticized, yet his method of binomial nomenclature is still used in biological science today.

Philosopher John Stuart Mill (1875) critiqued the system of taxonomy, asserting it as a simplistic method that categorizes life into artificial groupings – what he calls “natural kinds.” In a taxonomical sense, a category is a “tree of classifications, or else the most general classification at the top of such a tree” (Hacking 1995, 355). When dealing with “human kinds”
(353), we also use the terms category or class. This opens a whole can of worms because it allows for socially constructed categories of humans – homosexuals, extroverts, Hispanics, etc. – to seem compatible with Mill’s “natural kinds.” This is due to what Ian Hacking describes as the ongoing trend of biologicalizing humans: “Old and powerful is the idea that we acquire knowledge of humanity by replacing human kinds by physiological or mechanical or neuroelectrical or biochemical ones. This is not just a tradition of research, but also represents a metaphysics.” In order to have “real causation in psychology,” we must transform “psychology, and all else that is human or social, into biology” (353). In other words, the way we understand humans and produce new knowledge should be based off models that parallel the laws of nature. Genetics and neurochemistry are considered the gold standard when it comes to deciphering the human mind, and a mental illness is considered real when its processes can be observed on some molecular level. At the same time, however, it is “well recognized that most traits and disease categories do not line up in a straightforward way with characteristics of the human genome” (Navon & Eyal 2016, 1417). Biological scientists and social scientists alike must decipher genetic findings in light of social complexities and incompatibilities. Nonetheless, there “remains widespread hope that knowledge about genetic variants will allow researchers to unlock the biological basis of disease, leading to novel forms of treatment and a more biologically grounded nosology in fields like psychiatry” (1417). This is made possible only with a “type of science geared to normalcy and deviation from the norm, when the idea of human nature had been displaced by the idea of normal people” (Hacking 1995, 364). In regards to diseases that are not well defined in terms of biology, there often lies a belief that it is not a real disease or that we have not yet discovered its biological basis.
The use of race to classify human diversity is a perfectly suitable example for this discussion. Racial categories were originally developed as a hierarchical system of taxonomy, used to rank people by biological superiority. The idea of race as a biological measure is still pertinent today, despite extensive evidence suggesting otherwise. In comparison with many other animal species (including non-human primates), modern-day humans make up a species with relatively low genetic diversity. Since we inhabit almost every type of terrestrial ecosystem, both near and far, this is somewhat surprising. However, archaeological and genetic evidence suggests that humans have undergone multiple population bottlenecks, resulting in reduced genetic diversity. Evidence suggests that the human population was reduced to a few thousand individuals between 70,000 - 100,000 years ago, shortly before modern humans migrated out of Africa. This means that the vast majority of human genetic diversity comes from that group of individuals. Individuals that migrated to new lands brought with them fractions of the gene pool, resulting in smaller gene pools (i.e. founder effects). Studies looking at patterns of genetic variance have also shown that human populations possess much greater variation within rather than between groups. This, of course, depends on how the populations are defined, but different modes of analysis have been fairly consistent in these findings. When examining variation among racial categories, for example, approximately 85% of genetic variation exists within races, while only 15% occurs between them (von Cramon-Taubadel 2014). Racial categories become exponentially fuzzy when we take into account effects of globalization. In a country like the US, in which people from all over the world settle and mix, a great deal of people classified as one race actually have ancestors from multiple. A person’s ancestry points to his or her ancestors’ geographical origins, migration patterns, and admixture – all of which are simplified
and mistakenly allocated to a category of race. In this way, race does not represent a system of biological classification, but instead a socially constructed concept. This does not mean that race is not real or that racism has no effect on human biological outcomes (Gravlee 2009). On the contrary, individuals of a certain racial group may experience similar problems of health and overall wellbeing due to social barriers and marginalization.

So how does all this connect to eating disorders? There are two main points that I argue: first, diagnostic categories of eating disorder are socially constructed, and, second, these socially constructed categories have real effects on those that are labeled with them.

*Social Construction of Mental Illness*

Rates of ADHD have exploded in recent years, triggering public uproar. I have already mentioned how conditions pertaining to mental health and behavior are not always considered real unless they align with scientific models of understanding. This is why we have followings of people asserting that ADHD, among other disorders, are not real. One common argument for why ADHD should not be considered an actual disorder is that the conditions necessary for someone to experience an attention deficit are created by society. We like to believe that mental illness is caused by something within, and when the opposite is the case, we tend to see it as something less serious. Social influences play a role in many kinds of disorders, however, including eating disorders. And although these socially induced disorders are sometimes said to not be real disorders, they have very real repercussions on the afflicted individuals and therefore deserve attention. If the underlying goal of diagnosis is to properly identify and treat the problem, then, if the disorder does not align with biomedical understanding, it may simply mean that biomedicine is not the right tool to use.
Ian Hacking’s well-known concept of “looping” is a concrete demonstration of how seemingly biological diseases are socially constructed. There is a great deal of controversy surrounding the issue of increasing prevalence of autism within the general population. Hacking argues that these changing rates are not actually a reflection of more cases of the disorder, but rather the way we define it. Many children suspected to have autism are subsequently tested for the associated genes. Because research on autism is ongoing, and genetic studies have pointed to a number of potential genetic markers, new developments often lead to changes in the way we screen for and diagnose the disorder. In other words, looping processes trigger “classifications, practices, and the ‘kinds of people’ who are classified to recursively change one another over time, sometimes quite dramatically” (1418). This concept can be applied to virtually any disorder that has been formally classified. Let’s reconsider the historical development of the DSM and eating disorder categories (previously outlined in the literature review section). Generally, the DSM moves in one direction: that is, it grows over time. With the formal recognition of disordered behaviors, the trend has been to identify that particular set as a newly discovered syndrome. As this syndrome gains recognition, more studies are devoted to add to the body of knowledge. In order to study the syndrome, however, the lens must focus on a particular sample of individuals that possess those symptoms. Because the underlying goal of this type of research is to add knowledge, the literature that came before is used as the foundation. In this way, it is more likely that the newer literature will support rather than contradict the initial recognition of a particular disorder. In other words, the newer research questions generally pose the question “what else can we learn about this disorder by studying those that fit its criteria?” instead of “should this designated group of people constitute a particular disorder?” All in all, this positivist process of knowledge production helps to explain why every new version of the DSM expands
its lexicon of diagnostic categories, and why any omission or combination is notable. In Western culture, we like to believe that we know more and more over time. The scientific method is supposed to propel us “forward,” as if we are always getting closer to the ultimate truth. Our forefathers are said to be less knowledgeable than we are now, but, at the same time, they are highly revered for their foundational discoveries.

Eating disorders are no exception to this rule. The conception of eating disorders as official mental disorders began with the acknowledgement of restrictive consumption. The acknowledgement of binging and purging behaviors occurred much later, once anorexia nervosa had already been deemed a legitimate condition. Although these behaviors were first documented in anorexic patients, bulimia nervosa and then binge eating disorder were eventually outlined as separate types of eating disorders. Once these categories were formulated in the DSM, research on eating disorders only further validated them. So, which comes first – “the classification or the causal connections between kinds? There are two coarse pictures of concept formation. In one, people first make certain distinctions and then learn the properties and causal relationships between distinguished classes. In another, causal relationships are recognized between individuals, and these relationships are used to distinguish classes” (361). In other words, the process behind the emergence of a social category begins with the recognition of either (1) the cause of the human kind, or (2) the human kind itself. In regards to disordered eating, identification of the human kinds has always preceded causation. When causative factors are misunderstood, symptoms are used to form categories. While the understanding of disordered eating has morphed dramatically time and time again, its classification as particular pathological disorders has solidified. With each version of the DSM, criteria for eating disorders are refined and elaborated without attention to the process itself.
I will now describe a hypothetical example that is characteristic of this sort of positivist logic I have been describing. Person A wants to learn about whether neurotransmitters play a role in eating disorder risk. In order to do so, she must design an experiment. She decides to compare the serotonin among three groups of people: anorexics, bulimics, and normal eaters. The first two are experimental conditions, and the third is the control. She selects for individuals that fit the criteria of their labels. She may decide to do this, for example, by recruiting individuals that have been diagnosed with either anorexia or bulimia and then determining herself whether they do indeed fit the diagnostic criteria. If they do not, they will be excluded from data collection. She measures the serotonin levels of all the participants and statistical analyzes the results to search for significant differences among the groups. If she finds any, she may conclude that serotonin can explain in some way the difference among the three conditions. In this way, she has simultaneously validated the biological boundaries of these socially constructed categories.

In the next section of the analysis, I will use the basic inductive approach to look for patterns in the ethnographic data. In doing so, I will also demonstrate whether my participants fit into the socially constructed eating disorder categories.

*Basic Inductive Approach*

In a nutshell, the basic inductive approach involves seeking patterns within one’s data set (Thomas 2006). This type of method is often used when researchers are exploring a new topic, in which they have not yet developed their own models. The basic inductive approach allows for one to analyze data with a set of fresh eyes, looking for recurrent themes and patterns that arise outside the influence of preexisting frameworks. As outlined by Bernard and Ryan (2010), some of the emergent patterns to look out for include repetitions, categories, metaphors, transitions, similarities and differences, linguistic associations, missing pieces and theory-related data. Using
the basic inductive approach, I will attempt to look at the ethnographic data objectively, free of the rigid models and methods used within the fields of biomedicine and psychology. As David Thomas (2006) explains of the inductive approach, “the primary purpose… is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies (238).” I will highlight if and how the participants cluster into distinctive behavioral groups; and, if so, how those groups compare to anorexia nervosa, bulimia nervosa, BED and OSFED. In this way, I will look at disordered eaters on the ground level and assess the accuracy of ED categories that have been collectively constructed by investigators and clinicians at the institutional level.

**Loose Categories**

The major areas of focus in my interviews, focus groups and observations included participants’ diagnoses (whether self- or given), specific food-related behaviors, and what they thought of both. The majority of participants exhibited symptoms that fell outside any one ED boundary. This was especially interesting when participants strongly identified with their diagnoses, despite their overlap with other diagnoses.

Molly also sees herself as bulimic, even though she also restricts and has never been formally diagnosed. She is able to pinpoint the exact time when her disordered eating began: the period leading up to her sister’s wedding. She began dieting and exercising to lose weight for the occasion and successfully dropped almost 20 pounds. As the date approached, she began purging to give herself “a little push towards reaching the goal.” After trying it once, she thought

OK, this was easy. This wasn’t that bad, ya know… And I knew that, ok, this is not a habit I want to make. So, I’m doing this, fine, but I’m never doing it again. But a few days later, or a few weeks later, I feel like ‘hey I just ate so much ‘cause I didn’t have a choice and didn’t think much, but now I need to get rid of this because this will stay with my body – will like, build with my body, and I’m just gonna like, set myself two days
back and I’m gonna eliminate the last two days of exercise, so let’s do that again. And then I throw up, and then at some point it basically – the frequency increases, and at some point, I think it becomes like, this thing where I eat and then multiple times in a day I feel like ‘no, this cannot be in my body.’ Like, I need to not eat this but I already did, so I don’t have a choice but to throw up. Even if it was like, healthy food, if it was like, fish, like grilled fish or like, yogurt or some vegetables or something, and I was like – in my head, I’m like ‘how much is this gonna harm me?’ And I’m like, ‘no, you have a goal, you have to reach that. No, no, no.’ So I just do it. So, eventually it becomes more frequent.

When Molly began purging, it was to rid herself of food so that she could lose weight. Now it’s a little different. Before the wedding she would throw up anything – even small amounts – just to get her closer to her goal weight. Now, however, “it’s definitely if I overeat or – ‘cause I have this rough calorie-intake thing in my head, which I try to stick to, just like healthily.” Sometimes she plans her binges, and other times they happen in the moment: “Sometimes, I’m like ‘fuck the world – you know? It’s just like, I want to eat a whole bag of wings, and then I want to throw it up.”

Molly still restricts herself – in terms of both amount and type of food. She sees her diet as healthy, however. She follows an online calorie calculator that indicated, according to her body mass and exercise routine, she should eat approximately 1,200 calories per day. In order to stay below this number, Molly replaces meals with protein powder. She describes her perfect routine: “I’ll have like a bowl of oats in the morning – that’s fine. I drink protein shake for lunch because that’s usually around the time that I’m exercising – it turns out to be that way, like, I’ve scheduled it that way. So that’s, yeah that. And then, umm, and then at night, I usually eat like a meal, which is like, roughly 500.” Molly would most likely be diagnosed with OSFED: she restricts, but not severely, she binges and purges, but fewer than once per week, and she is overweight.
Sharon is a similar case to Molly, in that she describes herself currently as bulimic and has never been formally diagnosed. Also like Molly, her disordered eating started with under-eating and then switched to overeating. When she began dancing professionally, “it just escalated. It went from, ok, I can kind of restrict, so I did fall into the anorexic category, and then it was laxatives, and then it was purging, and then it was binging.” When Sharon’s dad died her freshman year of high school, it got a lot worse. “I started out just binging, and I didn’t like the idea of vomiting. But then, it became I didn’t like the idea of keeping it in. I had to get it out. It was just like, it would just, like, mess with my mind.” It started out slowly and got progressively worse over time. Now it’s really bad. I’m noticing I’m binging a lot. Like on Hostess [Cakes], and those are so good – you should enjoy them!” Desserts, especially cake, and Chinese food are binge triggers for Sharon. These are foods she loves, but she explains that, sadly, “the thing with binging is you skip over the enjoyment. It goes straight to the compulsive. Like, I don’t even enjoy what I’m doing or what I’m eating.”

Ronda is another case of someone that falls across eating disorder categories but was diagnosed with anorexia nervosa. In middle school, her mom sent her to a psychiatrist after noticing her weight loss. At the time, Ronda thought she was being healthy: “I was convinced I was never hungry, so I was like, ‘oh I’m eating enough because I’m not hungry.’ I thought restricting foods was good ‘cause they were unhealthy according to the stupid book I was reading about the South Beach diet.” On a normal day Ronda would try to not eat anything until 3 o’clock, when she got home from school. She had particular foods that were ok to her standards, including kosher meat – turkey, chicken, roast beef – eggs, and certain vegetables. She wouldn’t eat fruit because of the high sugar content, or certain starchy vegetables – peas, carrots, corn, etc. She also drank a lot of coffee to curb her appetite.
At times, Ronda also engaged in binging and/or purging. Her first major bout of anorexia included small spurts of bulimia/BED, and the second time they were more frequent. Sometimes she would eat an entire just of honey or entire jar of peanut butter. She remembers: “one time I bought a cake from Shaw’s, and I ate the whole thing. But when these events would happen, it was almost like, kind of fun or something. I didn’t feel guilty when this happened because I knew I had really good self-control all other times, and I felt good that I could eat an entire cake and still be skinny.” During another “cake incident,” she was with two other friends, and they were all eating cake: “normally I would have never eaten that, but I was doing it just to show that I could – I knew that I could. I felt like it wasn’t going to affect my body the way that it was going to affect their bodies. I could restrict the next day.” This is why she never felt guilty after eating during the first anorexia phase: “I was really good at restricting.” At that time, the binges were always a type of reward, when she was celebrating or feeling carefree. When she relapsed later on, things were different. She was older and couldn’t seem to keep her weight down as easily. During that second period she felt much worse after overeating because she knew that restricting afterwards wouldn’t have the same effect.

Jolene has a similar mix of behaviors, but she was diagnosed with bulimia nervosa. When she was 16, she collapsed due to dehydration from purging. Her parents brought her to the hospital, and she was subsequently diagnosed: “I think I was just diagnosed with bulimia because it was one of the things that I did more regularly.” Jolene recognizes that she has symptoms from multiple EDs. Unlike Amanda, however, she sometimes suggests that her bulimic tendencies are at the root of even the restrictive behaviors:

I think I got really used to purging, so I think that it got to the point where my stomach couldn’t really handle food. So I would eat something and then I would feel like I needed to throw up. So it got to the point, ya know, where I wouldn’t even need to stick my finger down my throat… So then sometimes I felt like I might as well just not eat, to not
throw up after. If I had the chance to not eat or only eat, like Iceberg lettuce or something random like that, I would do that too.

At other points, however, she seems to contradict this point. Aside from not eating to “not throw up,” she also describes restricting for the sake of restricting. She explains that she was very obsessive with calorie counting and fat and carbohydrate content. She used to avoid starchy and fattening foods at all costs, eating only lean meat and vegetables for stretches of time. “For some reason,” she recalls, “I thought it was very healthy to live off of 300 calories a day, which doesn’t make any sense.”

Other times, she would be so hungry that she would binge on a large amount of food, followed by a purge: “I would be starving. We would be dancing five or six times a week, so I would be getting in a lot of exercise on not that much food, and I would be totally starving after a few days. And I would eat a huge amount in one go because I was so hungry and then feel so guilty about it, and then, ya know, just go to the bathroom right after.” Jolene offers few more details about binging and seems somewhat embarrassed to talk about it. I don’t know how often these episodes occur.

As I have already mentioned, the participants in my study reported behaviors from more than one, or even all, eating disorder categories in the DSM-5. At the same time, those that received treatment had been diagnosed with particular eating disorders that did not necessarily fit all of their symptoms. There are different reasons that patients are diagnosed with different disorders. Sometimes diagnoses reflect the most severe component, sometimes the clinician is unaware of everything going on, and sometimes body size is the determining factor. The bottom line, however, is that the disorders listed in the DSM-5 are the only tools available for official diagnoses in the clinical setting.
Another common themes among my participants was the concept of *cyclical behavior*. *Cycle* is a term that several participants used repeatedly and, for the most part, used it in the same way. In the following pages, *cycle* or *cyclical behavior* is defined as experiencing different kinds of eating habits at different times, but in repetitive sequences. If someone describes his or her cycle as anorexic-bulimic, this may mean that he or she restricts for a given period of time, followed by a period of binging and then purging, followed again by restricting, followed again by binging and then purging, and so on. Individuals may experience periods differently, in terms of length of time, severity, etc., but what they share in common is the repetition of behaviors in the form of a *cycle*.

Amanda was diagnosed with anorexia nervosa in middle school. She has since been hospitalized on a few occasions for both risk of starvation and suicide watch; the attention she has received from professionals has centered on increasing her weight and treating her depression. It is entirely possible that her records have contributed to national data on eating disorders, in which she would be counted as a case of anorexia nervosa. At the same time, however, Amanda tells me she feels that she’s been both anorexic and bulimic at times: “I’ll not eat anything for a while, and then I’ll be ok with eating, but then anything I eat I’ll have to throw up.” She refers to her eating patterns interchangeably as “cycles” or “relapses.” She has noticed that this cycle is similar every time. It usually begins with restriction, followed by binging and purging when she can’t seem to limit her intake as much as she’d like. The disordered behaviors start out slowly and become increasingly severe until she has “negativity associated with 100%” of what she eats and drinks. She feels ok with drinking water to a certain extent, but even too much of that is off limits. In between cycles, she describes her eating habits as “more or less
normal.” She notices when the relapse is over because she stops thinking about food constantly.

“I think about food all the time,” she explains about her disordered phases.

I will compulsively think about what I’ll have for lunch and dinner, and then like, what time will that be, and if I should, like get a snack in between and what snack that should be. And then sometimes I’ll just compulsively eat, like if I have a thing of almonds near me or, like, a thing of cereal, I just won’t stop eating it. And then I’ll go to the bathroom and puke it all up. Or, as I mentioned, I bake. Sometimes I’ll, like, bake things for my boyfriend while he’s not there and decide I want to try it and then end up having like six cookies and then throw them back up. It’s not always logical, it’s just kind of compulsive, I guess.

There are certain trigger foods as well:

I’ll eat like half a jar of it at a time and can’t stop. They have, um, I don’t know, it’s like Peanut Butter & Co. I don’t know, it’s like a vegan Nutella Brand. The chocolate one is my weakness. I’ll have so much of it without even noticing, I’ll have, like, the entire jar. Or if I have that and graham crackers around. Almonds or, like, cashews. When I make cookies, I can’t stop eating them. When I have that, I’ll be aware that I’m doing it, but I can’t stop, and sometimes I’ll have more cookies than I can count. A lot of times, I’ll be eating on autopilot and then realize what I’m doing, and I’ll be like ‘what the fuck.’ I don’t really understand how I can eat so much.

After binging episodes, Amanda feels that she needs to throw up to get her body back to how it’s supposed to be:

After I puke, I don’t feel bad about it. It’s all positive emotions because leading up to it, I’ll feel so down about myself and my body. There have been times that I’ll start walking out of the house after having, like, a peanut butter sandwich and a chai, and I’ll feel like it’s an out-of-body experience – that my feet are just taking me into the bathroom, and my hand is being forced down my throat, and I’m not doing all of this myself.

During restrictive periods, it’s a different story. When she lived in the dorms, it was much easier to restrict because she would often allow herself to visit the dining halls once or twice per day. On those days she would have “seven carrots, water and a teaspoon of honey.” Not having easily accessible food in her dorm, as well as eating in front of a large group of students, was usually enough to keep Amanda from binging during that time.
Kat is yet another case of cycling among binging, purging and restricting. Often it depends on the how her day went. If she had a stressful day, she doesn’t want to eat at all. Sometimes she’ll go a few days at a time: “If I can skip breakfast, I can go up to a week without eating barely anything. But I go to work at 4 in the morning, so there is breakfast usually there.” During binge trips, she’ll eat anything and everything – even healthy food. She’ll eat an entire watermelon. It’s about being filled to the brim. Then it’s gone quicker than it entered, “I don’t wait. The last thing I eat, I’m in the bathroom eating it. Sometimes I’ll make an entire box of pasta and just put salt and pepper on it, and eat the entire thing… it doesn’t matter what it is but I want a large quantity of it… the more there is, the easier it is to come up again, so you can get all of it, as sick as that sounds.”

Previously binging and purging was just for the weekends, “It was like an occasion, it was exciting: oh, it’s Sunday and I can eat whatever I want, and eat a whole Domino’s pizza and not feel bad about it.” During the week she didn’t necessarily eat only healthy, but she would exercise excessively. In terms of Saturday and Sunday, she would want to sit on the couch and eat all day.

Kat’s eating has gotten so out of control in the last two years that she now throws up sometimes 8 or 9 times a day. Then she eats nothing on the weekends. Typically she binges and purges Monday to Wednesday, slows down Thursday, and eats nothing Friday to Sunday. The cycle shifts to fit her routine. She has never been diagnosed or received treatment, but refers to herself as bulimic. When asked why she identifies that way, she explains that it’s because she is “completely out of control.”

If Kat were to see a professional, she could be diagnosed with anorexia, bulimia or OSFED. This would really depend on what the clinician viewed as the biggest issue, which could
vary. Technically speaking, she should be categorized into OSFED because she has a strong combination of symptoms. Binging and purging disrupts her life the most in terms of behavior (i.e. bulimia nervosa), but the most immediate danger is probably her excessively low body weight and amenorrhea (i.e. anorexia).

Sharon never binges on “healthy stuff.” She enjoys eating healthy foods and describes her relationship with them as “balanced.” At 31 years of age, Sharon has had on-and-off disordered eating for nearly two decades. Like the other participants, she describes her eating in cycles. She admits that she has “relapses all the time. It goes in periods. Like, I can go six months, and I can go – like, I did it yesterday. I had an argument with my mom, and that kind of, umm, got me upset.” Sometimes it happens randomly, and then other times she’ll have several daylong binging episodes. “I can’t even tell you,” she says to me, “it’s, like, all over the place. It’s completely sporadic.” As she gets older it seems to be more about the habit than the food itself. She describes her experience when she was younger as very different than how it is now: “when I was binging and purging, it was, like, this relief. Like, it was this amazing feeling that I got, and I don’t get that anymore but I still do it. It was like nothing was in my stomach, like I was skinny. Like I was six feet tall and just beautiful. Stupid stuff like that. I felt powerful actually.” In between binging and purging she restricted her calorie intake and was able to effectively control her weight: “I lost like 20 pounds during that time. I was down to like 98 pounds.” Now that she’s older and binges more than she restricts, it’s harder to keep the weight off.

While Sharon is similar to the aforementioned participants in that she bounces between disorders, she is different in that cycles span over years. For the first few years, Sharon may have fit into the anorexic category, followed by a short period of BED, and now closely with bulimia nervosa. Even though she labels her current behavior as bulimic, she acknowledges that the
categories don’t make much sense: “I could be restricting for weeks and weeks, but does that label me as an anorexic? You know? Or you could be doing it for the last 10 years and you’re not doing it now or last year – does that mean you’re still anorexic?”

The cyclical component of disordered eating behaviors is likely connected to biological functions that almost all humans share. Over and over, participants reported different combinations of starving themselves to lose weight, overindulging because they were so hungry from restricting, and then purging to make up for overeating. This basic sequence falls in line with the body’s many defenses against starvation (i.e. biological signals released to induce food seeking and binging when consumption has been inadequate). In this way, it makes sense that many would exhibit all of these behaviors at different times.

‘Real’ Effects of Socially Constructed Categories

In addition to critically analyzing the accuracy of diagnostic divisions, I argue that the use of these divisions may have very serious effects on the people that fall into them. For decades, social scientists have recognized how medical labels shape the ways that those diagnosed behave and understand themselves. Almost 20 years ago, Ian Hacking (1998) noted, “people classified in a certain way tend to conform to or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised” (21). Studying a disorder may seem like a purely scientific endeavor, but we cannot forget that disorder only exists within humans. A gene, for example, may “be a natural kind, [but] a person with a gene is a human kind; while the gene may work the same way before and after being labeled, telling people that they have a gene for cystic fibrosis or some other condition and treating them on that basis is another matter entirely” (Navon & Eyal 2016, 1420). Aside from the obvious issue that improper understanding of the disorder may
push us further away from proper diagnostic and treatment measures, the way we define disordered eating has many other tangible effects on disordered eaters. This is an important point, yet it is often overlooked.

Stigma created by eating disorder diagnostic criteria can act as a barrier to treatment-seeking behavior. Since I recruited participants from eating disorder support groups (as opposed to clinics or rehabilitation centers) I was able to speak with many disordered eaters that had never received psychological therapy. There are many reasons as to why an individual would or would not pursue treatment. One theme I came across during my research was that people might not believe they truly have a problem if they are not super skinny. Disordered eaters are usually ashamed of their body mass in the place, but to be labeled as anorexic or bulimic often puts more pressure to “look” the part. Sharon is one example. She explains, “it’s weird because I don’t think I’m good enough. I think I’m gonna go into one of those treatment places and everyone is gonna be like skin and bones, and they’re gonna look at me and be like ‘what the hell.’” This is undeniably a monstrous issue in the world of eating disorders. A person of any body size can have an eating disorder, and size alone does not necessarily determine the seriousness of his or her condition. But when it comes to eating disorders, both the media and academia have historically focused attention on excessively thin bodies. The DSM even includes body mass as part of the diagnostic criteria for eating disorders. In order to be diagnosed with anorexia, for example, one must be considered underweight (i.e. have a BMI under 18.5). People like Sharon feel even more stigmatized when clinicians, those who are supposed to provide safety and support, are literally judging them based on their size.

Barriers to seeking treatment deserve considerable attention. Research suggests that, on average, disordered eaters wait approximately 10 years after the onset of their behavior before
seeking help (Norton & Cooper 2008). The numbers are probably even higher, however, since there are many that never get treated. The reasons for this are plentiful, but fear of getting fat upon entering treatment is arguably the most common reason that disordered eaters are afraid to seek help. For disordered eaters that cannot stop gaining weight, treatment-seeking behavior may be affected from either end. Individuals that practice restrictive-purging cyclical eating often fear they may gain even more weight if they are forced to stop restricting. On the other hand, overweight individuals are sometimes much more eager to change because they are desperate to stop the weight gain. Maxine is an example of the latter case. Since she first gained a great deal of weight, she did whatever she could to stop binging. In addition to experimenting with purging and fasting, Maxine has confided in her primary care physician, a nutritionist and a psychologist. Although she struggled with other areas in her life previously, she feels she is now in a better place. But her eating disorder holds her back: “I feel – sometimes I feel less of a successful person, and I have a decent job, I’m doing ok, ya know, living on my own. I consider myself an adult, but then this – but whenever I think about myself being a binge eater, I think, like ‘oh, I’m kind of a failure,’ or that I’m, umm. I feel guilty, like, I don’t deserve what I have, I don’t deserve the salary that I make or whatever if I can’t even control myself.” This sense of failure attached to fat discriminates against disordered eaters specifically with large bodies. Stigma is not only a barrier to treatment seeking, but it can also hinder healing once someone has already taken steps to get help. Some overweight individuals may feel too embarrassed to deal with the situation at all. As in the case with Sharon, it may be enough to shy people away from getting help; or once they have gotten help, it can obstruct them from learning to love themselves. Even when individuals are happy with certain parts of themselves, simply being fat can be enough to cause psychological distress.
In addition to fat stigma, disordered eaters may feel stigmatized from being labeled mentally ill. Many are reluctant confide in anyone outside of the anonymous support groups. Kat, for example, has been hiding her secret for a decade now. She is so humiliated of her disorder that she goes through careful daily procedures to keep it private. Going “out” for lunch on restricting days and stuffing herself with salads on binge days keeps her colleagues from guessing anything is wrong. The only ones in her life who know are her husband and best friend, and both know not to ever bring up the subject. Her husband broke their rule once to give her information on a nearby treatment center, since they have been struggling with getting pregnant. After some time, she worked up the courage to call the center, but she found the receptionist to be completely insensitive to her situation. She told Kat they only do intakes during the day, but Kat informed her that she works fulltime. The woman answered, “Well we can’t help you then.” Kat felt stupid for even bringing it up, as if she wasn’t worthy of treatment. Kat tries to be the strong one for her younger sisters, and she doesn’t like to show vulnerability. To her, disordered eating is a symbol of weakness. It conflicts with who she wants to be and how she wants others to see her. Like Kate, many disordered eaters feel shame for being labeled as disordered. This can cause further damage to self-esteem and prevent individuals from reaching out and getting the help they need.

I felt this way as well. I didn’t want to believe that my problems were severe enough that I deserved a label. I had never been diagnosed with any kind of serious disease or disorder, and I felt as though a diagnosis would sully my record. I wanted help, but I couldn’t bring myself to admit it to anyone. I wanted my dad to think everything was fine, and having him know I wanted to see a psychologist broke my heart. So I never said anything. I kept everything completely secret, binging and purging only when no one else was home. At the same time, I limited my
disordered eating behaviors to remain just outside the criteria for a formal diagnosis. I had read online, that the criteria for bulimia included two or more binge-purge episodes per week for three or more months – according to the DSM-IV, the latest version at the time. After learning this, I successfully limited myself to only one binge per week, justifying the behavior because I wasn’t technically bulimic. At my lowest weight, my BMI was 19.2. Again, I never planned to fall below a BMI of 18.5 because I didn’t want anyone to think I was anorexic. Of course I could have been diagnosed with OSFED, but that didn’t carry the same weight as “anorexia” or “bulimia.” Not many people have even heard of OSFED, as opposed to the latter diagnoses that are frequently mentioned in the media.

Sometimes a label can offer, in some strange way, a sense of relief. When people have disordered eating, they suffer whether or not they have been officially or self-diagnosed. Nonetheless, a diagnosis can change how they see themselves in many complex ways. Molly is another example of someone who has never been treated (or officially diagnosed). She binges, purges and restricts at different times and identifies as a bulimic. When asked why she has never gotten help in her several years of disordered eating, she explains that she can figure it out herself by observing her own patterns and researching the subject. She rationalizes, “the more I think about the issue, the more I try to understand the issue, the better I solve it, the better I help myself. That’s why I try to think that yes, this is definitely bulimia. Because reading about what bulimia is, it looks like it. Only for a few years actually, because initially I didn’t label myself. In the past couple of years, I have been able to express myself – tell people I’m close to that yes, I have depression, yes I have anxiety, and they might not be diagnosed and I feel like I am able to label myself because somehow I just, I know. And it may be wrong, but there’s a 90 percent chance that yes, I am that. And the more I accept it, the more I am able to help myself. Because
then I know what the issue is, because then I can tackle it. So I feel like if I look at the issues as like, overcoming adversities – sort-of-a-thing – so it kind of makes my emotions stronger and that’s why I like to label it, so I know what the issue is.” Molly feels that accepting that she is bulimic has been a big part of her journey towards health. For her, health means going to the gym and maintaining a reasonable weight. In order to combat her bulimia, which she defines as binge/purge episodes, she often skips breakfast and drinks protein shakes for lunch. In problematizing her situation as bulimia, she has simultaneously reduced the issue to weight maintenance. Although she has been able to “solve” the issue of weight gain following frequent binges, Molly’s eating patterns remain erratic and dangerous.

Molly is not the only one. I have listened to countless EDA attendees talk about their progress in disordered eating in terms of their body size. If someone has reduced the binges orcompensated by restricting, he or she may view this as success. If someone can restrict to the point where she is thin but not attracting attention, he or she will often hope to stay on this path forever. Eating disorder diagnostic divisions are not solely to blame for this, but they are certainly part of the problem. These socially constructed categories reflect how our society views disordered eating because they are just that: socially constructed. There is no gene separating anorexics from bulimics or binge eaters, and, as I laid out in the history chapter, binges were first ‘discovered’ as a symptom in anorexic inpatients. Two people could behave and eat in the exact same ways, but what ultimately separates them in the way we look at them is body size. This is overly simplistic at the least and detrimental at worst. Again, it is enough to keep many from getting the help they need. Whether it’s that they are too fat to fit in with the anorexics at rehab, or they don’t think they have a real problem because their BMI is normal, or they are too ashamed to bring attention to their fat, focus on the body is both off-putting and misleading.
CHAPTER 8

Conclusion

The overarching lesson to anthropology is pretty much always that culture matters. Over the course of my research, I have been thinking a lot about culture’s impact on science specifically. Science is generally thought of as neutral explanations of the natural world. From an anthropological perspective, however, science can be defined as data produced by socially driven investigations with the use of positivist logic. As humans we are constantly developing information on every topic imaginable, following the assumption that we (collectively) know more over time. We build off of what others have done before us. We like to think of scientific development as progress, as if we are reaching towards ultimate truths and getting closer by the minute. Anthropology can reveal fallacies within these beliefs, highlighting the confounding political, economic, and social variables that guide research efforts.

The concept of disorder, as conceptualized under the umbrella of Western medicine, is always deserving of visitation. It is something often taken for granted, easily accepted as a fixed category. Our perceptions of health and disease are culturally dependent, as we learn from those around us when and how to respond to experiences of the mind and body. The ways in which we express symptoms are also therefore culturally dependent, in regards to the “attention, interpretation, labeling, and social presentation” thereof (Kirmayer & Sartorius 2007). Methods of diagnosis are built off these concepts of health, disease, and disorder, all of which are socially constructed representations of seemingly biological phenomena.
People are considered disordered when they deviate significantly from what society deems normal. Effective treatment is supposed to address the problem by realigning them into the realm of socially acceptable boundaries. This type of disease framework can be very useful in identifying certain extreme cases, such as anorexics at the brink of starvation, but, when it comes to dealing with the majority of mental suffering, its scope is inadequate. When we focus on biological pathways, we often lose sight of the bigger picture. Looking back over the last century or so, the literature on disordered eating has shifted back and forth with the latest trends in academia. Unfortunately, it is not clear that we are now any closer to a comprehensive understanding of disordered eating.

Disordered eating can have detrimental effects to the body, and sometimes even cause death. Severe eating disorders receive greater attention from family, peers, and specialists, as well as the general public because they are harder to miss. Cultural models of health, embedded both implicitly (e.g. normal weight ranges) and explicitly (e.g. formal diagnosis), tend to focus on illness rather than wellness. In other words, they determine either the presence or absence of disorder. This sort of attention bias towards symptoms of illness leads to many unintended consequences, including stigma around mental illness. Illness itself brings about stress, especially when it is not well understood and the prognosis is unknown. In this way, a diagnosis can sometimes bring relief, since it allows people to put a name to a problem. At the same time, it alters the ways in which people view themselves. They may see their behaviors, thoughts, emotions, or themselves at whole as a product of disorder. Understanding what their diagnosis actually means, and therefore understanding themselves, is dependent on the socially constructed notions that have already defined the disorder. This is especially risky when it comes to eating disorders because they have been entrapped by prescribed narratives. Society deems skinny as
good and fat as bad, and out of these mantras come oversimplified folktales. Anorexics are pitied for their delusional self-perceptions, yet at the same time revered for their austere martyrdom. At the pinnacle of perfectionism, anorexics practice self-control gone too far. Their bulimic counterparts try just as hard, but they are defeated by their impulsive tendencies. Their behavior is reckless, switching from dramatic outbursts to clandestine food trips and keeping their weight down by restricting in between. They are filled with shame, but not nearly as much as the binge eaters. These individuals are portrayed as hideous, lazy and gluttonous pigs that lack drive to better themselves. When a person is given a diagnosis, he or she must also accept the role with which it comes.

The deep irony is that the vast majority of disordered eaters dabble in restricting, binging and purging. This conundrum is often swept under the rug because it doesn’t fit with the theatrical character illustrations, and it doesn’t make for clean science. But in reality, restriction, binging and purging often come as a package deal. It is a natural physiological response to overeat following periods of undernourishment. The body has a complex line of defense, and it uses many different tactics to avoid starvation. Metabolism slows down following weight loss, meaning that continued loss is only possible if the incoming calories continue to diminish, and recent studies are showing that effects on metabolism are much more prolonged than previously thought (Fothergill et al. 2016). The body will also trick itself into feeling hungrier by adjusting hunger hormones, reducing those that interact with satiety – leptin, insulin, amylin, peptide YY and cholecystokinin – and increasing levels of ghrelin – a hormone that signals hunger (Sumithran et al. 2011). Once the body is starved to the point that there are no more fat stores, however, it will start taking from the brain. The insula, a region of the cerebral cortex that is likely involved in homeostasis and hunger regulation (Wright et al. 2016), has been shown to
malfunction under conditions of extreme starvation (Troscianko 2010). This may help to explain why certain cases of disordered eating are unsalvageable without intervention, but also why it is so common for anorexics to dip into binge-mode during periods of “recovery.”

Neuroscience can help reveal some of the biological components that play a role in disordered eating, but it does not tell us the whole story. Eating disorders are not merely products of our biology, nor are they solely determined by the environments in which we were raised. Instead of looking at biological and environmental factors as isolated arrows of influence, we should strive to understand the ways in which socially influenced “patterned practices” (Roepstorff, Niewohner & Beck 2010) become embedded in neurological pathways and alter brain chemistry. We all arrive at eating disorders from diverse paths – whether it be late night eating to compensate for ballerina diets or depriving oneself in the name of Godly sacrifice. We can all agree, however, that body shame and toxic food relationships are ongoing themes in all of our struggles, whether they brought us there or we found them along the way.

While striving to be thin in an environment with an abundance of fattening temptations, it is a wonder that we are not all driven mad. When we are diagnosed with a disorder, it doesn’t help that we are subsequently branded with a stereotype. A quick search on Google Images yields the very obvious appearances associated with each disorder. Anorexics are skinny, binge eaters are fat and bulimics are in the middle. Since disordered eating is so entangled with poor body image, forcing us into body-shaming categories of disorder adds another layer of shame. I have discussed at length how disordered eaters do not arrange into three or four categories, as modeled in the DSM-5, and when we bring these points together, it becomes clear that we need to take the body out of eating disorders.
As an applied component of my research, I decided to return the narratives back to my participants. In addition to opening the communication channels for further discussion, I wanted to provide something meaningful to each person that contributed to my research. Speaking about one’s issues is therapeutic in itself, and this is one of the main advantages that keep people coming back to support groups. Disorder is so much more than mental illness. It is a label that becomes, whether we like it or not, part of our identities. Figuring out what it means to have an eating disorder is a crucial component of moving towards recovery and finding balance. This meaning is completely subjective and even somewhat arbitrary. Understanding how we became sick is not revealed in textbooks; rather, it takes introspection and exploration into one’s life history. Whether we explain our illness in terms of genetics, self-esteem, perfectionism or addiction, finding significance brings on relief – whatever that may mean to each individual. In conversing with my participants and providing them summaries of what they have found significant, I hope to help them find meaning in their disorders.
References


Mill, John Stuart. 1875. “Of classification, as subsidiary to induction.” In System of logic, ratiocinative and inductive, being a connected view of the principles of evidence and the methods of scientific investigation, Mill, John Stuart; London: Longmans, Green, Reader, and Dyer. 2(9): 270-287.


Appendix A: Study Flyer

VOLUNTEERS NEEDED FOR RESEARCH ON DISORDERED EATING
Would you like to participate?

Department of Anthropology at the University of South Florida

I am looking for participants to take part in a study on eating disorders. The purpose of this study is to raise awareness on the problems associated with disordered eating. As a participant, you would be asked to participate in a focus group and/or one-on-one interview about your experiences with disordered eating. The focus group will run approximately thirty minutes, and the interview will take between a half-hour to an hour. In appreciation for your time, you will receive refreshments and a personalized write-up of your interview.

For more information about this study, or to volunteer for this study, please contact Prime Investigator, Channah Leff (Anthropology Graduate Student at the University of South Florida) at (781) 929-9155 or cleff1@mail.usf.edu

Thank you!

This study has been reviewed and approved by the Institutional Review Board, University of South Florida. If you have question about your rights as a research participant please call the USF IRB at (813) 974-5638 or email at RSCCH-IRB@usf.edu. IRB#26694
Appendix B: Script for Obtaining Verbal Informed Consent

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: Diagnostic Divisions of Disordered Eaters. The person who is in charge of this research study is Channah Leff. This person is called the Principal Investigator.

You are being asked to participate because you participate in an eating disorder support group. The purpose of this study is to better understand eating disorders. If you take part in this study, you will be asked to participate in a focus group and/or a one-on-one interview. The focus group and interviews should take no more than a half hour to one hour each. If you grant permission, the focus group and interview sessions may be audio recorded. You have the alternative to choose not to participate in this research study.

You should only take part in this study if you want to volunteer and should not feel that there is any pressure to take part. You are free to participate or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

This research is considered to be minimal risk. The only potential harm may involve discomfort or embarrassment while talking about your eating disorder. You may skip any questions that you do not wish to answer. There are no direct benefits from participating in this study, and we will not pay you for the time you volunteer while being in this study.

We must keep your study records as confidential as possible. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are: the research team, including the Principal Investigator, the Advising Professors, and certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include:

- The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
- The Department of Health and Human Services (DHHS).
If you have any questions about this study, you can contact the investigator: Channah Leff (CLEFF1@usf.edu). If you have question about your rights as a research participant please contact the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

Would you like to participate in this study?
Appendix C: Person-centered Ethnographic Interview Questions

Person-centered Ethnographic Interview Questions:

1. What is your relationship with food like (past/present)?

2. How does it affect you to be considered as a disordered eater?

3. In what ways would you define your disorder as emotional, biological, psychological, etc.?

4. Tell me about your history in regards to eating.

5. In your opinion, how did you develop an eating disorder?

6. If applicable, tell me about your path towards recovery.
Appendix D: Focus Group Questions

**Focus Group Questions:**

1. How do you personally define disordered eating?
2. How do you or did you fit into that definition?
3. Describe your eating cycles and patterns (past/present).
Appendix E: Letter of IRB Approval

7/29/2016

Channah Leff Anthropology  4202 East Fowler Ave Tampa, FL 33620

RE: Expedited Approval for Initial Review  IRB#: Pro00026694  Title: Shaping Identities of Disorder among Disordered Eaters

Study Approval Period: 7/28/2016 to 7/28/2017

Dear Ms. Leff:

On 7/28/2016, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Please note, no research activities can begin until the required letter of support is submitted and approved through the IRB amendment process.

Approved Item(s):  Protocol Document(s): IRB_Protocol_Version1.docx

Consent/Assent Document(s):

Script_for_Informed_Consent_Version1.docx

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:
(6) Collection of data from voice, video, digital, or image recordings made for research purposes.
(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

The observation portion of your study qualifies for a waiver of the requirements for the informed consent process as outlined in the federal regulations at 45CFR46.116 (d) which states that an IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the IRB finds and documents that (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practicably be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation.

The focus groups and interview portions of your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.
Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson USF Institutional Review Board

[Signature]