Women, Economy and Labour Relations

Eating Disorders in a Capitalist World

Super Woman or a Super Failure?

Jelena Balabanić Mavrović

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Women, Economy and Labour Relations

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Eating Disorders in a Capitalist World: Super Woman or a Super Failure?

BY

JELENA BALABANIĆ MAVROVIĆ

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United Kingdom – North America – Japan – India – Malaysia – China

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INVESTOR IN PEOPLE

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About the Author

Jelena Balabanić Mavrović was born in Split on 16 June 1972. She graduated in 1998 after completing a single major study of Sociology at the Faculty of Humanities and Social Sciences, University of Zagreb. That same year, she enrolled in a 5-year study of psychotherapy at the European Institute for Reality Therapy in Kranj, Slovenia, where she studied intermittently and graduated in 2015. From 2001 to 2005, she studied at the Department of Sociology and earned her Master's degree, her thesis being 'The concept of reflexive modernisation in contemporary sociological theory' completed under the mentorship of Prof. Rade Kalanj, PhD.

She finished her doctoral studies in 2022 at the Department of Sociology at the Faculty of Humanities and Social Sciences in Zagreb.

She is professionally active in the non-profit sector, where she has headed several associations focused on the promotion of health. In 2012, she started specialising in mental health problems, i.e. prevention and provision of psycho-social support to patients with eating disorders. She is one of the founders of the NGO BEA Centre for Eating Disorders, where she still works. She works closely with the Day Hospital for Eating Disorders at the Sveti Ivan Psychiatric Hospital and with other institutions treating patients with anorexia, bulimia and other specified feeding or eating disorder.

She authored the eating disorder prevention programme '*Tko je to u ogledalu?*' ('Who is that in the mirror?'), which has been implemented in secondary schools in the Republic of Croatia since 2009 and is the co-author of the prevention programme '*Baš je dobro biti JA*' ('It's good to be ME') for elementary schools. She works as a counselling therapist at the BEA Centre, helping people suffering from anorexia, bulimia and other specified feeding or eating disorder and their family members on a daily basis. She regularly designs and implements training programs for experts, parents and the wider community aimed at prevention and identifying and treating patients with eating disorders. She organised expert visits by top therapists and authors in the field of eating disorder treatment from the United Kingdom, the United States and Italy for the purpose of building a system of prevention and treatment of eating disorders in the Republic of Croatia. She is a member of HURT (Croatian Association for Reality Therapy) and EAP (European Association for Psychotherapy).

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Chapter 1

Introduction

This book explores sociological aspects of the body, eating and gender role expectations in women with eating disorders. This is a very current topic as eating disorders are on the rise, and scientists are still struggling to find the right way of interpreting them (Bulik et al., 2019; Munro et al., 2017). We can say that the conceptualisation of eating disorders is incomplete, and no theoretical model has yet offered an exhaustive explanation for the development, maintenance and treatment of eating disorders (Pennesi & Wade, 2016). This is evident in the fact that outcomes of eating disorder treatment are relatively poor (Bulik, 2014; Smink et al., 2012) since it is a very lengthy and expensive process (Toulany et al., 2015), with anorexia having the highest mortality rate of all psychiatric conditions (Smink et al., 2012).

In this book, we shall focus on the socio-cultural context of how eating disorders develop and are maintained, but this does not mean that we mean to diminish the importance of genetics, the biological basis of eating disorders (Bulik et al., 2019), personality traits (Culbert et al., 2015) and family dynamics (Gander et al., 2015), which have been proven to be associated with the development of eating disorders. The biopsychosocial model of understanding eating disorders has been called into question in recent years with the discovery of a biological basis of anorexia ('anorexia as a disease of the brain' Bulik, 2014; Treasure et al., 2014). Some authors have announced a paradigm shift in terms of treating anorexia as a metabolic as well as a psychiatric condition (Bulik et al., 2019) and accepting a biopsychiatric model (Treasure et al., 2014) as opposed to the current paradigm of recovery (Treasure et al., 2014) or the socio-cultural model of understanding eating disorders (Stice et al., 2017).

No matter how we conceptualise eating disorders, the fact remains that millions of children, women and men all over the world suffer profoundly or even die because of their disturbed relationship to their body and food. The fear of gaining weight, the obsession with being thin, starving oneself or excessive consumption of food followed by vomiting, fasting or obsessive exercising all lead to fatal consequences: poor health, stunted growth and development of children and young people, heart disease, digestive disorders, bone loss, tooth decay, kidney failure, brain starvation and also death as a result of medical complications or suicide (Crow et al., 2009). People with anorexia can be equally detached from the normal psychosocial functioning as people suffering from schizophrenia (Martin

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et al., 2015; Treasure et al., 2001) to the extent that people with chronic anorexia do not finish school, are not employed and cannot live independently.

Such a serious decrease in life expectancy, quality of life and psychosocial functioning of the affected individuals encourages clinicians, theorists and researchers to continue the search for answers as to why eating disorders occur in the first place and what sustains this self-destructive behaviour.

I carried out the research presented in this book in 2019. I conducted semi-structured interviews with 30 women, who were or had been patients of the Day Hospital for Eating Disorders at the Sveti Ivan Psychiatric Hospital in Zagreb, Croatia at the time, and I performed a thematic analysis of these interviews. I included the interviewees in the research as an expert by experience (Tehseen, 2013), and it was important for me to understand the actual experience of the interviewees, their views and perspectives on the research topic. In order to reduce the traumatic potential of conducting the interviews, I chose interviewees for whom this was not the first time that they talked about their disorder to someone they did not know and who were taking part in a professional help programme. During the in-depth interviews, I also asked for procedural consents (Allmark et al., 2009): as soon as I noticed discomfort or hesitation in an interviewee, I would remind her that we could end the conversation then and there, and that she could decide which questions she would answer and which she would not. It was important to me that the interviewees felt safe during the interview and that I protected their dignity and well-being as much as possible at all times.

Some authors recommend that, before conducting semi-structured in-depth interviews with vulnerable groups, interviewers first spend some time working in that particular environment (Ensign, 2003) or even attend counselling training sessions to make sure that, when they communicate with members of vulnerable groups, their words or behaviour would not lead to misunderstandings or psychological harm for the interviewees (Parkes, 1995). In this research, this condition was met by the fact that I had completed a 5-year education programme for a psychotherapist in reality psychotherapy (EAP certificate). My many years of experience as a counselling therapist for people with eating disorders also proved invaluable.

As a researcher and the author of this study, I acknowledge three professional roles that have influenced my work: the role of a sociologist and social scientist, a therapist working in a counselling centre specialising in people with eating disorders and finally an activist promoting the need for prevention and treatment of eating disorders. The fact that these roles overlap has its advantages and disadvantages. Advantages include in-depth knowledge of the research area, and many years of practice in counselling, preventive and educational work with patients with eating disorders and their families, which has earned me my insider status. Most of the interviewees had heard about my work in advocating the rights of patients with eating disorders and were eager to participate in the research. It was easier for them to trust me since I had demonstrated sensitivity to the specific issues of this population in the past. At the beginning of each interview, I introduced myself and my research, but in most cases, the interviewees had already come with a positive attitude and were very much open to dialogue, which

I attribute to my earlier professional work in the field of eating disorders. This is supported by how they used the words 'us' and 'them' during the interviews: placing people with eating disorders and those who understand them in one group, while the other referred to the 'rest of the world' supported by the media which associate eating disorders with vanity, self-indulgence and 'weak will' while simultaneously insisting on the 'perfect appearance' of women and 'health food'. As a researcher, I was perceived either as part of the 'us' group or as an intermediary, a person who could help to dispel myths about eating disorders through her research. Generally, I see myself as a bridge between people with eating disorders and the scientific community, and I feel a double loyalty: on the one hand, to the academia, which is interested in research results and on the other hand, to people with eating disorders, whose attitudes, experiences and feelings I want to 'translate into scientific discourse' as faithfully as possible while still maintaining their authenticity.

1.1 Sociology and Eating Disorders

Insufficient research of eating disorders in a social context represents a challenge for every researcher who decides to delve into this topic. I believe it is crucial to shed light on the relationship between eating disorders and the social meanings attached to the body, food, eating and abstaining from food and especially gender roles as an important factor of one's personal identity related to the experience of physicality.

In this book, I adopt the definition of gender as a 'social construct of femininity/masculinity, i.e. the meaning these categories take on through the processes of socialization and construction of gender roles in society' (Galić, 2002, p. 227). Gender, gender roles and gender identity are cultural terms that suppose socially constructed and expected differences between men and women (Galić, 2008). Different norms, values and conventions, as well as representations, images and expectations, are thus attributed to the biological sexes (Galić, 2008). The female gender is biologically (through its reproductive role) and culturally connected with the meanings of the body (Grosz, 1994), and it is, therefore, important to look at the incidence of eating disorders through the sociological prism of gender construction.

To social scientists studying eating disorders, the relationship between eating disorders and cultural influence is particularly interesting and has been interpreted in various ways, from completely negating the existence of any connection to emphasising cultural influence as a key factor in the development of the disorder (eating disorders as a culture-bound syndrome, Swartz, 1985). The phenomenon of eating disorders has, therefore, been interpreted in various ways, and the quest for a clear interpretation is nowhere near over yet.

In medical circles in the early twentieth century, anorexia was defined as a disease of the pituitary gland (Dell'Osso et al., 2016), or in terms of psychoanalysis, as a subconscious fear of oral impregnation (Brumberg, 1989), and the starvation of young women (and occasional young men) was not brought into

connection with any wider social influence. After the Second World War, the German psychiatrist Hilde Bruch, who worked in the United States, laid the foundations for the modern study of anorexia as a developmental personality disorder. She treated anorexia as a serious psychiatric illness and not as a difficulty in eating (Treasure & Cardi, 2017) and pointed out that the starvation of young girls represented a struggle for autonomy and confidence (Almeida et al., 2019). Many of Hilda Bruch's ideas are still fresh today and are consistent with contemporary understanding of eating disorders (Treasure & Cardi, 2017).

In the second half of the twentieth century, attempts were made to attribute the cause of eating disorders to family relationships, so concepts such as the 'anorexogenic family environment' (Dell'Osso et al., 2016) emerged, focusing on insecure attachment between mothers and children with eating disorders.

In the 1970s, the 'desire for thinness' was introduced into the diagnostic criteria (Dell'Osso et al., 2016), and 10 years later, with the recognition of bulimia as a separate form of eating disorder, there was a strong shift towards socio-cultural theories of the causes and rising prevalence of eating disorders. Such an understanding of eating disorders was facilitated by the rising rates of anorexia and bulimia among young people (Hall & Hay, 1991; Hoek et al., 2005; Jones et al., 1980; all according to Keel & Klump, 2003), which was interpreted as a consequence of the objectification of the female body in the media, the western cultural pressure for women to be thin and the new diet culture and the fitness industry (Hesse-Biber, 1991). Such social trends encouraged late twentieth century feminist theoreticians to link media pressure towards a thinner appearance in women with the greater prevalence of eating disorders. Through a series of influential books and the popularisation of original but also controversial concepts such as 'anorexia as a hunger strike' (Orbach, 1986) or 'anorexia as a crystallization of culture' (Bordo, 1993), these authors deepened their criticism of patriarchal society and the media's objectification of women. Feminist theorists based their criticism on the 'continuity theory' (Tylka & Subich, 1999), believing that there was nothing pathological in anorexia and bulimia, but that these forms of behaviour were only a radicalisation of the experience of 'being a woman' in modern Western society, in which all women were more or less constantly compared to ideal images of the female body found in the media and were thus hindered in the realisation of their own authentic personality. These authors offered gender theory as the key to the interpretation of eating disorders by analysing the specificity of the bodily aspect of the woman's experience in contemporary society.

Parallel to the feminist approach, an increasing number of researchers, mainly psychologists, wanted to operationalise the influence of the environment on the development of eating disorders, and influential models were created that are still used in research today: the tripartite influence model (Thompson et al., 1999) and the dual pathway model (Stice, 2001). These emphasised the influence of parents, peers and the media on the development of body dissatisfaction in young people, and emphasised the internalisation of the thin ideal and social comparison as mediators of these influences. In addition to these two models, especially influential is the transdiagnostic model (Fairburn et al., 2003), as the basis of the cognitive behavioural therapeutic approach to eating disorders. According to the transdiagnostic model, there is a fundamental psychopathology common to all

types of eating disorders (i.e. anorexia, bulimia and other specified feeding or eating disorder), and that is a dysfunctional cognitive scheme which includes low self-esteem, high perfectionism, intolerance of 'bad' moods and difficulties in maintaining relationships with other people (Brytek-Matera, 2021).

Even though there are many inspiring theories and approaches, we are still faced with limited knowledge and insufficient effectiveness of current treatment methods for eating disorders. This creates a kind of uncertainty in research and clinical work. Relatively poor success rate and long-term psychotherapy (Pennesi & Wade, 2016) make the field of eating disorder studies open, self-reflexive and, ultimately, self-critical (Aradas et al., 2019; Bardone-Cone et al., 2018; Escobar-Koch et al., 2010; Hay, 2012; Holmes, 2019; Lilienfeld et al., 2013; Lock & Le Grange, 2018; Strober & Johnson, 2012).

The self-reflexivity of scientific efforts in the understanding and treatment of eating disorders strengthens the awareness of the historical basis of knowledge, so that the system is very flexible and is continuously searching for new solutions. As there is currently no 'silver bullet' for eating disorders, either in the form of pharmacotherapy or efficient psychotherapy with predictable outcomes (Keski-Rahkonen, 2007), we can conclude that the system does generate uncertainty, but at the same time encourages researchers and clinicians to keep a historical perspective and to be innovative and self-critical.

In this book, I shall deal with the issue of gender and gender stereotypes in women with eating disorders. Ever since the first cases of anorexia were recorded, this mental disorder has been associated with young women (Witztum et al., 2008), and gender issues were an integral element in the interpretation of anorexia, which was even called hysterical anorexia in the late nineteenth century (Lat. anorexia hysterica, Dell'Osso et al., 2016).

During puberty, a woman's body changes from that of a child to that of an adult, and symbolically it exhibits the need to assume the female role. For people with eating disorders, the body becomes the arena of internal struggle. Along with a number of other factors (genetic predisposition, neurological vulnerability, family situation, etc.), psychological conflicts intensify due to external pressure towards an unrealistically perfect appearance presented through the media, but also through social coding of femininity as the weaker sex (Bordo, 1993). The thin ideal as an ideal of female beauty, prevalent in Western society since the 1960s, has become the dominant way of expressing idealised femininity which symbolises self-discipline and the ability to succeed in competitive societies (Malson, 2009).

In addition to defining eating disorders in terms of gender, the twenty-first century has brought an objective increase in obesity in developed post-industrial countries and, consequently, a 'global war on obesity' (WHO, 2000). Scientists and doctors have now added to aesthetic demands on the female body by advocating weight loss, thus providing legitimacy to body monitoring and assessing health through the body mass index. The body as the basis of identity stems from a broader cultural understanding of health, desirable body weight and even morality. Numerous studies indicate that in Western society, in addition to aesthetic qualities, thin and obese bodies are also associated with moral qualities. Therefore, in addition to thin bodies being beautiful and desirable, they are also seen as healthy

and they testify to responsible behaviour, self-control and moral virtues of the individual (Riley et al., 2008). In contrast, fat bodies are labelled as ugly and sick, and they are signs of overindulgence, greed and laziness (Malson, 2009).

In such a public health atmosphere, the prevention and treatment of eating disorders is even more challenging (Levine & McVey, 2015) since the values that inspire patients with eating disorders are in full agreement with the generally accepted values of 'the war on obesity' (Malson, 2009).

Despite all these challenges (or maybe precisely because of them), research in the field of eating disorders in the context of today's society is intriguing and exciting. It offers the possibility of shedding further light on these enigmatic and fascinating mental disorders, the way they are sustained and connected with social meanings that determine our gender identities, our relationship to food and the perception of different forms of the female body.

This book consists of two parts. In the first, theoretical part, we shall present the historical paradigms of interpretation of eating disorders and place them in the context of various social and technological changes that occurred over the past 100 years, namely the development of psychiatry, the feminist movement, the social processes of globalisation, industrialisation and urbanisation but also the technological development of science that enabled new ways of studying the genome and the functions of the brain. As was already mentioned, the twenty-first century has seen another paradigm shift (Bang et al., 2017; Bulik et al., 2019), and eating disorders are increasingly studied and defined as biologically based illnesses (Schmidt, 2003). After presenting an overview of the key achievements in the conceptualisation of eating disorders and of the fundamental research conducted so far, I shall move on to the findings of my own research. The second part of the book brings a description of the research and the results of the thematic analysis.

1.2 Eating Disorders

Eating disorders are mental disorders associated with a range of negative consequences which include medical complications and disruptions in an individual's cognitive, emotional and social functioning (APA, 2013). They constitute the third most common chronic diagnosis in the adolescent population after obesity and asthma (Kakhi & McCann, 2016), and anorexia is the mental disorder with the highest mortality rate (NICE, 2017). The Diagnostic and Statistical Manual of Mental Disorders describes eating disorders as 'characterized by a persistent disturbance in eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs health or psychosocial functioning' (APA, 2013) (Table 1).[1]

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[1]Types of eating disorders as classified in the 2013 American Psychiatric Association DSM-V manual include the following diagnoses: anorexia nervosa, bulimia nervosa, binge-eating disorder, pica, rumination disorder, avoidant/restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), unspecified feeding or eating disorder (UFED).

Table 1. Anorexia Nervosa.

Anorexia Nervosa	
Lifetime prevalence	EU sample of 6 countries: 0.9% women; no recorded male ANs (Preti et al., 2009) Finnish sample: 2.2% women; 0.24% men (Keski-Rahkonen, 2007) USA sample: 0.9% women; 0.3% men (Hudson et al., 2007)
Malnutrition Dieting – starvation	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. (DSM-V, 2013)
Fear of gaining weight	Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight (DSM-V, 2013)
Distorted body image Attributing central importance to body weight Denying the health consequences of one's extreme thinness	Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or persistent lack of recognition of the seriousness of the current low body weight. (DSM-V, 2013)
Other physiological effects of anorexia	Amenorrhoea (the absence of menstruation) or delayed menarche in girls, (no longer a diagnostic criterion in DSM-V) Dry flaking skin, fine downy hairs on neck and face, brittle nails, the yellowing of the skin, bradycardia, obstipation, low body temperature and muscle weakness (Mehler & Brown, 2015)
Health complications include	Osteopenia/osteoporosis, low blood pressure/orthostatic hypotension, heart arrhythmia, impaired kidney function, damage to the digestive system, stunted growth, infertility (Sidiropoulos, 2007)
Mortality	6% – of which 1.2% are suicide deaths (Arcelus et al., 2011)

Anorexia and bulimia are predominantly female mental disorders with a ratio of 9:1 in favour of female patients in anorexia (Micali et al., 2013), and 7:3 in bulimia (Dell'Osso et al., 2016). They typically develop in adolescence – most diagnoses of anorexia and bulimia are made between the ages of 15 and 24 (Smink et al., 2012). Anorexia and bulimia were first recorded in young high-class girls (the so-called golden girls from rich bourgeois families) (Bruch, 1973). Although anorexia and bulimia are different mental disorders, the transition rate between these two disorders is higher than between either of them and any other psychiatric diagnosis (Smolak & Levine, 2015). Therefore, we shall analyse the cultural context related to two of the three typical forms of eating disorders (the third typical form being the binge-eating disorder; Galmiche et al., 2019) since they represent a clearly differentiated sample of similar socio-demographic characteristics (Table 2).[2]

In addition to anorexia and bulimia, there is a category of 'other specified feeding or eating disorders'. This group of disorders, which used to be called eating disorders 'Not Otherwise Specified' in the DSM-IV, is actually the most common form of eating disorders. They include a disturbed relationship with food and the body which does not meet the diagnostic criteria of the so-called 'pure' anorexia, bulimia or binge-eating disorders (Table 3).

1.3 Diagnostic and Epistemological Controversies

The understanding of eating disorders has changed over time – the young science of psychiatry corrected and expanded the definitions of anorexia and bulimia in each new DSM manual since 1952. Until 1987, anorexia and bulimia were classified as one disorder, and in the DSM-III revised edition, they were split up into separate subtypes of eating disorders. The same thing happened in DSM-V (2013) with binge-eating disorder, which broke away from the group of not otherwise specified eating disorders into a separate diagnosis.

The high ambivalence and resistance which patients with eating disorders feel towards treatment should be emphasised, as well as the shame due to the strong

[2]Binge-eating disorder or compulsive overeating is a disorder that involves consuming a large amount of food in a short time (so-called binges or episodes of overeating), after which a person feels strong guilt and shame. In this book, we focus on anorexia and bulimia, and compulsive overeating will only be included sporadically since patients with binge-eating disorders are treated differently (da Luz et al., 2018); they often suffer from obesity (Hudson et al., 2007; Villarejo et al., 2012) and have a different socio-demographic profile. In order to compare the socio-demographic profile of people with anorexia and bulimia on the one hand, and people with binge-eating disorder on the other, we shall list the basic differences. In binge-eating disorder, the ratio of female and male patients is 3.5:2 (Hudson et al., 2007). People can develop it at any point in their lives, the peak being in the period of middle age (NIMH, NCS-R: 2001–2003). They suffer from social stigma because of their physical appearance (Palmeira et al., 2016), and there are studies which indicate greater prevalence of binge-eating disorder among the lower classes (Kim et al., 2020; Nicholls et al., 2016).