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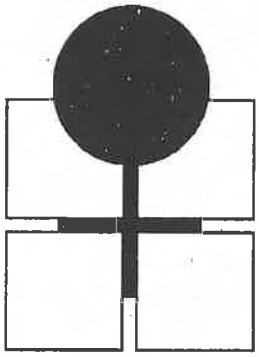

MAPPING RESISTANCE ON THE BODY: INTERSECTIONS OF VIOLENCE, ANOREXIA, AND BULIMIA IN GIRLS

by

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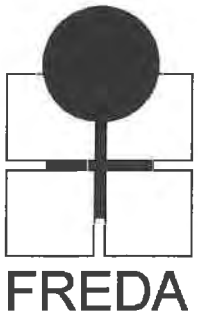

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MAPPING RESISTANCE ON THE BODY: INTERSECTIONS OF VIOLENCE, ANOREXIA, AND BULIMIA IN GIRLS

INTRODUCTION

Anorexia nervosa (AN) and bulimia nervosa (BN) have become central to feminist discussions of the female body. Over 90 percent of those experiencing these eating behaviours are girls and women (Kuba & Hanchey, 1991; Prince, 1985; Siever, 1996), thereby implicating gender as the critical lens through which to examine their etiologies. Moreover, the development of anorexic and bulimic eating patterns most often occurs during adolescence and during late adolescence or early adulthood, respectively (Kuba & Hanchey, 1991). As a consequence, the gender-specific experiences of girls during childhood have become an increasing focus of attention. In particular, the relationship of childhood abuse and the development of eating disorders has been increasingly hypothesized and studied over the last decade (Miller, 1996). Within the literature, the interpretation of the girl's body in relation to her sociocultural context, her personal history, and her own sense of self remain contested.

THEORIZING CONNECTIONS BETWEEN EATING PROBLEMS AND VIOLENCE

Wiederman (1996) notes that two decades of theory and treatment regarding anorexia have been shaped by the *psychoanalytic model*. Initial accounts of AN and BN focused on the girl's fear of oral impregnation. The legacy of psychoanalysis can be seen in views that anorexia is a method of avoiding sexual activity, sexual maturity, or sex-role conflicts (Weiner & Stephens, 1996). Links between violence and eating problems therefore centre primarily on sexual abuse. Theorists argue that the starvation of the body results in the de-sexualization of the body, through cessation of menses and the rejection of the mature female body shape. Psychoanalysis has been the precursor to *trauma-based theories* (Brown, 1997), in which AN and BN are viewed as survival strategies in response to crisis or overwhelming stress (Schwartz & Gay, 1996). A growing body of literature is examining dissociation as a common characteristic of both eating disorders and childhood abuse (Reto, Dalenberg & Coe, 1996). Feelings of guilt, shame, and disgust (Brown, 1997; Oppenheimer, Howells, Palmer & Chalmer, 1985; Rorty & Yager, 1996) that result from abuse are purged through the destruction of the body. Recent *Sexual Barrier Weight* theories have attempted to relate traumatic experiences to body size across the life span (Brown, 1997). For example, Weiner and Stephens (1996) found evidence in patients' individual weight graphs that some of the women experiencing BN and AN avoided weight points at which past traumatic sexual events had occurred.

The *biomedical* explanation of eating disorders is a mechanistic one. AN and BN are physiological failings and physiological dangers (Thompson, 1992). The girl is the victim of her body's dysfunction. Eating disorders have been attributed to brain tumours, serotonergic hypothalamus disorders, sensory disturbances and cognitive malfunctions, seasonal changes or lack of sunlight (Lester, 1997). Treatment emphasizes pharmaceutical strategies, such as imipramine, phenelzine, amitriptyline, tranylcypromine, and desipramine (Herzog, et al., 1991). Wonderlich, et al., (1997) link childhood abuse to the development of eating disorders by observing that trauma may cause lasting disturbances in noradrenergic, serotonergic, dopaminergic, and endogenous opiate neurochemical systems. The same systems regulate eating behaviour. Little attention is paid to historical or social factors in the biomedical model (Thompson, 1992). The discourse of the female body is one of reparation. The meaning that the girl assigns to her own body is outside of consideration.

Feminist models of anorexia and bulimia posit the oppression of girls and women as the primary causal factor (Kuba & Hanchey, 1991). AN and BN are viewed as logical extensions of an enforced feminine script that emphasizes thinness and controlled food consumption (Chrisler, 1991; Nasser, 1988; Thompson, 1992). These eating behaviours represent a pathology of society rather than the girl. They may be read as an internalization of female gender roles or as a form of social protest against control of the female body (Lester, 1997). "Over-dieting" and "the destruction of the female body" by girls is interpreted against a continuum of sexual exploitation, violence against girls and women, and fat-phobia (Stermac, Piran & Sheridan, 1996). Eating "disorders," then, are not sites of extreme abnormality, but rather of extreme normality. Indeed, Chrisler (1991) has argued that food is an addiction particularly suited to women, who are primarily responsible for its preparation and procurement. Moreover, Thompson (1992) has observed that, for adolescent girls, food may be the most accessible and socially sanctioned drug that they can obtain.

The model of anorexia and bulimia as *culture-bound syndromes* (CBS) suggests that these eating patterns are not universal, but are culturally and historically particular (Prince, 1985; Swartz, 1985). Whereas mainstream psychiatry recognizes sociocultural influences on the frequency of illness, CBS researchers examine how these influences define the illness itself (Prince, 1985). It has been consistently claimed that AN and BN are highly specific to western experience (Prince, 1985). In addition, anorexia has not been substantially documented in patients of colour (Robinson & Andersen, 1985). Prince (1985), a transcultural psychiatrist at McGill University in Canada, reports that AN has been rare or absent in New Guinea, India, and West Africa. But while research on eating disorders in white women has exploded over the past 15 years (le Grange, Telch & Agras, 1997), there remains a relative paucity of publications on North American women of colour and women of non-western countries (Hof & Nicolson, 1996; Osvold & Sodowsky, 1993). Many of the publications that do exist are case studies (Davis & Yager, 1992). Past research indicates that people(s) of colour(s) represent 1.8 percent to 5 percent of referrals for anorexia and bulimia (Davis & Yager, 1992). Anorexia has been reported from Japan since the mid 1970s (Davis & Yager, 1992) and has been characterized as "quite frequent" (Prince, 1985). Mumford, Whitehouse & Choudry (1992) found prevalence rates of 0.3 percent for bulimia nervosa and 1.6 percent for eating disorders including partial BN cases in Lahore, Pakistan. Case studies have been reported in Egypt (Ford, 1992) and among South Asian children in England (Bryant-Waugh & Lask, 1991). The latter researchers concluded that AN is

not a white illness. In North America, Snow and Harris (1989) found that 11 percent of Pueblo and Latina/o high school students (86 percent female) met DSM-III criteria for bulimia. The great majority said that they binged or skipped meals because they were worried about their weights. In a study by Smith and Krejci (1991), Aboriginal youth scored higher on all measures of eating disorders and bulimia than did Latina/o and white youth. Other research has shown no significant differences between women of colour and white women in reports of eating patterns or prevalence of eating disorder diagnoses (le Grange, Telch & Agras, 1997). The CBS approach acknowledges social and cultural influences on concepts of the body. It has generally minimized analyses of gender (Katzman & Lee, 1997), however, and has failed to account for the overwhelming predominance of girls and women among those experiencing eating problems. Furthermore, it is not clear whether the claim of AN and BN as western culture-bound syndromes can be conceptually or empirically supported. Cross-cultural findings cannot be interpreted outside of global, racial, and colonialist hegemonies, in which westernization is not only commodified but also enforced.

METHODOLOGICAL ISSUES IN STUDYING VIOLENCE, ANOREXIA, AND BULIMIA IN GIRLS

Literature reviews have repeatedly emphasized the methodological limitations of the eating disorder research (Wonderlich, et al., 1997).

Defining Abuse

Widely varying definitions of abuse, and particularly child sexual abuse (CSA), have made comparisons among studies and conclusions difficult (Dansky, et al., 1997; Miller, 1996). Some researchers define and measure CSA as both contact and noncontact experiences (Moyer, et al., 1997); others measure only contact experiences (Schmidt, Tiller & Treasure, 1993). Many definitions provided in the research are vague (Miller, 1996). Rorty and Yager (1996) have pointed out that a continuum of maltreatment must be considered that includes parental/caretaker intrusiveness (e.g., opening mail, eavesdropping, reading diaries) and inappropriately sexualized relationships (e.g., genital exposure, sharing pornography). One difficulty concerns how to define CSA to properly exclude consensual sexual experiences with peers (Connors & Morse, 1993) while including coercive sexual experiences.

Sampling

Studies have relied heavily on clinical samples (Moyer, et al., 1997). Reviews have shown that inpatients demonstrate higher sexual abuse rates than do outpatients (Connors & Morse, 1993), so results may not be representative of the community at large. Sample sizes have also tended to be small, which may be a function of the low incidence rates of eating disorders in the general population and the difficulty of obtaining community samples (Wiederman, 1996).

Response Bias

Some researchers have suggested that mixed results may be, in part, attributable to under-disclosure of abusive experiences, because of denial, repression, and dissociation (Connors & Morse, 1993; Miller, 1996). This may particularly affect girls and women who have experienced more severe forms of abuse (Miller, 1996). More inclusive definitions of abuse, the use of inverted funnel questioning (i.e., specific and overlapping questions about the experience), and interviewing tend to elicit greater disclosure (Connors & Morse, 1993; Miller, 1996). In Reto, Dalenberg & Coe's (1996) research, 42 percent of children who described multiple experiences of burning, biting, kicking, and beating with an object by parents did not self-label it as abuse. A third (33 percent) of women who did not disclose child sexual abuse on an intake questionnaire later disclosed in a research interview (Miller, 1996). Reports of childhood abuse by women generally demonstrate high rates of corroboration, exceeding 75 percent (Weiner & Stephens, 1996).

Measurement Bias

Diagnostic criteria of anorexia and bulimia have been inconsistent across studies, making comparisons and compilations of results problematic (Connors & Morse, 1993; Davis & Yager, 1992; Hof & Nicolson, 1996; Wiederman, 1996). There has been little attention to the development of standardized instruments in non-western samples (Davis & Yager, 1992; Lee & Lee, 1996; Littlewood, 1995), resulting in eurocentric diagnostic biases. For example, Lee and Lee (1996) have noted that references to "diet food" and caloric counting are inappropriate for use in Hong Kong samples.

Design Problems

Connors and Morse (1993) have observed that studies examining CSA in AN and BN women generally have reported higher prevalence rates than those correlating CSA and eating symptomatology in community samples. Studies have been almost exclusively retrospective. Both adult women and adolescent girls are asked to recall abuse history and childhood environments (e.g., DeGroot, et al., 1992; Miller, 1996; Moyer, et al., 1997; Schmidt, Tiller & Treasure, 1993). As a consequence, research has been almost entirely correlational and no real causal conclusions can be drawn (Stermac, Piran & Sheridan, 1996). Moreover, the use of retrospective approaches tends to focus on adult samples, remembering childhood through an adult perspective, rather than on adolescent samples when eating disorders tend to develop (Herzog, et al., 1991). Prospective studies are needed to confirm the direction of an abuse-eating disorder relationship, to explore concomitant variables, and to allow time-series or idiographic statistical analyses. Longitudinal data would also be suitable for investigating mealtime experiences and other family patterns surrounding food, power, and beauty (Miller, McCluskey-Fawcett & Irving, 1993).

Interpretive Issues

One reviewer has questioned whether correlations between eating disorders and sexual abuse are meaningful, given that both occur predominantly for women and girls (Connors & Morse, 1993). The high prevalence of CSA in women with anorexia and bulimia has been ascribed to high base rates of both occurring in clinical populations (Reto, Dalenberg & Coe, 1996), which is the population used most often for sampling (Moyer, et al., 1997). Several reviewers have highlighted the lack of comparison or control groups in research of CSA in AN and BN women (Dansky, et al., 1997; Moyer, et al., 1997; Wiederman, 1996).

FINDINGS ON EATING PROBLEMS AND ABUSE

Past research has demonstrated that women with adverse family backgrounds or childhood experiences are more likely to develop eating problems (Kinzl, et al., 1994), particularly bulimia (Schmidt, Tiller & Treasure, 1993). Variables contributing to this environment include parental indifference, excessive parental control, intrafamilial discord, and parental disapproval (Schmidt, Tiller & Treasure, 1993).

Sexual Abuse and Trauma

Sexual abuse has been a topic of research and interest since the mid 1980s (Thompson, 1992). Studies investigating possible associations between childhood sexual abuse (CSA), anorexia, and bulimia have been primarily North American (Davenport, Browne & Palmer, 1994). Results have been inconsistent (Connors & Morse, 1993; Mullen, et al., 1993; Reto, Dalenberg & Coe, 1996). Interest in the connection between CSA and eating problems has grown because high prevalence rates of sexual abuse history have been observed in women presenting with anorexia and bulimia. Reviews have cited broad-ranging rates, such as 6 to 66 percent (Connors & Morse, 1993), 6 to 62 percent (Miller, 1996), and 7 to 66 percent (Reto, Dalenberg & Coe, 1996) of women with eating disorders who report CSA. Connors and Morse (1993) noted that prevalence rates tend to cluster around 30 percent. Consistent with this observation, others have found rates of 38 percent in New Zealand (Mullen, et al., 1993) and 25 percent in Canada (DeGroot, et al., 1992). Miller (1996), however, found that 61 percent of white North American women with eating disorders had been sexually abused before their 18th birthday. On average, the women were 10 years old when they were first abused. Half of them experienced accompanying force and 85.5 percent contact abuse. The reported age of onset for their eating disorders was *after* their first experience of sexual abuse.

Evidence has been found by various researchers for an association between past sexual trauma and bulimia (Dansky, et al., 1997; Everill & Waller, 1995a; 1995b; Lanzi, et al., 1997). Correlations are statistically significant but not strong (e.g., r=.21, p<.001, Baldo & Baldo, 1996; r=.224, p<.001, Connors & Morse, 1993). In her study of African-American, Latina, and white North American women, Thompson (1992) found that sexual abuse history was the trauma that participants most frequently related to the development of their eating problems. Dansky, et al.

(1997), in a national U.S.-based study of 3006 women found that women with bulimia had experienced higher rates of rape, sexual molestation, aggravated assault, direct victimization, and current and lifetime posttraumatic stress syndrome. Some researchers have reported no relationship between eating behaviours and CSA (Kinzl, et al., 1994; Moyer, et al., 1997). Others have found no distinction in CSA rates between anorexic and bulimic symptomatology in urban English (Schmidt, Tiller & Treasure, 1993) and urban Canadian (DeGroot, et al., 1992) samples.

Whereas Wonderlich, et al. (1997) concluded in their review of 53 controlled studies that AN and BN were not related to severity of abuse, they and others (Miller, 1996) observed that physical force accompanying sexual abuse is associated with eating disorders. Higher numbers of unwanted sexual experiences (Mullen, et al., 1993) and higher numbers of abusers (Davenport, Browne & Palmer, 1994) have also been pinpointed as contributory factors. Women who have experienced past extrafamilial child sexual abuse have reported bingeing, vomiting, fasting, and using diet pills more frequently than those who have not (Hernandez, 1995). Intrafamilial sexual abuse (Baldo, Wallace & O'Halloran, 1996), particularly by a close male relative (Mullen, et al., 1993), has been linked to greater likelihood and more serious manifestations of eating disorders.

Reviewers have concluded that child sexual abuse is neither necessary nor sufficient for the development of eating problems, but does act as a contributory factor in a multidimensional etiological model (Connors & Morse, 1993; Dansky, et al., 1997; Reto, Dalenberg & Coe, 1996; Rorty & Yager, 1996). Overall, gender differences in responding to sexual abuse have been noted in which female adolescents may be at greater risk for suicidal ideation and behaviour, eating disorders, and more frequent use of alcohol (Chandy, Blum & Resnick, 1996). Chandy, Blum and Resnick suggest that this is because girls respond with internalizing strategies and boys respond with externalizing strategies. Brown (1997) has offered a parsimonious and direct explanation of existing links between childhood sexual abuse and eating behaviours. She describes the role of food within an abusive context, where childhood abuse can include starvation, force-feeding, forced ingestion, emotional abuse around eating and weight, forced eating of vomitus or spoiled foods, physical abuse during meals, use of food as rewards or bribes following abuse, and use of food in sexual acts. Food itself may simply be unpalatable, an aversion, or a provision to which the girl is not accustomed to having control or access.

Physical Abuse

Childhood physical abuse has received much less attention in the literature than has childhood sexual abuse (Reto, Dalenberg & Coe, 1996; Rorty & Yager, 1996). The occurrence of physical assault in the absence of sexual trauma has not generally been investigated (Dansky, et al., 1997). Some research does exist, however, that supports the inclusion of physical abuse in etiological models. Childhood violence history predicted both the presence of and severity of bulimia in 169 white and 14 Latina/o North American students (Reto, Dalenberg & Coe, 1996). Schmidt, Tiller & Treasure (1993) found that 25 percent of women with BN and 3 percent of women with AN reported a history of physical abuse. Research on 2986 sixth, ninth, and twelfth grade North American girls (85 percent white, 9 percent Aboriginal, 7 percent African-American) demonstrated that physically abused participants were significantly more likely to report eating disorders (Hernandez, 1995).

Battering[1]

There has been virtually no research to examine the role of battering in adolescent girls' romantic relationships and their pre-existing or developing eating problems. Yet, 35 to 50 percent of young adults are involved in some level of physical partner abuse (Danielson, et al., 1998). In research by Mercer (1987), 20 percent of Toronto secondary school women reported experiencing abuse in their romantic relationships. Moreover, adolescent wives (aged 15 to 19) are murdered three times more often than adult wives (Canadian Centre for Justice Statistics, 1994). Leighton (reported in BWSS, 1997) has noted that observation of woman abuse by children is linked to the development of eating disorders. Almost two-thirds of women interviewed by Danielson, et al. (1998) who experienced severe spousal abuse met the criteria for one or more psychiatric diagnostic categories and had elevated rates of mood, anorexic/bulimic, and substance use problems. These findings suggest that battering and other forms of abuse in adolescent girls' heterosexual and lesbian romantic relationships should be a topic of future investigation within the field of eating disorders.

The relationship between childhood and adolescent history of abuse and the etiology of anorexia and bulimia is both an empirical and clinical question. Rorty and Yager (1996) address the relationship between these two contexts: "Empirical research cannot – and need not – answer questions of individual meaning. Clinical accounts, as well as our own work with eating disordered women, have demonstrated that many women experience and interpret their eating disorder as an intricately connected direct or indirect response to the trauma of childhood abuse" (p. 24).

STATE AND SYSTEMIC OPPRESSIONS AND THE DEVELOPMENT OF EATING PROBLEMS

Bowen, Tmoyasu, and Cauce (1991) have noted that eating disorder research has ignored the effects of poverty and race even though their importance in AN and BN has been documented for 20 years. It is not simply racial, cultural, sexual, and class *differences* that have been under-represented. Rather, racism, classism, anti-Semitism, and heterosexism as *systems of oppression* have been neglected factors. If feminist theory posits the body as a site of power and violence, then the role of racism is unexplainably absent in hypotheses about the genesis of anorexia and bulimia. The body has been a terrain of racialized, sexualized, and classed power negotiation through enslavement, indentured labour, imprisonment, rape, reservations, segregation, and genocide. Oppressive experiences are a site to examine how the "idealized body" interacts with the "hated body." Indeed, feminist theory has been critiqued for separating out and elevating sexism above other intersecting forms of marginalization, both generally (Agnew, 1996; Bannerji, 1997; hooks, 1984; Lugones, 1992; Lugones & Spelman, 1995) and specifically in the field of eating disorders (Robinson, et al., 1996; Thompson, 1992). Bowen, Tmoyasu & Cauce (1991) have pointed out that many references to "cultural attitudes" and

[1] Research by Mercer (1987), Canadian Centre for Justice Statistics (1994), and Leighton was integrated by Battered Women's Support Services, Vancouver, in the 1997 report: *Violence Against Women in Relationships in British Columbia: A Fact Sheet.*

"cultural influences" within the eating disorder literature focus exclusively on white middle- to upper-class women's experiences.

Thompson (1992) has proposed that eating problems may develop from women's strategies for coping with the traumas of racism, classism, sexism, heterosexism, and poverty. African-American women's heavy work burdens, their de-valuation, racial isolation, and experiences of racism have been linked to eating problems (Thompson, 1992). Black women's levels of body satisfaction have been significantly related to their levels of political and racial identity (Harris, 1994). African-American and Latina women in Thompson's study indicated that the pressure of assimilation, particularly in a context of class mobility, was a factor in their own eating problems. Poor women and/or women of colour experience more limited access to health care (Robinson & Andersen, 1985). Ethnocentrism in the health care system has resulted in a lack of information about health issues affecting women of colour and has discouraged women from seeking help for fear of reinforcing racial stereotypes of themselves as "nurturing, well-nurtured, and overweight" (Bowen, Tmoyasu & Cauce, 1991:134; Dolan, 1991). As a result, African-American and Latina women are underdiagnosed, misdiagnosed, and late being diagnosed for eating disorders, leading to greater severity prior to diagnosis (Thompson, 1992).

Brumberg (1988) has referred to anorexia nervosa as a "middle-class psychopathology" (p. 134), reflecting the widespread belief among current researchers that eating disorders are class-bound (Nasser, 1988). But in a review by Gard & Freeman (1996), a greater number of studies and more rigorous studies found no class relation or found an inverse relationship between class and eating symptomatology. One woman interviewed by Thompson (1992) believed that her eating problems were attributable to the stress of her poverty. There has been little research examining the etiology of AN and BN among poor women, who are less likely to diet chronically or participate in institutional or recreational exercise than middle-class women (Bowen, Tmoyasu & Cauce, 1991). Moreover, these women may face more weight-related stigmatization due to overlapping stereotypes of both poor and fat women as lazy, unhygienic, disorganized, and incapable. Studies on poor and working-class women may be difficult using instruments normed on middle-class white women, however. Data provided by Eisler and Szmukler (1985) support this concern, as responses to individual items on Eating Attitudes Tests systematically differed by class. Requirements imposed on women to modify their bodies for obtaining access to employment, education, economic resources (Littlewood, 1995), and marriage implies a logical association between class and eating.

Studies on sexuality and eating disorders have generally addressed the salience of the male gaze in etiology (Beren, et al., 1996; Heffernan, 1994; Siever, 1996). The effects of compulsory heterosexuality and heterosexism have not been directly examined. Thompson (1992) reported that some of the 12 lesbians in her study reported bingeing in response to the isolation of coming out. She has hypothesized the role of heteronormativity in AN and BN:

> Expectations about heterosexuality were partly taught through messages that girls learned about eating and their bodies....As the girls approached puberty, many were told to stop being athletic, begin wearing dresses, and watch their weight. For the women who weighed more than was considered acceptable, threats about their need to diet were laced with admonitions that being fat would ensure becoming an "old maid." (p. 555)

Results by French, et al., (1996) that eating disorders emerge in bisexual and gay men in the absence of any sexual experience with men suggests greater consistency with a gender nonconformity hypothesis than an isolated male gaze hypothesis to explain higher reports of AN and BN among gay men (Beren, et al., 1996; French, et al., 1996; Siever, 1996). Thus, systemic suppression of sexualized gender violation may be a contributory factor in the etiology of eating problems.

Abuse imposed by individuals and families has been examined within patriarchal, and thus systemic, context. But state violence against girls has been an omitted area of research. It is unclear how the development of eating patterns, such as AN and BN, might relate to residential schools, immigration policies, reservations and the Indian Act, state apprehensions of Aboriginal children, imprisonment, institutionalization, compulsory education, war, and Holocaust survival. Past histories of peoples that are linked to food deprivation or food control may be related to eating patterns and to the way in which eating problems manifest. Initial findings by Garfinkel, et al., (1995) that bulimic women in a Canadian community sample had spent more time at foster or group homes as children suggest that hypotheses about institutionalization need to be generated and tested.

An examination of systems of oppression leads to a reconsideration of current etiological models of AN and BN. Thompson (1992) has best summarized this: "Ultimately, the prevention of eating problems depends on women's access to economic, cultural, racial, political, social, and sexual justice" (p. 559). To address eating disorders as unidimensional and as individual pathological responses to a thin beauty ideal does not address the issue of justice. "In countries [celebrating] glorified images of youth, whiteness, thinness and wealth, it makes painful sense that dissatisfaction with appearance often serves as a stand-in for topics that are still invisible" (Thompson, 1994:10, cited in Katzman & Lee, 1997:389), such as racism, classism, and colonialism.

DEBATING THE ROLE OF THE BODY

The predominant model of feminist theorizing about anorexia and bulimia has been a "fat-phobia" etiology. Women are described as more concerned about weight, as restricted socially to a narrower range of appropriate weights, and as socially penalized for fatness (Chrisler, 1991; Siever, 1996). Thinness is not a universal standard, however. For the majority of societies, fatness is valued as a secondary sexual characteristic (Nasser, 1988; 1997). Abood and Chandler (1997) found that white North American women were more dissatisfied with their bodies than were Black North American women, although the latter, on average, weighed more. This finding is consistent with a statement by a 34-year-old Black woman in Bowen, Tmoyasu & Cauce's study (1991): "At work, where there are only a few of us Black women, I feel pretty fat. At home, with my friends, I don't think about it hardly at all. I guess it's because I'm closer to the middle [of my Black friends' weight range]" (p. 123).

The fear of fatness as a diagnostic criterion for AN and BN is a relatively recent development. It did not appear in the literature as a symptom or factor prior to the 1970s (Hof & Nicolson, 1996; Palmer, 1993), coinciding with a rise in the Euro-North American feminine ideal of thinness

(Prince, 1985). Initially, the etiology of anorexia was ascribed to women's increasing independence, role changes, and struggles for liberation (Hof & Nicolson, 1996).

Bowen, Tmoyasu & Cauce (1991) remind researchers that the meanings of food and eating vary culturally, regionally, and spiritually. Work by Sing Lee has challenged the centrality of fat phobia to the definition of anorexia and bulimia. Many Chinese women and men in Hong Kong exhibit non-fat phobic anorexia (Hsu & Lee, 1993; Lee, 1995; Lee, Chiu & Chen, 1989). Instead, these individuals indicate that bloating or abdominal discomfort accounts for their food refusal (Hsu & Lee, 1993; Lee, Chiu & Chen, 1989). Thompson (1992) found that fat phobia was not the primary source of eating problems for African-American, Latina, and white women interviewed. Fat phobia has also been absent from cases of anorexia among Indian women (Littlewood, 1995). Palmer (1993) has argued that "weight concern and consequent slimming may be the most frequent mode of entry into the disorder in some cultures but not in others" (p. 461). Littlewood (1995) notes that erotic zones of the body are culturally specific, citing differences among Hindu, Northern Indian Muslim, and North American white women. A fat-phobic model of eating disorders that is based on thinness standards of the body torso cannot apply cross-culturally. Instruments normed on white western women for assessing AN and BN are more likely to preclude women and girls whose food refusal is not derived from or associated with a fear of fatness. Moreover, under DSM-IV criteria requiring fat-phobia for classification, these girls would not be diagnosable as "real cases" (Katzman & Lee, 1997).

Critiques by Lee (1991; 1995) that eating disorder criteria are eurocentric have not yet led to substantial clinical, popular, or theoretical re-conceptualization. As Prince (1985) has noted: "Because of the ethnocentric biases of Western psychiatrists (even those of us who are concerned with cultural matters), we seem to believe that true psychiatric syndromes occur only in the West (as described in Western textbooks), and we label only variations from these 'norms' in other cultures as culture bound syndromes" (p. 199). Littlewood (1995) reiterates how the construction of the cultural "other" reifies the West as the standard of both normality and abnormality.

Thompson (1992) stresses how over-reliance on a cultural thinness model reduces the portrayal of white women to one of vanity. She adds: "This construction of white middle- and upper-class women is intimately linked to the portrayal of working-class white women and women of colour as their opposite; as somehow exempt from accepting the dominant standards of beauty or as one step away from being hungry and therefore not susceptible to eating problems" (p. 558). Feminists have theorized an "embodied self" (Lester, 1997). Anorexia and bulimia are viewed as a disembodiment in which the female body is rejected in favour of the valued and disciplined male mind (Lester, 1997). Lester has argued that this explanation recapitulates a (western) mind-body dualism rather than eradicating it. She claims that girls experiencing AN and BN are *very* embodied and very aware of their corporal identities as women. To extend Lester's model, anorexia and bulimia become actions of resistance against *controlled* embodiment and become acts of *re*-embodiment.

To de-centre fat phobia as a diagnostic and theoretical criterion of AN and BN requires a new model. Perhaps, as Thompson (1992) implied, *justice* is an appropriate core for new theorizing. Two (non-orthogonal) dimensions of a Justice Model might include the *Internalization of Injustice*, where social hatred of the body plays out in one's own corporal self-relation, and *Resistance in the Pursuit of Justice*, where control over one's own body is defined and exerted. Rather than being limited to fat suppression, "justice" can be defined through the woman's own

positionality and subjectivity. This model would then dynamically represent the interaction of oppressive "embodiments" (e.g., sexism, racism, heterosexism, anti-Semitism, ableism) and self-liberating struggles for "re-embodiment" (e.g., food refusal, bingeing, purging). Finally, a Justice Model re-orients remedial attention away from an individual pathological girl to hegemonic structures of society.

CONCLUSION

The feminist model of anorexia and bulimia has not fully addressed its purpose of examining the oppression of girls and the societal construction of girls' bodies, as it has relied on a eurocentric lens for its analysis. Katzman and Lee (1997) have called for a synthesis of feminist and cross-cultural theories to bring race and gender together. An essentialized woman's body is not an emancipatory body. It cannot promise "embodiment" for Aboriginal women, women of colour(s), Jewish women, lesbians, poor women, women with disabilities, or transgendered women, whose very em(body)ments are separated from the liberatory model proposed.

DIRECTIONS FOR FUTURE RESEARCH

Several suggestions for future research emerge from this review.

First, it is necessary to expand the scope of "abuse," both in the literature and in clinic intakes. Information is needed on the effects of date rape and of sexual coercion within romantic relationships on AN and BN. Moreover, research on battering and childhood physical abuse is required. The impact of state-imposed violence and systemic oppression on the development of eating disorders must be investigated. During intake and assessment, information should be gathered about experiences of institutionalization, imprisonment, marginalization, residential school history, poverty, sexual trauma, and child apprehension and how these have affected the girl's self-perception.

Second, popular and DSM-IV definitions of AN and BN must be re-examined. In particular, food refusal, self-starvation, and purging in the absence of fat-phobia must be accommodated into diagnosis and treatment. Assumptions regarding the universal etiology and presentation of AN and BN must be challenged and culturally-specific manifestations studied. A greater emphasis on interview techniques would offer detailed and individualized histories prior to AN and BN onset, as would the use of idiographic methodologies.

Third, research on the precursors and concomitants of AN and BN must be expanded. Information regarding the specific role of food in the individual girl's abusive history should be obtained and treatment programs tailored to personal etiologies. Broader measures of "attitudes toward the body" must be developed, that include dimensions of gender, race, class, sexuality, and disability, so that the impact of marginalization can be addressed.

Finally, prospective studies are badly needed to examine childhood patterns of meal interactions, gender socialization, abuse, sexual and erotic conditioning and their associations with subsequent eating disorders.

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