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NOT YOUR "TYPICAL ISLAND WOMAN": ANOREXIA NERVOSA IS REPORTED ONLY IN SUBCULTURES IN CURAÇAO

ABSTRACT. Anorexia nervosa (AN), once thought to be a problem of wealthier, Western countries has now been documented in survey studies and case reports across geographic and economic groups; however, few epidemiological studies including interview have been done on these populations. We report on a comprehensive study on Curaçao, a Caribbean island in economic transition, where the majority of the population is of predominantly black African origin. As part of an epidemiological study on the island of Curaçao indigenous cases of AN were identified. Participants were interviewed and asked to complete standardized measures of eating behaviors and cultural attitudes. In addition, matched controls completed the same measures and were seen in a focus group to assess their knowledge of eating disorders and perceived current and future challenges to young Curaçao women. Six of the nine indigenous cases of AN were successfully traced; all were of mixed race. No cases of anorexia were found among the majority black population. The women with AN were from the high-education and high-income sectors of the society and the majority had spent time overseas. The women with a history of anorexia reported higher levels of perfectionism and anxiety than the matched controls. All of the women reported challenges to maintaining an active professional and personal life and viewed themselves as different from the norm. Women who presented with AN evidenced vulnerability to a triple threat to identity formation: (1) they were of mixed race, aspiring to fit into the mobile elite (and mostly white) subgroup while distancing themselves from the black majority; (2) they had the means for education and travel that left them caught between modern and traditional constructs of femininity; and (3) they had lived overseas, and therefore struggled upon reentry with the frustrations of what was possible within the island culture. The race, class and overseas exposures of the women with anorexia were anything but typical on the island. Cases of anorexia in other developing countries may similarly be limited to specific subgroups, which require specialized treatment and planning efforts.

KEY WORDS: anorexia nervosa, cross-cultural psychiatry, eating disorders, identity confusion, women

"*We are not typical of Curaçao women in general*, *we are typical of educated Curaçao women*, *and that means we had to leave the island*."

—Focus Group Participant

INTRODUCTION

Anorexia nervosa (AN), once thought to be a problem of wealthier, Western countries, has now been documented in survey studies and case reports across geographic and economic groups (Miller and Pumariega 2001). Its democratic

Culture, Medicine and Psychiatry **28:** 463–492, 2004.
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DOI: 10.1007/s11013-004-1065-7

presence across societies has challenged the notion that AN is bound to cultures or even hemispheres (Katzman and Lee 1997) and the reductionist view of the 1980s and 1990s that attributed AN merely to an increased cosmetic compliance to a thin ideal has been increasingly replaced with an appreciation of the complex interplay of social and biological risk (Hoek et al. 2003). Nasser et al. (2001: xv) describe AN as "a global marker of change," while Bordo (1985: 5) asserts that "anorexia calls our attention to the central ills of our culture."

If one accepts that "anorexia develops in response to a complex orchestration of sociocultural elements including industrial capitalism, urbanization, immigration, food abundance, rising population weight norms, advanced information technology, proliferation of body oriented advertisements, decreased birth rate, and change in social norms of women" (Lee 1995: 3), then the condition may be considered bound to the culture of "modernity" rather than any geographic site. From this perspective, AN may still be culture-specific, albeit not necessarily specific to a Western locality, but to a process of development (Lee 1995).

Research into other disease entities suggests that societies in transition show clear evidence of changing health profiles toward diseases more often noted in developed countries (Susser and Watson 1962). As a result, tracking the presence and permeations of AN in changing societies may provide a window into etiological or risk variables.

Past efforts to count and clarify the cultural contributions to AN have been hampered by several methodological problems. Most epidemiological studies have been done in high-income countries with relatively homogeneous populations (Striegel-Moore and Smolak 2002), and none of these have included nonsymptom-focused interview data to assess the motivations and meanings behind women's choice not to eat. In the few two-stage studies, the psychometric measures employed have generally asked only about weight, shape, and eating attitudes (Hoek et al. 2003). When cross-sectional work has been done in developing countries, researchers have often engaged in a binary analysis: are the eating, weight, and diet attitudes the same or different between the two countries being compared? Often a cultural toxin (e.g., expectations for success, immigration, or exposure to foreign media) is assumed (but not measured), and in the studies attempting to assess cultural contaminants there is little overlap in the tools being used, making comparisons across studies difficult. Most cross-cultural studies have relied on paper-based means of assessment, with no interview or effort placed on decoding local reasons for food refusal. However, the few studies that have adopted an emic approach to the examination of eating problems and body concerns have produced a more nuanced understanding (Rubin et al. 2003; Thompson 1996). We know of no population-based investigations that have included qualitative data that might help illuminate why a select few women seem to opt not to eat.

In addition, for many cultural comparison studies the eating disordered samples are ones of convenience (taken from mental health clinics and schools) rather than from community-based canvassing. This is, despite the growing literature revealing that members of ethnic minorities with eating issues are less likely to access or receive treatment (Becker et al. 2003; Striegel-Moore and Smolak 2002), either because they do not define their problem in biomedical terms or because clinician assumptions about who might be vulnerable prevent them from asking about symptoms.

Work conducted in the United States and the United Kingdom on ethnic minority subgroups suggests that altering one's body may be a powerful way of accelerating a sense of belonging for women navigating several cultural subsystems, and as a result, if professionals were trained to probe, problems might be identified in subcultures previously considered "protected." For example, Schwartz (1986) suggests that thinness has become a parameter of black achievement and social mobility within the American middle class, and in fact case reports of anorexia in the black communities of the United States and the United Kingdom reflect the psychological problems girls struggle with while fitting into a new society (Andersen and Hay 1985; Hsu 1987; Jones et al. 1980; Lacey and Dolan 1988; Silber 1986; Thomas and Szmukler 1985). In South Africa, where eating disorders were once seen to be only the province of Caucasian women, Szabo et al. (1995) reported three cases of AN (bulimic subtype) in black patients, all of whom either had or were currently receiving higher education.

Reflecting on why reports of eating disturbance in the black American community may still be limited, Striegel-Moore and Smolak (1996) theorized that for this group a valued robust body and clearly defined social roles may serve as a shield against eating distress. It is possible that within any society subcultures may provide different degrees of role prescription for young girls such that only those girls for whom the "way to be" is less clear or more in conflict with their mothers would be at risk. For example, Katzman and Leung (1996) reported that for Chinese girls in Hong Kong, those whose values challenged the more traditional roles of their mothers were more likely to report increased eating disturbance. It is therefore possible that women of all racial and ethnic backgrounds might display disturbed eating during times of economic transition, albeit with differing vulnerabilities.

The only incidence study conducted in a developing country documented incidence rates for AN on the island of Curaçao (during the 1980s) on par with the lower ranges of those in the United States and Europe (Hoek et al. 1998b). This study, the title of which claimed "a lack of relation between culture and anorexia," received a great deal of professional and public attention including BBC reporting coverage. Its suggestion that anorexia could exist in a "non-Western, predominantly black island with no pressure to be thin" countered cultural theorists and garnered strength for more biological and genetic interpretations of the disorder.

However, the findings were critiqued by Katzman (in email exchanges and conference discussions during 1999) for not defining what the *culture* was that was being measured when one assumed no relation, having no means of assessing pressures to be thin, and not including any report of potential subgroup difference or interview data to justify the claim. Hoek, intrigued by this notion and already planning to return to the island to replicate his findings, invited Katzman to join his team and to further examine the possibility that cultural subgroups might be differentially affected by changing economic and social pressures.

In accepting the invitation, Katzman, who was in the process of designing cross-cultural studies in South Africa and the former Soviet republic of Georgia (Tchanturia et al. 2002), requested that a common set of questionnaires be adopted for all locations in addition to an interview. The questionnaires used are discussed in the "Methods," but also appear in the study by Le Grange and colleagues in South Africa, published in this issue.

Curaçao is particularly well suited for epidemiological studies in that it has a comprehensive health care system and population database (modeled on the Dutch system), which makes it possible to identify cases. Curaçao is the main island in a group of five islands collectively known as The Netherlands Antilles. Historically, Curaçao was a society based on plantation slavery and it is still part of the Kingdom of The Netherlands. It is run by a parliamentary democracy. Its economy is based on four industries: tourism, international financial services, international trade, and oil refinery and transshipment. Curaçao was recently reclassified by the World Bank as a high-income country (Miller 2002), albeit the least affluent of that grouping.

According to the 2001 Curaçao Census (Central Bureau of Statistics [CBS] 2002), 23% of people 15 years old and older had no income, compared to 29% in 1992 (CBS 1993). Dutch and United States television is widely available, and other cultural influences from North America and Europe are increasingly evident as the island is open to all means of multinational influences through commerce, media and its status as a frequent stop for tourists from all over. Curaçao has an active female work force (Alberts et al. 1996; CBS 1999, 2002). It boasts fast food options of equal frequency to local markets: Kentucky Fried Chicken, McDonald's, and others light up many street corners, while traditional vendors in open air stalls remain a common sight.

At the beginning of the study in 1995, Curaçao had a population of 149,963 (CBS 1999). Census data indicate that in 2001 82% of the population had been born on Curaçao and another 6% on one of the other islands of The Netherlands Antilles (CBS 2002). Papiamento, the local language, is spoken at home in the vast majority (81%) of households. The official language is Dutch—it is used in schools, but it ranks second as a spoken language. The census did not record ethnicity. According to the Curaçao Health Study ($N = 2,248$), in 1993–1994

79% of the population of Curaçao was identified as black, 13% as mixed race, 7% as white, and 1% as Asian (Alberts et al. 1996).

We explored several hypotheses as we embarked on this investigation. If AN was related to culture, bound not by Eastern or Western mores *per se* but by increased access to media and modern opportunities (such as higher education, international travel and business, and increased options for the female work force), we would expect some variation across sociocultural groups, but every woman would be equally vulnerable. Alternatively, AN *may* be a product of modernity, but racial groups may have differing mediating variables in their response to societal change. If this was the case, diagnoses may divide along racial lines.

In order to uncover preliminary clues as to why some women might be more vulnerable to AN than others, we sought matched controls for women who were identified as having AN. In addition, we believed that if we ran a focus group with women who potentially shared a risk for eating disorders, then perhaps we could break out of the epidemiological mold of counting eating disordered behavior and begin to contemplate how culture might "color" the problems presented. As a result, we returned to the island in 2001–2002 to conduct a qualitative study of cases with AN detected in 1995–1998 (Hoek et al. 2004). It was part of a comprehensive investigation on the epidemiology of eating disorders on Curaçao that is still ongoing.

METHODS

The Curaçao study was conducted with the approval of and a grant from The Netherlands Antilles Foundation of Clinical Higher Education, which in association with Groningen University Hospital in The Netherlands was responsible at the time for overseeing medical research conducted on Curaçao, including human subjects concerns. All interviewed patients signed informed consent forms.

Subjects

Subjects were selected from an epidemiological study that was in progress (Hoek et al. 2002). This research on the incidence of AN on Curaçao in the 1990s is a more comprehensive examination than the previous study conducted in the 1980s (Hoek et al. 1998b) and is quite likely to have counted nearly all possible cases of AN on the island. Final results of the incidence study will be published separately (Hoek et al. 2004).

When we returned to the island in 2001 and 2002, we attempted to contact all eleven cases with AN detected in 1995–1998. Nine were of mixed race and two were of Dutch heritage. Because we were interested in indigenous women, an effort was made to contact the nine of mixed heritage. Three of the nine mixed

cases were no longer on the island and could not be traced. The remaining six were approached and asked to participate in a case control study to "better understand the role of culture in how women view themselves and their bodies." None of them refused. We invited each of these women to come to the outpatient clinic to complete forms and be interviewed once more. We initially attempted to obtain control subjects by asking each of the cases with a history of AN to bring a friend. However, some did not have one to bring. One brought her sister, who was later excluded because she had a subclinical eating disorder. Women with similar socio-economic environments and educational experience and aged within five years of the anorexic women were recruited as additional control subjects by the research team. All six controls were chosen for their similarity to the subjects, as comparison to women of different racial or economic backgrounds would obscure the assessment of vulnerabilities within a similar milieu.

Assessments

Questionnaires

All six cases and their six controls completed the Eating Disorders Inventory (EDI; Garner 1991; Garner et al. 1983), the Eating Attitudes Test-26 (EAT-26; Garner and Garfinkel 1979), the Binge Inventory Test, Edinburgh (BITE; Henderson and Freeman 1987), and the Questionnaire for Eating and Weight Problems-revised (QEWPB-R; Spitzer et al. 1995). All measures were in English, the language of the participants' schooling.

We included these quantitative assessments as a means of identifying eating pathology independent of interviews and in order to get a measure of current distress. Subclinical eating pathology has been documented in young female professionals in the United States and United Kingdom (Fairburn et al. 2000), and it was possible that some of our controls might be exhibiting disturbed behavior as well. The use of these standardized measures plus the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith 1983) allows comparison with other studies in the field, many of which have used these same scales (including the study in South Africa described in this issue by Le Grange and colleagues). There is some debate in the literature as to whether measures developed in the United States and United Kingdom can be applied to other countries (Lee and Katzman 2002), and their inclusion in the Curaçao study would provide additional information in that regard as well.

The Cross Cultural Questionnaire was selected, as it represents the first multinational attempt to assess social and acculturation variables with eating disordered subjects. The Cross Cultural Aspects and Gender in Eating Disorder Questionnaire (CCQ; Fernandez-Aranda et al. 1999) was created by the multisite European study (Key Factors in Food, Nutrition, and Health) to assess work, leisure, and

family activities, early experiences with food, and participation in what are often considered "Western" activities such as shopping in malls, watching Western films, reading entertainment magazines, *etcetera*. It is currently being used in a number of European countries (Spain, England, Italy, Austria, Georgia, Slovenia, and Finland) with the goal of creating a shared data set.

Interviews

All cases and controls were seen by one or two members of our research team, four by M.K. and K.H. on Curaçao, and two by K.H. alone, one in The Netherlands and one on Curaçao (K.H. is a Netherlands-trained doctor from Curaçao, fluent in Papiamento and English; however, the session was conducted in English only, a language that all the women spoke with ease). A semi-structured interview format was followed in which women were asked to discuss any issues they had with eating or their bodies, and asked if they saw them as a problem. They were asked to relate what meaning these behaviors (that were identified at least by others as "symptoms") might have. We also inquired what alternative activities they might be engaging in if they were not attempting to manipulate their weight. The interviewers discussed any migrations the women had experienced, along with exposure to different cultures and the possible impact this might have had on the way they saw themselves and their bodies. They were asked to comment on success, their role models and any advice they might have for other women. Interviews took from 60 to 90 minutes and were conducted in English which all of the women spoke fluently.

Focus group

Control subjects were seen in a focus group. This was facilitated by M.K. and K.H. The discussion was guided by an open-ended, semi-structured interview schedule with probe questions that included: "Tell us about yourself, your age, time on island, if you have been away, mother and father's heritage and where you live and work," "What is it like to be a woman on Curaçao?" "Are you a 'typical' woman?" "How do you measure success for a woman on Curaçao?" "Who is your role model?" "How important is appearance to success?" "Where did you get that message?" "Have you heard of eating disorders?" "Why would women have an eating problem?" "What would it mean?" "What would you do to prevent them?" These questions were developed to reflect current theorizing about possible role strain and the development of eating disorders and to assess the participants' understanding of eating disorders and their potential meaning.

The group spoke for 90 minutes and was videotaped. A flip chart was used in the room to record themes as they emerged. Transcripts were reviewed by M.K., and thematic summaries, including supporting quotations, were developed and then reviewed by two members of the research team.

RESULTS

Questionnaire findings

Subjects and case controls

The AN cases and case controls did not differ significantly on age: the anorexic subjects had a mean age at interview of 27.7 years (SD = 3.7); the control subjects had a mean age at interview of 30.8 years (SD = 4.1); $t = -1.406$, $p > 0.5$. As the controls were selected based on education, by design they did not differ from the anorexic group. Five pairs obtained university degrees, and of the other two women, one had completed junior high school and one senior high. All anorexic and control subjects had lived off the island at some point in their early teens. All women in the anorexic group were diagnosed initially as part of the incidence study.

We have not conducted a survey ourselves among the general population of nonanorexic women on Curaçao. However, from the census data and the Curaçao Health Study ($N = 2248$; Alberts et al. 1996) we know that the anorexic subgroup differed in socio-economic status (SES) and race from the general population on the island. In the epidemiological study, 18% of the AN cases were white; whites comprise only 7% of the general population. Eighty-two percent of the cases were mixed race, while only 13% of the island population is of mixed race. There were no black cases, while the majority (79%) of the Curaçao population is black.

Data analysis

The total number of subjects providing questionnaire data was quite small and as result the data are best employed for descriptive purposes.

Results

To facilitate comparisons with other studies the results of the anorexic subjects and controls on the psychopathology scales are displayed in Table 1. As the number of subjects is quite small all conclusions must be made with great caution. The anorexic group differed significantly from the controls on two scales of the EDI, ineffectiveness (IE) and perfectionism (P), with the anorexic group reporting higher distress on both.

There was no difference between groups on the EAT, while the total BITE scores suggested that at the time of the interview two anorexic subjects revealed clinical characteristics of bulimia, and four revealed subclinical characteristics, in contrast to two subclinical cases in the controls and four controls without any concerns reported.

Scores on the QEWP-R suggested that, on average, neither anorexic nor control women were binge eating or purging. The HADS depression scale reflected no depression. However, the HADS anxiety scale revealed significant differences

TABLE 1
Comparison of Anorexia Nervosa (AN) Cases and Control Subjects on Various Psychopathology Scales

Scale	AN ($N = 6$)		Control ($N = 6$)	
	Mean	SD	Mean	SD
BIT severity***	7.0	2.5	1.7	1.4
BIT symptom*	20.5	12.9	6.8	7.4
BIT total**	1.3	0.5	0.3	0.5
EAT bulimia and food preoccupation	3.7	3.9	1.5	3.7
EAT dieting	12.3	13.8	3.5	4.3
EAT oral control	4.5	4.8	0.3	0.5
EAT total score	20.5	19.7	5.3	8.3
EDI body dissatisfaction	14.2	6.9	10.2	9.0
EDI bulimia	1.7	1.6	1.3	1.8
EDI drive for thinness	11.5	7.6	5.2	7.2
EDI ineffectiveness*	6.7	4.7	1.2	2.0
EDI interoceptive awareness	7.3	5.4	2.5	3.3
EDI interpersonal distrust	6.0	3.4	3.2	4.4
EDI perfectionism**	11.3	3.1	4.5	3.3
HADS anxiety*	9.8	2.5	5.7	2.3
HADS depression	4.5	2.7	2.7	2.1
HADS total	14.3	5.0	8.8	4.6

Note: $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

between controls and subjects, with two anorexic subjects reporting probable anxiety problems, three indicating possible anxiety problems, and one reporting no anxiety. Only one control case reported anxiety, and it was at the possible problem level.

Responses on the CCQ revealed that anorexic women reported greater family, peer and current fashion influences on their eating patterns, a greater importance placed on popularity by friends and fathers, a greater importance placed on conformity by the subject and her mother, more conflicts over attending to the needs of others, and more frequent experience of an overprotective mother or a mother dependent on the subject when the subject was younger than 12 years old (Table 2).

To assess the degree to which women placed high expectations on themselves, all questions inquiring about behaviors associated with success were grouped together for a dichotomized analysis. This revealed no difference between groups: both anorexic and control groups believed that to be successful they had to achieve professionally while still being good wives and mothers and attending to the needs of others.

If one looks across CCQ items, for both the anorexic and control groups no strict rules for food consumption were experienced as youths–food was neither restricted nor used as a reward or punishment. Both groups saw their mothers as

TABLE 2

Significant Differences (One-Tailed, $p < .05$) on the CCQ Between Anorexic Cases (AN) and Controls

Item	Mean rank		Mann–Whitney U	Exact significance: $p<$
	AN ($N = 6$)	Control ($N = 6$)		
Influence on eating pattern by family	8.6	4.4	5.5	.03
Influence on eating pattern by friends*	9.2	3.8	2.0	.006
Influence on eating pattern by current fashion	8.4	4.6	6.5	.04
Mother dependent on subject at age <12 years	7.8	3.8	4.0	.04
Importance of popularity to friends	8.6	4.4	5.5	.04
Importance of popularity to father*	8.5	4.5	6.0	.02
Importance of conformity to subject*	8.8	4.2	4.0	.02
Importance of conformity to mother	7.7	4.0	5.0	.05
Level of conflict over attending to needs others	8.8	4.3	4.5	.03
Mother overprotective at age <12 years*	8.2	3.4	2.0	.009

Note: Items marked with an asterisk are significant when correcting for chance capitalization ($p < .025$).

heavier than themselves; no subjects were particularly dependent on their parents, nor did they report being abused or criticized by family. Most reported current internet use of about 2 hours a week and no difference in the amount of time spent reading or watching TV. Both groups of women thought that intelligence and independence were important for success in life.

Interview findings on cases

Four of the six cases were born on Curaçao, and two were born in Holland (one moved to another Antillean island before moving to Curaçao, while the other was brought up on Curaçao from age two). Five of the anorexic cases interviewed had left the island at around age 18 to attend university. In three of the five cases, the anorexic subject was diagnosed *after* returning to Curaçao from her extended time overseas, and one of the women who was diagnosed with anorexia *before* moving to Holland had gone to summer camp in the United States in earlier years and therefore may have experienced some of the same reentry stress that the three other cases did.

Mixed race prompts search for identity

Bruch's (1982) early writings on AN placed the need to compensate for an "identity deficit" at the core of anorexic symptomatology. Self-in-relation theorists

furthered this discussion (Jordan et al. 1991), proposing that young women seek both autonomy and interdependence or connectedness, not total independence, which is seen as the sister of isolation. Many of the women we interviewed related a desire to belong (or be connected), along with the social operatives associated with race that prevented this desire from being realized. All six interviewed cases were of mixed race, which is quite notable and seemed to compound identity concerns.

One of the women who developed AN in her early twenties after returning from a four-year stay in Holland related that she "wanted to be a part of something—to look good you need to be thin." She indicated that as she was of mixed race she did not feel as though she was part of the island culture. The group that accepted her was "wealthier and white" and the lower body weight was "a ticket in"–dieting was "not about weight, it's about accomplishment." She described multiple ways in which she felt out of place. "I don't belong to the whites or the blacks, I never belonged anywhere. My dad's side excludes me because I am dark; at school I have no place and when I went to Holland I didn't fit in there either!" For her dieting was "accomplishment," a chance at "belonging" to the white group and ameliorating the isolation her skin color had produced for her.

Another woman shared, "My boyfriend is white, I am Creole, my pals are white and there is a lot of pressure to be thin, especially in the rich community—everyone looks so beautiful." Here again, being of mixed race, this woman opted to seek acceptance in the white community, and "being white" means being thin, and being thin "means" being rich.

Thin is rich

The women who developed anorexia on Curaçao reported that a thin body was indeed equated with greater success and belonging. Its attainment not only complied with appearance expectations but was worn as a blazer for those of an elite (wealthier) club. It is not surprising that women saw thinness as a sign of financial accomplishment, as those on the island who were more financially accomplished reported a greater desire to lose weight. According to the Curaçao Health Study (Alberts et al. 1996), half of obese Curaçao women with low SES do not consider themselves too fat (Grol et al. 1997), whereas half of obese, nonblack, intermediate/high-SES women do.

Selective belonging

It appeared that the women who developed anorexia were not only exposed to a different culture off the island but were part of a rarified community while on Curaçao. One woman, now working for her father after obtaining a degree in the United States, made the following comments:

Even before I went to the United States, on Curaçao, at school, all our friends read magazines from America and competed to be thin, popular, and well dressed. I think I look only at thin women on the street because I know that the majority of the women on Curaçao are not that thin.

I am not that abnormal in my group, everyone is so involved with weight and how they eat. One pal takes laxatives; the other is worried about her belly.

Thirteen years ago no one was talking about food, now it's everywhere, or at least my pals whom I think are attractive and smart. Then again, we do go to different schools than many on the island and my grocery store is different than some of the others.

Another woman born and raised on Curaçao had studied in the United States. Her eating disorder began before she left the island for college. She described her friends as "very concerned about being thin and smart." She related that her peers were "exceptions," "not like the island women who are black and who eat what they want and still wear sexy clothes."

Although the quest for a thin ideal was not universally observed on Curaçao, observations about weight certainly were. One mixed-race woman indicated that her eating disorder began when she returned from her studies in Holland. She started eating less. She ate only at night. She went to the gym regularly and engaged in sports. Her goal was to be as thin as possible; she was working for the first time in her life and had made all new friends. These new friends shared her thirst for career success. Her peer group also placed a high value on looking good. These social pressures combined with liberal commentary about body shapes to impact the development of her eating disorder. After one year in Holland she returned to the island for the holidays. As she described it, everyone felt free to talk to her about her weight. "On Curaçao everybody has something to say about your weight. Although a lot of people are quite heavy they will comment on your weight gain."

Early autonomy and "heavy" expectations (from self and others) prompt a "thin" solution

Deeds et al. (1998) observed that in modernizing cultures where children previously had longer stays in the parental home, daughters struggle with "premature" expectations for independence and its associated economic and sexual pressures. After living in a very involved home, many of the women we interviewed had their first solo living experience in a foreign country away from family and social supports. Not all of them felt equipped to care for themselves. High self-expectations, a propensity for anxiety, and perceived pressures combined to create a very stressful environment both overseas and upon their return.

For example, one mixed-race woman repatriating to Curaçao after studying in Holland, where she lived alone for the first time in her life, discussed being afraid to fail, experiencing very high expectations from her mother, and as a result having difficulty making her own decisions. For this woman, while she felt the

pressure to succeed, she lacked the tools to make the complex choices that would satisfy her own and her family's expectations. However, the media images of an ideal body offered a tangible means of coping and potentially winning praise. She believes her eating disorder is partially a product of media images as well as "the stress from what people expect from you. And what you expect from yourself: relationships, career and everything that comes with that."

Another mixed-race woman, who was born and brought up in Holland, related,

> I am a perfectionist, I like everything in its place but I know the world is not like this. I can't achieve what I want and I go to the gym to try to feel better and then my mom questions me all the time, she says that Curaçao men like big women but I don't want to be like that.

An aspiring accountant who returned early from her studies in The Netherlands shared,

> I am the tensest one in my family. Nothing is good enough for me; I think if I did not have an eating disorder I would have obsessive–compulsive disorder. I wanted an advanced degree and to do that I have to leave the island. My mom tells me not to worry about my weight but I feel better about myself when I do. I know I have to believe in myself and not let anything hold you back, going abroad isn't the most important thing but I don't think I can be a success without it! I did not finish my studies in Holland and now I feel even more like a failure. I will do whatever I can to go back, but it was not easy and I know that. I have to learn not to be afraid to fail and to deal with loss.

Role ambiguity as both a family member and a young workingwoman greeted the anorexic women upon their return. Having achieved some mastery while away, it was difficult to fit back in at home. Manipulating food was one way to assert independence. A mixed-race professional woman described her stay in Holland as pressured and isolating, with a great deal of exposure to good food. She was teased about her increased weight upon returning. She found that the "home" she had missed while away was now very stressful. She was still under her parents' authority, with limited options for social independence and little opportunity for financial success or independence given the economy. She moved to Curaçao for a job, but her problems with eating had already begun soon after she had migrated from Holland. She found starving to be a "good way to rebel against strict parents."

One woman cited all the changes in her life upon returning to the island from her studies abroad as the key precipitants.

> It was difficult to live at home again especially when my mom was so overprotective. I gave up everything I had to go to Holland, I wanted to get a good education but I missed my mother. I did not belong in Holland but now my move back makes me feel like I don't belong anywhere.

The isolation of successful women–women's roles in transition

Katzman (1998a) and Katzman and Lee (1997) urge that the understanding of eating disorders be conceptualized in terms of isolation, dislocation and oppression, arguing that the mere focus on diet, weight and calories obscured the struggles

many women were expressing in their bodily manipulations. The anorexic women of Curaçao revealed the threats to their identity in terms of race, family role, and ultimately the female role in society. They expressed isolation and disconnection as they struggled to integrate the education and experience they earned with the expectations of the island culture. The dilemma of how to be powerful professionally while still succeeding socially is captured in the quotes below. When asked about achievement, one woman shared that, for her, success would be "power: having my own business, taking the vacations I want, having my own car, a good education, and meeting lots of different people." She did not think that women's roles were changing with the economy on Curaçao. She said that women could always have a high position: indeed, a woman had been prime minister. The problem as she described it was, "the men on Curaçao are promiscuous, they are not competing for your jobs, they just distract you from doing your work because you have to make money and take care of the family and you cannot count on them to help." She believed that "women in lower socio-economic classes have to be even stronger." To her eating disorders symbolized "wealth and perfection, not a problem with food."

This challenge to succeed independently was echoed by another woman, who described the additional challenges she faced when returning to the island, in particular with respect to how she envisioned her future. In the past, she used to think "a woman should marry, stay home and look after the children." Now she thinks "a woman should work on her career and be more emancipated," but she went on to say, "This conflicts with what Antillean men want." Her self-view is different than the one she has of the "typical Curaçao woman," the later being someone who "has a second place behind a man, takes a lot from them and cares for them." "They look 'criollo': fat, black, *etcetera*." She did not see herself as a typical woman—"Not at all," she emphasized. In her view, "success for a typical Curaçao woman would mean finding a good man, having children, not necessarily working and surely not being career-minded."

The two world hypothesis

As indicated in their comments above, the women who presented with AN were straddling several worlds simultaneously. They were all of mixed race, aspiring to fit into the mobile elite (and mostly white) subgroup while distancing themselves from the black majority. They had grown up in communities that communicated 'difference' from the island norm, yet when they went overseas they found they did not feel any greater sense of belonging in the host country and in fact felt challenged to fit back into their family home when they returned. The women were encouraged to be independent yet had overprotective parents. Like the Asian women of Hong Kong and the orthodox Jewish women of New York described by Katzman and Lee (1997), the anorexic women of Curaçao were caught in

the crossroads of modern and traditional values. With all of these warring self-concepts they found themselves in a psychological diaspora, one in which food obsessions offered a home.

Focus group findings on controls

The participants in the focus groups included a psychologist, a hotel administrator, a marketing manager, and a government employee, all of whom spent time off the island, in each case for education and then to live and work for a while. Two of the women were born on Curaçao, but all but one had grown up on the island, and even this woman had been there for three years. In other words, the women in the control group mirrored the anorexic sample in having lived most of their lives on the island, but having spent some time away.

Selective belonging—the denigration of typicality

Like the anorexic women we interviewed, the control women in our study saw themselves as different from the others on the island; they denigrated typicality and esteemed their "uniqueness." This is not surprising given that we sought control subjects who were part of the same social milieu as the anorexic women. As best we could say they were matched on family SES and level of education. The focus group echoed the segregation of women who were pursuing a higher education and the limitations to success without at least a transient relocation. Both groups attempted to compensate for the frustrations they experienced when trying to achieve a "new normal," though in different ways.

The control women said they were "not typical of Curaçao women in general, we are typical of educated Curaçao women, and that means we had to leave the island." Unlike their anorexic counterparts, they reported that educated women focus less on appearance, and therefore must have other ways to achieve success. They indicated that they needed to learn to be themselves, "to dress and act comfortably." Most rejected the more "usual island style of tight and revealing outfits."

One woman described herself as a "woman who knows where she is going and how to get there." She had been on the island since she was two but had often been away for vacation. She worked at an international accountancy firm. She described the typical woman on Curaçao as "competitive and exotic" (referring to relationships with men and style of dress), but said she was only 60% typical. She related that success is "*up to you*" and that she saw her parents as role models. Unlike the reports of some of the anorexic women, this interviewee rejected the notion that success should be determined by others. While she looked to her parents as role models she did not feel oppressed by their expectations.

The women reported little internal prejudice on the island but no mixing between social groups in clubs. There was a stereotype of the "typical" woman, which all the women felt did not reflect themselves, but which each could clearly identify. In differentiating themselves from the typical woman, the control sample women joined the symptomatic sample in a desire to set themselves apart from the majority of women on the island. They felt ashamed and apologetic to state this stereotype but did so with much agreement. The characteristics generated by the group to describe the "typical Curaçao women" were: "fat," "black," "hanging out of clothes," "dating men in flashy clothes," "not thinking of the big picture," "acceptance of self," "noncritical," "nonglobal," "party oriented," "not future-oriented," "not health-concerned."

Having it all

The women in the focus group worried about being isolated and growing old, their careers ("Will I be successful?"), their health, motherhood, how to set priorities, balancing work and family, and whether the men in their lives would "support me in my work and help with my children." The women in the control group aspired to have fulfilling careers and family lives, yet they recognized that balance was necessary. While they struggled to figure out how to obtain it, they knew that they aspired to it, thus demonstrating a flexibility with "perfected success" that the anorexic women seemed to lack. To the control group women success was measured by "juggling work and social life—not losing themselves."

They talked of role models who had "spirit" and who had fun, as well as those who were very independent. Their role models included Anthony Robbins, who was described as someone who "did it on his own," and one woman's sister, who had a big career and was a single mother with "a lot of spirit." They admired independent women who were happy, and one woman pointed to her mother as a model, as she had made it on her own in business and in family and had overcome the macho culture. What the control group recognized and the anorexic group seemed to lack was the importance of taking a risk. As they said, role models were"People who dare to live."

A shared problem of successful women

Like their anorexic counterparts, the focus group women observed, "there is a problem of *machismo* on the island" and "women need to find a way to feel powerful other than appearance—they do not have direct power on Curaçao." This was in contrast to the way in which all the women said they had to count on themselves because men could not be counted on to be there for them. Most of the women said they had to be independent because many anticipated being single mothers supporting their children through their work and counting on their

mothers to watch their own children. Men were not listed as part of this survival equation.

The meaning of eating disorders

When asked why there might be eating problems on Curaçao, focus groups members replied, "People are influenced by the media," "not a real problem," "now breasts have to be big," "plastic surgery is coming here as it has in Surinam," "no one knows what is real but they know they want it," "MTV is a big influence," and "Venezuela is a big influence." In addition to seeing eating disorders as a concern for appearance, the women in the control group understood anorexia on a more psychological level. For example, they indicated that having an eating disorder means "Looking for a form of control," "low self-esteem," is "a way to look good," and "reflects problems at home." The women at risk, in their view, are those who are "perfect girls," "charismatic girls," "ones who entertain others," "stressed people," and "people who believe all the sex songs." They believed that people who "feel a great deal of pressure" would be more prone to eating disorders and they knew many who had them. When asked what differentiates them from women with eating disorders, one control group woman said, "For me appearance is important for success but achievement means succeeding in life." For the nonanorexic women, success and happiness were defined in much broader terms than bodily control or conformity.

All the women said they thought eating disorders would be more of a problem in the future as larger groups of people on the island were exposed to different ways of life either through the media or the possibility of travel. In addition they believed that information about diets and proud displays of plastic surgery were on the rise and that people who might be more vulnerable could be more tempted.

In order to prevent eating problems the women thought it would make sense to "Educate people about healthy eating," "accept yourself," "feel good about yourself," "emphasize what you can do and have slogans about women's power."

DISCUSSION

This study is the first comprehensive investigation of AN in a country in economic transition. It was based on a comprehensive counting of cases, along with detailed interviews, data on eating habits, and insights into social attitudes and values. It also included a comparison to controls and a discussion of potential nonsymptom-oriented risk factors. The women who experienced AN on Curaçao revealed characteristics similar to those reported by anorexics elsewhere in that they had high expectations for themselves both personally and professionally (Gillberg and Råstam 1998), yet perceived themselves to be ineffective,

perfectionist, anxious, and isolated. All of the cases had left the island for at least a year to study in The Netherlands or America. None of them were black. Although previous studies of social transition and eating disorders have focused on migration, urbanization, and modernization (Nasser et al. 2001), this is the first study to suggest that reentry or reintegration might be a risk factor for eating disorders.

Anorexia nervosa in a country in transition

During focus groups and interviews, the anorexic women and the control group women described themselves as different from the norm, an assertion supported by their race, education, and wealth. All were from the mixed-race population. They had achieved greater schooling and obtained a higher SES relative to the general island population. The finding that all cases were not "typical island women" suggests that during economic transitions not all subgroups of a culture respond in the same manner. Some will be more vulnerable to eating disorders.

Appadurai (1991) describes the porous nature of national identities and the continuous quality of modernization. These are not either-or, past-future dichotomies, but rather flows of time, people, and images. While perhaps seemingly obvious to the anthropologist, for the mental health professional national comparisons and attempts to measure the impact of culture change and modernization have been relatively binary.

However, the need for a more fluid analysis has been gaining some recognition. Fairburn et al. (2002) have recently proposed a transdiagnostic approach in which women are not grouped as either anorexic or bulimic but along a spectrum of illness. The anorexic women and their matched controls in the current investigation both revealed a continuum of eating and weight concern, one that even for the anorexic women varied over time. None of the women were immune. The data suggest that the vulnerability toward developing an eating disorder was impacted by ethnicity, class, psychological characteristics (some of which may be biologically predetermined), and culture. The anorexic women in the current study struggled to develop a cohesive sense of self, and they wore their dilemma with their weight.

Psychological vulnerability

Given that the controls as well as the anorexics left the island and had similar life experiences, why did only one group develop AN? Perhaps the difference lies in ability to handle anxiety, perfectionism, conformity, and conflict avoidance. Certainly on the latter two variables the anorexic women in this study scored higher than not only their local counterparts but also women in other studies in other countries.

Clinical and epidemiological data support substantial co-morbidity between AN and anxiety disorders. In a population-based United States sample of over 2,000 female twins, odds ratios for generalized anxiety and panic disorder were significantly elevated in women with anorexia (Bulik 2002). A number of anorexic women in the present study had elevated anxiety scores, even after the eating disorder symptoms had dissipated, in contrast to limited reports of anxiety in the control group.

Perfection and conformity

Although both groups reported career interests and a goal of economic independence (along with a realization that appearance may contribute to professional success), the control group in their discussion seemed to be better able to distance themselves from unrealistic expectations of greater success than the anorexic women. Steiner-Adair (1986) found that white American women who accepted the "superwoman" ideal unquestioningly were more likely to report disordered eating. This may be part of the process for the women in this study, as indicated by the greater importance placed not only on perfection and popularity but also on conformity. For example, Davis and Katzman (1999) found that the pursuit of perfectionism was a form of acculturation for young women from Hong Kong immersed in American society.

Conflict avoidance: silent protest

Bruch (1979) describes the childhoods of her American anorexic patients as ones of "accommodation" rather than "assimilation." She believed that the premorbid personality of individuals with AN was characterized by imitation and passive acceptance of rules laid down by others rather than a gradual modification and incorporation of general themes into a personality structure. This early theory has been echoed for over a quarter century as researchers have reported either a psychological or potentially biological predisposition toward risk avoidance in anorexic women coupled with a propensity to avoid overt conflict and a prevalence of "black and white" thinking, rather than a more nuanced interpretation of life events (Fairburn and Brownell 2002). The women in this study struggled with how to be simultaneously different (from the norm) as well as the same (as their preferred reference group). Katzman (1998b) has called anorexic women "silent waif protesters," referring to their ability to accept the rules of the prevailing culture while also bringing attention to the difficulties of cultural constraints through their extreme bodily 'accomplishment.' This certainly may have been the case with some of the women we saw on Curaçao.

Cultural vulnerability

Questionnaire as well as interview data reflected the cultural norm for thinness within this Antillean subculture, and more anxious, more conforming women desperate to please may be more vulnerable to adopting a "symptom" that is at once pleasing in its attainment of a thin ideal and reflective of the need for help in women who are struggling to cope.

The culture at home

Neither the anorexic nor control groups reported great value conflicts with their parents, although this has previously been identified as a potential risk factor (Vandereycken 2002). This may reflect the active role women on the island have with respect to income generation, such that the expectation for involvement outside of the home may not vary across generations. The mothers of anorexic subjects were described as more overprotective than those of control subjects and while it may be a chance finding, the data also suggest that anorexic subjects experience greater conflict over attending to the needs of others. It is possible that the anorexic women, living independently while overseas, were subjected to more frustrating familial demands upon returning to the home environment. It has certainly been hypothesized that one seeks to control one's body when there are limited alternatives to assert one's power (Gordon 1990).

The culture at school: peer relations

That the anorexic women felt pressures to be popular and were highly influenced by their peers when it came to food selection also may have contributed to their increased risk. Stice (2002) reports that peer interest in, pressure for, and teasing about weight not only impacted eating disordered behavior but also increased as friendships became more cohesive. In addition to the valance placed on appearance, peers impact eating behavior as they learn to share a hypersensitivity to negative interpersonal interactions, a stressor often relieved by comfort eating or its alternate, starving.

In describing the risk for eating problems in young women, Striegel-Moore (1995) discusses the great value women place on interpersonal relationships to define themselves, and on the skills needed to initiate and maintain reciprocally respectful relationships in order to develop a healthy self-esteem. Girls report greater identity instability, more social anxiety, and lower self-esteem than boys in general, and potential anorexics do so even more. This certainly appeared to be the case with the anorexic group in the current study and may have been an important differentiator from the controls. To the extent that physical attractiveness defined as a thin ideal is related to interpersonal success, it makes sense that those women who seek approval, conformity and relationships would be more susceptible to eating disorders than others.

Self-definition in conflicting social groups

The women in both the control and anorexic groups lived in multiple worlds and played multiple roles. It may be that for the more anxious and insecure woman, the process of self-definition when navigating plural social contexts provides an additional stressor, one that may be relieved through body conformity and self-starvation. The anorexic women, all of mixed race, found that starving to be thin brought greater acceptance in the white wealthier community that they aspired to join. They related a triple threat to identity formation: (1) they were of mixed race, aspiring to fit into the mobile elite (and mostly white) subgroup while distancing themselves from the black majority; (2) they had the means for education and travel that left them caught between modern and traditional constructs of femininity; and (3) they had lived overseas and therefore struggled upon reentry with the frustrations of what was possible within the island culture.

The challenge of reentry

Narrative data revealed that at the time of the study most women felt they had to leave the island to receive advanced training. Many described the "August airplane" that took large groups of students from Curaçao to Holland for at least a year of university study. This appears to be a socially accepted and almost expected answer to higher education for those who can afford it. All of the women described difficulty upon reentry. While away, many sampled an appealing array of educational opportunities and social roles but lacked the proximity and supports of family. Upon returning to Curaçao, several of the women's mothers offered support with household or childcare requirements, which enabled the women we interviewed to pursue work. However, the exchange for this assistance was greater involvement with the family, which in some cases produced ambivalent feelings regarding dependency and mutual expectations. In addition, many women found it hard to find local male partners who were as achievement-oriented as they were. Suddenly they were at odds with the very home they missed while away in a foreign country that had also failed to become home.

The thin solution

In addition, the women were exposed to slim body ideals while overseas and potentially within their stratified Curaçao community. For example, an informal examination of local grocery stores suggests that in higher income areas there were greater displays of sugar substitutes and diet products, while the shelves in regional stores stocked a wider array of oils.

Several of the women also described pressures for plastic surgery, citing Venezuela (not the United States or Europe) as the source. Eating disorders have been reported extensively in South America, and in particular Argentina (Meehan and Katzman 2001). It is interesting to note that women in Argentina describe a

similar dynamic to the one described by the women on Curaçao. They are expected to be both coquette and bread winner, to manage economically (even when the men do not or cannot), while at the same time not appearing too threatening. As Meehan and Katzman suggest, "during a slumping economic period, women may be slipping the food on the table and accessing certain powers, yet their slight bodies may make them less of a threat" (2001: 158).

Race and class

Clearly the anorexic women differed both in race and class from the island norm. Race and class factors are likely related to the development of anorexia, yet it is unlikely that any of these factors *alone* could produce the pathology. However, they may function in a protective way.

Protective factors

The results of the Curaçao Health Study (Alberts et al. 1996) indicate that almost all of the higher SES obese women on the island actually regard themselves as fat, whereas of the low SES obese women only half consider themselves to be too fat, and fewer women in the lower socio-economic classes opt to diet (Grol et al. 1997). Perhaps it is the comfort with one's body that functions as a protective factor for the women of color. Rubin and colleagues (2003) in a study of African American and Latina women in the United States, found that these women described a more expansive sense of beauty in which "body ethics" (style and grooming) took precedence over body ideals such as the pursuit of bodily control and manipulation. The anorexic and control women in the current study believed that the "typical island woman" revealed a comfort with her sexuality and a willingness to accentuate her body parts, no matter how "imperfect." This comfort with curves is reinforced by local expressions, such as a woman looking *bon kome*, or "well eaten," a compliment meaning that she has a lot of meat to hold on to and is a "beautiful mama."

Like the anorexic and control participants, the young local women live mostly in matriarchal households; however, unlike the sub-group involved in the current study, the majority of Curaçao women likely saw their racial as well as role identities mirrored in their mothers. While future studies will require further examination of the island's black population, it is possible that less perfectionism and performance anxiety occurs for women whose life choices and group identification are more similar to past generations.

The absence of anorexia nervosa in black women

The finding that none of the black women on the island reported AN concurs with findings in the United States (Striegel-Moore et al. 2003), and in Africa

(Le Grange et al. 2004). However, black women on Curaçao may become more susceptible to eating disorders as they struggle with what Ifekwunigwe (1999: 8) calls the "dynamic construction of identity in a globalizing world." This is the very identity struggle that Szabo and Le Grange (2001) fear will bring not only more role opportunity for South African black women, but also more conflict about what excesses will be esteemed, such that fat–once a sign of abundance–may be converted to a symbol of past subordination. In the ensuing years it will be critical to observe whether increases in bulimia and/or binge eating are observed in the black population, rather than AN, which may have more of a biological or genetic component.

Biological factors

The importance of culture in the development of AN does not negate the possibility of a neurobiological risk for AN (Hoek et al. 1998a; Walsh and Devlin 1998). The ways in which one deals with the stressors posed by society may be impacted by genetically influenced temperaments, frustration tolerance, and neuro-chemical regulation of appetite and anxiety responses (Connan et al. 2003; Hebebrand and Remschmidt 1995). Indeed, more of the anorexic women reported anxiety than did their control counterparts. Future studies are needed that examine the biological and physical interactions related to what may be called role or acculturation stress, leaving open the possibility that ethnic majority and minority individuals may respond to these risk factors differently (Striegel-Moore and Smolak 2002).

The previous study on Curaçao suggested that "AN is not a culture-bound disorder" (Hoek et al. 1998b) because eating disorders were identified on an island described as non-Western and with no slimness culture. It was reported that "a person can develop AN in a place where there is little pressure to be thin." While the later assumption may be true (Lee 1995), it is likely that the failure to look at subgroups within a culture blurred the pressures to be thin identified in the current study. In contrast to the black majority of Curaçao, the women diagnosed with AN were white or mixed race, had a higher SES, and had traveled abroad. In essence, they were anything but "typical." The addition of interview data unearthed some of these important differences, which were masked in record review-based epidemiological work. As the cross-cultural study of eating disorders develops it will be important to include not only community canvassing and questionnaires, but also interviews with careful attention paid to potential subcultural "surprises."

There were several limitations to the current study. No data were available on what proportions of all Curaçao women who live for a period of time in The Netherlands or the United States during young adulthood subsequently develop an eating disorder, nor was there a random sampling of interviews with women from the majority community. Clearly the interviews were conducted on a very

small group. The anorexic women interviewed for this study were seen several years after their initial diagnoses, which may have provided greater perspective on their experiences, but also some distance. Data from the EAT and EDI suggest that the women once diagnosed with AN were now partially or fully recovered. Part of the control group was sampled by convenience. There were no differences in internet or television use between the anorexic and control group, but this may be due to a ceiling effect that might not have occurred had a general community sample been employed.

An additional concern is that AN may not really be confined to the rarified subgroup we identified—it is possible that lower SES women do fulfill criteria for AN but either sufferers or professionals failed to conceptualize the behavior in biomedical terms, or, due to misconceptions about who might have AN, did not identify it as such. Women who may have starved voluntarily but never came to medical attention would not have been picked up through case screening, and as a result, atypical anorexics may have been missed. While this is unlikely, even with well-trained physicians and public awareness not all cases come to medical attention.

The current data do not necessarily imply that the black women of Curaçao are protected or immune from body dissatisfaction; however, as has been observed in the literature, the nature and expression of these concerns may have their own distinctive patterns (Kuba and Harris 2001). It is interesting to note that the focus group's suggestions about what one needs to prevent eating problems reflected many of the qualities of the "typical island woman." For example, group members suggested that one needed to be less critical and more positive, more accepting of one's body, and overt expressions of sexuality and better able to accept the situation one finds oneself in. It appears that capturing the adaptive qualities of the indigenous view could be an important way of not only celebrating local culture but also presenting a valuable mental health message.

CONCLUSION

The current study demonstrates the importance of *conversing with*, and not merely *counting*, incidence cases. While this is the standard in the anthropological literature, it is done much less often in the eating disorders field, which is populated by mental health professionals. Work done in Fiji and Belize, described in the current issue, is unusual in that it combines qualitative and quantitative data. This study is unique in that it combined a population-based study with qualitative interviewing. It also represents a significant revision of earlier conclusions about the island of Curaçao. Rather than confirming that anorexia and culture are not related, as previously stated (Hoek et al. 1998b), the data indicated that looking within subcultures reveals etiological risk factors specific to the social context that may not

hold for the population as a whole. Cases of AN in other developing countries may similarly be limited to specific subgroups. This is the first study to reveal reentry as a possible risk factor. It also details the triple threat to mixed-race women in transitional cultures living in a postcolonial country with continued dependencies on the original colonial power, and lacking familial and social supports for success.

The current work and its reversal of earlier findings are the result of collaboration between a Dutch psychiatrist and epidemiologist (Hoek) and an American feminist oriented psychologist (Katzman). It is the outgrowth of much debate and discussion that began when the two coedited (along with Treasure) *Neurobiology and the Treatment of Eating Disorders* (Hoek et al. 1998a). The teaming across disciplines and orientations (while still within the field of mental health), allowed for a further refinement of mutual interests in the contribution of culture to the diagnosis of eating disorders. In working with the editors of this special issue the benefits of anthropological rigor to the field of psychology were further highlighted as we were prodded to define our terms and assumptions even more clearly. We hope that the debate that began behind the scenes in this study comes to the fore in future collaborations in the fields of human behavior.

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