Eating Disorders

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The best was having nothing. No hope. No name in the throat. And finding the breath in you, the body, to ask.

Tracy K. Smith

One cannot think well, love well, sleep well if one has not dined well.

Women have served all these centuries as looking glasses possessing the magic and delicious power of reflecting the figure of man at twice its natural size.

Virginia Woolf

Abstract

Eating disorders are highly important and affect women more frequently than men. This is because of their clinical severity, comorbidities, and increasing prevalence, as well as their social repercussions. It is impossible to deny that eating disorders are multidetermined conditions. Most of those who treat or research them are reconciled to the need to approach them broadly and flexibly. Implicating genetic factors in a disorder such as anorexia or bulimia nervosa is sensitive and the potential for misunderstanding and misusing gender theoretical concepts is very real. Psychiatry has a long, unfortunate history of

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misconstructing and pathologizing female behavior. Only recently has there been broader theoretical appreciation of the power of gender differences in self-development and the adverse effects of stereotyping children too rigidly by sex or gender. This is our objective in this chapter. Clinicians have made an effort to create a multidimensional model for the explanation of eating disorders. However, this tends to omit the crucial dimension of culture, which includes the gender perspective.

10.1 Introduction

Hunger and appetite are bound together in the history of the world. Eating behavior communicates socially through the symbolic meaning that transcends the act of ingesting. From birth, we are prone to seeking relationships with others while simultaneously satisfying our hunger instinct. The body is the means of experiencing the world and it forms part of all our learning. Through our eating, we relate to the world. We see the world from our body and so the psychopathology of our eating behavior is closely linked to the psychopathology of our body image. Neuroscience has reached the same conclusions through its different methodologies toward phenomenology, psychiatric anthropology and philosophy. Mind, body, and the world interact in the way the individual adapts and survives. Identity is constituted around the physical body and the way we develop a feeling for what our body is like, as sensed by ourselves and as visible to others. This is very different for women and men. We require a relationship between body and culture with a gender perspective. Anorexia nervosa as a psychopathological condition that accords with our current criteria was first described in the nineteenth century, although Richard Morton had noted it two centuries earlier. Bulimia nervosa is a much more recent clinical condition: Gerald Russell first described it in the 1970s. Both pathologies are characterized by abnormalities in eating behavior and the need to control weight. This causes physical consequences and/or alteration of the individual's psychosocial functioning. The psychopathology that is most frequent in a clinical setting is anorexia nervosa (the restriction of food with considerable weight loss as well as body distortion and extreme fear of fatness) and bulimia nervosa (binging episodes and compensatory behaviors such as vomiting as well as fear of gaining weight). Pica, rumination, and sitiophobia are rarer. The incidence of binge eating disorder (BED) and obesity are increasing to pandemic proportions. There seems to be a connection with the cult of the body in Western society and the number of people on a diet, especially women and girls. Both are diagnosed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

10.2 Conceptual Aspects: Hunger and Appetite

Roland Barthes stated that "Feeding constitutes a means of communication with the rest" in *Pour une Psycho-Sociologie Contemporaine*, where he demonstrated the individual symbolic relationship maintained with everything involved in de facto nutrition [1].

Feeding has conditioned the evolutionary course of history. *Der Mensch ist, was er isst* (Man is what he eats). Human feeding is one of the basics of culture. However, feeding is not only eating. Food and the act of eating not only involve nutrition; they are also associated with multiple and various existential circumstances. "You are what you eat" cannot be distinguished from "you eat what you are."

The primitive relationship between women and men and food is related to the physiological sensation of hunger. Hunger, rather than appetite, is a biological need. It can cause an individual to die. In today's world, over 10 % of the world's population—or 800 million people—are starving. Hunger is a danger; it biologically limits our existence [2].

Hunger is described as the need for food as a physiological alarm. It is the urge to eat an amount of food to survive. Appetite is understood in a different way. It implies the preference or qualitative selection of what we are going to eat [3]. The difference is obvious: while hunger implies the urge, appetite is linked to the culture, society and customs in which it is immersed [4].

From birth, eating is a social act and a means of communication with others. When the mother breastfeeds she also speaks, looks at, and smiles at the baby. Breastfeeding serves as a bond and communication between them. The baby is designed to seek the relationship. There is a predisposition toward the relationship from birth. The neurologist Damasio saw this as a corporal disposition. Children up to 6 or 7 years old are asked what a mother is: for feeding us. In French, *mam-mam* means both "eating" and "mother" [5].

This is hunger as a vital feeling. In *The Life of Hunger*, Amélie Nothomb stated: "hunger is me."

"By hunger, I mean the terrible lack within the whole being, the gnawing void, the aspiration not so much to utopian plenitude as to simple reality: where there is nothing I beg for there to be something."

In the same way, food might be sad, exquisite nourishment that can be refused and even vomited in a conflicting or lived situation that threatens the individual. In a social psychology experiment, university students on campus were fed minced meat steak and then told that it had gone bad and that the infirmary would be open all night long. A significant percentage visited the infirmary showing typical symptoms of food poisoning.

The same happens with religious taboos. Mohamed, a 9-year-old boy who had recently arrived from Iran, was given pork by mistake at a Parisian school. Instantaneously, he ate it with pleasure. However, when informed of the mistake made by the canteen, with Islam prohibiting pork, the boy vomited the whole afternoon and needed to be taken home [6]. What was said had activated an area in the brain and when this reacted, it activated digestive motricity. Another experiment was performed using students on a university campus, adding caffeine to their milk and offering them caffeine-free coffee, which significantly altered the hours slept by the group who drank the coffee without caffeine [5].

We should not forget that there is nothing more threatening and intimidating than introducing something alien into the body. This happens every time we eat, when we use the mouth for nutrients to transact [7, 8]. By contrast, nourishment can be exquisite in satisfying situations.

The same happens in a religious sense. In Hebrew to eat is *A'hol*, which literally means unity-total. "Assimilate nutrients," do the same to yourself. Eating for Hebrews is to make a piece of the world a piece of oneself, a piece of God. In the case of Christians, it is the opposite. It is the piece of the world, a piece of God that will become a piece of oneself. "Take this, all of you and eat of it: for this is my body" [5].

Eating means coming into this world with your hands. Eating means knowing in which world you are living. When you make yourself the nourishment, in a way you organize the world, you make it coherent. One who eats calms the anger against the world and oneself while digesting the world of which one is a part.

The nourishment role is very diverse in different cultures and so is the social meaning linked to feeding and the ingestion of food. To Western societies like ours, food is basically what we find on our plates. Nowadays, we consume food that has been packaged in plastic and is decontextualized. There is no story behind it, where it comes from, who has made it, its symbolic value, and its meaning.

In Papua New Guinea, food is considered to have a "vital essence" known as ngaka. This is fundamental for the development and health of the members of that society. Moreover, vital essence is not only within one's body; it is also in the objects with which one makes any kind of contact, including food. One can acquire the properties of the person consuming the dishes that another person prepares ("you are what you eat"). Based on this principle, cannibalism is a common practice in these tribes. They eat their parents once they pass away, incorporating their virtues and abilities.

In the Hindi religion in India, food is shared in an intimate act of class-conscious solidarity. If someone belongs to a lower caste, she or he is rejected.

In their study, Baas and colleagues [9, 10] number the varied uses of food within societies and hence the different meanings that may be attributed to these uses (Table 10.1):

Food and sexuality are widely related in colloquial language and slang, as in words and phrases such as "juicy," "melons," and "forbidden fruit," together with the cherry and its associations related to virginity. "Getting your greens" refers not only to adequate consumption of vegetables but also a regular supply of sexual intercourse.

If eating can, and usually does, take on multiple meanings beyond merely nutritional aspects, the same may be said about a failure to eat or, more accurately, to eat "nothing," as with the first suffragettes whose hunger strikes had a political component: they refused the world in which they had found themselves living. With regard to hunger as an ideology, Susan Bordo analyzed the differences displayed by men and women when they were represented eating. A woman's appetite requires continence and control, while a man's appetite is legitimate and stimulated. "The man-eater" is seen as a dangerous image of female desire, "the temptress." These provocative bodies, "bodies that can talk," have enabled them to be viewed culturally as being responsible for the aggressive and sexual bodily responses of men. In industrialized societies, discipline, control, and the creation of "docile bodies" is a reality for women who receive greater gratification in nourishing and

Table 10.1 Varied uses of food within societies

1. To satisfy hunger and nourish the body
2. To start and maintain personal and business relationships
3. To prove the extension and nature of social relationships
4. To give chances for developing community activities
5. To express love and affection
6. To express individuality
7. To announce differences in the group
8. To prove group belonging
9. To face psychological and emotional stress
10. To indicate social status
11. For rewards and punishments
12. To reinforce self-esteem and merit social recognition
13. To practice political and economic force
14. To prevent, diagnose, and treat physical illnesses
15. To prevent, diagnose, and treat mental disorders
16. To symbolize emotional experiences
17. To manifest piety and devotion
18. To display confidence
19. To express moral feelings
20. To indicate wealth

feeding others than themselves. This underlines the gender divide of power: male public space and private female space.

In practice, there are no social or cultural groups without collective prohibitions with regard to the intake of certain foods. These are solidly established food taboos [11]. In fact, the principal taboos of our culture refer to food and sexuality: cannibalism and incest.

Anthropophagy, or cannibalism, was the most important consequence when the Australopithecus changed to a carnivorous diet. Both then and at any other time in history, cannibalism has appeared in its different forms [12].

Many peoples became cannibals because they lacked the proteins in meat and had no other way of finding them. Thus, the aborigines of Polynesia and Australia were habitual practitioners of anthropophagy until Captain James Cook introduced the pig to these lands. Cook himself fell victim to these practices when he was murdered and devoured by his enemies, who believed that they would acquire the manna, or extraordinary powers, that they attributed to the explorer.

In the sixteenth century, Sawney Bean, a highwayman in Angus (Scotland), held up travelers, killed them and ate them in his cave. Years later, his own daughter was burned alive on a bonfire when it was discovered that she had adopted the same practice. The search for both new food and hunger has been highly important in the development and dissemination of cannibalism. One example comes from Germany during the Thirty Years War (1618–1648), and recently, the tragedy experienced by the survivors of a plane crash in the Andes in the 1960s.

Art has never been far removed from this type of practice either. We only need to take a look at Goya's Black Paintings. The artist's inimitable style leads us to anthropophagy in his oil painting *Saturn Devouring His Son*, which may be viewed at the Prado Museum in Madrid.

10.3 Historical and Social Perspective of Eating Behavior

Historically, food has been closely linked to status and social prestige. The way we eat is a means of affirming and acquiring prestige with regard to others. The desire for social advancement has been a powerful driving force in the transformation of eating [10]. This manifests itself basically through the adoption of foods, dishes, and table manners inspired by those of a social stratum considered to be superior and for whom the aim was to equal or imitate. "I eat, therefore I am," Miguel de Unamuno said in an interesting prologue to the work by the biologist and philosopher, Ramón Turró, *Origins of Knowledge: Hunger* (1945).

10.3.1 Primitive Societies

The first references to body image date back to the Paleolithic era, 30,000–20,000 B.C. This was demonstrated by the discovery of the Venus of Willendorf, a statuette of a woman symbolizing fertility in a village on the banks of the Danube. Currently on show at the Vienna Natural History Museum, it is the image of a prehistoric woman.

Over all the cultures, the representation of the female body has been significantly larger in size than its male counterpart. In Paleolithic representations, female characteristics are unmistakable: adiposity of the torso, large buttocks and huge breasts, all of which underline the role of fertility and nutrition as a symbol of elevated social status.

It is unknown, however, whether the archeological Venuses are faithful representations tailored to the reality of what was observed or are an artistic and idealized vision that symbolizes the desire for abundance and fertility, particularly in a period of the history of humankind when hunger was a threat to human life.

Ford and Beach [13] studied 190 tribal societies and, as was observed in the Paleolithic figures, found in virtually all of them that obese women were considered more beautiful than their thinner counterparts owing to their greater procreative and feeding capacity. On the other hand, men's attractiveness lay rather in their skills and social standing.

Prehistoric sculpture representing the female prototype usually symbolizes female fecundity together with birth-giving and breastfeeding capacity. This was also contained in myths such as Hera's drop of milk, which gave rise to the Milky Way while she was suckling Hercules.

A large woman's body symbolized prosperity and luxury. It even suggested an abundant harvest. Both of these were necessary for group survival. Thinness

signified sterility and penury. At a time of frequent famines, thinness was considered to be a messenger of death [14]. This evaluation of the physical attributes of females has never occurred in the animal kingdom, where the males possessing greater size and brighter colors (as well as other characteristics) conduct courtship.

10.3.2 From the Classical World to the Eighteenth Century

In Classical Greece, the attractiveness of the male body took precedence over that of the female. The cult of the male form, including being in good physical condition within the broader context of understanding the body–mind duality in this culture, represents a very different viewpoint from the subsequent concepts defended by Christianity [8].

In Ancient Greek, the word *limos* means "hunger." On adding the word *bou*, which means "a large amount," or *boul*, which means "ox," the resulting term may be translated as "voracious hunger" or "ravenous hunger."

In 970 B.C., Xenophon, in the *Anabasis*, described for the first time in Western culture what we now see as bulimic practices. This referred to the eating habits of some Greek soldiers who withdrew to the mountains of Asia Minor after mounting a campaign against Artaxerxes. It is interesting to note that these soldiers received only scant food rations [15]. Hippocrates distinguished *boulimos*, unhealthy hunger, from ordinary hunger. Aristophanes also used the same term in its meaning of "ravenous hunger."

For the Greeks, the measurement of beauty was the aureal proportion, a practical application of their cult of balance. Hippocrates defines in his work the functioning of the body according to physical elements and bodily humors. Health was synonymous with a state where there is proper balance between the humors, while illness appeared as an imbalance in the interaction between them. The female body is considered weaker and more prone to illness.

In the history of psychiatry, the pathological condition of the female body is a constant. For Greeks, hysteria is a word that means "uterus." Plato [56] in his text *Timaeus* (which has entered Western medical tradition through Galen and the Hippocratic writers) asserted that:

> . . . the matrix or womb in women, which is a living creature within them which longs to bear children. And if it is left unfertilized long beyond the normal time, it causes extreme unrest, strays about the body, blocks the channels of the breath and causes in consequences acute distress and disorders of all kinds. If it is not 'appeased by passion and love' the womb moved from its natural position within the body and, attaching itself to soft internal tissues, gave rise to a wide variety of symptomatic disturbances. (Plato 2005, p. 123)

Hippocrates identified the relevance for health of such factors as dietary restraint, an increase in exercise and a reduction in sleep. Hippocrates was the first to indicate the risk to health of obesity, which he associated with the existence of menstrual changes and infertility in women. He explained that infertility is a consequence of the fat accumulated in obese people, hindering intercourse, and

closing the mouth of the womb. Hippocrates saw the therapeutic rules for combating obesity as: having a tough job, sleeping in a hard bed, eating only once a day and preferably food with a high fat content (in order to be satiated quickly), and walking naked as much as possible. More specifically, food needed to be taken soon after a hard day's work when the body was still tired and one had difficulty breathing.

Ancient Rome disagreed with Classical Greece in most of its body esthetic criteria. The Romans were more interested in the peculiarities of faces and people [8]. However, they produced a culture that valued thinness or at least tended to avoid excess weight. As they enjoyed copious banquets, they used vomiting as a means of regulating weight. Both bingeing and vomiting were socially accepted and therefore were integrated into their culture, especially in the middle and upper classes. Roman banquets could include over 20 courses. Whenever the stomach of the diners was full, they went to an adjoining room, the *vomitorium*, where vomiting enabled them to recommence their blow-out. In his treatise on morality, *Dialogi*, Seneca writes in *De consolatione ad Helvia* about Roman practices: "Vomunt ut edant, edunt ut vomant" (they vomit to eat and they eat to vomit).

Moreover, a woman was appreciated fundamentally for her role as mother in which she was obliged to present many children to a State that needed them to ensure its survival against the continuous threat of the intrigues of its enemies [16]. In return, this led some women to rebel against their fate, as was denounced in the writings of the philosopher Favorinus: "Not only do they refuse to breastfeed their children but they resort to a thousand tricks to avoid becoming mothers." Metrodora, a female physician of Greek origin who practiced in the Rome of the first century, wrote a treatise on female illnesses. In her chapter devoted to young women, she described *sitergia*, a Greek term whose literal meaning was "rejection of food."

Medieval cooking stems from a reaction to the banquets and abuse of wine that characterized the final days of the Roman Empire. Just like the Egyptian hermits and anchorites who barely ate enough to stay alive, the early Christians and some mystics interpreted food restraint from the religious viewpoint and practiced fasting as a penance (intensification of prayer, rejection of the world), and as a means of reaching the highest, purest spiritual state. "An emaciated body will pass more easily through the narrow gate of paradise; a light body will resurrect more quickly and a consumed body will be better preserved in the tomb" (Tertullian). Religious asceticism constituted a means of being above bodily needs and reaching a "pure" spiritual state.

In the Middle Ages, the reproductive woman and her figure were the predominant value on the esthetic scale. The female body had to denote corpulence, with a rounded belly as the symbol of fertility. It is significant that the ruling aristocracy were then generically called *popolo grasso*, (plump people), while the working classes are recognized as *popolo magro* (thin people) [10].

The appreciation of fatness implied the rejection of thinness, that is, a flight from hunger, illness, and poverty. The body and its functions were not hidden; everything was natural. It was possible even to defecate or have sexual intercourse in public without creating a scandal or a commotion [17].

For its part, Christian doctrine viewed the body as weak and sinful, requiring strict control and regulation by the mind. Ascesis was the path that led to perfection. Flesh needed to be overcome; the spirit had to triumph. Fasting was the ideal way to achieve this. Religious demands existed so that women would detest their bodies. The less their flesh was consented to, the holier they were. In this way, many women from comfortable classes left their homes and families for a religious life rather than marriage, the only way out for a woman; the convent also offered them the chance to receive an education which otherwise would have been impossible. We should remember that these were patriarchal societies where women were second-class citizens. (At the Council of Trent in 1563, the Inquisition established guidelines to be followed by women whose bodies did not belong to them. If they were virgins, they belonged to God who could call on them and, if not, they belonged to their husbands. If they were possessed, they belonged to the Devil and were persecuted and tortured; at prior Councils such as Nicea, it was discussed whether women had souls.)

Indeed, fasting was a symbol of medieval ascesis. But while monks fasted to purify their bodies and strengthen themselves before the temptations of the outside world, women sought the liberation of their own bodies, which were considered in Christian thought to be the true origin of sin. We should not forget that Christianity blamed original sin on Eve; she was the one to offer the apple to Adam, whose weakness was to accept it. Eve's original sin was in herself while for Adam sin was positioned in the outside world. It was in this context where "holy anorexia" (anorexia suffered by following God), appears, as noted by Rudolph Bell, a history professor at the University of Rutgers [18]. Bell reviewed the biographies of over 261 Italian nuns from the thirteenth century to the present day and found that many may have suffered anorexia nervosa. One was St. Liberata (St. Wilgefortis, a name that comes from Latin and means "strong virgin"). She challenged her father, the King of Portugal, by refusing to eat when he arranged her marriage. Asking God to take away her beauty, her body became hairy (lanugo, owing to malnutrition) and she even grew a beard. Her father decided to have her crucified rather than allowing her to enter a convent. Another example was St. Catherine of Siena. When she was 26, her idea of devoting her life to God clashed with her father's plan to marry her off. This situation led her to lock herself in her bedroom and refuse to eat. In the end, she entered the Dominicans' order, although she had lost half her body weight. Her head may be found in the church of Saint Domingo in Siena as a relic exhibited behind a glass urn; the rest of her body is buried in Rome and one of her feet is in Venice, as an example of holiness. She said in her final writings that she believed she was ill.

In the Renaissance, and principally in the various European courts, the body and overall appearance was granted a significance that was unknown in medieval Europe. In the court, food was usually guaranteed and habituation to it enabled it to be savored. Physical strength and the battle gave way to personal intrigues. The maintaining or improving of social status did not depend as much on fertility or body frame as on the social importance attributed to an individual, this being down to bearing, speech, manners and appearance [19]. The body became socialized.

From the fourteenth and fifteenth centuries, anorexia began to spread from the convents and the abbeys like an epidemic. This phase, called "secularization of anorexia," continued into the sixteenth and seventeenth centuries. The miraculous maidens appeared, most of them youngsters of humble origins who, by refusing food, attempted to attain the sublime, perfection and purity and, in the process, improve their social and economic standing.

Anorexia was progressively stripped of its religious background and moved to a more vulgar circle, with the appearance of so-called artists of hunger, who would exhibit at fairs and could even be seen in some cafés. Kafka described one of them in his story *An Artist of Hunger*." As Paul Auster asserted in his essay *The Art of Hunger* [20], these new, secularized anorexics did not fast in the same way or for the same reasons as the mystics of the past. Their rejection of food was not an attempt to reject earthly life in order to gain entry to heaven. It was simply a refusal to live of the life into which they had been born. The more prolonged their fasting, the greater the space that death occupied in their lives. Their fasting was a contradiction: to go on with it meant death, but death also ended fasting. Therefore, they needed to stay alive, but only to remain on the edge of the abyss, as reflected in the novel *Hunger* by the Nobel Prize winner, Knut Hamsun.

From the fifteenth to the eighteenth centuries, the large woman remained the model, however. This woman, even when obese, was considered to be attractive and elegant [8], like the fleshy women portrayed by the Italian Renaissance painter, Titian.

The history of the western world, and that of Europe in particular, is littered with characters, eras, and social groups in which bingeing and then vomiting was practiced assiduously. These vomiting individuals included England's Henry VIII and his closest subjects; Pope Alexander Borgia and his courtiers; Bruegel's playful Flemish peasants and Bosch's lacerating throngs; and, much more recently, Britain's King Edward VII of the UK or US President William Taft (all of them men) [21].

According to the Encyclopaedia Britannica of 1797, bulimia is defined as a disease in which the person is affected by a desire to eat insatiably and perpetually, and unless this is satisfied, it leads to fainting. Motherby, in 1785, had already described three types of bulimia: that characteristic of pure hunger; that where hunger ends in vomiting; and that associated with fainting.

We find the most complete reference to this disorder in James, who in 1743 devoted two pages to describing *boulimos* [6]. He noticed that while some patients experience the complication of vomiting after ingesting large amounts of food, others do not. He distinguished in this way between *boulimus* and *caninus apetitus*. Basing his approaches on Galen, he remarked that *boulimus* was caused by an acidic humor contained in the stomach, which produced intense but misleading indications of hunger.

At around the same time, the word "anorexia" was used in medical literature as a synonym for lack of appetite. The first medical approximation to the disorder came in 1689 from Richard Morton, the court physician of William II. In his work *Phthisiologia, seu Exercitationes de phthisi*, which is translated into English and subtitled *A Treatise of Consumptions*, he described a condition of anorexia nervosa

with great accuracy. He related the condition of an adolescent boy of 16 and that of a young woman 18, of whom he said: ". . .I cannot recall in all my life anyone who was so involved with living and so consumed. . ." [22].

Subsequently, in 1764, Whytt described "nervous atrophy," based on the case of a boy of 14 who, after a period of loss of appetite and weight loss, went through a phase of impulsive ingestion, the symptoms not being attributable to any known pathology. In describing the case, Whytt referred for the first time to bradycardia as a symptom associated with cachexia.

In 1798 in France, Pinel published his *Nosographie Philosophique* [23] where he included anorexia, bulimia and pica in the chapter on digestive neuroses. The writer considered anorexia to be a frequently-presented gastric neurosis.

10.3.3 The Nineteenth Century: The Victorian Model

Many of our sociocultural values appeared to develop and become consolidated in this period, including the origin of slimming culture. Among them were: the existence of a growing bourgeoisie, the development of urban centers, the industrial revolution, and, subsequently, the development of the media [11].

In 1840, Imbert's *Traité Théorique et Pratique des Maladies de Femmes* was published. He included anorexia, bulimia and pica as stomach neuroses and distinguished gastric anorexia from anorexia nervosa, attributing the former to a digestive disorder of gastric origin and the latter to brain alterations. He also remarked on how patients with anorexia nervosa showed a loss of appetite and a great variety of neurotic signs, becoming melancholy, choleric, and fearful.

Two decades later, Marcé (1860), a physician from the University of Paris, described a form of hypochondriacal delirium that was consecutive to dyspepsia and was characterized by rejection of food. Patients, either because of a loss of appetite or discomfort caused by digestion, reach the crazed conclusion that they could not or must not eat.

It was in the midst of the Victorian Age when the contributions by William Gull and Ernest-Charles Lasègue appeared. These two authors began the scientific study of anorexia nervosa. Gull, Queen Victoria's physician, described "hysterical apepsia" in London in 1868. He said that this was a typical condition of young women that led to emaciation and that was initially felt to be of organic origin [24, 25].

Soon afterward in Paris, in 1873, Lasègue published the manuscript *De la Anorèxie Hysterique* where he described the cases of various patients aged between 18 and 22. He emphasized the emotional etiology of the disease, presenting it as a perversion or intellectual anomaly and indicating at its heart perturbed interpersonal relationships and, on occasion, unconscious desires as the basic personality traits of such patients [26].

In his description, Lasègue added something that we feel is important, bearing in mind subsequent interpretations of the anorexic syndrome: "fasting is not total and is completely unconnected with the rejection of foods practiced by the

melancholy." As well as underlining emotional alterations resulting from the transition to an adult age in the etiology of the anorexic syndrome, he also indicated the existence of social aspects for the first time. He is probably the first doctor to consider the possibility of inter-family conflict between anorexic patients and their parents [27].

Six months later, Gull (in 1874) used the term "anorexia nervosa" for the first time. This was in an article in which he described the findings derived from the malnutrition of three anorexic patients, without paying attention to emotional aspects. This new name for the disease came about for two reasons: the rejection of the term "apepsia" as no alterations in digestion of food were observed and the rejection of the term "hysteria" on specifying that these patients did not present the clinical history of the typical hysteric. It recognized, however, the role of different psychological aspects that may well intervene in the etiopathogeny of the anorexic condition.

Gender perspective cannot be ignored in the genesis and maintaining of the eating behavioral disorders suffered mainly by women. Men and women have different ways of living in their bodies. At that time in history, women lacked the right to vote, they had no access to university, and they did not even have access to the inheritance of their parents unless they formed a good marriage. Hence, anorexia nervosa may be understood to be a challenge to the established order. It questions health criteria and questions the symptoms as social by incarnating a body exposed to the gaze. The appearance of the disease as a clinical diagnosis occurred at the same time as the appearance of novels written by women, such as Wuthering Heights (initially published under a male pseudonym as this was the only way to get published) by Emily Brontë (who was suspected to suffer from anorexia nervosa), and including the work of Jane Austen. All the female characters in literature up to that time had only been seen from the viewpoint of their relationship with the opposite sex. "And this is such a small part of the life of a woman" (as Virginia Woolf said). Love was the only role possible for women. Woolf [28] wrote that if in Shakespeare's tragedies men had been presented only as lovers of women and never as friends of men, as thinkers, as dreamers: "What few roles they could play! How literature would suffer!" This is how women have suffered in history, with the symptomatic expression of inequality and social unfairness frequently being anorexic symptoms. Many women allow themselves to be locked in the "prison of the body" represented by anorexia nervosa. "Hunger, insomnia, disease" were the three words Oscar Wilde used to describe his time in Reading prison in letters to friends and relatives. The problems of prison are also problems of the body and, in this case, prison became the body for these women.

The prestigious French physician Charcot, known for his study of hysteria at La Salpêtrière Hospital in 1889, proposed parentectomy (the isolation of the patient from her/his family) as a therapeutic formula for patients with anorexia nervosa. He was the first to indicate "fear of obesity" as a reason for refusing to eat.

Meanwhile, Lord Byron was the prototype of the romantic writer whose fame and literary prestige helped to publicize his ideas on the body and the mind. He fasted to clear his mind; he defined himself as "ascetic vegetable eater." He

abhorred fatness as in his view it symbolized lethargy, clumsiness, and stupidity. His food restraint was accompanied by physical exercise: "I don't find it at all hard to fast for 48 h. Two years ago, I lived permanently on a diet of a thin slice of bread for breakfast, a dinner of fresh vegetables, only green tea and carbonated water in the interim. These days, when I start thinking that I am consuming, I chew tobacco, mastic gum or laudanum. . ." [29].

The first description of a diet was published in 1863. In it, a layman explained the way to reduce food ingestion with the aim of losing weight. This appeared in all the books that referred to food over subsequent years.

The image of women historically perceived and conceived in terms of their reproductive function started to show a clear change with the development of science. At this time, talk began of combating obesity by reducing food ingestion and increasing physical exercise. In fact, this was a return to Hippocratic advice.

In 1875, the concept of energy balance was described and it was postulated that a greater intake of the foods the body needed led to an excess of weight. Greed or gluttony emerged as the principal cause of obesity. It was also in this period that two causes of obesity were described. On the one hand, there was talk of obesity caused by a physical problem (with symptoms similar to Prader–Willi syndrome), and on the other, obesity due to hyperphagia secondary to a defect in the person's character (with symptoms resembling Pickwick syndrome).

It may be asserted that it was really in the nineteenth century that the first progress in the study of obesity was made, with an important role played by writers who worked almost simultaneously in Edinburgh, Paris, and, subsequently, Germany. In fact, the interest in obesity in the latter country gave rise to numerous physiological theories, some of which are discussed even today [30]. These include body composition, energy conservation, the excess of fat cells as a cause of obesity and the concept of family obesity. In late nineteenth century Belgium, Quetelet developed the Index that bears his name and that relates a person's weight in kilograms to the square of their height in meters. Subsequently, following the introduction of the Lavoisier calorimeter, it was suspected that obesity could well be a metabolic disorder.

10.3.4 Our Most Recent History: The Twentieth Century

In the twentieth century, a true explosion occurred and anorexia nervosa and bulimia nervosa increased to almost epidemic proportions. Specific intervention programs were created for these pathologies and there were major advances in research into obesity. Why was there such a large increase in the number of cases?

Psychopathology, as Jules Henry said, "is the final outcome of all that is wrong with a culture" [31]. Nowhere is this more strikingly true than in anorexia and bulimia, which were barely known two centuries ago, but which have reached epidemic proportions in the twentieth century. Far from being the result of a superficial fashion phenomenon, these disorders reflect our attention to some of the central ills of our culture, from our historical heritage of disdain for the body, to

our modern fear of loss of control over our future, to the disquieting meaning of contemporary beauty ideals in an era of greater female presence and power than ever before" [32].

Changes in the incidence of anorexia have been dramatic. In 1945, when Ludwig Binswanger chronicled the now famous case of Ellen West, he said, "from a psychiatric point of view, we are dealing here with something new, with a new symptom" [33].

Anorexia nervosa is clearly, as Paul Garfinkel and David Garner have described it, a multidimensional disorder. It has familial, perceptual, cognitive, and biological factors that interact in varying combinations in different individuals to produce a final common pathway [34].

Bray [35] cited the principal areas connected with scientific developments over the century: the study of food intake and its control, and the use of behavioral measures for losing weight.

Habermas [36], who studied the historic concept of the voracious appetite (*Heisshunger*), saw bulimia nervosa as a much more recent disorder than anorexia nervosa and placed its origin at the start of the twentieth century. He also believed that pressure and the struggle of doctors against obesity originated in this phenomenon.

The contraceptive pill revolution allowed women to separate sex from procreation, as women on the pill could control their fertility. However, although it was acceptable for single men to have sex, when women showed the same attitude it proved disturbing for 1950s Western society. At that time, contrasting with the middle-class women who were once again out of the factories and safely immured at home, the dominant ideal of female beauty was exemplified by Marilyn Monroe. She was often described as femininity incarnate, femaleness embodied.

It is necessary to explore why it is that women who are more oppressed by what Kim Chernin calls "the tyranny of slenderness." This particular oppression is a post-1960s, post-feminist phenomenon.

Gerald Russell published a paper describing and naming bulimia nervosa in 1979. It was not long afterwards that the disorder was recognized as a common problem affecting young women in western societies.

In the early 1980s, attention began to turn to the significance of cultural factors in the pathogenesis of eating disorders. What we should ask is why our culture is so obsessed with keeping our bodies slim, pert, and young; when 500 people were polled about what they feared most in the world, 190 replied: "getting fat." This fear is more bizarre than the anorectic's misperceptions of her body image or the bulimic's compulsive vomiting. This is the desperate placing of our bodies into arenas of control, perhaps one of the few arenas of control that remained available to us in the twentieth century.

In the 1980s, a student of Bordo's described Marilyn Monroe as "a cow." Was this merely a change in what hip, breast and waist sizes were considered attractive? Or had the very idea of incarnate femaleness taken on a different meaning, different associations, the capacity to set up different fantasies and images for the culture of the decade? [37].

Psychopathologies that develop within a culture, far from being anomalies or aberrations, are characteristic expressions of that culture; indeed, they are the crystallization of much that is wrong with it. Every age, Christopher Lasch says, develops its own peculiar forms of pathology that express its underlying structure in an exaggerated manner.

The greater risk of women and girls developing eating disorders has been attributed to social pressure in a male-dominated world. Background cultural factors are often implicated, not only fashion, but also more relevant background structure and social norms.

In the 1980s, Bordo claimed that anorexia is the product of three cultural axes that mark the socially and culturally-mediated relationship that human beings have with their bodies and the way that, through this mediation, they are normalized. First, there is a dualistic axis upon which the body is felt to be separated from the experience of being a person and a mind (Descartes and his separation between mind and body). The second axis is body control, where the body is seen as a mute instrument to be controlled by the person. The third axis is gender/power in which women are subjected to images of female beauty that include youthfulness and slenderness. This is the ideal image of a woman who is not yet a woman, and the tendency of anorectics to retain their adolescence and to resist the more developed womanly form, which is often perceived as fatter and more curved.

Bordo remarked that the body of the anorectic is an illustration of how deeply power relations are etched on our bodies that serve them [38, 39].

Sheila MacLeod also wrote as a recovering anorectic a text that took an existential approach to anorexia nervosa. Female identity is seen as central to the state of anorexia nervosa, which MacLeod viewed as a manifestation of an existential crisis resulting from women's confusion about their being-in-the-world. She focused on the meaning of anorexia nervosa serving as a symbol for both, oppression and resistance, with starvation having its own esthetic.

MacLeod viewed anorexia nervosa as a particular existential dilemma facing women and a specific aspect of female identity. Anorexia nervosa is still constructed as a disease condition that is gendered.

Far from being fundamentally stable, a cultural constant with which we must contrast all culturally relative and institutional forms, the body is assumed to be constantly "in the grip," as Foucault put it, of cultural practices. There is no "natural body." Cultural practices are already and always inscribed, as Foucault underlined, on our bodies and their materiality, their forces, energies, sensations, and pleasures. Our bodies, no less than anything else that is human, are constituted by culture.

Women, besides having bodies, are also associated with the body, which has always been considered the sphere of women in family life, mythology and in scientific, philosophical, and religious ideology. This is related to the maintenance of power relations between sexes throughout history.

Anorexia is not a philosophical attitude but a debilitating affliction. It is quite often a highly conscious and articulate scheme of images and associations presented in these women. In this battle, thinness represents a triumph of the will over the body, and the thin body (that is to say, the non-body) is associated with

absolute purity, hyper-intellectuality, and transcendence of the flesh. Fat is associated with the tainting of matter and flesh, wantonness, mental stupor, and mental decay.

"In early Christianity, individuals were exhorted to offset the threat raised by bodily appetites through fasting. Present-day societies have adopted a secular counterpart; it is called the diet. Lacking a moral vocabulary, contemporary societies have projected the notions of good and bad on the images of our own bodies: the idea of God (perfection, purity, and kindliness) is now enclosed in the image of thinness; while that of the Devil (sloth, corruption through appetite and avarice) is incarnated in fatness. We are certainly closer to puritanical tradition than to the early Christians, particularly in our fight for individual self-regulation and our devotion to the work ethic" [17].

Indeed, obesity and eating behavior disorders have an increasing impact on our culture with greater prevalence. There is no break in continuity between the attitudes and behaviors with regard to the body and the diet of the general population, sub-clinical eating disorders and actual clinical cases [11].

Nowadays, religion has lost its privileged position. Our dietary concerns are closely linked to two factors: aesthetics and death. To be "good-looking," "young," and "thin" is an imperious narcissistic necessity; quality of life, new social acquisition, overcoming ageing as a surrogate for immortality. Gaining weight is dangerous because it leads to death in the short or long term. There is now a dark and imperious need for health and beauty, gripped to the self of each individual, that has taken the place of ethics and religion [5].

People have grown increasingly self-centered in today's Western world. Wars may be declared, entire regions may be wiped away by earthquakes, unemployment is bellowing at the door, there is a global economic crisis, but what is most important for certain patients is whether they have been able to control their binges or the lack of control of various types of impulses. The cult of the self is characteristic of all eras but this way of making the body itself the center of everything may lead ethically and culturally to a cul-de-sac [5]. There is the socially transmitted belief that drinking abundant amounts of water is healthy "for internal cleansing" and this has a moral connotation. There is guilt in being fat. The only obsession is weight and the body aesthetic on which thinness and youth depend.

Moreover, we should not ignore the impact of globalization on the world food system. In a world where more food is produced than at any time in history, over 10 % of the population go hungry. The hunger of those 800 million people coincides with another historic record: "globesity," over a billion people are overweight. The obese and the hungry are interconnected. Hunger and obesity are symptoms of the same problem. The road that may lead to eradicating hunger would serve to prevent global epidemics of diabetes and heart complaints. There are moral excuses that act to calm a troubled conscience: the poor are hungry because they are lazy or the rich are fat because they eat fattening food. The prevalence of hunger and obesity affects people too often and in too many places for it to be the consequence of any personal defect. In Mexico, a developing country, there are more obese adolescents than ever, although the number of poor Mexicans is

growing. The crucial factor is not economic revenue but the proximity to the border and the habits of their northern neighbors whose processed food is rich in fats and sugar [33].

The weight of sociocultural factors in the genesis of eating behavior disorders are a reality, as described in this historical introduction. So is the role of gender, the distribution of power, ethnicity and social class and wealth distribution at a global level. Everything influences what we eat. We are what we eat and we eat what we are, as we said at the start of this chapter.

10.4 Psychopathology of Eating Behavior

Eating disorders are the pathology most frequently presented by young people. Their medical complications, comorbidity and seriousness make them eligible for inclusion here.

We have divided this section into three parts. The first is devoted to the two syndromes that are most frequently presented in habitual clinical practice and that fundamentally affect women as often as they did two centuries ago: anorexia and bulimia nervosa. The second part discusses eating disorders that have been recently included in the DSM-5, such as bingeing disorder (which is also mostly presented by women) and childhood eating disorders such as pica and rumination (which are presented equally by both sexes). Finally, there are now new ways of presenting the psychopathology of eating behavior that still require a great deal more research in the future.

Epidemiological studies have found that anorexia nervosa and bulimia nervosa occur generally ten times more frequently in women than in men; thus the estimated female-to-male gender ratio would seem to be 10:1 [40].

10.5 Anorexia Nervosa

10.5.1 Epidemiological Data

The lifetime prevalence of anorexia nervosa almost doubled when the broad definition was used, 4.2 % (DSM-5) versus 2.2 % (DSM-IV). The crude mortality rate (CMR) was 5.1 deaths per 1,000 person-years [41].

10.5.2 Clinical Features

The distinguishing clinical feature of anorexia nervosa is extreme restriction of food intake, resulting in extensive weight loss (or a failure to gain weight during growth periods).

The refusal to maintain body weight at or above a minimal level for age and height has two fundamental aspects. First, individuals with anorexia nervosa,

mostly women, are required to be significantly underweight, weighing less than 85 % of what is expected. The other essential aspect is that the individual wishes to be underweight and makes conscious attempts to avoid gaining weight.

Despite the fact that individuals with anorexia nervosa are by definition underweight, they are convinced that they will become substantially overweight if they cease their vigorous efforts to remain in control of their eating and exercising.

There is a disturbance in the way in which one's body weight or shape is experienced, an undue influence of body weight on self-evaluation, or a denial of the seriousness of the current low body weight.

Women with anorexia nervosa do not menstruate. Most women have progressed normally through pubertal development and have begun to menstruate before the onset of the eating disorder. However, some girls develop anorexia nervosa before the onset of menstruation.

Once anorexia nervosa has been diagnosed, the clinician is asked to classify the patient into one of two groups:

Restricting type: during the current episode of anorexia nervosa, the person has not regularly engaged in binge eating or purging behavior.

Purging behavior: during the current episode of anorexia nervosa, the person has regularly engaged in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Individuals with anorexia nervosa usually perceive their size accurately. The problem lies more often in the judgment they make about the size they see. This is determined by socio-cultural factors and affects women more frequently.

It is also striking that this fear of becoming fat typically intensifies as more weight is lost.

The most powerful illustration of the effects of restrictive dieting and weight loss on behavior is an experimental study conducted in 1950 by Ancel Keys at the University of Minnesota. The experiment involved 36 carefully chosen, young, healthy, psychologically normal men who restricted their caloric intake for 6 months as an alternative to military service. What makes the study so important is that many of the experiences observed in the volunteers were the same as those patients with eating disorders. The question is that while anorexia nervosa is mostly presented by women, only men were used for this study. What does this mean? Table 10.2 shows the effects of starvation in the study.

Table 10.3 presents common reasoning errors among patients with eating disorders, as described by Garner and Garfinkel [42].

When a woman insists that the only way to succeed in our culture is to be thin, she could be described by clinicians as possessing distorted reasoning or a misperception of reality. But for most people in Western culture, especially women, slenderness is equated with competence, self-control, and intelligence. There is no firm demarcation between the normal and the pathological, as most women are affected in some way by the cultural construction of female beauty as involving slenderness. This means that most women have some sort of problem in relation to

Table 10.2 Effects of starvation

Attitudes and behavior toward food
Food preoccupation
Collection of recipes, cookbooks, and menus
Unusual eating habits
Increased consumption of coffee, tea, and spices
Gum chewing
Binge eating
Emotional and social changes
Depression
Anxiety
Irritability, anger
Lability
Psychotic episodes
Personality changes on psychological tests
Decreased self-esteem
Social withdrawal
Cognitive changes
Decreased concentration
Poor judgment
Apathy
Physical changes
Sleep disturbances
Weakness
Gastrointestinal disturbances
Hypersensitivity to noise and light
Edema (water retention, particularly in ankles)
Hypothermia and feeling cold
Paresthesia
Decreased metabolic rate
Decreased sexual interest
Dry skin
Hair loss

food consumption. There is a continuum of eating problems from dieting to the extremes of anorexia and bulimia nervosa.

Body image disturbance plays a prominent role in the psychopathology of eating disorders. Historically, either the perceptual or the cognitive-affective components of body image disturbance (body image distortion or body image dissatisfaction) have been incorporated into the diagnostic criteria for both anorexia nervosa and bulimia nervosa and focus on the influence of body shape and weight on self-evaluation.

Multiple factors of body image disturbance have been identified. These include body image distortion, body image dissatisfaction, and body image avoidance, which are all highly correlated. Patients with more severe body size distortion

Table 10.3 Reasoning errors

Selective abstraction, or basing a conclusion on isolated details while ignoring contradictory and more salient evidence
Over-generalization, or extracting a rule on the basis of one event and applying it to other dissimilar situations
Magnification, or over-estimation of the significance of undesirable consequent events. Stimuli are embellished with surplus not supported by an objective analysis
Dichotomous or all-or-none reasoning or thinking in extreme and absolute terms. Events can be only black or white, right or wrong, good or bad
Personalization and self-reference, or egocentric interpretations of interpersonal events or over-interpretations of events relating to the self
Superstitious thinking, or believing in the cause–effect relationship of noncontingent events (Garner and Garfinkel)

may benefit most from treatment that focuses on correction of size and weight overestimation. When body image dissatisfaction is more prominent, modifying negative and distorted thoughts and working toward acceptance of one's body may be indicated. Finally, treatment incorporating exposure to situations that provoke anxiety-provoking thoughts about appearance will be beneficial for those patients who exhibit extreme avoidance behaviors.

The anorectic's distorted image of her body, her inability to see it as anything but too fat, although more extreme, is not radically discontinuous, then, from fairly common female misperceptions [37].

Hilde Bruch reported that many anorectics talk of having a ghost inside them or surrounding them, "a dictator who dominates me," as one woman describes it; a little dictator, the "other self," was always reported by Bruch. The anorectic's other self, the self of the uncontrollable appetites, the impurities and taints, the flabby will, and the tendency to mental torpor is the body [37] but it is also the female self. These two selves are perceived as constantly being at war. But it is the male side, with the associated values of greater spirituality, higher intellectuality, and will-power that is being expressed and developed in the anorexic syndrome. For Bordo [37–39], there are two levels of meaning. The first concerns the fear and disdain for traditional female roles and social limitation. The other concerns a deep fear of the female, with all its more nightmarish archetypal associations of voracious hungers and sexual insatiability.

Adolescent anorectics express a characteristic fear of growing up to be mature, sexually developed, and potentially reproductive women. And indeed, as Bruch reports, many anorectics, when children, dreamt and fantasized about growing up to be boys.

Some authors interpreted these symptoms as a species of unconscious feminist protest, involving anger at the limitations of the traditional female role, rejections of values associated with it, and fierce rebellion against allowing their futures to develop in the same direction as their mothers'.

For women, the fatness that goes with normal adult body weight will always have had a sexual dimension, serving as it does both direct reproductive and related social and biological purposes, such as its attractiveness to men. The attempted regulation and control of weight and shape are commonplace among teenage girls searching for a greater sense of ownership of the body and its impulses; the success of such attempts leads to enhanced self-esteem.

The greater risk of women developing eating disorders has been attributed to social pressure in a male-dominated world. Background cultural factors are often implicated, not only fashion-related, but also more relevant background structure and social norms.

An explanation of a multidimensional model of anorexia nervosa should include the crucial dimension of culture and the construction of gender to understand the sociocultural analysis of the phenomenon. This is gender as primary and productive in the emergency of anorexia, rather than as merely a contributing factor.

10.6 Bulimia Nervosa

10.6.1 Definition

From *bous*, ox and *limos*, hunger, bulimia was used in Greece to define a devouring hunger. The term bolism (*bolisme*) appeared in all French medical treatises at least until the fourteenth century, although Pinel, in his *Nosographie Philosophique*, conceived of bulimia as a morbid type consistent with "hunger which is too intense and often insatiable" and included it in the "neuroses of the nutritional functions." During the nineteenth century, the term maintained a semiological meaning synonymous with terms such as *citorexia*, *hyperorexia*, *hyperphagy*, and *sitomania* [1]. In the latter half of the twentieth century, English literature established the nosological nature of bulimia nervosa, this being described by Russell as the appearance of recurring episodes of excessive voraciousness followed by inappropriate compensatory behavior. As in anorexia nervosa, there is both an irrational fear of gaining weight and severe alterations in the body image.

Epidemiologically, several community studies found that the prevalence of bulimia nervosa increased by 30 % when DSM-5 criteria were used, leading to a lifetime prevalence of around 2 % for women.

Mortality and suicide risk are elevated in bulimia nervosa as well, albeit not as markedly as in anorexia nervosa. CMR: 1.7 per 1,000 persons-years [41].

10.6.2 Clinical Features

The salient behavioral characteristic of bulimia nervosa is the frequent occurrence of binge eating episodes. A binge is defined on the basis of two elements: consumption of a large amount of food, and a sense of a loss of control during the eating

episode (the feeling that one cannot stop eating or control what or how one is eating).

A second critical characteristic of bulimia nervosa is that following the eating binges, the individual engages in inappropriate attempts to rid her or himself of weight gain. In clinical samples, the most frequent inappropriate behavior is self-induced vomiting. Vomiting is often difficult to induce when the illness begins, but becomes less difficult and more habitual over time. Many individuals with bulimia nervosa eventually induce vomiting not only following binge episodes but also following the consumption of any meal, whether large or small. They also use utilize medications in an attempt to counteract the binges. Commonly, they use laxatives, diuretics, enemas and thyroid medication.

Bulimic episodes usually start from the afternoon and generally include every type of food. However, some studies have demonstrated that patients tend to ingest foods considered to be "taboo" for them, foods that they normally reject because they consider them to be high in calories, carbohydrates and fats. The manner of eating also tends to be altered, being rapid and voracious and mixing tastes, textures and foods. The binge frequency varies according to the seriousness of the disorder, morale, and finally becomes a routine act, without the existence of clear triggers.

Between binges, patients maintain a restrictive diet or even fast, which primes and facilitates the episodes of uncontrolled intake. Many patients find difficulty in feeling satiated at the end of a normal meal and may continue eating. This gives rise to continuous weight changes but without the notable weight loss of anorexia nervosa. Bulimic behavior begins after a period of dieting and there is a record of patients having previously suffered from anorexia nervosa in a significant percentage of cases.

The final aspect in the characterization of bulimia is persistent concern over figure and weight, with a morbid fear of weight gain. For many authors, this is the nuclear psychopathological aspect as it leads the patient to exclusive self-evaluation in terms of weight and figure.

Most bulimic patients present depressive symptoms such as sadness, guilt feelings, low self-esteem and suicidal thoughts.

High anxiety levels form an inseparable part of bulimic behavior. The moments prior to a binge are characterized by unease, excitation, tension and an imperious desire to eat. In this way, anxiety and dysphoria accompany and trigger most binges in bulimic patients. After the loss of control, anxiety may be reduced and subsequently there is an increase in guilt feelings, low self-esteem and fear of growing fat, leading the patient to cause her or himself to vomit. As well as the anxiety associated with the binge, high levels of anxiety between episodes are presented. Abuse of substances, mainly alcohol, together with kleptomania, are among the compulsive behaviors most frequently found in these patients. Many of them present borderline personality features and interpersonal relationship problems.

Complications result from purging and bingeing behaviors (as in the purging behavior of anorectics):

1. Electrolytic alterations such as dehydration and alkalosis as a consequence of vomiting. On occasions, there may be metabolic acidosis due to laxative abuse.
2. Cardiac alterations, with arrhythmias secondary to hypopotasemia and even sudden death.

10.6.3 Conclusion

Like patients with anorexia nervosa, those with bulimia nervosa are over-concerned with their body shape and weight and their self-esteem is regulated in the extreme by these aspects of their appearance. They feel under intense pressure to diet and avoid weight gain. This is more frequent in female patients.

As Bordo points out most women affected by eating disorders are pursuing today's boyish body ideal, which seems to be surrounded by an aura of freedom and independence. However, the body shape of most mature women does not fit the ideal and therefore they must either spend hours each day dieting and exercising or simply give up trying to attain it. In opposition to this, the bodies of mature women tend to have more body fat than the bodies of younger boys and are rounder and fuller. In turn, this "womanish fat" seems to symbolize women's supposedly voracious appetites, and also, for many women, the domesticity they associate with their mothers [37].

Thus, for many women, this appears to be a fight with their own bodies. This is not the pathological body. Instead, the average adult female body that is complexly and ambiguously symbolized is the problem for many women and not an internally distorted perception of their own body or cognitive malfunctions in the processing of information.

There is an embodied perception of the world. This is lived from a situated perspective that is both individual (the person's relation to the world and their experience of life events) and socio-historical. Behind this lies a culture that is driving more, and younger, girls and women into the regimes of rigorous dieting and exercise, largely by encouraging the fear of weight gain. This is normalizing images and ideologies of femininities and notions of female beauty (body image in men is muscular, fit and youthful; masculine beauty as the Grecian model or the David of Michelangelo). This will determine in some way how actual women are much more affected by these pathologies. People live in their bodies with the world, especially the social world. From this viewpoint, culture is seen as lived through the body.

10.7 Feeding and Eating Disorders Included in DSM-5

10.7.1 Pica

This is also known as "allotriophagy," which derives from Latin and refers to the magpie, a bird celebrated for its excessive appetite [43]. Pica is an extreme degree of dysorexia, that is, a severe disorder of the criteria of qualitative food selection.

The essential feature of pica according to DSM-5 is the eating of one or more non-nutritive, non-food substances on a persistent basis over a period of at least 1 month that is severe enough to warrant clinical attention. Typical substances ingested tend to vary with age and availability, and may include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal or coal, ash, clay, starch, or ice. The term non-food is included because the diagnosis of pica does not apply to ingestion of dietary products that have minimal nutritional content. There is typically no aversion to food in general. The eating of non-nutritive, non-food substances must be developmentally inappropriate and not part of a culturally supported or socially normative practice. A minimum age of 2 years is suggested for a pica diagnosis to exclude the developmentally normal mouthing of objects by infants that results in ingestion. The eating of non-nutritive, non-food substances can be an associated feature of other mental health disorders (e.g., intellectual developmental disorder, autism spectrum disorder, schizophrenia). If the eating behavior occurs exclusively in the context of another mental disorder, a separate diagnosis should be made only if the eating behavior is sufficiently severe to warrant additional clinical attention in DSM-5. Pica occurs in both boys and girls. It can occur in women during pregnancy; however, little is known about the course of pica in the postpartum period.

In some populations, the eating of earth or other seemingly non-nutritive substances is believed to be spiritual, medicinal, or of another social value, or may be a culturally or socially normative practice. Such behavior does not warrant a diagnosis of pica. Some individuals may swallow potentially harmful items (e.g., pins, needles, knives) in the context of maladaptive behavior patterns associated with non-suicidal self-injury in personality disorders.

It has also been reported that there is an increase in the comorbidity of pica with other eating disorders (particularly bulimia nervosa), with obsessive–compulsive disorder, with the obsessive personality, and with the dysorexias that characterize pregnancy. With regard to the etiopathogeny of this disorder, this takes in cultural factors, psychological factors including those deriving from inadequate relationships between the child and her/his parents as well as factors that are characteristic of the family dynamic, this being more frequent in families that are seriously dysfunctional and with a greater prevalence of alcoholism, obesity and substance addiction.

The medical complications of pica, over and above those characteristic of the primary disorders that condition it, derive from malnutrition and the harmful nature of the substances ingested, with a frequency of poisoning, intestinal obstructive

conditions due to bezoars or foreign bodies (phytobezoars, trichobezoars), perforations or processes of an infectious type.

Rumination (from the Latin *ruminare*, which means "chewing the cud") or mericism (a Greek term with same meaning) [4] is a disorder of low prevalence present in the early stage of life (between 3 and 12 months old). Its presence in adults is very unusual other than in severe cases of mental retardation. It was described by Fabricio d'Acquapendente in 1618 and included by Pinel under digestive neuroses in his *Nosographie Philosophique*.

Rumination consists of repeated and voluntary regurgitation of food ingested followed by new processing (mastication, salivation, swallowing) or expulsion from the oral cavity with the consequent reduction in intake and weight gain. This phenomenon occurs in those who previously presented a correct swallowing function and is therefore secondary. Despite being comparatively unusual, it has an elevated mortality rate, which is approximately 25 % of cases, due among other causes to the high risk of malnutrition or secondary complications in the form of food inhalation and the subsequent development of bronchopneumonia. Over and above the psychological factors involved in the origin of this disorder (almost always related to the mother-child relationship or to other learning aspects and psychomotor development), it is necessary to rule out possible organic causes of the anatomical and physiological aspects of the digestive function that may condition this process. Accordingly, the gastro-esophageal reflux is usually the most frequent cause of mericism [4].

The essential feature of rumination disorder in DSM-5 is the repeated regurgitation of food that occurs after feeding or eating over a period of at least 1 month. Previously swallowed food that may be partially digested is brought up into the mouth without apparent nausea, involuntary retching, or disgust. The food may be re-chewed and then ejected from the mouth or re-swallowed. Regurgitation in rumination disorder should be frequent, occurring at least several times a week, typically daily. The behavior is not better explained by an associated gastrointestinal or other medical condition (e.g., gastro-esophageal reflux, pyloric stenosis) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, BED, or avoidant/restrictive food intake disorder. If the symptoms occur in the context of another mental disorder, they must be sufficiently severe to warrant additional clinical attention and should represent a primary aspect of the individual's presentation requiring intervention.

10.7.2 Selective Eating and Food Rejection

This condition is included in the section on ingestion and eating behavior disorders in the DSM-5. However, these are not accompanied by the symptomatic group of body image distortion, purging behavior or fear of getting fat [44] such as avoidant/restrictive food intake disorder.

This diagnosis replaces and extends the DSM-IVTR diagnosis of feeding disorder of infancy or early childhood. The main diagnostic feature of avoidant/

restrictive food intake is avoidance or restriction of food intake manifested by a clinically significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food. One of the following key features is present: significant weight loss, significant nutritional deficiency (or related health impact), dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning. The determination of whether weight loss is significant is a clinical judgment; instead of losing weight, children and adolescents who have not completed growth may not maintain weight or height increases along their developmental trajectory.

Determination of significant nutritional deficiency is also based on clinical assessment (assessment of dietary intake, physical examination, laboratory testing), and the related impact on physical health can be of a similar severity to that seen in anorexia nervosa (e.g., hypothermia, bradycardia, anemia). In severe cases, particularly in infants, malnutrition can be life-threatening. Dependence on enteral feeding or oral nutritional supplements means that supplementary feeding is required to sustain adequate intake.

This does not include avoidance or restriction of food intake related to lack of availability of food or to cultural practices (e.g., religious fasting or normal dieting), nor does it include developmentally normal behaviors (e.g., picky eating in toddlers, reduced intake in older people). The disturbance is not better explained by excessive concern about body weight or shape or by concurrent medical factors or mental disorders.

In some individuals, food avoidance or restriction may be based on the sensory characteristics of the qualities of food, such as extreme sensitivity to appearance, color, smell, texture, temperature, or taste. Such behavior has been described as restrictive eating, selective eating, choosy eating, perseverant eating, chronic food refusal, and food neophobia, and may manifest itself as a refusal to eat particular brands of foods or to tolerate the smell of food being eaten by others. Individuals with heightened sensory sensitivities associated with autism may show similar behaviors.

Food avoidance or restriction may also represent a conditioned negative response associated with food intake following, or in anticipation of, an aversive experience, such as choking: a traumatic investigation, usually involving the gastrointestinal tract; or repeated vomiting. The terms functional dysphagia and globus hystericus have also been used for such conditions.

It is equally common in boys as in girls in infancy and early childhood. If it is comorbid with autism spectrum disorder, it has a male predominance. Food avoidance or restriction related to sensory sensitivities can occur in some physiological conditions, most notably in pregnancy, but it is not usually extreme and does not meet the full criteria for the disorder.

The question is that feeding disorders presenting in childhood have equal prevalence in male and female patients. However, anorexia nervosa, bulimia nervosa, and BED are most frequent in the female population.

10.7.3 Binge Eating Disorder

To our knowledge, no incident studies on BED yet exist. The 12-month prevalence of BED among adult women is 1.6 % and among men it is 0.8 %. Data on the long-term outcome of BED, including mortality, are scarce. In a sample of 68 female in-patients with BED, CMR was 2.9 % after 12 years' follow-up [41].

This is a condition characterized by recurring food binges without the compensatory maneuvering typical of bulimia nervosa.

Binge eating disorder usually makes its appearance in late adolescence or young adulthood and most often affects women who have subjected themselves to strict diets to lose weight and have suffered relapses. The clinical condition is characterized by subjectively perceived recurring binges and behavioral manifestations, or a lack of control over them.

The delimitation of BED as a nosological condition is very recent: it arose as the result of a multicenter study published in 1992 by Spitzer [57]. This established the diagnostic criteria met by a group of individuals who presented recurring binge eating problems but without compensatory behaviors characteristic of bulimia nervosa, such as repeated vomiting or laxative abuse. It was observed in this study that this disorder could be diagnosed with a high index of reliability and that it was very frequent in hospital slimming programs, affecting 30 % of obese patients.

The key aspect of the psychiatric aspect of bingeing does not refer to the amount of food ingested but to the individual's lack of control over intake. This is the feeling the individual experiences on not being able to stop eating, or control what or how much she or he is going to eat. The manifestations of this lack of control are eating very quickly, eating so much that an unpleasant feeling of postprandial fullness is felt, the ingestion of a large amount of food, even though the individual is not hungry, and the feeling of disgust, guilt or depression after the episodes. According to the DSM-5 [45], for a diagnosis of the BED, the binges need to cause a clinically significant malaise, with dissatisfaction during and after the episodes and concern over its effects on weight and body image. The patient may obtain a degree of gratification while she or he is eating, but her or his experience after bingeing is always negative, with feelings of guilt, remorse, rage etc. After bingeing, the patient experiences a deep unease, but in general does not display the compensatory strategies of bulimia nervosa.

Differential diagnosis of BED therefore is made above all with atypical bulimia nervosa. However, the use of compensatory strategies characteristic of bulimia, such as fasting and excessive exercise, is not as frequent. Another difference between the two disorders is the degree of obesity. Indeed, patients with BED frequently present serious obesity (defined as a body mass index equal to or greater than 35) and greater weight fluctuations than patients with bulimia nervosa [46].

Some studies have suggested that "emotional eating" might exist. This affects a group of obese patients whose bingeing responds to emotional stress [45].

Patients with BED compared with other obese patients present a higher rate of personality and panic disorders [47], as well as family dysfunctions with abuse and emotional abandonment although not aggression or sexual abuse [48].

Environmental factors are essential in virtually all the patients in whom obesity develops. Epidemiological studies demonstrate that in the past 20 years the population of obese people in the USA and UK has doubled and this is increasingly affecting the child population. There is talk now of a pandemic and "globesity" [49]. The socio-cultural conditions of the population, the "consumer culture" and the "McDonaldization" of society, together with food technology, subject the public to a pressure that explains the increase in the prevalence of obesity [49], no matter how much the thin esthetic, of the slim body, is imposed. This causes in large sectors of the population, especially in women and girls, dissatisfaction with body image and an increase in the prevalence of eating behavior disorders in the female population.

Personality traits may play a major role in the development of this disorder through three possible mechanisms: first, they may show a predisposition to excessive eating; second, obesity itself, when it begins in the early stages of life, may affect personality development; and finally, the two mechanisms mentioned may act as a combination. The attitude to the body, the impulsiveness, and the relationship with food learned from young ages are key aspects in the genesis of obesity.

Classic literature has associated the passive-dependent personality with obesity, although this has not been demonstrated scientifically. However, it has been reflected in history and literature as in the character of Ignatius Reilly in the novel *A Confederacy of Dunces*. Specific aspects, such as insecurity, hypersensitivity and emotional instability, are more frequent than in the population as a whole; what is not clear is whether it is a prior disposition or a form of adaptation in a subject who finds difficulties in adapting to normality.

On the other hand, comorbidity with personality disorders such as borderline personality disorder is frequent. This suggests that a causal relationship exists between the two conditions, either with a common origin with a genetic and/or environmental basis, or because obesity is secondary to the alteration of the control of impulses that are so frequent in borderline personality disorder. In Western societies, thinness prevails as part of the present canons of beauty and obese people are aware of the social rejection and discrimination that they often receive, as well as suffering the limitations that their weight imposes on them in everyday life. This situation may produce dissatisfaction with their own body and with their body image. Their image becomes a principal source of their concerns and thinness takes top place in their scale of values, above everything else.

An example of the unease these people may experience is "mirror avoidance," which makes them travel large distances to avoid having to look at themselves in the mirror or in the reflection of a shop window. In fact, this suggests that these individuals present a body image disorder that is similar to what occurs in eating behavior disorders.

Body image disturbance that is not modified despite weight loss demonstrates to us the need to treat underlying psychological aspects such as body dissatisfaction and dysmorphophobic and alexithymic aspects.

Also, the anxiety secondary to the undertaking of slimming treatments comprising diets without psychotherapeutic support is often associated with this problem [50], above all in the female population.

The anxiety disorders most frequently associated with the severely obese are agoraphobia, simple phobia and post-traumatic stress syndrome, which is much more frequent than in the general population. It has been suggested that women with a background of violence and rape may seek relief in food [51].

Obesity in women is associated with a greater prevalence of depressive symptoms owing to a greater perception of social stigma, which is much more intense in women and girls. Corporality and body experience constitute a nuclear part of the female identity, as has been explained in previous articles.

10.8 New Conditions Related to the Psychopathology of Eating Behavior and/or Body Image

10.8.1 Orthorexia

This is an ill-defined and insufficiently studied spectrum at present. It consists of extreme concern over whether foods are healthy and contaminant-free. This condition may be related to obsessive health worries, to hypochondriacal fears of illness, and, to a certain extent, to cultural attitudes linked to diets and foods. It is true that restrictive diet anomalies and weight loss may be presented but these may not be considered as atypical or incomplete cases of anorexia nervosa [52]. This disorder may give rise to anemia or vitamin deficiencies and affect the health of children raised with this type of diet, leading to malnutrition. This has created raw vegans, who only eat uncooked vegetables. For example, *Rawer* (2012) is a Dutch documentary about 14-year-old Tom and his mother, Francis, who adhere to a strict diet of raw food (dairy, fish, meat, and eggs are also off limits). It is discovered that Tom is malnourished and not growing at the rate doctors think he should be and child welfare steps in. These are some of the controversial issues raised in the film. There are difficult questions that stem from conflict between health-care providers and families in a world where alternative nutritional practices continue to be viewed as oppositional to the logic of Western science.

10.8.2 Bigorexia

This condition is characterized by excessive concern over seeking bodily perfection through physical exercise. This leads to great dissatisfaction with self-image, exaggerated amounts of exercise, special diets and foods to a degree where there is dependence, and also the consumption of doping substances [53]. This condition

is ill-defined at present and related to obsessiveness, perfectionism and dysmorphophobia. It is more frequent in men.

10.8.3 Night Eating Syndrome (Nocturnal Eaters)

Sleep is interrupted in those affected and in this situation/state they overeat. Whether these conditions are due to an eating behavior disorder or whether sufferers are individuals affected by primary sleep anomalies has not yet been defined [54, 55].

10.8.4 Ebriorexia (Drunkorexia)

Food restriction achieved through the ingestion of large amounts of alcohol with the aim of reducing food intake. This type of presentation is more frequent in young women.

10.9 Discussion

Young women present eating disorders more than any other pathology. The effects, complications and comorbidity of these disorders oblige us to assess why it is that they continue to affect women in similar proportions (10:1) to two centuries ago. We have chosen to ignore existing biological factors, studies of genetic factors with greater concordance between monozygotic twins, and the presence of alterations in neuropsychological aspects. Instead, we have focused on the sociocultural aspects that, to a certain extent, shape biology and make these disorders persist over time in a Western world where, owing to a lack of other ethical values, youth and thinness are what matter most.

An image of female thinness leads these dominant cultures to influence teenagers, who internalize these figures as personal values. It is a major achievement to be aware of this. In a society that emphasizes freedom, individual ability and free will and choice, awareness of the complexity and nature of the culture in which we are immersed is an advance with regard to those underlying aspects that condition our behavior, personal choices and even our professional vocations, according to Bourdieu's habitus model. One only achieves success by playing to the cultural norms. It is alienating that a woman feels "nothing" in this post-modern world unless she is slim, thin, unwrinkled, blemish-free, and fat-free (apart from her breasts). Literally a smaller body in the physical sense. We should remember that the ideal male figure has remained the same since the ancient Greeks and an athletic build has been the male beauty ideal throughout history. The post-modern discourse is disturbing, with fixed concepts such as "youth" or "old age" and their corporal expression becoming unstable, fluid, fragmented, and undetermined. They are dominated therefore by more sophisticated technologies that make us believe, for

example, that any woman can become a mother after the menopause. "You only need an egg donor." The same happens with the gender paradigm. These discourses are altering the conception and experience of our bodies, encouraging us to imagine possibilities and to close our eyes to limitations and consequences. Anorexia nervosa and bulimia nervosa/binge eating reached epidemic proportions in the twentieth century. The prison of the body in which these patients' lives are transformed has become a clinical reality. New ways of addressing this problem are required. More research is needed to determine the role of gender in the construction of these symptoms. A failure to include the gender paradigm in clinical construction will make it impossible for us to practice good science.

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