

Cambridge University Press
978-0-521-61312-5 - Eating Disorders in Children and Adolescents
Edited by Tony Jaffa and Brett McDermott
Excerpt
[More information](#)

Part I

Introduction

Cambridge University Press

978-0-521-61312-5 - Eating Disorders in Children and Adolescents

Edited by Tony Jaffa and Brett McDermott

Excerpt

[More information](#)

1

Historical and current conceptualizations of eating disorders: a developmental perspective

Mytilee Vemuri and Hans Steiner

Stanford University School of Medicine, Stanford, CA, USA

There is no human society that deals rationally with food in its environment, that eats according to the availability, edibility, and nutritional values alone.

(Hilde Bruch, 1973, p. 3)

Introduction

Eating disorders are complex, multi-faceted and acutely sensitive to societal and cultural pressures. They challenge clinicians to expand their understanding beyond the individual and consider external pressures that trigger and maintain the process of disordered eating. In this chapter, we review how conceptualizations of eating disorders have evolved, and highlight the power of social context in the development and maintenance of these ‘diseases’. We shall also review current research into eating disorders, which spans numerous disciplines, including psychology, psychiatry, sociology, and more recently genetics and molecular biology. Multidisciplinary approaches are particularly helpful for conceptualizing eating disorders. As these disorders generally develop in childhood and adolescence, we pay particular attention to a developmental approach that also considers societal pressures, developmental norms, mutability of behaviours, and the individual’s unique response to his or her environment.

History of anorexia nervosa

While the term ‘anorexia nervosa’ (AN) was first introduced into medical literature in 1874 by Dr William Gull, reports of self-starvation may date back to times of early Christianity (Keel & Klump, 2003). Cases of self-starvation

Eating Disorders in Children and Adolescents, ed. Tony Jaffa and Brett McDermott. Published by Cambridge University Press. © Cambridge University Press 2007.

3

4 M. Vemuri and H. Steiner

attributed to demonic possession were documented in the fifth century (Keel & Klump, 2003). Saint Wilgefortis, thought to have lived between the eighth and twelfth centuries, reportedly engaged in self-starvation resulting in emaciation and (what has been speculated to be) lanugo – the fine downy hair that may result from anorexia and malnutrition (Keel & Klump, 2003). Detailed accounts of eating disorders prior to the twelfth century are limited, therefore it has been difficult to apply the diagnosis of AN or bulimia nervosa (BN) to such cases.

Holy starvation

Self-starvation in medieval times was often seen in the context of religious piety. The best known of the abstinent medieval religious figures was St Catherine of Siena who entered a pattern of self-starvation that ultimately resulted in her death in 1380 at age 32–33. Of note, starvation was only one of many austerities St Catherine partook in, including self-flagellation, scalding and sleeping on a bed of thorny substances (Brumberg, 1989), raising the question of whether starvation was a meaningful (or pathological) behaviour in its own right. The various accounts of self-starvation (primarily in women) in the Middle Ages were often interpreted as signs of extreme religious piety, or perhaps even miracles that they had continued to survive on so little nourishment. However, with the coming of the Christian reformation, self-starvation as a means of achieving holiness was viewed with greater suspicion, and perhaps even viewed as demoniacal (Brumberg, 1989; Keel & Klump, 2003).

Miraculous maids

By the seventeenth and eighteenth centuries, young women who abstained from food were termed ‘miraculous maids’ and were scrutinized with both scepticism and awe (Brumberg, 1989). During this period, prolonged abstinence from food was seen as a symptom of organic illness. Richard Morton’s 1694 thesis on consumption is often cited as the first clinical description of what we currently call anorexia nervosa (Strober, 1986). He described a state of ‘nervous atrophy’ characterized by decreased appetite, amenorrhea, food aversion, emaciation, hyperactivity and indifference to the condition. He attributed the condition to a malfunction of the brain and nerves as well as observing a pathological emotional component contributing to a mind-body process (Strober, 1986). The eighteenth century, which saw advances in anatomy and reflex neurophysiology, also brought new conceptualizations of eating disorders. For example, in 1767, the English scientist Richard Whytt attributed food aversions and food cravings to the gastric nerves. Until the

Cambridge University Press

978-0-521-61312-5 - Eating Disorders in Children and Adolescents

Edited by Tony Jaffa and Brett McDermott

Excerpt

[More information](#)

5 A developmental perspective

nineteenth century the term ‘anorexia’, or loss of appetite, was applied to the symptom associated with a variety of physical and emotional disorders such as hysteria, mania, melancholy, chlorosis and psychotic disorders.

Emergence of anorexia nervosa in the 20th century

Anorexia nervosa emerged as a distinctive syndrome in the latter part of the nineteenth century, as described by separate reports by William Gull and Charles Lasègue. Gull took note of onset during adolescence, preponderance in females and significant psychological component. Lasègue’s report on ‘l’anorexia hysterique’ likewise underscores the psychological component to the disease in his case study,

A young girl . . . suffers from some emotion which she avows or conceals . . . At first she feels uneasiness after food. At the end of some weeks there is no longer a supposed temporary repugnance, but a refusal of food that may be indefinitely prolonged.

(Cited in Strober, 1986, p. 235.)

It also pointed out the role of the family in the disease form and process.

The family has but two methods at its service which it always exhausts – entreaties and menaces, and which both serve as a touchstone. The delicacies of the table are multiplied in the hope of stimulating the appetite; but the more the solicitude increases, the more the appetite diminishes. (Cited in Strober, 1986, p. 235.)

The debate over fasting girls existed against the backdrop of the Victorian debate between science and religion. The existence of these young women, despite their abstinence from nourishment, seemed to defy science, and aroused suspicion particularly from scientists and medical doctors. As fame and fortune were potential outcomes of the publicity surrounding such girls, scrutiny of their means and motivation was not uncommon.

While Gull and Lasègue’s work clearly defined the clinical features of AN, conceptualizations of the disease and treatments remained controversial. The beginning of the twentieth century saw a trend towards medicalization of diseases. In 1914, Simmond published a case report about cachexia due to pituitary dysfunction. For several years following this publication, the notion of hypophyseal insufficiency and a largely biological/medical conceptualization of the disease dominated popular conceptualizations (Vandereycken, 2002).

Psychoanalytic theories

The 1940s and 1950s saw the rise of psychoanalysis in psychiatry, and so followed a dominance of psychoanalytic perspectives on anorexia and obesity.

6 M. Vemuri and H. Steiner

Hunger was seen as an innate drive, and food viewed as an unconscious symbol of desires (e.g. love, hatred, sexual gratification, pregnancy). The fear of food intake seen in anorexia was linked with unconscious fears of oral impregnation, or fears of adulthood and sexuality (Bruch, 1973; Brumberg, 1989).

Psychodynamic theories

Hilde Bruch's prolific studies of eating disorders in the latter half of the twentieth century brought a broader, deeper perspective to eating disorders. She supported the notion of early developmental problems resulting in a disruption of an individual's emotional and physiological experience of food and satiation (Bruch, 1973). She argued that inappropriate reciprocal feedback patterns between mother and child around feeding may result in disturbances in hunger awareness, particularly if feeding occurred to gratify the mother's needs over the child's (e.g. in order to keep the child quiet, or timing feeds to suit mother's needs). Such disruptions may affect a child's development of autonomy or inner-directedness (Bruch, 1973). She noted in both obese and anorexic patients: a misperception of their body size, misperceptions of satiety, misperceptions or resistance to their sexual role, and misperceptions of their affective states. She speculated that anorexic and obese patients alike experience their bodies as not being truly their own, but under the influence of others. She viewed the behaviours associated with anorexia as a means of undoing feelings of passivity, ineffectiveness and control by outside forces.

History of bulimia

The term bulimia nervosa (BN) was first introduced into the medical literature by Gerald Russell in 1979 and, it should be noted, was first introduced as a sub-type of AN. While historical examination shows evidence of behaviours similar to AN, it is difficult to find the same pattern for bulimia. Bingeing behaviours and purging behaviours have certainly existed prior to the twentieth century. Vomitoriums existed in ancient roman times, and bingeing/purging may have been common behaviours. Excessive appetites have also been described historically. However, a consistent pattern of behaviours, or afflicted populations, has not been elucidated. Many of the historical descriptions cited in literature seem more consistent with other disorders such as AN, or psychogenic vomiting. Moreover, many of the afflicted individuals were known to be men, rather than adolescent women. Access to food may have also been a key factor to the development of the disease. Historically, food consumed a much

7 A developmental perspective

larger part of household income, and was possibly more scarce, making binge-eating much more difficult, and/or more likely to occur in men (Keel & Klump, 2003).

Contemporary social trends influencing the development of eating disorders

In the nineteenth century, Charles Lasègue observed the importance of home environment in shaping eating disorder pathology, as well as precipitating emotional stress. Historian Joan Jacob Brumberg points out that during this period in history, middle-class sons and daughters were spending greater amounts of time at home, creating a 'prolonged dependency and intensification of parent-child relationships' (Brumberg, 1989), which she suggests provided fodder for psychological predicaments surrounding individuation. Moreover, as food was becoming more abundant, family meals took centre stage in daily life and perhaps became an accessible (and socially appropriate) venue for daughters to express themselves through their eating patterns. In the twentieth century a new thin ideal for women emerged. Vandereycken notes,

Until the 17th century, the tummy-centered and – by present day standards rather plump – woman was admired. This 'reproductive' type was then replaced by the 'hour-glass' model, with a narrow waist, full bosom, and round bottom. Since the late 19th century, the idealized shape for women has been the lean, almost 'tubular' body type, deprived of any symbolism of fertility and motherhood. (Vandereycken, 2002.)

Fatness became associated with the middle or lower classes in the nineteenth and twentieth centuries. The 'flapper era', where slenderness was stylish, emerged in the 1930s – a time when old established sex roles were being questioned (Boskind-White & White, 1986). Ready-made, mass-produced fashions emerging in the twentieth century favoured lean, more androgynous shapes. The 1960s and 1970s saw the emergence of models such as Twiggy, who personified youthfulness, and asexuality, during a period when pre-adolescents made up a large part of the American population. The emphasis on a thin, possibly pre-adolescent body physique for women, and devaluation of fatness and old age, has generally been embraced by culture since then.

Current conceptualizations

Models for understanding eating disorders based on diagnostic criteria

History illustrates that eating disorders are heterogeneous in presentation as well as in background; such heterogeneity makes it difficult to apply a diagnosis. In clinical practice, our diagnostic efforts are generally guided by

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition; APA, 2000) or ICD-10 (International Classification of Diseases, 10th edition) criteria. The clinician must place the patient and their behaviour into distinct categories, in order to separate normal from pathological behaviour. Currently the DSM-IV includes the following under eating disorders: AN, BN and eating disorder not otherwise specified (EDNOS). Anorexia nervosa is characterized by the refusal to maintain a minimally normal weight. Bulimia nervosa is characterized by repeated episodes of binge eating, followed by inappropriate compensatory behaviour (including vomiting, fasting, excessive exercise, laxatives, diuretics). In addition, the DSM-IV includes fear of becoming fat, and amenorrhoea in postmenarchal women as necessary criteria for AN. Disturbance in perception of one's body weight and size is included as a necessary criterion for both disorders. Two additional diagnoses are included in the DSM-IV: EDNOS and binge-eating disorder (BED), which is included as a provisional category. Eating disorder NOS is essentially any eating disorder which does not fulfil criteria for AN or BN. Obesity, while arguably a result of maladaptive eating patterns, does not appear in the DSM-IV because it has not consistently been associated with a specific psychological or behavioural syndrome.

In addition to guiding our diagnosis of eating disorders, the DSM-IV criteria naturally influence the way we conceptualize disorders. In that respect, it may fall short – it is not designed to focus on pathogenic processes, and therefore does not inform the clinician about aetiologies of disease. Its categorical approach has also been criticized for being both overinclusive and underinclusive. For example, the DSM-IV criterion of weight phobia for AN may not apply across cultures. Weight phobia is more often seen in westernized countries than in other cultures, and has therefore been speculated to be a culture-bound feature of eating disorders. Additionally, individuals with atypical behaviour (i.e. who purge, but do not binge, or who use insulin to control their weight) would be excluded from DSM-IV criteria for either AN or BN. Amenorrhoea may be an overinclusive criterion in that it may be a consequence of malnutrition (not primarily AN), which may occur as a result of numerous medical disorders.

The categorical approach of the DSM-IV has also been criticized for creating artificial boundaries among various eating disorders, and from 'normal'. The developmental perspective argues that the pathological phenomena, which are the criteria for eating disorders, in fact occur quite commonly in so-called normal populations. Descriptive criteria imply a level of independence and stability of disorder that is not justified in the context of rapid

9 A developmental perspective

changes, such as in adolescence. Sometimes patients fulfil all diagnostic criteria at one point, only to rapidly exit from the illness as they grow older and operate in a different social and temporal context (peer group, family, middle vs. late adolescence). The developmental perspective also challenges the notion that symptoms are sole expressions of internal deficits. It asserts that symptoms are also the function of external environment, represent adaptations to that environment, and thus are impossible to understand without taking psychosocial context into account.

Models for understanding eating disorders based on aetiology

Eating disorders are best understood as final common pathways that result from a wide range of interactions between psychosocial influences and endogenous vulnerabilities. We review diverse fields from genetics to feminist theory, which have contributed to our understanding of eating disorders.

Biological vulnerabilities and conceptualizations

Eating disorders have long been observed to run in families, and genetic epidemiological studies have uncovered evidence that eating disorders are, to some degree, heritable (Wade *et al.*, 2000). Thus far there has been little evidence of genetic main effects. Gene–environment interactions ($G \times E$) with the effect of environment conditional upon the individual's genotype are a promising research area (see Leor, Krispin & Apter, Chapter 6, this volume). Mercer (Chapter 2, this volume) summarizes biological food intake and weight control systems that are potential targets for future single gene, polygenic and $G \times E$ research.

Psychological/individual: influences and models

Personality types have often been linked to eating disorders (Wonderlich, 2002). The personality style of patients with restricting type AN is often described as obsessive, socially inhibited, compliant and emotionally restrained (reminiscent of obsessive-compulsive disorder). The personality style of patients with BN is often described as impulsive, interpersonally sensitive and low in self-esteem (more akin to borderline features).

Cognitive behavioural models hold that anorexic and bulimic symptoms are maintained by a characteristic set of beliefs about weight and shape. Core cognitive disturbances are understood in terms of 'schema' (organized cognitive structures) that unite the views of the self and the culturally derived beliefs about the virtue of thinness for female appearance. Such schema give rise to the belief that the solution to a view of the self as unworthy, imperfect and

10 M. Vemuri and H. Steiner

overwhelmed is thinness and weight loss, which are therefore pursued relentlessly (Shafran & de Silva, 2003). This approach does not account well for the fact that the majority of women holding similar beliefs do not necessarily lead to eating disorders or even dieting.

Environmental influences and models*Media and social milieu*

The 'cult of thinness', a term coined by Gerald Russell, has been observed in art, fashion and the media in the latter half of the twentieth century. Models, actresses and Miss America contestants were observed to become thinner in the twentieth century (Garner & Garfinkel, 1980). A greater emphasis on dieting emerged in the media, targeting women more than men (Stice, 2002). Effects of media are particularly profound upon young women who had body image dissatisfaction at the outset, suggesting a profound interplay between the individual and environment. The increased prevalence of eating disorders during the latter half of the twentieth century, as well as the emergence of BN, have been connected to the emergence of the thin-ideal and the increased pressure towards dieting. However, Garner & Garfinkel pointed out that the thin-ideal represented much more than just that – thinness has come to represent beauty, attractiveness, health and achievement (Garner & Garfinkel, 1980). In addition, parental pressure to lose weight, family criticism of weight and maternal investment in daughters' slenderness have been positively correlated with adolescent eating disturbance (Stice, 2002).

Dieting leading to eating disorders

Prospective studies have linked dieting to eating disorders (Fairburn *et al.*, 1997). Whether dieting *leads* to eating disorders is controversial. The 'continuity theory' suggests that the risk of developing an eating disorder is proportional to the intensity of dieting, and is based on observations that culturally acceptable dieting may blur or merge with what is considered pathological thinness (Nasser & Katzman, 2003). Alternatively, the discontinuity theory suggests that dieting leads to the development of eating disorders only in the presence of other risk factors (see Stice & Buston, Chapter 4, this volume for further discussion).

Eating disorders as reaction to changing roles/a voice for women

By the latter half of the twentieth century, Hilde Bruch commented on the pressure of conflicting feminine roles creating ambivalence in young women

11 A developmental perspective

about their bodies. Nasser & Katzman (2003) argue that the increasing incidence of AN during this period existed against the backdrop of decreasing hysteria, and may each have been ‘adaptive processes’ in the face of particular environmental factors. Specifically, ‘hysteria’ was commonly thought to be a product of a sexually repressive environment while the anorexic thinness began to be viewed as responding to new environmental demands that promote the desirability for thinness (Nasser & Katzman, 2003).

Culture-bound syndromes

Rising incidence of eating disorders, tendency to afflict young women in westernized countries and gender bias favouring women has given rise to speculation that eating disorders are culture-bound syndromes. Keel & Klump’s (2003) meta-analysis investigating eating disorders cross-culturally and cross-historically found little evidence that AN is a culture-bound syndrome, but did find evidence that *weight phobia criteria* may be culture-bound, again calling into question the usefulness of a descriptive approach offered by the DSM-IV. In contrast to their observation of stable rates of AN across time and culture, Keel & Klump’s investigation did demonstrate a statistically significant increase of BN over the latter half of the twentieth century, concluding that BN, as well as the weight concerns associated with AN, may be culturally bound phenomena.

Multidisciplinary conceptualizations: the biopsychosocial approach

Biopsychosocial approaches recognize component contributions of biological vulnerabilities, psychological vulnerabilities and environmental triggers. But even this comprehensive perspective is incomplete, because it does not lead us to a carefully integrated account of the various processes leading to the disorders. Ideally, a diagnostic model would provide such an account and may lead the clinician to treat specific processes which have to be ameliorated for a disorder to improve. Biopsychosocial models may be more helpful in retrospectively conceptualizing the contributory aspects to the disease, in a developed adult. However, eating disorders are largely diseases of adolescence with specific risk ages of onset at 14 and 18 and a usual range of 12 to 25, mostly in females (Fichter & Quadflieg, 1995). Conceptualizing these diseases therefore may be most productive if the approach appreciates the temporal development of the disease, with close attention to the development in childhood and adolescence.