CONSIDERING CULTURE IN ANOREXIA NERVOSA

SOME FINDINGS FROM SOUTH AFRICA

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Introduction

Struggling with anorexia nervosa, I often wondered why not eating gave me so much solace. It was not as if I consciously decided to harm my body in such a way that it would make me sick and vulnerable, nor did I specifically want to be thin. Yet peers as well as professionals who did not understand the illness frequently reduced it to a diet that got out of hand. In our current Western society, where there is a great emphasis on being slim for women, eating disorders are often seen as an unfortunate result of these beauty standards. Many average sized females get uncertain about their appearance and start losing weight by reducing their food intake.

However, the pathology of eating disorders is much more complex. Morbid self-starvation is seldom caused by discontent about one’s body shape only. Rather, in eating disorders, feelings of body dissatisfaction reflect deeper issues that may or may not be unconscious. To me, restricting or fasting equalled reducing my body to a war zone where I could overcome underlying problems I was facing. As a child, growing up in a dysfunctional family, I never learned how to properly access my emotions. By strictly narrowing my focus on what I ate, I was distracted from negative feelings I didn’t know how to deal with. In contrast, being able to resist hunger made me feel strong, so that restricting quickly became a matter of self-empowerment whenever I felt insecure. Following episodes of intense starvation, my empty stomach and childlike features expressed an inner void and a fear to grow up. In university, after I was sexually abused, the function of the eating disorder changed, as from then on, I turned to it to no longer look nor feel feminine.

So, whilst thinness was never an aesthetic goal, it seemed to provide me some crucial benefits in coping with my past. My own experience taught me that, when merely seeing self-starvation as a result of endorsing Western beauty standards, one neglects the underlying functions of it. In this regard, a more holistic viewpoint on eating disorders is needed (O’Keefe & Kastaldo, 2008).

However, different studies exclusively attribute anorexia nervosa to these Western values. Most well studied in this regard is the culture-bound syndrome approach
(Yap, 1967), which indicates psychosomatic diseases that only seem to occur in certain sociocultural environments. Culture-bound syndrome advocates such as Prince (1985) and Swartz (1985) argue that anorexia nervosa only occurs in Caucasian, middle- and upper-class women as a result of pressures in modern Western society (Hesse-Biber, Howling, Leavy, & Lovejoy, 2004).

Yet this labelling is not without consequences. First, it presupposes the idea that it did not occur in the past. However, accounts of anorexia nervosa have been reported from as early as the 19th century (Gull, 1997 [1873]; Lasègue, 1873). Second, the approach implies that, as eating disorders are only linked to inhabitants of Western Europe and North America, they will not be shown in non-Westerners. Yet eating disorders are increasingly being discovered among adolescents in, amongst others, former socialist Central and Eastern European countries (Rathner, 2001), Hong Kong (Lee, Ho, & Hsu, 2009), Ghana (Abu, Van den Berg, Raubenheimer, & Louw, 2017), and Turkey (Fichter, Elton, Sourdì, Weyerer, & Koptagel-Ilal, 1988).

Consequently, as anorexia nervosa apparently does occur outside the West, the culture-bound syndrome approach has been criticized (Lee, 1996). Questions are raised to what extent Western societal standards play a role in the development of eating disorders, and how non-Western anorexia nervosa differs from its Western counterpart. More fluent approaches have been proposed, such as ‘culture-related specific syndromes’ (Tseng, 2001) or ‘culture-change syndromes’ (Di Nicola, 1990). As Tseng writes, “it would be more accurate to describe a syndrome that is closely related to certain cultural traits rather than bound specifically to one cultural system or cultural unit” (Tseng, 2006, p. 561). Di Nicola (1990) addresses cases of anorexia nervosa occurring in people undergoing migration or rapid cultural or socioeconomic change.

In Africa, eating disorders are equally on the rise. For anorexia nervosa, cases have been described in Nigeria (Nwaefuna, 1981), Zimbabwe (Buchan & Gregory, 1984), Kenya (Njenga & Kangethe, 2004), Egypt (Nasser, 1986), Tanzania (Eddy, Hennessey, & Thompson-Brenner, 2007), Ghana (Bennett, Sharpe, Freeman, & Carson, 2004), and South Africa (Szabo & Hollands, 1997). South African reports in
particular are valuable in reviewing the culture-boundedness of anorexia, since the abolishment of apartheid and the change to democracy lead to the so-called ‘Rainbow nation’ in which different cultures now live together. The racial integration resulted in identity confusions, particularly among blacks, as they had to straddle between traditional and Western value systems. Unfortunately, identity issues are often said to be at the core of eating disorders, in Western as well as in non-Western research (Netten, 2017; Szabo & Le Grange, 2001). Consequently, the new reality, together with a pervasive Western emphasis on slimness, became a trigger for black adolescents to develop anorexia nervosa (Szabo & Le Grange, 2001).

This study aims to further elaborate on the interconnectedness of anorexia nervosa and culture. A first part critically examines the concept of anorexia, its history, and its different aetiologies. Specific attention is given to problems of diagnostics and using universal criteria. A second part revisits anorexia nervosa as a culture-bound syndrome. It questions which Western values are implied in handling such an approach, and discusses more fluid approaches to consider the link between culture and eating disorders. A third part concerns eating disorders in Africa. Two groups are distinguished, non-restrictive and restrictive eating disorders. Considering the restrictive eating disorders, attention will be given to possible reasons why Africa is considered next to immune for such disorders. Lastly, common trends and concerns on anorexia nervosa in African countries are being discussed. A fourth part zooms in on the emergence of anorexia nervosa in black adolescent South Africans. Here, the work of Prof. dr. Szabo is of particular value, as he was the first to conduct extensive research among these adolescents. Also, limits of self-report questionnaires in this regard are being addressed. A fifth and final part explores the field through existing case studies and the extended testimony of Kagiso Matlala, a black South African woman who considers herself recovered from an eating disorder. After that, a discussion will be raised touching the relevant trends and concerns.

My interest in this topic was triggered by my own experience as well as by anthropological courses throughout my academic education in African studies. Also, whilst studying abroad, I attended three relevant courses at the University of Lubumbashi (Democratic Republic of the Congo), namely, ‘medical anthropology’,...
‘medical systems’, and ‘nutritional anthropology’. The combination of having suffered from anorexia myself, which made me understand the illness quite well, and an anthropological education causes a unique viewpoint for this study, namely, having insight in the disease itself as well as in ways to look at various cultural systems.

I do not aim to get answers on whether or not disturbed eating in black South Africans proves or contests the culture-boundedness of eating disorders, that is, whether it reflects actual accounts of anorexia nervosa or not. Such defining claims easily reproduce Eurocentric standards and can only possibly be made after extensive, doctoral research combined with prolonged fieldwork. Rather, the question at stake is of a relativistic matter. Cultural relativism takes on the idea that one’s beliefs, values, and practices are logical within their own context. It goes against former ideas of cultural evolutionism that saw the West as the superior norm and civilisation the way to get there. A relativistic approach to anorexia nervosa thus implies that it must be understood as a cultural phenomenon, and that forms of disturbed eating outside the West have a meaning of their own. Therefore, it is important to look at local meanings of thinness and dysfunctional eating, and to start from the patient’s own experience rather than checking prescribed criteria.

Given some crucial differences in psychopathology, and my own experiences with the illness, the scope of this study is limited to anorexia nervosa. Other eating disorders are not or only occasionally being addressed. However, I do not entirely eliminate other or more general denominations of restricted eating, as symptoms might be classified differently across cultures. For instance, one of my respondents who had drastically reduced her food intake says she “knew she wasn’t anorexic, yet definitely had an eating disorder”, as she linked anorexia to the desire to be thin and she herself did not express such wish (Matlala, 2017).

Also, I do not focus on male accounts of anorexia nervosa, even though they do occur, because research shows that the experiences of male and female anorexics differ significantly and thus maybe cannot be examined in the same way (Gila, Castro, Cesena, & Toro, 2005). Moreover, comparing Western versus non-Western eating disorders is already complex, so variables should be limited. Due to the
preponderance of women suffering from an eating disorder, little research has been
done on eating disorders in males. Also, there are less known male patients, even
in Western society. It is unclear to what extent they encounter the same problems
as female patients, and whether treatment plans should be gender adapted. More
research is needed to understand the psychopathologies of this underestimated
group.
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Nele Callewaert is lecturer Nutrition and dietetics and Occupational therapy at University College Ghent, and as of 2018 coordinator of the new postgraduate ‘Organization of holistic care in eating disorders’. She also works at Nieuw Eetverbond, a Ghent based group practice of dietitians with expertise on eating problems and disorders. I both thank them for their help and support.

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This thesis is dedicated to all those who have struggled with eating disorders, and those who are still struggling.
PART I: ON ANOREXIA NERVOSA

1. Critical note on the concept of anorexia nervosa

Before examining the features and prevalence of anorexia nervosa, it is important to underline that the discovery and description of it were shaped by and within Western knowledge. Therefore, the term is not free of culture to start with. In this matter, an interesting note has been made by Swartz (1985). In *Anorexia nervosa as a culture-bound syndrome* (1985), she examines whether the culture-bound syndrome approach offers a useful framework in thinking about anorexia nervosa. After having discussed four criteria of definition, she addresses the consequences of using such an approach. According to her, two domains will be influenced: theory and therapeutic practice. For psychological theories, the approach implies an element of relativism. She says: “When applying labels of pathology to sufferers, theorists should be careful to recognize their own part in creating and maintaining a certain kind of reality” (Swartz, 1985, p. 728). Indeed, diagnosis is affected by the way professionals understand and present reality.

This observation can be extended to the transposing of a label of pathology from one culture to another. When theorists use Western terms to describe similar symptoms in other cultures, relativism is just as much needed. Cultural relativism upholds that elements constituting a culture are logical within their own context. In doing that, it attempts to avoid ethnocentrism. Here, the value of anthropological approaches comes forward, since they consider Western culture to be cultural too. Anthropology does not see Western culture as dominant as a result of superior civilisation, but rather as but one of many possible cultural systems. For anthropologists, sciences and scientific models are never objective, as they reflect the sociocultural context in which they circulate (Hahn & Inhorn, 2009).

Earlier, however, looking for disorders throughout the world happened on the basis of Western diagnostic systems. This is what Kleinman (1967) called ‘the old transcultural psychiatry’. To examine the existence of anorexia nervosa across the world implied that one would seek epidemiological evidence that fitted the Western diagnostic criteria (Prince, 1983, cited in Swartz, 1985). Later, a shift happened. In
the ‘new cross-cultural psychiatry’ (Kleinman, 1967), diseases are examined in terms of the cultures they reflect, which is a principle of cultural relativism (see II, 1.1.)

According to Di Nicola (1990), a distinction should be made between syndrome-centred and meaning-centred definitions of illness (see II, 1.1.). The medical model indicates distress and names syndromes and diseases according to an overarching international classification. Hence, it emphasizes symptoms and behaviours. Social sciences, on the other hand, read symptoms for their meanings and try to understand diseases in their context (Kirmayer, 1989). Different disciplines thus look at illness in different ways. The value of a relativistic, anthropological viewpoint lies in its tendency to look at local meanings of phenomena.

The idea of cultural relativism was established by Franz Boas in the 20th century (Boas, 1911) and further popularized by his students (Benedict, 2005 [1934]; Herskovits, 1993 [1941]). It arose as a reaction against earlier models of cultural evolutionism, which viewed Western culture as the norm and other cultures just ‘trying to get there’. According to Boas and his students, as scientists grow up and work in a particular culture, they are in essence ethnocentric. To overcome the limits of this ethnocentrism, the method of ethnography is proposed, since it involves living with the local people in an effort to get enculturated.

Labelling peculiar behaviour as disordered equally translates a subjective and ethnocentric discourse, because it sets standards of what is normal that are not the standards of the groups being studied. (Swartz, 1985; Tseng, 2006). In the case of eating disorders, normal and abnormal behaviour should be described from within. For instance, in the West, skipping meals is considered anomalous, whilst other cultures may not have the habit of eating three times a day. Therefore, treatment plans should be culturally adapted. Obviously, within cultures, there also must be attention to individual differences in taste and needs.

A relativistic attitude implies that one acknowledges that research in itself is a cultural construct. Therefore, researchers should be aware of the effects of their work on the people or the situations that are being studied. In the case of anorexia
nervosa, one must avoid asking questions that are already implying Western psychopathologies. Following this, a criticism can be voiced on studies in non-Western countries using Western-based diagnostic criteria, such as the DSM-5, the EAT-26 test, or the Eating Disorder Inventory test. It is better to look at local meanings of food and eating patterns. As anthropological research takes culture itself as a starting point, it does not focus on whether anorexia occurs in cultures outside the West, for that would imply Eurocentric diagnostics, but rather how meanings of thinness and dysfunctional eating vary across cultures and are understood by people living in such cultures. In this regard, Kleinman (1980), in an effort to get at diverse local accounts of mental illness, proposed ‘explanatory models’ that denote asking questions sensitive to the patient’s own experience. This way, it is possible to get at diverse local accounts of mental illness, and how they correlate with culture.

Indeed, food systems in themselves can illuminate broader societal processes, such as political-economic value creation, symbolic value creation, and the social construction of memory (Mintz & Du Bois, 2002). For instance, food taboos and food preferences can reflect a society’s principles. Among the Hemba in Lubumbashi in the Democratic Republic of the Congo, the consumption of ntema, a dish based on grinded manioc and maize flour, is favoured and used as a figurative discourse. As ntema is a heavy and satisfying dish, it symbolizes the resistance of the Hemba in combat (Kakudji & Lubembo, 2004).

However, cultural relativism can be taken too far when entire groups are strictly categorized based upon assumed core elements. This ‘cultural essentialism’ upholds the idea that cultures are delineated and unchangeable (Stroeken, 2013). In contrast, Stroeken (2017) proposes a model of culture as being historical, relative, and dynamic. Following this, global ideas should not be completely eliminated. As globalisation enhances the worldwide interaction between people and ideas, local meanings can start to interfere with values of the dominant culture, here, the drive for thinness. It is interesting to look at how this cross-fertilization manifests. Studies on eating disorders outside the West have emphasized that Western acculturation plays a role in the adoption and maintenance of disturbed eating attitudes (Adegoke, 2013; Di Nicola, 1990; Gordon, 2001). This implies that the more one identifies
oneself with Western values, the greater the risk of disordered eating will become. However, reality might not be that linear. Local and global standards are fluid and can co-exist in different ways.

2. Definition and characteristics of anorexia nervosa

Etymologically, anorexia comes from the Greek ‘anorexia’. It literally means ‘lack of appetite’ (Moskowitz & Weiselberg, 2017). In 1873, the English physician William Gull added ‘nervosa’ to indicate the hysterical state of mind of patients. Thus, the term ‘anorexia nervosa’ refers to neurotic loss of appetite or “emaciation as a result of emotional disturbance” (Gull, 1997 [1873]). In 1970, Gerard Russell (1970, cited in Fairburn & Brownell, 2002) was the first to propose defining signs and symptoms of anorexia nervosa, which evolved into the current criteria used in the Diagnostic and statistical manual of mental disorders, DSM-5 (American Psychiatric Association, 2013a).

2.1. DSM-5


The current DSM-5 prescribes the following conditions for a person to be diagnosed with anorexia nervosa (American Psychiatric Association, 2013a, p. 338):

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. ‘Significantly low weight’ is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected (Rosen, 2010).
• Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight (Yager & Andersen, 2005).

• Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight (Yager & Andersen, 2005).

The manual distinguishes between restrictive and binge-eating/purging subtypes. Patients diagnosed with the first subtype mainly try to achieve weight loss by reducing their food intake and/or excessive exercising, whilst patients in the second category show recurrent episodes of binge eating or purging behaviour. The severity of the illness is measured in terms of body mass index (BMI) ranging from mild (≥ 17 kg/m²) to extreme (< 15 kg/m²) (American Psychiatric Association, 2013a).

Associated features supporting diagnosis include physiological disturbances (Mitchell & Crow, 2006), depressive signs and symptoms (Yager & Andersen, 2005), obsessive-compulsive features, concerns about eating in public, feelings of ineffectiveness, a strong desire to control one’s environment, inflexible thinking, limited social spontaneity, and overly restrained emotional expression (American Psychiatric Association, 2013a).

As risk factors, the DSM-5 lists a presence of anxiety disorders (Walsh & Attia, 2011, cited in American Psychiatric Association, 2013a), a cultural or occupational valuation of thinness, and genetic and physiological factors.

In the recent 2013 DSM-edition, adjustments have been made to address the limitations of the DSM-IV-TR criteria. For instance, in the old edition, one of the criteria of anorexia nervosa was “weight loss leading to a body weight less than 85% of expected”. As individual human bodies are different and weight cannot be that strictly categorized, this criterion has been replaced by “restriction of energy intake related to requirements leading to a significantly low body weight in the context of age, sex, development trajectory and physical health”. Also, amenorrhea was removed as a defining condition. These changes led to an increase in the number
of patients being diagnosed (Sysko, Roberto, Barnes, Grilo, Attia & Walsh, 2012; Mustelin et al., 2016).

2.2. Criticisms on DSM-5

Many criticisms have been voiced on the DSM, among other by eating disorder theorists. For instance, severity ratings solely measured by body mass index don't allow for specific behaviours and other factors related to eating disorder pathology, such as low self-esteem, anxiety, and impaired functioning (Dakanalis, Timko, Colmegna, Riva, & Clerici, 2018). It is true that a lower BMI often goes hand in hand with an increased preoccupation with body shape, eating, and weight, as these are also normal psychological effects of human starvation (Keys et al., 1950; see I, 2.4.). However, other features have at least as great an impact on a patient's well-being. Moreover, body mass index comparisons don't consider individual body compositions. A muscled athlete might show a higher BMI, but can still be severely malnourished. Equally, it is said that black people have a higher bone density and a different somatotype (Saranga et al., 2008), and thus generally weigh more than their non-black counterparts, even in starvation mode. This raises questions on which criteria have to be met for Africans to be diagnosed with anorexia nervosa, what markers their therapists use, whether body weight is considered and if so, how it is determined whether it is too low.

Jacob (2013), professor at the Department of Psychiatry at Christian Medical College Vellore (India), states that universal models of psychiatry de-emphasize the role of context and culture. Despite mentioning the impact of culture on diagnosis in the DSM-5, most of the changes suggested remain in the introduction and appendices of the manual. Criticisms on the DSM come, among others, from biologists (Insel, 2013, cited in Jacob, 2014), who argue that using the DSM-5 as the ‘golden standard’ neglects the inherent heterogeneity of clinical categories. Jacob himself (2013) wrote that by failing to consider the context and psychosocial adversity, the DSM-5 medicalizes normal human distress. The goal of regular psychiatry to achieve diagnostic homogeneity by diagnostic subtyping appears to have its limits. In contrast, cultural psychiatrists question the DSM classification.
They criticize the lack of direct correspondence between cultural concepts and psychiatric diagnosis.

Biomedical approaches, says Jacob (2014), play out different dichotomies: biological versus psychological, nature versus nurture, mind versus body, and so on. Debates on framing issues within such polarities leave little room for considering holistic approaches to mental health and illness.

The idea of holism was developed by Smuts (1927). It is the belief that everything is connected and that each system (physical, biological, social, mental, etc.) should be considered as a whole, rather than just as the sum of its components. Only in this ‘wholeness’ the cohesion can be understood. In this regard, Engel’s (1980) biopsychosocial model attempted to include psychosocial dimensions (personal, emotional, family, community, culture, spirituality) in addition to the biological aspects of disease. However, while the biopsychosocial model was theoretically praised, its implementation in practice appeared to be challenging. One such difficulty is that “psychotherapeutic strategies require time and expertise while social interventions are beyond most psychiatrists” (Jacob, 2014, p. 90).

O’Keefe and Castaldo (1985) write that anorexia nervosa is often treated in unifocal or unimodal terms, despite the fact that it is characterized by complex interrelated psychological and physiological processes. According to Jacob (2014), treatment remains mainly focused on the biomedical ‘doctor-centred’ model. Such a model appears to neglect patient’s own beliefs about causation, impact, and treatment, as they are not essential to diagnosis. Consequently, patients and their physicians can hold up contradictory viewpoints. Objective clinical phenomena are considered transcendent, while patients’ subjective experiences are trivialized and translated into universal concepts of dysfunction (Jacob, 2014).

In this regard, O’Keefe and Castaldo (1985) discuss multimodal therapy for anorexia nervosa and propose an holistic approach to treatment. Such an approach considers the various areas of behaviour, affect, sensory, imagery, cognitive, interpersonal, and drugs. They write that “therapy methods include identifying the
triggering modalities, ‘bridging’ the client from one modality to another, and tracking the intervening modalities" (O’Keefe & Kastaldo, 1985, abstract).

Applying a holistic approach to treatment may lead to more patient-centred therapy, because it considers all aspects of the patient and her illness. As a result, the therapy will be more individually customized. Such patient-centred treatment is more likely to be successful, because it acknowledges the individual as a whole instead of reducing her to a set of symptoms that should be tackled in a prescribed therapeutic way. For instance, regarding dietetic advice, it can be valuable to consider one’s own food preferences, rather than applying general meal plans. When a patient has pleasant memories on oatmeal because it was made by her loving grandmother, re-introducing oatmeal into her diet may lead to a more positive attitude towards food.

2.3. Cultural variations

The DSM writes that anorexia nervosa is most prevalent in post-industrialized, high-income countries. However, the illness does occur in culturally and socially diverse populations, and its presentation varies across these different contexts (Keel & Klump, 2003). For instance, in a study conducted by Becker et al. (2009), cases are mentioned of patients who do not express an ‘intense fear of gaining weight’, as described in the DSM, whilst otherwise corresponding to the same clinical picture as conventional patients. This non-fat phobic anorexia raises questions on whether or not fat phobia is an intrinsic feature of the disorder, and how the classification system should deal with it.

Reports of non-fat phobic anorexia nervosa come from Hong Kong (Lee, 2009), Singapore (Ung, Lee, & Kua, 1997), West Malaysia (Goh, Ong, & Subramaniam, 1993), Ghana (Bennett et al., 2004), and India (Khandelwal & Saxena, 1990), as well as in Asian patients residing in Australia (Rieger, Touyz, Swain, & Peumont, 2001) and in South Asian patients residing in the United Kingdom (Tareen, Hodes, & Rangel, 2005). These studies are mostly based on clinical data from non-Western populations (Becker et al., 2009). This is a pity, as it suggests that the main difference between Western and non-Western anorexia lies in the presence and
absence of fat phobia. However, case series and prevalence studies do not support a complete absence of conventional, that is, fat-phobic, anorexia nervosa in non-Western cultures, and Western anorexics as well don’t always exhibit a fear of fat or weight gain (Moskowitz & Heiselberg, 2017).

Alternate reasons for food refusal among non-fat phobic anorexics include religious idioms, lack of appetite, self-discipline, and complaints of gastrointestinal symptoms such as abdominal discomfort or stomach bloating, “a somatic idiom of distress more acceptable given local cultural values and expectations” (Becker et al., 2009, p. 622). However, it must be noted that conventional anorexics seldomly just fear fat as such. Instead, weight gain often symbolizes deeper fears. For instance, by keeping a child-like body, anorexic girls might unconsciously attempt to postpone maturity, sexuality, and womanhood (Banks, 1992). In this example, thinness represents safety.

2.4. Physiological and psychological effects

In the DSM-5, the American Psychiatric Association (2013a) mentions the following consequences of malnutrition linked to anorexia nervosa: heart problems, osteoporosis, disturbed blood levels, dehydration, lethargy, amenorrhea, constipation, abdominal pain, social isolation, general feelings of depression, and premature death.

An important study related to the psychopathology of eating disorders is the Minnesota Starvation Experiment (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950). Between November 19, 1944 and December 20, 1945, at the University of Minnesota, a clinical study was conducted that investigated the physiological and psychological effects of severe and prolonged malnutrition. After a control period, a total of 36 men were put on a restrictive diet for 24 weeks. Apart from an average 25% weight loss and other physiological issues, the experiment evoked severe psychological effects, including depression, hysteria, hypochondriasis, emotional distress, self-mutilation, a preoccupation with food, social withdrawal, isolation, and a decline in concentration, comprehension and judgment capabilities (Keys et al., 1950).
Tucker (2006) found that the effects described in the Starvation Experiment resemble the experiences of patients with anorexia nervosa. Therefore, it has been postulated that many of the social and psychological consequences described in the psychopathology of anorexia nervosa may result from starvation itself, as they are normal biological reactions of the human body. Accordingly, in recovery, psychological treatment should be combined with physical nourishment.

3. Histories of self-induced starvation

It is important to understand that the modern clinical term ‘anorexia nervosa’ only applies to a disease of modernity. Current interpretations of anorexia nervosa explain this morbid self-emaciation as a coping mechanism with regard to inner conflicts and tensions of contemporary culture and middle-class family life: class and societal conflicts, individual history, personality, and issues of age and gender. However, voluntary starvation is not just a modern phenomenon (Brumberg, 1985).

3.1. Spiritual fasting

Abstinence of food for religious or spiritual reasons has been observed in many traditions, including Stoicism, Buddhism, Hinduism, Christianity, Islam, and Judaism. A famous example among women are the medieval ‘miraculous maids’ (Brumberg, 1985).

In the High Middle Ages (the 13th through the 16th centuries), religious fasting was highly praised among female saints. These women turned to extreme abstinence of food and passionate devotion to the Eucharist (Brumberg, 1985). The most famous of them is Catherine of Siena, who stopped eating after experiencing a vision of Christ in which He invited her to drink from his wounded side (Finnegan, 1991). According to Raymond (1980, cited in Finnegan, 1991), she no longer had appetite for ordinary food and was unable to digest it. When asked if she ever felt hungry, she replied “When I receive the most Blessed Sacrament [taking the wafer and the wine, a symbol of the body and blood of Christ], so complete is the nourishment our Lord grants me to find in it that I could not possibly feel any hunger for material
food… On any day on which I do not receive the Blessed Sacrament, the very presence and sight of it upon the altar is food to me” (Raymond, 1980, cited in Finnegan, 1991, p. 178).

Bynum (1984) found that writings by these women often contain extensive images of eating, drinking, and food, suggesting that they were obsessed with food and food rituals. Also, the female saints refused commensality, that is, eating at the family table. These behaviours resemble symptoms of current anorexia nervosa, as modern-day anorexics are equally preoccupied with anything food-related and often reject eating together with friends and family.

Later, in the 16th and 17th centuries, examples of prolonged fasting among women can be found in Catholic and Protestant countries. Brumberg (1985) writes that young women, so-called ‘miraculous maids’, undertook fasts that were perceived as signs of divine providence. They claimed to persist up to several months without food, sometimes even without sleep. A certain Jane Stretton, for example, went without sustenance for 9 months. Two cases are described of women going years without food: Katerin Cooper, who fasted for 9 years, and Eva Fleigen, whose fast lasted 14 years. Strikingly, these women did not die, leading Brumberg (1985) to believe that they secretly continued consuming tiny portions of substances with enough nutritional value to keep them alive, just as modern-day anorexics exhibit patterns of covert eating.

According to Brumberg (1985), however, these behaviours should not be equated with present day anorexia nervosa. Continuities in symptoms over time do not necessarily indicate the same disease, as similar symptoms can arise from different origins and meanings. Religious fasting was not seen as a disease, neither did it hold the same emotional significance as expressed in current anorexia nervosa. Brumberg (1985, p. 97) says that “to call Catherine of Siena an anorexic distorts her psychological orientation, misreads her actions as she understood them, and misrepresents the context in which she lived”. This writing supports the necessity of relativism: understanding phenomena in their own context, letting cultural and historical facts speak for themselves rather than using contemporary psychosomatic models to explain them.
Also, following the Minnesota Starvation Experiment (Keys et al., 1950; see I, 2.4.), some of the anorectiform symptoms described in the accounts of religious fasting are merely reactions of the human body when being malnourished, such as food obsession and sleep deprivation.

3.2. Hysterical anorexia

Food refusal started to get connected to disease in the 19th century. In 1873, both Lasègue (Lasègue, 1873) and Gull (Gull, 1997 [1873]) described cases of self-induced starvation in young girls as a result of a morbid mental state, calling it ‘hysterical anorexia’. Symptoms included amenorrhea, severe weight loss, low body temperature, slow pulse, slow breathing, extreme exhaustion, and restlessness (Fairburn & Brownell, 2002). Various remedies were tested, including medication, a balanced diet, and the application of external heat along the patient’s spine. Gull prescribed that “the patient should be fed at regular intervals, and surrounded by persons who have more control over them” (Gull, 1997 [1873], p. 501).

Here, the want of appetite in young women was thought to be a sign of hysteria. Gull (1997 [1873]) noted that these girls were especially susceptible to mental perversity. Lasègue (1873) wrote about the difficult relation of patients with their parents, and how the girls obsessively pursued a peculiar and inadequate diet, for instance, pickled cucumbers in café au lait. Neither Gull nor Lasègue mentioned religiosity as a contributing factor. Rather, they implicated the nuclear family, especially the middle- and upper-class family, able to “pander to the eccentric dietary tastes of their demanding adolescent daughter” (Brumberg, 1985, p. 101).

Brumberg (1985, p. 102) suggests that the late 19th century change from spirituality to disease reflects a larger transformation in society, called ‘secularization’. Historians use this term to indicate a declining preference for religious explanations of the universe, of one’s own actions, and of sickness and health. Also, modern anorexia has been linked to the evolution of the late 19th century bourgeoisie, that emphasized social interactions between family members and raised expectations to behave, putting pressures on daughters growing up. Lastly, the professionalisation of medicine, that medicalized any extraordinary behaviour, resulted in distorted
eating patterns being called a disease. These changes in society led to the emergence of anorexia nervosa as a disease entity with a distinct and workable nosology (Brumberg, 1985).

Thoughts on the aetiology of anorexia have been influenced by developments in laboratory medicine, by changing theories of human development, and by the prevalence of the disorder (Lucas, 1981, cited in Brumberg, 1985). In the 20th century, the understanding of anorexia nervosa has moved in and out the psychosomatic camp (Brumberg, 1985). For instance, Fairburn & Brownell (2002) write that a few decades into the 20th century, anorexia was associated with pituitary disturbances. After World War II, the focus shifted back to the mental field with the rise of psychoanalysis. Psychoanalytic views linked abstinence of food to unconscious fears of sexuality. Starvation was used as a defence against love relations, as the oral component of eating symbolized impregnation, and obesity represented pregnancy (Brumberg, 1985).

From the 1980s onwards, treatment became multidisciplinary, combining behaviour modification with psychotherapeutic follow-up. These therapies were less concerned with unconscious views on food refusal, they rather emphasized the personality and development of patients and their family (Brumberg, 1985). Also, the German-born psychiatrist Hilde Bruch showed a great interest into patients' lack of self-esteem, their pursuit for thinness, and their distorted body image. This led anorexia nervosa to become an intriguing disorder that also interested the general public (Fairburn & Brownell, 2002).

4. Aetiology of anorexia nervosa (according to Western research)

Although a lot of research has been conducted on the illness, anorexia nervosa remains a complex and arduously understood disease. Many authors now agree that its aetiology is multifactorial, depending on personality traits, life events, upbringing, genetics, biology, psychological factors, and the socio-cultural environment (Moskowitz & Weiselberg, 2017; Fairburn & Harrison, 2003; Le Grange, 2016). The following paragraphs discuss some of these factors. A
distinction is made between 'biological and sociopsychological factors' and 'cultural and religious factors', as biological and sociopsychological factors concern issues of the individual and her direct surroundings, while cultural and religious factors deal with issues that are more situated on a macro level.

4.1. Biological and sociopsychological factors

Moskowitz and Weiselberg (2017, p. 72) list a combination of biological, psychological, and social factors contributing to anorexia nervosa. Biological factors are susceptibility loci, neurotransmitter abnormalities, hormone abnormalities, family history, and being a twin. Psychological factors include specific traits (perfectionism, obsessionality, inflexibility, and neuroticism), low self-esteem, autonomy issues, maturity fears, and comorbid psychiatric disorders such as depression, anxiety, and personality disorders. In terms of social factors, the authors note cultural influences, family influences, peer influences, dieting, and stressors like college, moving, being bullied, abuse, and death.

Lacoste (2016) addresses two topics associated with anorexia nervosa aetiology: family issues and different forms of abuse. Difficult relationships with primary caregivers, distant as well as overprotective, seem to attribute to anorexia development. Shoebridge and Gowers (2000) discovered that the mothers of anorexic patients often show high levels of near-exclusive child care, separation distress, and maternal trait anxiety. In this view, disordered eating can be a way to manifest distress or desire regarding the family dynamics (Legrand & Briend, 2015).

Regarding abuse, Lacoste mentions that childhood emotional, physical or sexual abuse considerably leads to anorexia nervosa during adolescence (Favaro, Tenconi, & Santonastaso, 2010). Fischer, Stojek and Hartzell (2010, p. 192) explain this as follows: “An emotionally abusive environment does not teach adaptive emotion regulation skills, and (...) the use of maladaptive emotion regulation skills results in eating disorder symptoms.”

Early psychoanalytic models explain anorexia as an expression of unconscious conflicts, such as maturity fears, repudiation of sexuality, and oral-sadistic fears...
(Beumont, Abraham, & Simson, 1981). Fitzgerald and Lane (2000) point to the role of the father in the psychological development of his anorexic daughter, such as the need of his affirmation at the onset of adolescence. Other theories refer to early parent-child interactions in which parents fail to reinforce a child’s separate sense of self, and to chronic disturbances in the empathic relationship between parents and child (Banks, 1992, and references therein). Psychoanalysis then interprets suppression of the body’s developmental growth as an attempt to avoid fusion with parental objects (Palazzoli, 1974).

Studies on family dynamics equally indicate parental rigidity and overprotectiveness as risk factors for anorexia development. The mother in particular seems to have a significant impact. Maternal perfectionism and self-sacrifice make sexual maturity threatening for young females (Gordon, Beresin, & Herzog, 1989). Chernin (1985) refers to problems of mother-daughter envy and feelings of guilt, rage and need, which the anorexic symbolically projects onto her own body. Palazzoli (1974) points to failures in the early mother-daughter relationship, resulting in lack of trust and an inability to test out hostility and aggression against a reliable and forgiving maternal presence. These findings shed a different light on the preponderance of women suffering from anorexia, which is often attributed to cultural pressures of female thinness and to differences in male and female experiences during puberty and adolescence (Garner, Olmstead, & Polivy, 1983).

4.2. Cultural and religious factors

Fairburn and Brownell (2002) explain how emaciation can be used to make a statement. Since the late 19th century, the female body no longer represents motherhood and fertilization, but rather sexual liberation and rejection of the traditional female role, which is marked by leanness and a ‘tubular’ body type (Fairburn & Brownell, 2002, p. 154). This is confirmed by Lawrence (1979), who wrote that anorexics share a need to define their own limits and set boundaries around themselves. “The setting of boundaries around the self is a difficult problem for women as they are at least in part regarded as an aspect of the environment of others. Woman is the carer, the facilitator, receptive and waiting to allow herself to become ‘something’ in someone else’s life. Being very thin seems to say to the world
‘I have sharp contours, I am not soft, I do not merge with you’” (Lawrence, 1979, p. 94). These findings are consistent with studies on anorexia nervosa and culture, which will be discussed later (see II & III).

A lot of social science research on eating disorder aetiology mentions a cultural focus on dieting and slimness. In Western cultures, that often stress youth and androgyny rather than the mature female body, body dissatisfaction is of frequent occurrence. An increasing number of young girls who compare their bodies to preferred standards of beauty are prone to eating disorder development (Garner, Garfinkel, Schwartz, & Thompson, 1980). According to Fairburn & Brownell (2002), these trends go back to the 19th century, when a new ideal of slenderness amongst the upper classes introduced an ongoing battle against obesity and the emergence of a modern diet culture. However, not all girls exposed to thin beauty ideals develop an eating disorder. This can be attributed to the fact that only those vulnerable to such pressures will respond to them with eating disorder symptoms, such as those with a history of weight preoccupation, pre-existing depression or anxiety, low self-esteem in childhood, and perhaps genetic predispositions (Fairburn et al., 1997, cited in Nasser, Katzman, & Gordon, 2001). Similarly, not all girls with an eating disorder are influenced by beauty ideals, as triggers are different for each individual.

Islamic anorexics lies in the participation in Ramadan, which can both enhance and cover eating disorder symptoms.

Appealing traits of religious asceticism for anorexics include self-denial, a dualistic split between the body and mind or spirit, sexual disinterest, rejection of bodily death, and heightened morality and idealism (Banks, 1992). Palazzoli (1974, p. 74) explains the logic behind an anorexic’s dualistic body-mind thinking, namely, that crushing the strong body enhances the weak spirit. Equally, the favouring of self-control and the abstaining of indulgence leads anorexics to believe that they are morally superior (Bemporad & Ratey, 1985).

The relation between anorexia nervosa and religiosity is however multidimensional. Other studies than the ones hereinabove mentioned show an inverse relationship between the two, implying that religion brings solace and acceptance (Doumit et al., 2017).

5. Prevalence

Generally, eating disorders are perceived as predominant in white, affluent girls. Studies in Western countries show prevalence estimates of anorexia nervosa in female teens and adolescents ranging from 0.1% to 5.7%. As for the EAT-26 questionnaire, which is a self-report survey (see IV, 3.1.), the rates are a lot higher: scores varied from 8.3% in Switzerland to 26% in the USA (Makino et al., 2004, and references therein). This can be attributed to the fact that such self-report questionnaires do not actually aim to predict eating disorders as such but rather indicate eating behaviours that might form a risk for developing eating disorders. A high EAT-26 score, which reflects the prevalence of abnormal eating attitudes, thus not necessarily reflects the presence of an eating disorder.

Anorexia seems to occur more among students than in the general population. This might be due to the associated perfectionism and the pressure to perform, which are pitfalls for eating disorder development (Makino et al., 2004, and references therein). Also, eating disorders appear to emerge most in stages of life that are
marked by significant transition, such as girls entering puberty, adolescents starting higher studies, young people leaving home to live by themselves or together with a partner, and graduated students looking for their first job. Given the fact that much is changing in such transitions, these stages often entail feelings of insecurity. In this regard, focusing on one’s eating habits may provide a means to get a grip on life (Szabo, 2009).

Outside the West, eating disorders have also been identified, albeit to a lesser extent. According to Makino et al. (2004), community based and clinical based estimates of anorexia nervosa ranged from 0.002% in Hong Kong to 0.9% in Cairo, this last number referring to Nasser’s report on disordered eating among school girls in Cairo (1994). Lee et al. examined anorexia nervosa among Chinese undergraduates in Hong Kong (2009), and Rathner addressed the promotion of the thin ideal in former socialist Central and Eastern European countries transitioning to Western market economy (2001). As for EAT-26 scores, the highest rate, 39.5%, was measured in Pakistan among female nursing college students.

Such statistical numbers give an indication of the prevalence of eating disorders across the world, but they must be nuanced. Different problems arise when investigating the actual prevalence of anorexia nervosa. First, it is a matter of discussion whether anorexia is increasing in frequency. Whilst some of the assumed sociocultural factors may be strengthened throughout time, it is also true that cases get more easily discovered due to a heightened public and medical awareness. However, these discoveries are not objective, because knowledge and understandings of anorexia are not universally equal. Numbers on prevalence are also influenced by changing diagnostic criteria (Banks, 1992).

Second, taboo plays a role in eating disorder detection. For patients not conforming to the stereotype of white, thin, upper class, female anorexia, asking for help takes a lot of courage. Such sufferers can experience shame and a fear of not being taken seriously, and therefore neglect to seek professional help. Hence, their problems might remain undiagnosed (Eating Disorders Review, 2018). When patients exhibit the same mental and behavioural symptoms as regular anorexics but their weight is still within normal range, the term ‘atypical anorexia nervosa’ is used. Unfortunately,
due to weight stigma, these patients often hide in plain sight. They don’t easily get taken seriously by professionals or deny themselves that they are struggling with a severe and deadly eating disorder.

Third, diagnostic criteria and case detection methods are often culturally based. In this manner, we already discussed the limitations of the DSM manual (see I, 2.2.). Makino, Tsuboi, and Dennerstein (2004) say that researchers in non-Western societies often use translated versions of questionnaires developed in the Western hemisphere, such as the Eating Attitudes Test-26 (EAT-26). The EAT-26 is a psychological self-assessment test determining disordered eating attitudes. It does not provide a diagnosis, but it can be used as a predictive measure of eating disorder development. Also, many studies on non-Western eating disorders were conducted using convenience samples, such as high school students or hospitalized patients. Bottom-up population-based studies are rare (Makino et al., 2004).
PART II: ANOREXIA NERVOSA AS A CULTURE-BOUND SYNDROME

Di Nicola (1990) describes three possible views on the connection between anorexia nervosa and culture. Either culture is seen as a cause, a trigger, or an envelope. When culture acts as a cause, it provides a blueprint for anorexia nervosa. This claim was amongst others made by Orbach (1986), who described anorexia as a hunger strike in patriarchal societies. A second approach is that certain cultural factors can trigger the disease. In this view, it is not culture as a whole that directly causes anorexia, but rather specific cultural traits that enhance the development of anorexia in girls who are already vulnerable to it. This vulnerability may be due to family interactions, individual psychology or biological predisposition. In the third view, culture is a specific envelope for the expression of the illness, that is, how culture makes it possible for eating problems to develop into actual eating disorders.

Seeing anorexia nervosa as a Western culture-bound syndrome is rather new. It is only recently that the focus area of researchers studying culture-bound syndromes has been expanded to all cultures. In the past, the concept of culture-bound syndromes was only used for peculiar disorders outside the West.

1. On culture-bound syndromes

1.1. Definition and history of culture-bound syndromes

In most cases, research on culture-bound syndromes has been conducted by anthropologists and cross-culturally oriented psychiatrists. Karp (1985, p. 221) described three reasons for this attraction. First, cross-culturalists value cultural elements as markers of tradition. Second, Karp points to the exotic and flamboyant ways of behaviour associated with the syndromes, which according to him were likely to attract more attention than such prosaic afflictions as neurotic depression. Third, these syndromes contrasted with the bourgeois lifestyle standard amongst intellectuals and missionaries.
The history of culture-bound syndromes starts with colonization, at the turn of the 20th century, when unfamiliar mental phenomena or behavioural disorders were reported among non-European people. At the time, psychiatric classifications were based on Anglo-Saxon patient groups in Europe and North America. Clinical pictures that didn’t fit these classifications were marked as atypical. Hence, these views were ethnocentric, because they took Western ideas as the norm. When the new syndromes outside the West were discovered, they too were labelled ‘atypical’, which reinforced the idea that anything uncommon to Westerners was considered abnormal. Nevertheless, the attention drawn to non-Western diseases encouraged psychiatrists to consider cultural factors in psychopathology, and stimulated the development of cultural psychiatry (Tseng, 2006).

In 1962, Yap examined reports on these ‘peculiar’ disorders, and suggested the term ‘atypical, culture-bound psychogenic psychosis’, which he later changed to ‘culture-bound, reactive syndromes’ to cover the various syndromes that seemed to be bound to certain cultures as a result of psychological reactions. In 1967, he omitted ‘reactive’. Since then, the term ‘culture-bound syndromes’ has been adopted by psychiatrists (Tseng, 2006).

The initial tendency to view these syndromes as peculiar is what Kleinman (1967) called the ‘old transcultural psychiatry’, when Western diagnostic systems were used to describe various disorders throughout the world. Culturally specific diseases were either concealed, fitted in the existing system as variations of known disorders, or considered abnormal and categorized as ‘culture-bound’. At the time, the notion of culture-bound syndromes was however only used to indicate diseases outside the West.

Later, this started to get questioned, amongst others by Littlewood (1990, cited in Bhandari, 2012), who found the term ‘culture-bound’ redundant because all morbid reactions are to an extent culturally determined. Therefore, diseases should be examined in terms of the cultures they reflect. In this regard, for patterns characteristic of Western societies are as culture-bound as any others, anorexia nervosa was being proposed as a Western culture-bound syndrome (see II, 2.).
This newer trend of understanding all diseases as part of a cultural context is what Kleinman called the ‘new cross-cultural psychiatry’. It holds a cultural relativist point of view, that is, the idea that the beliefs, values, and practices of an individual should be comprehended within that individual’s own culture rather than being described in terms of the criteria of a foreign culture (see I, 1.1.). Changes in thinking about culture-bound syndromes thus reflect the evolution of cultural psychiatry from the old transcultural psychiatry to the new cross-cultural psychiatry.

Ritenbaugh (1982, cited in Swartz, 1985) was the first to propose a list of the criteria of culture-bound syndromes. According to him, a culture-bound syndrome holds the following characteristics:

1. It cannot be understood apart from its specific cultural or subcultural context.
2. The aetiology summarizes and symbolizes core meanings and behavioural norms of that culture.
3. Diagnosis relies on culture-specific technology as well as ideology.
4. Successful treatment is accomplished only by participants in that culture.

1.2. African culture-bound syndromes

In Africa, examples of culture-bound syndromes include brain fag and nodding syndrome. Brain fag was first discovered among high school and university students in Nigeria, but it is widespread in the whole of Africa south of the Sahara. Little research has been done on its occurrence in other countries of the Global South. One of the most striking symptoms is a severe headache, described by ‘burning in the brain’ and ‘worms crawling in the head’ (Prince, 1985, p. 200). At first, the symptoms seemed to result simply from studying and an overworked brain, which is why the students themselves referred to it as ‘brain fag’.

Apart from the headache, brain fag syndrome is characterized by visual difficulties (blurring, eye pain, excessive tearing); inability to grasp the meaning of printed symbols, and sometimes of spoken words; poor retention; and fatigue and sleepiness in spite of adequate rest (Prince, 1985, p. 200). Prince (1985) found that prevalence rates were higher in schools where students had a below average
proportion of literate parents, and lower in schools where parents had a high level of literacy, suggesting that brain fag is a social class phenomenon.

As brain fag syndrome has a very distinct pathology and rarely seems to occur outside these African countries, it is considered a culture-bound syndrome (Prince, 1985). However, some authors claim that patients are actually suffering from anxiety-depression, using non-Western somatic complaints to describe it (Savage & Prince, 1967; Jegede, 1983). Prince (1985) argues that it does not matter how the disease is labelled, but rather why, in those particular African contexts, it is described by symptoms of heat and crawling.

Another African culture-bound syndrome is ‘nodding disease’, an epileptic brain disorder described in children in Tanzania, Sudan, and Uganda (Spencer, Kitara, Gazda, & Winkler, 2016). The onset is mainly between 5 and 15 years. As the name suggests, its core clinical feature is a repeated dropping of the head in children apparently healthy prior to the nodding attacks. It has been seen in association with other seizures, stunted growth, wasting or delayed sexual development, and malnutrition. Also, there is an epidemiological association with areas endemic for a parasite called *Onchochercha volvulus*, which is transmitted to humans by the black fly and causes skin disease and river blindness (Spencer et al., 2016). Nodding syndrome outbreaks have been related to civil warfare, population displacement, food shortages, and disrupted vaccination programs. Children were also found to have different emotional and psychiatric problems. Neurologist Suzanne Gazda, co-author of the article cited here, prescribes the following treatment: a nutritious diet, closely monitoring seizure histories, specific medication, providing a special-needs education program, investing in a high standard of personal attention and care, and traditional Acholi music and dance therapy.

1.3. Culture-bound syndromes and the DSM

Since anorexia nervosa is recognized as an official mental disorder, it is listed in the DSM (American Psychiatric Association, 2013a) under ‘Feeding and eating disorders’. This means that seeing anorexia nervosa as a culture-bound syndrome is still only a theoretical discussion with proponents and opponents.
However, ‘other’ culture-bound syndromes are being omitted from the DSM or only listed in an appendix, such as dhat syndrome in India, ghost sickness among Native Americans, and kufungisisa in Zimbabwe (American Psychiatric Association, 2013a).

Whether culture-bound syndromes should be included in the formal DSM-classification is a controversial subject (Hughes, 1998). Tseng (2006, p. 558) argues that forcing culture-bound syndromes into the existing system would either classify them as ‘not otherwise specified’, or as variations of known disorders. It also risks making their unique meanings disappear, because it is near to impossible to resume such complex syndromes into a single diagnostic entity (Pfeiffer, 1982). Following Hughes (1998), Tseng (2006) advocates for the proper cultural consideration of every disorder, for that would annul the need to find room for specific syndromes in the current system.

In 1982, Ritenbaugh held up a similar view. According to him, research should not be focused on distinguishing between culture-bound and non-culture bound syndromes, but instead on the culture-bound meanings of all disorders. In this view, the whole of culture-bound syndromes indicates a continuum rather than a fixed category, with some diseases being more or less culture-bound than others (Ritenbaugh, 1982). This fits with Kleinman’s (1988) approach to illnesses: “Illness is created by personal, social, and cultural reactions to malfunctioning biological or psychological processes, and can only be understood within defined contexts of meaning and social relationships” (paraphrased in Banks, 1992, p 868).

The current DSM- edition does however offer a means to consider culture in diagnosis. In an additional section, the ‘Cultural Formulation Interview’ (CFI) gauges one’s views about illness and health. It is not a rating system, but rather a general tool that can be used to understand individual specificities. The survey questions several themes: the cultural definition of the problem, cultural beliefs about cause and content, the role of cultural identity, cultural factors in relation to coping and previous help seeking behaviours, and current help seeking behaviours (American Psychiatric Association, 2013b).
2. Considering anorexia nervosa as a culture-bound syndrome

Considering anorexia nervosa as a culture-bound syndrome evokes thoughts on which cultural values it reflects. Prince (1985, p. 199) emphasizes the calling for the equality of the sexes, the implied rejection of female contours and motherhood, and the praising of slimness. Sours (1980) points to a number of changes in Western societies in the second half of the 20th century: the rise of a consumer economy and its pressures on the achievement of personal satisfaction, an increasingly fragmented family and intergenerational conflicts, and the upheavals in sex roles, which introduced feelings of confusion in adolescents growing up. Indicating the changed ideal of feminine beauty, Garfinkel and Garner (1982) write that in 1976, visitors of London’s Madame Tussaud’s Wax Museum started favouring Twiggy, the emaciated model, instead of the more voluminous Elizabeth Taylor.

2.1. A closer look at some Western values at stake

2.1.1. Transitions in female identity

Since eating disorders affect mainly females and seem to revolve around issues of identity and the body, Gordon (2000, cited in Gordon, 2001, p. 2) finds it not surprising that observers “have linked the rise of eating disorders in the West with the crisis of female identity and the forces impinging on women that followed the cultural upheavals of the 1960s”.

In the late 20th century, as women became increasingly represented in the spheres of education and work around the globe, pressures for achievement have sometimes conflicted with continuous demands for dependency and submissiveness. For some women, these contradictory pressures resulted in personal uncertainty and self-doubt, and an increased sense of powerlessness (Gordon, 2000, paraphrased in Gordon, 2001, p. 3).

In The cost of competence, Silverstein and Perlick (1995) equally state that eating disorders and depression in women occur as a result of paradoxical expectations. Since the advent of the Western women’s movement, they argue, women have
made unprecedented progressions in different fields. Many girls growing up in this changing society ambition to excel academically and professionally. Whilst the emancipation of women certainly gives them opportunities, it also entails various pressures. For instance, as leaders and representatives of businesses carry out the image of the company, they have to look neat and pretty, thus a big emphasis is placed on appearance. Additionally, in some professional sectors image is important, again putting pressures on those performing them, such as models, beauticians, dancers, and stewardesses.

Yet at the same time, traditional gender roles still play a role, which leads to young women identifying masculinity with competence and success, and femininity with uncertainty. As a result, the female body is symbolically perceived as a barrier to achievement and recognition, triggering eating disorder development.

Katzman and Lee (1997) demonstrate the ways in which women ‘straddling two worlds’ (Katzman & Lee, 1997, p. 387) may employ food denial as a means to cope with the resulting confusion and disconnection they encounter. Following the new female opportunities at the end of the 20th century, the two-world hypothesis translates a complicated blend of traditional images of womanhood, pressures to conform to the new ideals, frustrations resulting from false opportunities, issues of role transition, culture clashes, and generational disparity.

2.1.2. Social protest and body politic

Anorexia nervosa can be seen as a way to take back control over one’s own body in contemporary society. As a way of introduction, it is interesting to elaborate on what Foucault (1976) called ‘biopower’. Where sovereign states applied violence to achieve the subjugation of citizens and the control of populations, modern nation states use disciplining power and social sanctions to regulate individuals. In this regard, Foucault (1975) introduced the notion of ‘body politic’. In this view, cultures are seen as “disciplines that provide codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order” (Scheppe-Hughes & Lock, 1987, p. 2). For instance, medicine has the power to medicalize and correct abnormalities. Other examples include criminal justice,
psychiatry, and the various social sciences, but also less institutionalized social norms of unlimited consumerism, beauty standards, fitness trends, capitalist thinking, and patriarchal values. It might even be argued that orthorexia nervosa, that is, a morbid focus on eating healthy, results from contemporary hypes of superfoods, veganism, organic eating, and gluten free and sugar free diets (Musolino, Warin, Wade, & Gilchrist, 2015).

As citizens feel obliged to go with those norms, they can experience feelings of pressure and loss of control and individuality. Consequently, coping mechanisms are searched for. Here, anorexia, which is, rigidly controlling what enters the body, is one such an example. Melosik (1999, p. 90, cited in Pyzalski, p. 191) writes that “controlling one’s body (...) gives the feeling of control over life, wherever this control should be placed”. Turner (1992) sees the body as a field of political and cultural activity which inspires numerous discussions and conflicts.

Feminists implicating Western patriarchy equally view anorexia as a means of resistance. By rigidly controlling what they eat, women reclaim their own bodies and protest against misogyny, patriarchal values, sexual division of labour, female subordination, and objectification of their bodies (Orbach, 1986; Chernin, 1985). Combined with the above described uncertainty of women straddling two worlds (Katzman & Lee, 1997), anorexia seems to both provide a way to get a grip and a means of resistance.

According to Banks (1992), however, viewing anorexia as a social protest against contemporary issues overlooks underlying unconscious motives. Brumberg (1988, p. 37) says that “the effort to transform [anorexics] into heroic freedom fighters is a sad commentary on how desperate people are to find in the cultural model some kind of explanatory framework, or comfort, that dignifies this confusing and complex disorder.” This is ratified by Banks (1992, p. 873): “These works do not consider the meaning and motivation of anorexia from the point of view of the anorectic nor the possibility that contemporary eating disorders may be encoded in cultural symbols and language other than those related to Western patriarchy or economy.”
Elaborating on this, Banks (1992) says that it is hugely important to consider a patient's own subjective understandings of symptoms, and how it relates to culture. She says that “anthropologists especially should not assume cultural uniformity or homogeneity in the genesis or subjective expression of any behaviour, including psychopathology” (Banks, 1992, p. 868). Banks (1992) assumes that all disorders mean something to sufferers. In this regard, she says, “an anorexic consciously understands and gives meaning to her symptoms using culturally explicit and objective symbols, beliefs, and language” (Banks, 1992, p. 868).

Patients might give different meanings to their illness than the ones held by diagnosticians, medical practitioners, and even other anorexics. If a healer does not care for cultural understandings of illness and behaviours, and thus fails to recognize the individual’s meanings and motivations, treatment is more likely to be fruitless (Banks, 1992). These ideas underline the need to combine sociocultural and psychological factors in the understanding of anorexia nervosa.

2.1.3. Body image

In the West, thin body image preferences co-occur with a dramatic increase in overweight in the general population. Obesity is stigmatized, whilst at the same time dieting is promoted and slimness is praised, which can trigger eating disorder development (Gordon, 2001). General thoughts on anorexia nervosa refer to the role of the media in advancing eating disorders among young girls and women. Although eating disorders are complex and do not solely rely on pressures to be thin, it cannot be overlooked that these pressures have a negative influence on girls vulnerable to anorexia nervosa development, and on the conservation of the illness in already anorexic girls.

Becker and Hamburg (2009) examine the pressure to be thin at the onset of anorexia nervosa, and the role of the media in perpetuating this pressure. According to them, there are two possible ways of impact. A person can be affected by either one of them or both. The first way is when popular images of thinness directly contribute to eating disorder development and maintenance, for instance, when girls start comparing their own body shape to those being presented in the media. This
can be illustrated by the so-called ‘thinspiration’ images of slim to emaciated women, often used on pro anorexia websites (www.myproana.com) as a motivation to lose weight.

The second way is more indirect, when thin images reflect standards of the wider culture. Here, it is not so much thinness as such that is pursued, that is, for aesthetic reasons, but rather for what being skinny represents in society. For instance, in the West, the thin female ideal reflects popularity and life success (Evans, 2003). In this regard, skinny images in the media do not directly cause or enhance eating disorders, but rather mirror deeper cultural norms. As a result, argue Becker and Hamburg (2009), “the issue is not so much which images are presented as ideal, but how they are rendered so compelling. The widespread dissemination and endorsement of particular images of women’s bodies have been conceived as ‘pressures’ to remake the body to match cultural aesthetic (and moral) ideals, without examining the issue of why men and women feel motivated to recontour their bodies in these ways - or even feel capable of doing so” (Becker & Hamburg, 2009, p. 163).

Furthermore, body image does not only refer to concrete looks. According to Scheper-Hughes and Lock (1987), body image can be explained as “the collective and idiosyncratic representations an individual entertains about the body in its relationship to the environment, including internal and external perceptions, memories, affects, cognitions, and actions” (Scheper-Hughes & Lock, 1987, p. 16).

Perceptions about the body are thus not only influenced by external images, but also by inner motives and emotions. In this regard, an anorexic’s sensation of ‘being fat’ can reflect deeper feelings of discomfort. And because anorexic patients often did not learn how to properly regulate their emotions (see I, 4.1.) they tend to merely focus on the bodily experience of the negative emotion: by controlling the body, the assumed cause of the discomfort, they will feel better.

Since anorexic patients are often highly sensitive, they tend to overestimate their body in three ways: the ‘body percept’, the ‘body schema’, and the ‘tactile form’ (Gadsby, 2017, p. 18). The body percept refers to the mental image we have of what our bodies look like. In therapy, an often-used exercise is to estimate and measure
the size of your thighs using pieces of rope. A non-recovered anorexic is more likely to predict the size to be way bigger than it actually is. The body schema is used for motor control and simulation. For instance, anorexics might think they will get stuck in a small passage, whilst in reality they easily can get through. The tactile form is related to the sense of touch. Anorexics appear to perceive physical contact in a more sensitive way than controls, especially with regard to the abdomen (Gadsby, 2017).

Thus, anorexics expressing that they ‘are fat’ or ‘feel fat’ has to be understood not just as a result of them comparing themselves to unhealthy standards of beauty, but even more as a translation of underlying issues. Consequently, there is little use in repeating logical, empirical arguments to convince an anorexic that she is not fat, if attention has not been given to the emotions disturbing her self-experience.

3. Culture-bound syndromes: a useful framework for anorexia nervosa?

Proposing anorexia nervosa as a culture-bound syndrome is a subject of discussion, with psychiatrists looking for universal features and anthropologists emphasizing cultural specificities. Proponents of the culture-bound syndrome approach point to specific traits in Western culture triggering eating disorder development, while opponents refer to differences in experience among various cultural groups or subgroups. For instance, Lee (1996) noticed that anorexics in non-Western societies often do not present weight phobia, asking for the culture-bound syndrome concept to be reviewed.

Swartz (1985) writes that the aim is not to define whether a disorder is culture-bound or not, but rather if the culture-bound syndrome concept provides a useful framework in reflecting about it. Based on Ritenbaugh’s criteria (1982, see II, 1.1., ‘Definition and history of culture-bound syndromes’), she concludes that for anorexia nervosa, it does. First, Ritenbaugh (1982) says that culture-bound syndromes cannot be understood apart from their specific cultural or subcultural context. Swartz (1985) confirms that the meanings of anorexia nervosa may change over time as cultural preoccupations change. It is fairly possible that the anorexic symptoms
reported in the 19th century meant different things than what they mean now. Moreover, meanings of symptoms can differ even within cultures. To illustrate, anorectiform symptoms are common in subcultures where image is essential, such as ballet dancing, modelling, and beauty therapy (Button & Whitehouse, 1981). As a result, those symptoms may mean something different for members of such subcultures than for other. Ballet dancers might not agree with the notion of ‘severe psychopathology’ often associated with anorectiform symptoms, because in ballet subcultures these symptoms are something of a norm. Identical symptoms thus can have different meanings in different contexts. Swartz (1985, p. 727) argues that “[this statement] focuses on the professional discourse surrounding anorexia nervosa and calls into question the practice of making blanket statements.”

Second, Ritenbaugh (1982) writes that the aetiology of a culture-bound syndrome summarizes and symbolizes core meanings and behavioural norms of that culture. Despite the unitary aetiology assumed in this feature, says Swartz (1985), it clarifies the nature of theorising about anorexia nervosa. As anorexia is often thought to be a disorder of Western culture, it is valuable to explore in which ways it serves as a vehicle for expressing preoccupations of Western culture: “it is interesting that as hysteria has become rare in Western culture, popular thinking has related it to a particular (not necessarily accurate) view of Victorian sexuality, but anorexia nervosa is rarely more than cursorily discussed as presenting a crystallized caricature of norms” (Swartz, 1985, p. 727). In fact, some authors are careful to differentiate between anorexia nervosa and ‘normal dieting’ (Palmer, 1980, cited in Swartz, 1985). This split between normality and abnormality may well be illustrative of cultural preoccupations. According to Swartz (1985), some reasons for this distinction may be the physical danger resulting from anorexic symptoms, the difficulty an essentially positivist biomedical model has with social theorizing, and a reluctance to discuss cultural issues within our own culture.

Third, Ritenbaugh (1982) states that diagnosis relies on culture-specific technology as well as ideology. In this regard, Swartz (1985, p. 727) writes: “Anorexia nervosa is to some extent a disorder which gains its reality through a form of negotiation between the diagnoser and the sufferer.” Diagnostic realities are thus subjective, as they are shaped and constructed within specific ideologies and with specific tools.
In the case of eating disorders, researchers as well as psychiatrists often use DSM-criteria or the EAT-26 to determine disturbed eating attitudes, which are set up in Western culture (Makino, Tsuboi, & Dennerstein, 2004). It is however questionable whether one can handle the same criteria to understand anorectiform symptoms outside the West.

In the past, says Swartz (1985), ideologies in the diagnosis and treatment of anorexia nervosa have been of particular concern to feminists addressing problems of patriarchy. For instance, Boskind-Lodahl (1976) wrote that many traditional approaches to therapy with women see men as solutions to problems of low self-esteem related to parental issues, such as Szyrynski (1973, cited in Boskind-Lodahl, 1976), who suggested that “since a great majority of such [eating disorder] patients are adolescent girls, a male therapist may be probably more effective than a woman. He can replace for the girl her inadequate father; on the other hand, he will not be identified by the patient with her hostile mother.” Boskind-Lodahl critiques this by arguing that female therapists can provide positive female role models for women who have a negative relationship with their mothers. In addition, she writes, one cannot expect that the presence of a man, or any other person, can countervail a non-existent sense of self.

Fourth, Ritenbaugh (1982) argues that successful treatment of culture-bound syndromes is accomplished only by participants in that culture. Leaving aside that the concept of success is already a subjective issue, Swartz (1985, p. 727) finds that major treatment centres for anorexia nervosa all involve communication within a particular cultural context: “There is some evidence to suggest that medication may remove anorectiform symptoms, and there is no shortage of physical theories about anorexia nervosa. (...) Of course, the ‘culture’ mentioned here may refer in part to a general medical or professional culture which cuts across regional boundaries and which is limited more by class and by educational background than by national origin”. In this regard, it may well be that a variety of practitioners from different countries are able to deal with anorexia nervosa, which goes against the idea that cultural heterogeneity creates greater divisions than class differences (Swartz, 1985).
Considering anorexia nervosa as a culture-bound syndrome has consequences both for theory and for therapeutic practice (Swartz, 1985). For psychological theories, the approach implies an element of relativism. Identical symptoms may be explained in a different way, due to differences in time, context, and psychological theorizing (Rychlak, 1982; Swartz, 1985). Also, even though anorexic symptoms exist as such, patterns of presentation are affected by professional practice. Therefore, the culture-bound syndrome approach encourages theorists to consider their own role in creating and shaping the disorder. Furthermore, it goes against a linear cause model of pathology which resides within the sufferer. Swartz (1985) explains that “many intertwined factors, some personal and some cultural, operate in the genesis of the disorder in every case. When the practitioner becomes part of what is being studied then linear causality cannot be applied, because there is no longer the possibility of unitary responsibility for or single meaning of symptoms” (Swartz, 1985, p. 728). Lastly, the concept of culture-bound syndromes allows for cultural standards of normality and abnormality to be reflected upon (Swartz, 1985).

Therapeutic practice is also affected by relativistic thinking, for different understandings of anorexia nervosa require different treatment approaches. According to Swartz (1985, p. 728), “the overarching culture-bound syndrome model calls into question whether it is appropriate to offer comprehensive individual psychological treatment to members of certain subcultures”. For instance, in groups of models or ballet dancers, where anorexic symptoms are quite common, symptom-directed therapy may be appropriate, while other subcultures might require more explorative work. However, there can be no official rules about this, because individual differences should be considered.

Furthermore, handling a more meaning-centred model is useful to overcome the medical gaze, a concept introduced by Foucault (1963) to indicate the oversomatisation of social phenomena in biomedicine. Focusing on the meaning of symptoms prevents the social content of symptoms to be reduced to psychopathology. As Swartz (1985, p. 728) puts it, “it is easy for the clinician to convince sufferers that aspects of their lives are pathological - it is a therapeutic responsibility not to do so indiscriminately”.

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Prince (1985) offers an interesting viewpoint to consider the usefulness of the culture-bound syndrome approach. According to him, one should differentiate between the many related theorists. Psycho-pharmacologists, psychiatric epidemiologists, and psychological anthropologists all have different interests and opinions, since they look at the matter from their own perspective. Thus, for some, the culture-bound syndrome concept might identify differences that make a difference, whilst for others, the meanings of symptoms are not that important.

According to Di Nicola (1990), a distinction should be made between syndrome-centred and meaning-centred definitions of illness. The medical model is syndrome-centred; it indicates distress and names syndromes and diseases according to an overarching international classification. In this view, diseases are thought of as fixed entities. On the other hand, social sciences (medical anthropology and medical sociology) models are meaning-centred; they reread symptoms for their meanings and try to understand diseases in their context (Kirmayer, 1989). Here, diseases are regarded as explanatory for culture. They should thus be described in relation to their cultural context, rather than as distinct entities (Di Nicola, 1990). To get at those local meanings, Kleinman (1980) proposed explanatory models, asking questions sensitive to the patient’s own experience.

Both approaches have their pitfalls. Just as the medical model has been criticized for being too ignorant for contexts, there are limits to the social sciences models when metaphors become reified (what Di Nicola calls ‘metaphors as illness’, 1990) or when nosology is replaced by cultural attributions using explanatory models (‘illness as explanation’, Di Nicola, 1990). According to Di Nicola (1990, p. 250) not all personal or cultural experiences of mental illness can be understood cognitively, because “human life is experienced and enacted, processed and organized, symbolized, celebrated and consecrated through many vehicles, including emotional, ritual and spiritual ones that are cognitive only in part.” When experiences are construed cognitively, they are not per se rational or amenable to negotiation with an interlocutor, for instance, when an explanatory model is based upon aesthetics, prejudice, or superstition (Di Nicola, 1990).
4. Other approaches: culture-change syndromes, culture-related syndromes

4.1. Culture-change syndromes

At the end of the 20th century, various accounts of anorexia nervosa outside the West started to get reported (Nasser, 1994; Becker, 2004; Adegoke, 2013), which raised questions on its actual culture-boundedness to Western culture. Therefore, other approaches have been proposed. Di Nicola (1990) differentiates between typically Western cases of anorexia and ‘orphan cases’ found elsewhere. Such orphan cases “occur among people geographically and culturally remote from any area in which any culture-bound version of the syndrome is endemic” (Simons, cited in Di Nicola, 1990). For anorexia nervosa, two kinds of orphan cases are mentioned: cases occurring in developing countries and cases occurring as a result of rapid economic or sociocultural change. Such radical change can for instance be experienced among immigrants from developing countries to more developed countries. In this regard, Mead (1947, p. 72) wrote that “as periods of cultural change inevitably carry with them a greater degree of heterogeneity, in the history of any culture or subculture, periods will be found in which adequate social forms for the expression of points of strain and tension in the personality will be forced back upon his own body for symbolic expression.” Anorexia nervosa can be a way to express such tensions through the body.

Following Mead (1947), Di Nicola (1990) speaks of ‘culture-change syndromes’ emerging under conditions of rapid economic and socio-cultural change (Steinhausen, 1985), such as cultural evolution and human migration. In groups experiencing such change, children and adolescents in particular are under a lot of stress, as they are not grown up yet and thus have to deal with cultural and personal transition at the same time. This can make them question their identity and look for ways to deal with that. As a result, they are more vulnerable to develop syndromes like anorexia nervosa.

Studies on eating disorders following socioeconomic or cultural change are numerous. Various research shows that culture change resulting from migration may indeed lead to anorexia nervosa. For instance, when Fichter et al. (1983)
compared anorexic symptoms of Greek girls in Greece and as immigrants in Germany, they found higher prevalence rates among the ones in Germany. Similarly, Nasser (1986) found that Arab college students in London are more prone to eating disordered behaviour than their counterparts in Cairo. Also, reports of anorexia nervosa have been reported in migrating to Western countries, suggesting that immigration and acculturation stress can trigger the illness (Di Nicola, 1990, and references therein).

When working with immigrants and refugees undergoing rapid cultural change, cultural family therapy offers two crucial tools: code-switching and the perspectives of insiders and outsiders (Di Nicola, 1986). Di Nicola (1986) described two cases of anorexia nervosa in which code-switching was functional. In the first case, a Greek immigrant family with a 19-year old anorexic daughter, language switches served as boundary markers, expressing the alliances and exclusions that occurred among family members. The therapist did not share the language and culture of the family, so he used an outsider’s perspective to learn their cultural and idiosyncratic family rules and rituals. The father and the daughter spoke English well, but the mother became lost when asked to discuss her own perceptions of family events. When the father was asked to act as a translator, she refused and turned to her daughter or tried to express herself in English nonetheless. This pattern showed internal family dynamics: the daughter was a prized confidante and the father was rejected.

In the second case, Italian immigrants with two daughters, code-switching helped to map sensitive topics, delineating with whom they could and could not be shared. As the parents spoke little English or French, therapy was conducted in Italian. However, the daughters switched to English when modern topics were discussed that did not match with their parents’ strict conservatism. Here, the therapist could act as an insider, since he shared the language and culture of the family (Di Nicola, 1990, p. 271).

These cases illustrate how anorexia nervosa can act as a culture-change syndrome. In the Italian family, the cultural gap between the two generations was bridged by their daughters living a cultural double life: dutiful daughters in ‘Italian’ and bright, outgoing teens in ‘English’. When the oldest daughter moved out, the younger one
desperately tried to slow things down by going on a hunger strike. The Greek family had been moving back and forth between Greece and Canada, trying to live up to their cultural ambivalence, which put issues of identity onto the daughter (Di Nicola, 1990, p. 272).

4.2. Culture-related syndromes

Another approach was carried out by Tseng (2001), who speaks of ‘culture-related syndromes’. As it appeared that in some cases, similar syndromes can be found in various societies that share certain cultural traits, he argues that it would be more correct to delineate a syndrome that is closely related to certain cultural features in its formation or manifestation of psychopathology, rather than specifically bound to one cultural system. “These syndromes tend to be observed more frequently in certain cultural areas that share common cultural traits or features than in others. Whether they are prevalent or infrequent in those areas is not as much of an issue in determining whether special clinical attention is warranted as the importance of cultural factors in their formation and the significance of local people’s reactions to them” (Tseng, 2001, p. 212). By phrasing it this way, Tseng shifts the focus from questions of actual prevalence towards meanings and impact of culture. He also nuances that “cultural factors impact every kind of psychopathology to some extent – whether or not it is predominantly psychological or biological in nature. However, unless cultural impact is very significant and deserves special attention, there is no point in identifying and labelling a pathology as a ‘culture-related specific syndrome’” (Tseng, 2001, p. 214).

According to Tseng (2001), there are six ways in which culture can influence psychiatric syndromes, namely, through:

1. “pathogenic effect, in which cultural beliefs induce stress and anxiety, which can cause the development of the disorders;
2. pathoselective effect, in which the culture chooses unique (pathological) patterns of coping with stress or anxiety;
3. pathoplastic effect, in which culture shapes the content of symptoms and manifestations of the clinical picture;
4. **pathoelaborating effect**, in which culture exaggerates certain mental conditions to an elaborate level, where they become unique;

5. **pathofacilitating effect**, in which culture influences the frequency with which the pathology occurs in a particular society; and

6. **pathoreactive effect**, in which culture impacts the patient’s family member’s, or the community’s reactions to the disorder, including how it is interpreted and managed, and often influences its outcome” (Tseng, 2001, p. 212).

Following this framework, the culture-related syndromes may be subgrouped by the ways in which they are affected by cultural factors (Tseng, 2001, p. 215-217):

1. **Culture-related beliefs as cause for the occurrence.** In this group, the syndromes are listed that “are caused primarily by psychological stress stemming from cultural beliefs. The belief explicitly exists and is consciously recognized by the folk people involved” (Tseng, 2001, p. 215). Here, culture plays a role through pathogenic effect.

2. **Culture-patterned specific stress-coping reactions.** This group includes syndromes reflecting the culturally selected coping mechanisms of dealing with stress. Culture thus contributes through pathoselective effect.

3. **Culture-shaped variations of psychopathology.** Notwithstanding that the psychopathological manifestations of all psychiatric conditions are to some extent shaped by sociocultural factors, the syndromes in this group are so remarkably culturally influenced in their manifestation that they are marked as ‘unique’ or ‘atypical’ variations of ‘ordinary’ psychiatric disorders. In these cases, culture has a pathoplastic effect.

4. **Culturally elaborated unique behaviour reactions.** For these syndromes, Tseng (2001, p. 216) writes that “although certain behaviours may be observed universally, they are exaggerated to extreme forms in some cultures through cultural reinforcement”. The occurrence of such behaviours may fulfil individual as well as societal needs. Culture thus elaborates on them through pathoelaborating effect.

5. **Culture-provoked frequent occurrence of pathological conditions.** These syndromes are grouped not because they share certain psychopathologies, but rather because their prevalence is influenced by certain sociocultural
conditions. As a result, their frequency varies significantly. Here, culture contributes through pathofacilitating effects.

6. **Cultural interpretation and reaction to certain mental conditions.** In this group, the focus is on the specific cultural ways in which local people react to certain mental conditions. It includes cultural interpretations of their causes, familiar labels, and culturally prescribed ways of dealing with them. In a strict sense, they are not culturally specific in their manifestation. Culture mainly plays a role through pathoreactive effect.

Tseng (2001) classifies anorexia nervosa to be a ‘culturally elaborated unique behaviour reaction’. He writes that it is mainly based on health-related concerns, but also on the cultural view that “keeping the body in good shape is important” (Tseng, 2001, p. 250). Therefore, many diets and exercise programs have been developed. “In other words,” says Tseng (2001, p. 250), “in addition to being healthy, people are under cultural pressure to be slim and beautiful, and develop elaborate ways to meet these expectations”. He continues that eating disorders are expected to be more prevalent in societies where food is reasonably abundant, and where slimness is emphasized as a sign of beauty or good health. As a result, anorexia nervosa can be considered a culture-related syndrome observed mainly, but not solely, in Western European or North American societies, because they share these cultural features (Tseng, 2001).

As globalisation causes an increasing interconnectedness of culture, anorexia nervosa may start to appear across the world (see I, 5.), albeit in various culturally adapted forms. This can be thought of as a process of ‘glocalization’, a term used to describe the ways in which universal and particular tendencies co-occur in contemporary societal systems (Daouk-Öyry, Zeinoun, Choueiri, & Van de Vijver, 2016). In this regard, varied forms of anorexia nervosa can also be thought of as ‘culture-shaped variations of psychopathology’ (Tseng, 2001).
PART III: EATING DISORDERS IN AFRICA

Although this thesis does not aim to go into detail on eating disorders other than anorexia nervosa, it is interesting to take a look at how the African continent relates to eating disorders in general. After all, issues of normality and abnormality apply to multiple eating disorders, not just anorexia nervosa. Shedding a light on various eating disorders can be illustrative for how cultural views on eating patterns may differ from views of standard diagnostic systems.

Two major categories are distinguished here, namely, restrictive and non-restrictive eating disorders. This used to be an official distinction in previous versions of the DSM, but here, it merely serves as a structuring tool. Solely differentiating between restrictive and non-restrictive eating disorders allows for the hegemony of standard subclassifications to be abandoned. However, as there are currently no other diagnostic entities than the DSM-5, the following paragraphs will start from official DSM-subtypes, yet critical thoughts will be offered to encounter the problems of using such diagnoses.

‘Restrictive eating disorder’ is mainly used to indicate anorexia nervosa and atypical anorexia nervosa. There is another eating disorder that can be placed under this category, namely, avoidant/restrictive food intake disorder, yet little to no research exists hereon conducted in Africa. Atypical anorexics meet some, but not all of the criteria for anorexia nervosa. For instance, they may perceive their bodies realistically or may not be underweight despite significant weight loss. Individuals diagnosed with avoidant/restrictive food intake disorder limit the consumption of certain foods based on the food’s appearance, texture, smell, brand, presentation, taste, or a past negative experience with the food (Fisher et al., 2014).

The term ‘non-restrictive eating disorder’ includes all sorts of disturbed eating that are not mainly characterized by restrictions of food or episodes of restriction, such as bulimia nervosa, binge eating disorder, orthorexia nervosa, and pica. Bulimia nervosa is distinguished by frequent episodes of binge eating. Those binges often consist of foods that patients normally would not allow themselves to eat. After a binge, however, bulimics can experience an immense fear of gaining weight or loss
of control, which is why they turn to different forms of purging to get rid of the food. Purging methods include vomiting, the use of laxatives and/or diuretics, excessive exercising, and fasting. Patients with binge eating disorder equally suffer from frequent and recurrent episodes of uncontrollable eating, but they don’t show purging behaviours afterwards, which is why they often have a higher body weight and might get obese (www.proud2bme.nl).

Orthorexia nervosa is characterized by an obsessive preoccupation with eating healthy food (Musolino et al., 2015). It is not described as an official eating disorder in the DSM-5, but it gets increasing attention in the therapeutic community. Given current ‘healthy eating’ trends in Western society, orthorexia may not easily be identified in sufferers. However, the obsession of orthorexics with health and healthy food goes way beyond just paying attention to their diet. For an orthorexic, quality of life is measured by the quality of food. Patients may strictly avoid entire food groups, such as fats, which can cause nutrient deficiencies. The last eating disorder mentioned here is pica, which is characterized by the abnormal appetite for non-consumable substances, such as paper, hair, paint, chalk, metal objects, stones, and soil. According to biomedicine, causes are either physical (f. e. iron deficiency anaemia) or mental conditions (Abu et al., 2017). Pica behaviour can cause significant health issues, for instance, the consumption of hair and metal may lead to bowel obstructions. The category of non-restrictive eating disorders is not strictly delineated, as patients with bulimia nervosa might show episodes of restriction, and orthorexia can be regarded as some form of restriction since those sufferers only eat foods that they consider to be healthy.

In the following paragraphs, binge eating (overeating) and pica (consuming non-foods) will be further discussed, because their symptoms correlate with common eating habits in the African context. Since those eating habits are culturally normal, they illustrate how identical symptoms can have different meanings in different contexts, and therefore will not everywhere be seen as problematic. In this regard, Swartz (1985) issued that, as standards of normality and abnormality are shaped within a certain context, they are not universal and thus cannot be considered objective when applied all over the world.
1. Non-restrictive eating ‘disorders’

1.1. Overeating

In many African countries, large bodies and a big appetite are favoured as symbols of fertility and an affluent lifestyle (Gordon, 2001). As a result, overeating is common among Africans who can afford it (Tulp, Obidi, Oyesile, & Einstein, 2018; Averett, Stacey, & Wang, 2014). The trend is especially visible in urban areas, an increasing urbanization has contributed to improvements in people’s standard of living (Schmidhuber & Shetty, 2005). Sodjinou, Agueh, Fayomi, and Delisle (2008) wrote that 20-25% of urban populations in Africa are grouped as either overweight or obese. In African as well as in white people, overnutrition has been linked to many health problems such as diabetes, coronary heart diseases, hypertension, and premature death (Tulp et al., 2008, and references therein).

In some West-African countries such as Mauritania, young girls are obliged to consume enormous quantities of food, even to the point of vomiting, in order for them to put on weight quickly. This practice is called gavage. The food is mainly forced upon them by the girls’ mothers or other female relatives in so-called ‘fattening houses’. Due to associated health risks, the practice is disappearing in some countries, but the traditional beauty norms remain part of culture (Ouldzeidoune, 2013).

Obesity in Africa is not only linked to the amount of food that is being eaten, but also to a changing diet. Dapi, Omoloko, Janlert, Dahlgren, and Håglin (2007) wrote that in Cameroon, nutrition transition is happening from traditional food composed of plantain, maize, cassava, beans, groundnuts, green leaves, and palm oil to modern and processed food such as rice, bread, pasta, doughnuts, chips, candies, pastry, and sweet beverages. In urban areas, the consumption of fast food outside the home is becoming more frequent. In addition, as frequent consumption of processed and sugary products causes blood sugar levels to fluctuate, people are likely to experience a ‘sugar crash’, which makes one feel lethargic and thus turn again to food for energy. This is called ‘cravings’ (Leslie, Turton, Burgess, Nazar, & Treasure, 2018).
Despite a common factor of overconsumption, these traditional African eating patterns cannot be equated with binge eating disorder (BED). BED is an actual eating disorder, implying that the behaviour is associated with deeper psychological problems, which is not the case in Africans overeating because of cultural standards. This shows that identical symptoms can have different meanings and thus must be understood in their own context. It also illustrates that standards of normality with regard to portion sizes are not universal. The same portion size can be perceived as normal in one culture and as abnormal in another. Moreover, individual needs vary too, based upon differences in age, gender, physical activity and so on (www.proud2bme.nl, consulted on July 29, 2018).

1.2. Consuming non-foods

The same issue of normality can be applied to the habit of eating non-consumable things. In Western countries, due to the associated health risks, this behaviour is called abnormal and should be addressed as an illness. In those settings, it is called ‘pica’. However, in different parts of Africa, consuming non-food items such as soil, soft stones, paper, chalk, or clay is a common practice among pregnant women as well as in the general population. A documentary made by BBC News Africa (2013) shows women in Tanzania selling up to 3000 pallets a day of special soil from Morogoro.

It is interesting to take a look at how the community perceives this behaviour. Attitudes of the community towards people consuming non-foods appear to differ from rejection (Abu et al., 2017) to acceptance (BBC News Africa, 2013). When the behaviour is rejected, treatment can be applied. One way of treatment involves consultation with church leaders, who take up a specific deliverance role believing that the sufferer is possessed by an evil spirit. A video by Emmanuel TV (2013) shows a young South-African woman who, for 19 years, frequently ate stones, chalk, and paper. Emmanuel TV is a television station founded by ‘prophet’ T.B. Joshua of The Synagogue, Church of All Nations in Lagos, Nigeria (SCOAN, n.d.), claiming to spread the word of God. The word ‘pica’ is not mentioned, yet the woman uses the term ‘addiction’, indicating an element of dependency:
“I am addicted to eating sandstones, chalk, and paper. (...) When at school, teachers would be using chalk to write. If they left a small piece there, a voice would tell me to take the chalk and eat it. (...) After that, I graduated from eating chalk to magazines. I would start by taking the magazine and smelling it. With the smell of ink, the way it smelt would please me. I would start by tearing it and then I would start eating it. (...) I do eat food but after eating food, there would be a voice telling me “After eating this, you should go and eat the paper, chalk or sandstone.” I would eat and drink water; then I would be full. But if I don’t eat those things, I will not be full” (Emmanuel TV, 2013).

Her testimony further suggests that she experiences her behavior as a burden, as she has “been to many places for deliverance from the spirit” (Emmanuel TV, 2013). After having told her story, the prophet elaborates that “The degree of this demon is more than whatever you [the audience] are complaining about” (Emmanuel TV, 2013). He then directs a doctor to give her ‘anointed water’, said to contain healing powers of God (SCOAN, n.d.), whereafter the woman falls loosely onto the ground. Then, the same water is used to wake her up, while calling for Jesus and saying ‘You are free’. After the ritual, the woman rejects a magazine offered to her to consume: “I don’t feel like eating them anymore, they don’t taste good” (Emmanuel TV, 2013).

Later, the woman testifies again, now summing up several health consequences of her addiction that she did not mention before. After being diagnosed with anaemia, she was prescribed a specific diet yet continued consuming sandstones, chalk, and paper. After the anointed water ritual, she claims to be symptom free and “delivered and free from this spirit forever” (Emmanuel TV, 2013).

Here, too, similar symptoms are perceived differently, namely, as an eating disorder in the West and as spirit possession in Nigeria and South Africa. What biomedicine might call the ‘eating disorder voice’ is understood as a demon. It is important to address such differences in understanding, as the framing of symptoms determines the chosen treatment as well as social acceptances, hence the value of medical anthropology.
2. Restrictive eating disorders

Restrictive eating disorders are thought to be rare in Africa. Authors supporting the culture-bound syndrome approach conceptualized eating disorders as a Western culture-bound phenomenon that results from certain pressures within Western society. Consequently, possible eating disorders outside the West were not studied. Also, the African continent has long been considered next to immune for restrictive eating disorders. This conviction may hold different layers. First, the full-figured African beauty ideal can be viewed to act as a protective factor (Villarosa, 1994; Adegoke, 2013). While in Western countries thinness is favoured, African countries embrace overweight as a symbol of wealth (see III, 1.1.). Thus, in traditional African settings, pursuing unhealthy weight loss for beauty would be rare. Second, ongoing stereotypes of Africa as a poor continent emphasize famine and malnutrition. In this regard, surviving is number one priority, thus weight and body concerns are believed to be absent. These views may see anorexia nervosa and obsessive dieting as first world luxury problems. Third, challenges in African psychiatric research and practice may cause knowledge and treatment gaps. The following paragraphs further elaborate on each of these factors.

2.1. Culture as a protective factor

Traditional beauty ideals for African women have always tended to include a large body, as fatness is celebrated as a sign of wealth and fertility (Gordon, 2001). This African full-figured ideal may suggest that culture serves as a protective factor in the adoption of restrictive eating disorders. However, traditional body size ideals have been challenged through enhanced globalisation, increased awareness of health risks related to obesity, and foreign interventions. Amenyah & Michels (2016) examined body size ideals, body size beliefs, and body size dissatisfaction among Ghanaian adolescents in Accra. Concerning sexual attractiveness, they found that the majority did not prefer to have overweight bodies. Generally, they also disagreed that boys prefer overweight girls. Body dissatisfaction was high, with more boys reporting that their body was too thin and more girls reporting that their body was too heavy.
Adegoke (2013, p. 22, and references therein) adds that differences in worldview may also contribute to the assumed protection. Where Africans emphasize spirituality, collective unconsciousness, kinship, an interconnectedness of all things, and a collective identity, the European worldview is more individualistic and personally competitive (Celious & Oyserman, 2001), two factors assumed to be risk factors for eating disorder development. Research suggests that women who sustain an Afrocentric orientation tend to be more flexible towards beauty ideals, and are generally more accepting of African aesthetics (i.e. skin colour, hair texture, larger body shapes). On the other hand, black women who internalize Eurocentric values are prone to disturbed eating behaviours and poor body image (Adegoke, 2013). This internalization of Western values is called ‘acculturation’.

2.2. Africa as a continent of misery

Eating disorders are frequently regarded as first world luxury problems, while Africans have to deal with ‘real’ problems. In the media, Africa is often portrayed as a continent of misery, allowing for Europeans to take up the role of saviour (Attiah, 2016). This behaviour is named the ‘white saviour complex’, referring to the need of white persons to help non-white people. It is not just an act of altruism, as the help offered is in some contexts believed to be self-serving. The term is based upon Rudyard Kipling’s poem ‘The White Man’s Burden’ (1899) (Halsall, 1997), in which he presents the Eurocentric belief of the Western world that white men are morally obligated to civilise non-white people through colonialism. However, the narrow viewing of Africa as a continent of backlog denies Africans a reality of their own.

Some of the problems associated with the African continent include violence and famine. Indeed, different African countries report situations of atrocities, war, and corruption. Recent famines in Africa include the 2005-2006 Niger food crisis, the 2010 Sahel famine, and the 2011 drought in East Africa (AghaKouchak, 2015). In this regard, one might assume that Africans would rather be concerned with physical survival than with mental health. However, reducing the African population to people in need neglects local complexities. Also, it is only logical that situations of misery co-occur with mental health issues (Foster & Brooks-Gunn, 2015).
2.3. Challenges in African psychiatry

2.3.1. Underdevelopment of African psychiatric research

For many years, mental health research in Africa has been underdeveloped (World Health Organization, 2011). The spectrum of psychiatric disorders studied as well as the research output are limited. For instance, up until 2004, the most frequently studied disorders in Africa were depression and anxiety, substance use, and psychoses (Sharan, Levav, Olifison, de Francisco, & Saxena, 2007). Many others, amongst which dementia, eating disorders, learning disorders, personality disorders, and suicide, had not gained much attention. Due to this underdevelopment, we cannot be sure about the extent of eating disorder pathology in Africa.

Challenges to increase mental health research in Africa include human resources, funding, poor institutional infrastructure, weak peer networks and collaborations, access to information, and protocol review (Ndeitei & Szabo (eds.), 2011). Skilled mental health researchers and psychiatrists are limited in Africa, with almost no possibility to significantly increase research capacity, due to lack of substantial financial support and development of researchers (World Health Organization, 2001). Funding is limited because governments spent very little budget on mental health (Sharan et al., 2007). Also, many African researchers do not have strong links with their colleagues in high income countries. Furthermore, access to current online journals is limited because most issues tend to incur a charge (Sharan et al., 2007). Lastly, the inefficiency of mechanisms in many African countries, such as the frequently delayed process of getting approvals, causes researchers to get frustrated and potential study sponsors to be hesitant to invest in such projects (World Health Organization, 2001).

Additionally, it is important to not see Western psychiatry as the only solution towards understanding mental illness. For instance, as mental illness in Africa is often attributed to spirit possession, many Africans turn to traditional healers to explain and treat health problems believing that they have expertise on these factors (Sorsdahl & Stein, 2011, cited in Ndeitei & Szabo (eds.), 2011). Therefore, it is
important to acknowledge their role and recognize them as health care professionals.

2.3.2. Access to care

Apart from lack of financial means, there can be other barriers to get professional help. With regard to access to medical services, it is illustrated that various social and cultural factors act in different ways to deny ethnic minority groups access to such care (Ndetei & Szabo (eds.), 2011). Also, help-seeking behaviour is influenced by cultural beliefs. For instance, in many African population groups mental health problems are attributed to ancestors or bewitchment (Stroeken, 2013). Therefore, it is crucial to work within the cultural framework and to deliberately seek to understand the barriers to psychiatric care. Migration also appears to be a risk factor for mental health problems. According to the UNHCR (United Nations High Commissioner for Refugees), Africa hosts large refugee populations that have fallen victim to political and social unrest. Their mental health needs are often greater than those of the native populations, yet the resources they are offered are significantly less (Ndetei & Szabo (eds.), 2011).

In South Africa during apartheid, the organisation of psychiatric care for blacks was subordinate to that for whites. In 1979, a report by a committee of the American Psychiatric Association (APA), which had specifically investigated psychiatric facilities in South Africa, stated that “medical and psychiatric care for blacks was grossly inferior to that for whites” (APA Committee, 1979, cited in Szabo & Le Grange, 2001). Szabo and Le Grange (2001, p. 27) write that “this resulted in significant inequalities in terms of health care to the degree that some disorders were regarded as the ‘domain’ of one racial group as opposed to the other”. Eating disorders were considered as first world ‘elitist’ diseases and thus were not thought to occur in non-Caucasian communities. As a result, the actual extent of eating disorders during the apartheid years is unknown (Szabo & Le Grange, 2001).

Also, sometimes language rather than culture acts as a barrier for accessing psychiatric care. Lambo (1956, cited in Ndetei & Szabo (eds.), 2011) gives the following examples: “The word for depression in Kiswahili is sononeka. Many
Swahili speakers use the Kiswahili word *kukasirika* (to be angry) to mean depression. Patients then point out that they are not angry but just not happy. Similarly, the Swahili word for suicide is *kitanzi*. Not many doctors know the word and therefore fumble around the subject”. It is thus crucial for a psychiatrist to learn and understand the local language, idioms, and nuances.

3. Common trends and concerns on anorexia nervosa in Africa

Despite these convictions, anorexia nervosa has sporadically been described in African countries since the 1980s. The countries mentioned were Nigeria (Nwaefuna, 1981; Famuyiwa, 1988; Oyewumi & Kazarian, 1992), Zimbabwe (Buchan & Gregory, 1984), Kenya (Njenga & Kangethe, 2004), Egypt (Nasser, 1986), Tanzania (Eddy et al., 2007), Ghana (Bennett et al., 2004), and South Africa (Szabo & Hollands, 1997). These studies have all made use of self-report questionnaires based on Western samples, such as the Eating Attitudes Test [EAT-40 and EAT-26] and the Eating Disorder Inventory, which may raise questions on their validity (see I, 1.; IV, 4.1. & 4.2.).

Reviewing the cases of reported eating disorders in Africa, Szabo (2009) found that black sufferers seemed to have a greater tendency towards developing bulimia nervosa rather than anorexia nervosa. This might simply reflect the fact that bulimia is more common than anorexia (American Psychiatric Association, 2000), however, it can also be related to urbanization, given the extent of it in Africa (Szabo, 2009). This is argued by the findings that bulimia nervosa is more environmentally mediated, whereas anorexia nervosa is more genetically mediated (Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997), and that urbanization has been postulated as a risk factor for the development of bulimia nervosa (Hoek et al., 1995; see III, 1.1.). However, this hypothesis should certainly be further examined, as the process of urbanization is multi-faceted and to date no specific factors have been directly associated with bulimic symptoms (Szabo, 2009).

Also, just as sufferers in Asian settings (Lee, 2009), African anorexics appear to not always present weight phobia as a clinical feature (Szabo, 2009; Bennett et al.,
2004). This raises an important issue about the centrality of direct weight concerns in the onset and progress of the disease. In certain cases, weight loss seemed merely a side effect of a process (involving altered dietary intake) that was motivated by reasons that had nothing to do with weight concerns or body dissatisfaction. Szabo (2009, p. 74) says that “the question arises as to whether they truly were eating disorders, or whether such cases challenge the established phenomenology of eating disorders i.e. that inappropriate weight concerns are central”.

Indeed, the absence of weight phobia raises questions on the universality of Western derived systems such as the DSM. In this regard, Lee (1993, p. 300) proposed an alternative set of ‘culture-free’ criteria of anorexia nervosa, considering the various forms of eating disorders noticed outside the West (see Table 1). Weiss (1995) notes that the innovative features are in the criteria on weight phobia and on disturbed body image. Instead of the DSM-IV criterion that specifies fear of gaining weight and becoming fat, Lee suggests phenomenological criteria based on what patients do to achieve or maintain dramatic weight loss. Similarly, the DSM-IV requirement of disturbed body image is replaced by one or more of various alternative motives for pathological fasting, based on extensive research and clinical experience.

Such a ‘culture-free’ proposal may entail different implications, especially for the prevalence of eating disorders in so-called traditional societies, where cases relative to those in Western society appear to be absent. It might demonstrate that eating disorders as such are not culture-bound, but rather that the criteria used are culture-bound. Cases outside the West may show similarities to Western cases and have unique features determined by culture-specific factors, leading to a more inclusive understanding of eating disorders (Szabo, 2009).

Furthermore, Szabo (2009) writes that the prevalence of anorexia nervosa and bulimia nervosa is influenced by milieu and value systems (acculturation) rather than by race. Blacks in urban settings even appear to show higher (Szabo & Hollands, 1997) or equivalent (Le Grange, Telch, & Tibbs, 1998) rates of abnormal eating attitudes compared to their white counterparts. Cini (2000) found that adoption of and exposure to Western beauty ideals and rejection of one’s own cultural values
increase the risk of disturbed eating attitudes, a process called ‘acculturation’ (see I, 1.; II, 4.1.; III, 2.1.). In the words of Szabo (2009, p. 16), acculturation describes “a phenomenon that results when groups of individuals from different cultural backgrounds come into first-hand contact, leading to changes in the original cultural patterns of both groups.” In the African-American community, cases have been reported of African-American women in the middle to upper classes who had comparable views on eating behaviours, attitudes, and body image as white women from the same social class (Williamson, 1998; Kempa & Thomas, 2000; Anderson & Hay, 1985). These findings encompass the idea that different levels of acculturation, rather than ethnicity, influence eating disorder prevalence. As a result, they also call for the hypothesis of white exclusivity when it comes to eating disorder prevalence to be reviewed.
PART IV: ANOREXIA NERVOSA IN SOUTH AFRICA

Although studies focusing on anorexia nervosa in African countries remain scarce in comparison to research focused on the West, academic attention is growing. In South Africa, pioneering work has been done by Prof. dr. Christopher P. Szabo, professor and psychiatrist at the University of the Witwatersrand in Johannesburg.

1. The first case reports

In South Africa, anorexia nervosa has been reported since the 1970s (Beumont, George, & Smart, 1976). These descriptions were however of hospital-based, clinical samples involving white females. In 1993, Christopher Szabo, who would become the leading expert on eating disorders in South Africa, first diagnosed anorexia nervosa in a black South African female (Szabo, 2009). In the following years, more cases were discovered. At the time, no blacks had been referred for treatment, in contrast to the extensively studied occurrence of eating disorders in white South Africans. The question arose whether these initial cases were part of an emerging phenomenon.

It became clear that eating disorders in blacks emerged specifically in urban settings, for instance at privately funded schools, that after apartheid became racially heterogeneous but remained dominated by an Anglophile ethos. As a result, students, blacks as well as whites, were prone to adopt Western values. Given the existing literature on the link between acculturation and eating disorders (Furkawa, 1994), one could presume that black females in such a setting might show a tendency towards the development of an eating disorder. When the hypothesis was tested by Szabo, it confirmed that a great number of black respondents demonstrated signs of disturbed eating attitudes (Szabo, 2009).

Intrigued by this, Szabo conducted further PhD research on the emergence of eating disorders among black adolescents in urban settings. He found that such adolescents showed eating attitudes and body figure preferences similar to their white counterparts, while black adolescents in rural settings differed in this regard.
as opposed to urban black and white adolescents. Thus, Szabo concluded that setting, rather than race or ethnic group, was a contributing factor on both eating attitudes and body figure preferences. This was an important discovery in terms of nuancing the idea that only whites were at risk of developing eating disorders (Szabo, 2009).

However, despite Szabo’s attention to the increasing number of black eating disorder patients, it was not reflected in the clinical reality (Szabo, 2009). Between 1998 and 2004, a total of 13 black female patients were admitted to a specialised eating disorder unit at Tara hospital, affiliated with the Division of Psychiatry at the University of the Witwatersrand in Johannesburg. 7 of them were diagnosed with anorexia nervosa (Delport & Szabo, 2008). During the same period, there had been a total of 435 admissions to the unit, hence black females accounted for only 3% of all inpatients. The criteria used for diagnosis were those of the DSM-IV, the then current edition of the manual (American Psychiatric Association, 1994). However, the actual number of cases might be higher, for not all eating disorder sufferers get professional help and thus are not counted in such statistics. These inconveniences also question the cultural relevance of the instruments used in South African eating disorder studies, namely, the EAT-26 test and the Eating Disorder Inventory, as they were both developed in the West (Garner, Olmstead, & Polivy, 1983). We will get back to this later (see IV, 4.).

2. Socio-political background

To understand the rise of disordered eating habits among blacks, it is necessary to look at the socio-political background in which they emerged. For the last few decades, South Africa has been a country in transition (Bornman, 1999). In 1990, apartheid was abolished, the policy of the white nationalist government that sought to create a racially divided society as well as to actively discriminate against those of colour. The apartheid policy carried out an extreme white superiority that had far reaching consequences for people of colour, even after abolishment. One discrimination against non-white people included the isolation of all ethnic groups in different ‘homelands’ situated outside the so-called ‘white’ South Africa.
When Nelson Mandela, the leader of the main liberation movement, was released from jail, an end was put to the apartheid system. In 1994, the first multiracial elections took place and a new political era emerged. However, the mindset of apartheid is still visible in daily life.

2.1. Racial integration and culture change

Since the abolishment of apartheid in South Africa, transformations have happened in many aspects of societal functioning, including racial integration of schools, affirmative action in the workplace, and African migration to urban areas. Also, as South Africa’s reputation has been restored to that of an acceptable member of the international community, cultural exchange is now common. However, the initial euphoria soon made way for the difficulties of turning a fractured country into a unified nation (Szabo & Le Grange, 2001). In this regard, South Africans are faced with “the heavy burden of creating a new national identity” (Szabo & Le Grange, 2001, p. 28).

It is in this changing societal context that the emergence of eating disorders among blacks must be understood. Different factors are at stake. One transformation was the increasing racial integration of formerly segregated facilities (Swartz, 1996). The abolition of apartheid made Africans more mobile as laws that restricted their movements were withdrawn (Le Grange, Louw, Breen, & Katzman, 2004). Szabo (2009, p. 19) says that “cultures that previously co-existed as almost mutually exclusive entities are now engaging”. Consequently, beliefs and value systems may be evolving towards being homogeneous in certain settings. Thus, black South Africans were increasingly exposed to Western culture and therefore also to its emphasis on physical appearance.

This racial integration was specifically noticeable at privately funded schools, dominated by an Anglophile ethos (Szabo, 2009). For students in such school systems, the changing societal context coincided with adolescence, a time marked by issues of identity and increasing self-awareness. On top of that, black students were confronted with their white counterparts upholding Western ideals of beauty and body size. They thus had to deal with both personal and cultural transitions in
a system that still favoured Western values. As identity issues and change often contribute to eating disorders (Netten, 2017; Di Nicola, 1990; see II, 4.1.), such students became vulnerable to developing disturbed eating attitudes (Szabo, 2009).

Additionally, the new ideologies encouraged a shift from African collectivism to Western individualism and competitiveness. Stevens and Lockhat (1997) describe the emergence of a ‘Coca-Cola culture’ among black adolescents, referring to American individualism, competition, individualistic aspirations, and general worldview. Black adolescents thus find themselves in a split between the apparently contradictory expectations of pre- and post-apartheid, which may result in confusion rather than integration. They are at the same time merging with Western values and alienating from their own traditional realities. Bulhan (1980), who calls this phenomenon ‘culture in-betweenity’, argues that the process of acculturation may lead to these black adolescents experiencing a psychological tension, as they are straddling different worlds that are inherently alien to each other. As eating disorders feed on tension and confusion, and on consequent feelings of loss of control, it can firmly be argued that these dynamics play a role in the emergence of eating disorders among black South African females.

Thus, within the racially mixed urban setting, eating disorders emerge in black and white groups, with reports in the black groups increasing. In rural areas, however, this appears not to be the case, suggesting that the environment is preventative in this regard (Szabo, 2009). Szabo (2002, cited in Szabo, 2009) found that at urban schools, black pupils demonstrated eating attitudes and body figure preferences similar to those of white pupils, irrespective of the race ratio. Also, different home language groups yielded no differences regarding eating attitudes, signalling a homogenisation within the urban black group. Grouping diverse ethnicities together as ‘black’ entity could have been too generalizing, but given Szabo’s findings, it appears to be an applicable approach (Szabo, 2009).

2.2. Women’s roles in the ‘new’ South Africa

In recent years, black South African women have experienced significant emancipation in various domains, such as business, corporations, and politics.
Women are now occupying positions of authority and responsibility and are thus being confronted with more pressures. Also, these responsibilities co-occurred with changing views on the body. In a news article, Philp (1999, cited in Szabo & le Grange, 2001) described the passage of a black woman from domestic servant to fitness enthusiast and spinning instructor in an almost exclusively white health club in Johannesburg. She says that the notion of fat as an African status symbol of wealth and abundance is ‘rubbish’. Szabo and le Grange (2001) write that notions of praising African fatness are not necessarily shared by black women in modern-day South Africa: “For some women in South Africa (...), wealth and success is associated with something other than indulgence. In fact, restraint, discipline, and self-control seem more suitable ways to demonstrate achievement” (Szabo & le Grange, 2001, p. 30). The authors illustrate this with increasing numbers of black women joining health and fitness clubs.

Additionally, the changing roles evoke in black women questions and conflicts of identity. As black women find themselves more and more involved in professional spheres, they are confronted with seemingly opposing identities. On the one hand, they aspire achievement in Western terms and are thus confronted with Western values, whilst on the other hand, they want to embrace a new-found pride in being African, in its culture, psychology, and literature. Howe (1999) called such pride in one’s African heritage ‘Afrocentrism’, as opposed to Eurocentrism. Afrocentrism emphasizes African agency and self-determination. It can be placed within the greater ideology of ‘Pan-Africanism’ that arose as a result of the many African dependency struggles and aims to support and strengthen bonds of solidarity between all people of African descent (Falola & Essien, 2013). Afrocentrism can also be seen in the so-called ‘natural hair movement’ encouraging women of African descent to keep their natural afro-textured hair (Metcalf & Spaulding, 2015).

Trying now to combine these two aspects of identity may create considerable psychological confusion in black women. If some of the central dynamics of eating disorders concern issues of identity, eating disorders may be one way in which this search for identity in black South African women is expressed (Szabo & le Grange, 2001). This is reminiscent of Katzman and Lee’s (1997) hypothesis of women ‘straddling two worlds’ at the end of the 20th century, who turned to food denial to
cope with the turmoil they encountered following transitions in gender roles. A related struggle is the one Ifekwunigwe (1999, cited in Szabo & le Grange, 2001) refers to as ‘the dynamic construction of identities in a globalizing world’. As part of these struggles, write Szabo and le Grange (2001, p. 29), “we suggest that a previously narrowly defined role prescription for black females is making way for one that creates room for greater choice and opportunity. It is in the way in which this challenge is addressed, at least in some individuals, that eating disorder pathology may become more evident”.

2.3. Discussing Westernization: body dissatisfaction and media exposure

It may be argued that with the pervasiveness of Western values, an increasing amount of South African women display body dissatisfaction. This can be motivated by the fact that, apart from individual factors such as low self-esteem and depression, body dissatisfaction appears to be influenced by sociocultural pressures, such as, in this case, idealized media images and a thin Western beauty norm (Mwaba & Roman, 2009, and references therein).

Indeed, studies conducted among urban black South African females mention increased rates of body dissatisfaction (Szabo et al., 1995; Szabo & Allwood, 2004; Szabo & Allwood, 2006). For instance, Szabo and Allwood (2006) found that 61% of their urban black respondents desired to be smaller, whereas rural black respondents were more evenly divided among those who were content (31%), desiring to be larger (29%) and desiring to be smaller (40%). The percentage found in urban white respondents (72%) was not much higher as opposed to the one in urban blacks, suggesting a racial homogenization considering body figure preferences in urban settings.

However, other studies report no such body dissatisfaction (Pedro et al., 2016; Mwaba & Roman, 2009). Mwaba and Roman (2009) conducted a study on body image satisfaction among black female university students in South Africa. They were motivated to do so because previous body image research in South Africa mainly focused on white women. The authors used a culturally revised version of the Body Shape Questionnaire, a tool to establish body shape satisfaction and
perception of body size (Cooper, Taylor, Cooper, & Fairburn, 1987). The questionnaire included 34 items measuring beliefs about body shape and attitudes towards it.

The sample included 150 female students in an introductory psychology class at a university in the Western Cape province. The girls were predominantly from middle income families and were exposed to Western media through magazines, television programs, movies, and advertisements. The results showed that a great number (76%) of participants were not ashamed of their body. The authors write that “only 30% felt that naked made them feel fat, while 60% did not believe that their thighs, hips, and bottom were too large for the rest of their body (69%) and thus did not avoid clothes that made them aware of their body shape (68%). Almost all the women reported that their body shape had little influence on their lives with 91% indicating that they enjoyed going out to social occasions while 89% did not feel eating a small amount of food would make them feel fat. Only 10% reported that they avoided running because their flesh might shake, while 15% indicated that they had felt so bad about their body shape that they had cried and 9% were worried about taking up too much space when they were with other people” (Mwaba & Roman, 2009, p. 907).

Nevertheless, 56% of the participants reported concerns of becoming fat or fatter. These girls expressed the need to start exercising or go on a diet and, to a lesser extent, start vomiting and taking laxatives (Mwaba & Roman, 2009).

Assumed media influences in the rise of eating disorders among black South Africans also must be addressed carefully. Carney and Louw (2006) investigated the relationship between media exposure and EAT-26 scores among South African university students. The findings showed that the higher the media exposure, the higher the EAT-26 were, which might suggest a link between media exposure and eating disorders. However, the EAT-26 scores did not exceed such levels that would be suggestive of an eating disorder. Additionally, follow-up interviews revealed that media alone was not linked to disturbed eating behaviour, and that subjects actively
sought out media images. Thus, the relationship is not simply one of cause and effect but rather more complex.

These findings suggest that the impact of ‘Westernization’ in the emergence of eating disorders among black South Africans should be addressed cautiously. Whereas some patients may adopt thin body preferences and get influenced by media images, others may not. Westernization is not strictly linear in the sense that the more patients relate to Western culture, the higher their disturbed eating attitudes would be. Furthermore, Westernization may be intertwined with local value systems in different ways. Whilst it is true that Western culture has an impact, there appear to be individual differences as to what extent and in what way it plays a role in the experiences of South African eating disorders sufferers. Therefore, it is important to always start for the individual’s own experience.

3. The problem of self-report questionnaires

3.1. Limitations in cultural translation

The last decades, a large number of community-based studies using screening questionnaires have implied the emergence of eating disorders in the black community in South Africa (Szabo & Hollands, 1997; Le Grange et al., 1998; Senekal et al., 2001; Caradas, Lambert, & Charlton, 2001). However, this is not represented in the clinical reality, as only a few reports exist of clinical cases of black eating disorder sufferers (Szabo et al., 1995; Szabo, 1999; Gabriel & Szabo, 2001; Delport & Szabo, 2008). One reason for this under representation might be that black patients do not easily find their way to professional treatment resources, due to stigma or culture gaps between them and the (often white) therapists.

However, the difference in representation of blacks between clinical studies and community-based studies using self-report surveys may also suggest that in black samples, the meaning of data derived from these questionnaires might be different, despite similar results to those of white samples (Szabo, 2009, p. 79).
The standard EAT takes under 10 minutes to finish and consists of questions gauging attitudes, concerns, and behaviours related to food, weight, and body shape. For each question, respondents are asked to pick one of five options ranging from ‘always’ to ‘never’. Those responses are then scored, with a maximum of 3 for an extreme option chosen, scores of 2 and 1 for adjacent options, and a score of 0 for any of the others. A total score of 20 or more is suggestive of disturbed eating attitudes and behaviours. (Garner, Olmstead, Bohr, & Garfinkel, 1985). EAT questions can be clustered to represent three aspects of eating related psychopathology: “the ‘dieting’ subscale, which reflects a preoccupation with being thinner and avoidance of fattening foods, the ‘bulimia and food preoccupation’ subscale, which reflects items describing thoughts about food as well as bulimic behaviours, and the ‘oral control’ subscale, which reflects the extent to which the individual exercises restraint around food or feels under pressure to gain weight” (Szabo, 2009, p. 121-122).

Le Grange et al. (2004) criticize such self-report questionnaires. They combined EAT and EDE-Q (Eating Disorder Examination - Questionnaire) surveys on eating disorder attitudes in South Africa with interviewing those who scored high on the eating disorder measures. That way, they attempted to take on a more relativistic point of view, starting from the experiences of respondents themselves. The authors criticize self-report surveys that are not followed by such interviews, and thus do not pay attention to the meaning of these survey items for black African respondents. In this regard, Swartz (2001, p. 34) writes that we do not know “whether self-report instruments of disordered eating have the same predictive value of disordered behaviour [in South Africa] as has been found elsewhere in the world.” Additionally, although translated versions of the EAT exist in several languages (Nasser, 1998), translations of words alone may not be sufficient to address Swartz’ concern regarding the meaning of such questionnaires (Le Grange et al., 2004).

As the EAT does not consider explanations of the reasons of behaviour, the interviews following Le Grange et al.’s surveys (2004) yielded some unexpected findings. For example:
“When respondents were asked if they found themselves preoccupied with food, some of the interviewees had indicated on the EAT-26 that this was always the case. However, the reason for this was not indicative of someone exhibiting disordered eating symptoms. Instead, the reason given in two cases, as recorded by the interviewer, was that their ‘family is poor, there is not always food in the house, and thus [they are] constantly hungry and thinking about food.’” (Le Grange et al., 2004, p. 449)

Another explanation concerned the habit of vomiting:

“When responding to the EAT-26 question whether they vomited after they had eaten, most of the interviewees indicated that they never did. However, one participant reported that she occasionally did. In the interview, two reasons were offered to explain the ‘purging’ behaviour. First, the participant indicated that she would sometimes vomit after eating ‘pig’s meat.’ When she was very hungry and that was the only food available, she would have to eat it. However, it was not allowed to digest in her stomach due to her cultural beliefs, and she would therefore have to vomit it up after she had eaten it. Second, she also induced vomiting as part of an internal cleansing ritual to protect the body from sickness.” (Le Grange et al., 2004, p. 449-450)

Thus, the reasons for endorsing preoccupation with food or vomiting were not due to eating disorder concerns, but rather to cultural habits and economic circumstances. This means that young black females endorsing in self-starvation attribute to their symptoms a different meaning from what would typically be expected from someone with an eating disorder. Also, in the interviews, it became clear that many respondents had struggled to understand the survey as it was written in English, even though English was the language of instruction at school. Subsequently, some of them just circled any answer when they did not understand the question. When the interviewer explained the same questions again, they provided different answers than the ones originally given (Le Grange et al., 2004).

Unlike the EAT-26, the EDE-Q specifies that the described behaviour must occur for weight or shape concerns. Therefore, it requires explanations. This specification
appeared to be relevant. For example, it was noted that common laxative use was due to prevent constipation given the high-carbonate foods in their everyday diet. Without this explanation, frequent laxative use may easily be attributed to eating disorder pathology (Le Grange et al., 2004). However, problems of cultural disconnect equally arose when the interviewees were asked whether thinking about food had a significant impact on their ability to concentrate on things that interested them. Here, as in the interviews following the EAT, those who answered affirmative ascribed it to the fact that food was scarce, and that “at times they were so hungry that they could not concentrate or think about anything but food.” (Le Grange et al., 2004, p. 451)

In this regard, it might be questioned whether the degree of eating disorder psychopathology among young black South Africans is actually that high. To clarify this, official records should be reviewed using a qualitative, anthropological approach.

3.2. Validating the EAT-26

As we have seen, simply copying the standard Eating Attitudes Test to an African context has its limitations. Following Szabo’s PhD research (Szabo, 2002, cited in Szabo, 2009), efforts have been done to address those limitations. In 2004, Szabo and Allwood applicated the EAT-26 in a rural, Zulu speaking, adolescent population in South Africa. Compared with EAT-26 scores in urban sample, the rural sample appeared to score significantly lower in any case. This paper and Szabo’s PhD work were important for two reasons. First, it was the first time that eating related pathology was researched in a rural setting, using a translated Zulu version of the EAT-26, while previous cross-cultural research worked with respondents of rural origin in the English language version. Second, the EAT-26 was subdued to a validation process. In urban samples, the wording of the questionnaire was altered to meet issues of language sophistication and familiarity, which could have impacted how respondents interpreted the questions. For example, in various schools, the word ‘impulse’ was replaced by the word ‘urge’ after having consulted with the school Principal on language and terminology. In the rural sample, the questionnaire
was translated into Zulu by a Zulu speaking psychologist familiar with eating disorders.

Nevertheless, says Szabo (2009, p. 122), “reliability could not be assumed (...) Clearly issues of both reliability and validity are critical both in terms of applying the EAT-26 and interpreting data from this [the rural Zulu] group.” According to Hammond (1995), reliability questions whether a test measures anything at all, whilst validity asks whether the test measures what it claims to measure. Hammond (1995) also wrote that validity can be tested in three ways: ‘content validation’, ‘criterion validation’, and ‘construct validation’. In retrospect, Szabo (2009) applied those ways onto his earlier research (Szabo, 2002, cited in Szabo, 2009).

‘Content validation’, also called ‘face validity’, involves a subjective evaluation of the relevance of the question items by the researcher. Szabo found that at first sight, the EAT-26 questions were relevant to the ideas being examined. Also, they were assessed by professionals in the field and could be accurately interpreted following consultation with the relevant educational authorities. Moreover, Szabo had experience using the questionnaire and was thus quite familiar with the content. Therefore, he concludes that the EAT-26 was employed on the basis of apparent content validity. However, as content validation lacks objectivity, it has not been given much credence (Szabo, 2009).

‘Criterion validation’ considers to what extent the test is predictable. It consists of two components, a predictive and a concurrent component. It has been shown that the validity of the EAT-26 is rather postdictive than predictive (Hammond, 1995), meaning that the test scores can accurately pick anorexia nervosa sufferers from normal controls, whilst in the other direction, high scores do not always indicate an eating disorder. This is reminiscent of the work by Le Grange et al. (2004), who found that respondents showing high scores on the EAT-26 attributed to their behaviours a different meaning that was not eating disorder related. Thus, in terms of predictive validity, the prevalence of abnormal eating attitudes in Szabo’s findings does not necessarily reflect the prevalence of eating disorders. With regard to concurrent validity, the findings of the relationship between mean EAT-scores in the urban samples, and age and body figure preferences, showed a predictable higher
EAT-26 score for older respondents and for those who desired to be smaller. This was not the case in the rural sample (Szabo, 2009).

‘Construct validation’ examines whether the internal variables are consistent. If so, the results can be considered as an actual indicator for what is being measured. To test this, Szabo (2009) uses Cronbach’s α coefficient, which is a statistical estimate of the lower bound of reliability in questionnaires (Cronbach, 1951). The higher the α value, the better the question items correlate. In Szabo’s study, each sample demonstrated Cronbach’s α values greater than 0.6, which generally reflects internal consistency. The highest α value was calculated for the urban white sample (0.85) and the lowest for the rural sample (0.61) (Szabo, 2009).

Given the low positive predictive value of the EAT-26 in terms of detecting actual eating disorders, it has been proposed that EAT-26 scores should rather be categorised in terms of potential risk for developing an eating disorder (Szabo, 2009, and references therein). A score of less than 10 would then indicate no risk, 10-19 would denote a low risk, and 20 or above would denote a high risk. Following this categorisation, 70.64% of the rural black sample, 43.43% of the urban black sample, and 50.59% of the urban white sample in South Africa would have been given the label ‘no risk’. It is interesting that urban blacks thus experience more risk than urban whites (Szabo & Allwood, 2004a). Compared with European samples, says Szabo (2009, p. 134), “it appears that South African samples are inclined to score higher on the EAT-26 which either reflects the extent of problematic eating attitudes or the way in which South African respondents interpret questions”.

3.3. Differences in EAT-26 scores

Although the situation may be changing, one might assume that dieting and reduction of food intake for non-medical reasons are generally more prevalent and acceptable in the white community. However, when comparing the total EAT-scores of the urban white and the urban black sample, Szabo (2002, cited in Szabo, 2009) found no significant difference. Zooming in on the subscales, it even appeared that the black sample scored significantly higher on the bulimia and oral control subscales as opposed to the white sample, whilst scores for the dieting subscale
were similar amongst both racial groups. The oral control subscale reflects the extent to which an individual presents dietary restraint around food or feels socially pressured to gain weight. Szabo (2009, p. 130) explains that "given that traditional black culture places a positive emphasis on eating and size, it may be that younger blacks may need to exert greater control in a milieu that actively supports food consumption as the parents are likely to be more traditional". As dietary restraint may lead to binge eating and associated compensatory behaviour such as purging, it is logical that the black sample scores higher on the bulimia subscale. However, it can be questioned whether the connection between dietary restraint and binge eating is universal (Szabo, 2009).

Regarding the prevalence of high EAT-26 scores in black versus white students, there appears to be a difference between studies conducted in state schools and those conducted in privately funded schools. In state schools, EAT-26 scores amongst urban black and white respondents were approximately identical (Szabo & Allwood, 2004b), while in private schools, the black sample showed significantly higher scores (Szabo & Hollands, 1997). Thus, in private schools, blacks appeared to be more prone than whites to demonstrate abnormal eating attitudes. At the time of the study, this difference was explained on the basis of acculturative stress, attributed to the post-apartheid racial integration in school systems that introduced black pupils to a dominant Anglophile ethos.

In their cross-cultural study of adolescent females’ eating attitudes in Johannesburg, Szabo & Allwood (2004b) did not find such difference. It is important to note that the research for this study was conducted only a year after the Szabo and Hollands study. This “would appear to eliminate time as a factor affecting the extent to which eating attitudes in black female adolescents varied i.e. diminishing acculturative stress over time due to increasing cultural homogeneity potentially impacting on the proportion of black respondents reporting abnormal eating attitudes” (Szabo, 2009, p. 136). Rather, the dissimilarity was attributed to differences in school systems. Within urban state schools, as opposed to urban private schools, race appears to be not predictive of the extent to which abnormal eating attitudes prevail.
4. Local meanings of thinness and dysfunctional eating

4.1. A meaning-centred approach

Maybe, instead of discussing the validity of screening questionnaires and the actual prevalence of eating disorders in South Africa, we should start from local meanings of thinness and dysfunctional eating. This correlates with what Di Nicola (1990) called a ‘meaning-centred approach’ to illness, as opposed to a syndrome-centred approach. By taking on a relativistic viewpoint, that is, acknowledging that all cultures are logical within their own context, a more comprehending approach to abnormal eating attitudes can be established, nuancing already that ‘abnormality’ should not reason from universal standards. Not only do these meanings vary from culture to culture, but even within Western culture patients attribute different meanings to their symptoms, hence the complexity of etiological research.

Authors studying such cultural variations of meaning include Pike and Borovoy (2004), Becker (2004), and Katzman, Hermans, Van Hoeken, and Hoek (2004). Pike and Borovoy found that in Japan, meanings of thinness were more about delaying maturity than about beauty ideals. Becker wrote that the shift towards thinness in Fijian women was motivated by economic and social competition where young women identified with media role models of success in modern, consumerist lifestyles. Katzman et al. discovered that Caribbean women used thinness to construct a coherent sense of identity when rapid social change occurred and women were caught between traditional and modern worlds. This is reminiscent of Di Nicola’s (1990) proposal of ‘culture-change syndromes’.

Lester (2004) stated that definitions which reason from body image concern as a cardinal symptom of eating disorders simply affirm existing epistemologies by moulding eating disorders and Western culture in a “kind of circular reasoning” where they are “posited as both evidence and explanations for one another” (Lester, 2004, p. 609). Lee (1996) wrote that research based upon such Western criteria marginalizes atypical eating disorders in non-Western cultures and prevents us from understanding them in their own context. Thus, both authors favoured ethnographic research that aims to understand local meanings and language of thinness and
dysfunctional eating. These factors should be considered in the execution as well as the interpretation of the research (Morris & Szabo, 2013).

4.2. Meanings of thinness and dysfunctional eating among black South Africans

In South Africa, Morris and Szabo (2013) conducted a study on local understandings of thinness and dysfunctional eating among black female students in four KwaZulu-Natal high schools. After apartheid, racial integration made many blacks exposed to Western ideals and pressures towards thinness. Morris and Szabo (2013, p. 339) argue that “this was seen as an internationally unique opportunity to capture society in the process of westernization and identify meanings of thinness across contexts with differing potential for westernization”. The authors examined how in this changing sociocultural context, thinness and dietary practices were perceived and how they interfered with traditional values.

There appeared to be a remarkable restraint among parents not to give their daughters permission to partake in this study, as it concerned a ‘white woman’ talking to them about a ‘white women’s disorder’. Nevertheless, many girls tried to join without parental consent, as they were keen to participate (Morris & Szabo, 2013).

Considering eating disorder experiences, all girls knew some fellow black students who they considered ‘too thin’, but generally they agreed that more white girls were too thin. Most girls thought that eating disorders were not a problem in the black community (Morris & Szabo, 2013).

4.2.1. Meanings of thinness

As primary reasons for ‘getting too thin’, the majority of participants named physical factors and stress. Physical factors included AIDS, tuberculosis, drug abuse, and food shortages (although this was thought to be extremely rare). Stress factors concerned family and financial problems, sexual, emotional, or physical abuse, and social difficulties. Interestingly, girls were seen as more sensitive to stress than boys: “Girls carry their stress, [they] tend to keep quiet and hold it in - it makes them
thin” (Morris & Szabo, 2013, p. 340). In one school, participants made a distinction between ‘sick skinny’, too thin, and ‘nice skinny’, which was seen as trendy. Only in one school body dissatisfaction was named as a reason for ‘getting too thin’, seen in “those [girls] who are caught up in modelling and appearance” (Morris & Szabo, 2013, p. 340). None of the participants spontaneously mentioned dieting as a contributing factor.

Other questions revealed typically Western pressures and desires for thinness. For instance, Naomi Campbell was seen as a ‘nice skinny’ role model. Pressures included fashion, where all the “trendy clothes are only available in small sizes”, attractiveness (“All the popular girls are skinny”, “Boys think they [skinny girls] are hot”), and teasing from peers and family in case of gaining body fat (Morris & Szabo, 2013, p. 340).

Comparison to white peers appeared to have an impact as well. In two schools, it was noted that “white girls are obsessed about their weight and we spend a lot of time with them, so we start comparing ourselves to them and that is where the pressure is coming from. We think if she is fat, then what am I?” In this regard, thinness was perceived as a way to social acceptance and self-esteem. Comparing themselves to their white classmates made black girls more self-conscious about their body: “We are very sensitive about our weight. When I look in the mirror, I just see fat. You try to push it [the pressure] away but eventually it gets to you. You have to look a certain look. If you don’t, there is something wrong with you. If you are fat you, you feel like you are useless. You have to be someone you are not, just to please others and be accepted” (Morris & Szabo, 2013, p. 340).

Additionally, girls in multicultural schools expressed stress caused by conflicting cultural expectations and cultural identity confusion: “We don’t know who we are because we are split between white and black… like its two totally different cultures… like you can’t mix them… you can’t become one person because you have to be one thing at home and another at school so then you end up not knowing your identity”; "It’s confusing… you are sort of like ‘what am I’ and you just can’t seem to adjust to it" (Morris & Szabo, 2013, p. 340).
Thinness was also perceived as a way to construct a more coherent sense of identity: “People comment so much on your weight that weight becomes you. People judge you not for who you are but what you look like, [so] you stop becoming a person [and] wherever you go, people just see your weight. You, you lose your identity, your identity becomes that... you lose your identity to your body, it becomes everything. Then, when you lose weight, everyone compliments you so you feel better about yourself and you want to lose more weight” (Morris & Szabo, 2013, p. 340).

4.2.2. Dysfunctional eating behaviours

Concerning dysfunctional eating habits, skipping meals was mentioned as a result of stress: “It’s too stressful in the mornings to eat breakfast”. In some cases, girls skipped meals because they were embarrassed by the food they brought from home: “We eat different food from white people, like cabbage and phutu [traditional maize] and stuff. It’s not in to eat food like that. It’s embarrassing when white girls ask us what we eat at home or when we bring food from home. Some girls throw that away, they just don’t eat at school”. Also, skipping meals was named as a form of weight control: “We all watch what we eat. It’s difficult to eat at school because everyone judges what you eat” (Morris & Szabo, 2013, p. 340).

Participants were also aware of girls who tried to lose weight by smoking, drug use, diet pills, drinking vinegar, fasting, exercising, purging, drinking hot water before eating, and using herbal laxative preparations. In all schools, purging was acknowledged as a means of weight control, while only a few girls in two schools mentioned altering the quality of their food intake or using ‘diet’ products (Morris & Szabo, 2013, p. 340).

Interestingly, in all schools it was noted that in the Zulu culture, purging is traditionally perceived as a necessary cleanse and a remedy for various physical and emotional maladies. They said that many black people, before eating breakfast, drink water and induce purging: “Like you drink your coffee, they [many black people] drink water and vomit in the morning” (Morris & Szabo, 2013, p. 340). One participant admitted purging after breakfast instead of before to get rid of the food in
her stomach. It is not mentioned why she wanted to do so, although the authors suggest that she may have been using it as a means of weight control. Also, regular laxative use was named as a part of culture. Many girls remembered how they were forced to purge regularly with laxatives when they were younger. When grocery shopping, their mothers also brought home big boxes of laxatives. “They [the family] use them [laxatives] all the time. More than you are supposed to. My mom buys a lot [of laxatives], because she says that when we eat too much sugar or other unhealthy things… she says that we must take laxatives to get rid of all the toxins or whatever” (Morris & Szabo, 2013, p. 340). Here, the act of purging is attributed to cultural and health concerns.

All groups knew girls who engaged in binge eating after having fasted all day at school. Also, they reported that it was customary to eat large quantities of food at social gatherings, particularly traditional, fattening foods, causing pressures to vomit either for weight control or to relieve gastric discomfort (Morris & Szabo, 2013).

The authors conclude that “dysfunctional eating practices in this community may thus be underscored by a wide range of different emotional or social stressors which may be expressed in terms of prevailing cultural idioms of distress and remediated by traditional rituals of purging. These findings suggest the presence of atypical forms of eating dysfunction which could represent a wide range of different subjective motivations and attributions; which may not include body image concern” (Morris & Szabo, 2013, p. 341). As these forms of dysfunctional eating may not be captured by Western diagnostic criteria, and parents and the community may not recognise this behaviour as clinically relevant, many black schoolgirls may be left without the assistance that they need.
PART V: EXPLORING THE FIELD

1. Methods

The best way to test the findings apparent from the existing literature is to conduct intensive fieldwork in black South African communities, using in-depth interviews that start from a relativistic point of view. Unfortunately, time and financial limits hindered the author to conduct such research. This decision was equally supported by the challenges that would be encountered in the field. For instance, finding respondents would be difficult, as black patients are underrepresented in official treatment centres. In fact, these centres appeared to mostly treat white South African sufferers and foreigners. Some centres were even mainly focused on admitting foreigners (http://www.montrosemnor.co.za/).

Instead of doing fieldwork, accounts of black South African patients were sought for in the existing literature and on the internet. In the existing literature, only three case descriptions were found, namely, in the study by Szabo et al. (1995). These cases will be shortly be discussed below. Apart from that, a call for case studies was launched on various social media and eating disorder platforms. On YouTube, there exists a recovery community of patients and ex-patients sharing videos wherein they tell their stories and warn others about the dangers of eating disorders. One such story was made by a black South African woman, Miss Kagiso Matlala, who additionally told about the challenges she had met being a black eating disorder patient. After getting in contact with her, frequent chat conversations followed about the topic in the months between April and July 2018. In these conversations, it appeared to be useful to share personal experiences in order to establish a trusted relationship.

Following the critiques by Le Grange et al. (2004), the aim is not to use such individual cases to prove or contest the prevalence of eating disorders among black South African females. Much more research, quantitative as well as qualitative, is needed to make such claims. Rather, it is more interesting to look at the experiences and challenges of South African sufferers who identify themselves as having an eating disorder. The fact that they identify themselves as such implies that we
should take this for granted. Thus, even though we might doubt whether respondents truly suffer from an eating disorder, we cannot deny them their own reality. In fact, deciding whether if respondents do or do not have an eating disorder upholds the Eurocentric standards we are attempting to question here.

A list of questions was made up to start from in the conversations with Kagiso, gauging her beliefs and attitudes towards her illness. These questions were however not fired one by one, but rather just kept in mind in view of what was being researched. This left the conversation to go its own way, which yielded some unexpected findings.

Unfortunately, despite extensive searching, including several announcements on social media and eating disorder platforms, no other respondents were found to talk to. This may simply be due to not having the right contacts or only using online ethnography, but it can also reflect that black patients are stigmatised and thus do not find their way in general platforms. Another reason may be cultural, namely, that black sufferers, as opposed to white sufferers, less intend to share their vulnerabilities online. Further research may clarify these hypotheses. However, Kagiso’s story on its own is still valuable, as it is a meaning-centred account that expresses her own experiences, rather than an interview based upon Western questionnaires.

Also, different South African professionals were contacted to gauge their views on the topic (see Table 2). First, two treatment centres were contacted, but they could be of no assistance since they mainly treated white South African and foreign patients. Second, a woman was approached who organised a nutrition project in Cape Town, but she appeared to only deal with disease related weight loss. Third, on www.findhelp.co.za, 138 relevant therapists were found to contact by email. The same email was taken up as an announcement in the weekly mailing list of the ADSA (Association for Registered Dietitians in South Africa), which was sent to about 1.500 dietitians in the country. After that, such an email was once again forwarded to various nutritionists found on www.nutrionists.co.za and www.nutrionsociety.co.za. Also, an email was sent to Prof. dr. Christopher Szabo, leading expert on eating problems in black South Africans (see IV, 1.).
The many emails that were sent had little useful response. However unfortunate, this does not mean that black eating disorder patients do not exist, but rather that we don’t know much about it. It may confirm that black patients do not easily find their way to professional help (see III, 2.3.2.).

The professionals that did answer mentioned that they had not or only rarely treated black eating disorder patients. However, nearly all of them found this research to be very interesting and valid. Only four of them said that they could be of significant help, namely, G. Le Roux, Debbie Marais, Yael Kadish, and Christopher Szabo. Some others referred to fellow colleagues, but most of those colleagues did not reply to the email that was sent and two of them said that they could not be of any assistance. A Skype interview was scheduled with G. Le Roux, who had confirmed that he had been seeing a worryingly increasing number of black girls who were eating too little in order to lose weight. Unfortunately, he never returned to the call. Debbie Marais wanted to help, but only after getting an ethics approval form, which a) is not required in our Master’s program, and b) would take too long a procedure in order to finish this thesis on time. Yael Kadish said that she would not be able to comment on most of my questions as she was only seeing a limited number of eating disorder patients at the moment, and none of them were black. In the very last week of finishing this thesis, leading expert Christopher Szabo replied to the email that was sent, which made it possible to get a second opinion on some findings.

2. Existing case reports

The following paragraphs list reported cases of abnormal eating attitudes among blacks in South Africa. They were described by Szabo et al. in 1995 using the criteria of the then current DSM-III-R edition.


These cases were described by Szabo et al. (1995) in collaboration with the Eating Disorder Unit at Tara hospital in Johannesburg. The authors do not mention the patients’ residence nor their specific cultural background, which is a pity.
2.1.1. Case 1

A 22-year-old student had started restricting her food intake at the time of her final exams. She had begun cutting out starches and sugars, switching from full-cream to skim milk, and avoiding junk food. After the initial weight loss, she turned to herbal laxatives to lose more weight. She also consumed large amounts of diet soft drinks, water, and coffee, and chewed gum excessively. Later, appetite suppressants were found among her belongings. During the period of restricting, she mentioned episodes of binge eating (consuming a whole chicken) without purging afterwards. At the time of the study, the patient’s height was 1.52 m and her weight were 42 kg, but some weeks before she had only weighed 38.5 kg. When interviewed, she had been amenorrhoeic for 2 months. She stated that she was not overly concerned about her weight, nor did she weigh herself frequently. There did not appear to be any body image distortion, and she acknowledged that she was too thin and needed to gain weight. As a result of her thinness, her friends frequently asked her if she was ill, which made her feel uncomfortable. She had never experienced loss of appetite, in fact, she loved food. However, she desperately wanted to be at a low weight, even though rationally she could not explain why (Szabo et al., 1995).

When confronted about her eating habits by her mother, the patient dismissed her behaviour as secondary to exam pressure. However, the family history may be suggested to have contributed as well, as her parents were divorced and she only had a distant relationship with her father. Both parents were self-employed professionals (Szabo et al., 1995), which may suggest the family to be of the middle to upper classes.

2.1.2. Case 2

Case 2 involved an unemployed 26-year-old mother of two who was in the process of completing a university degree. She referred herself to the Eating Disorder Unit, suggesting that she acknowledged having a problem. The patient reported bingeing 8 to 10 times a day, followed by vomiting and/or laxative abuse. She was 1.60 m and weighed 44.2 kg, which made her 19.6% underweight based on standard BMI scales. However, she did not consider herself too thin and expressed that weight
gain would depress her. In the past, she had only weighed 38 kg and was amenorrhoic. Over time, her eating pattern had changed from severely reducing her food intake to alternatingly restricting and binge-purging together with alcohol abuse. She had committed several suicide attempts. The patient said that her family were always on diets and that she herself had been dieting since the age of 13. After admission at the Eating Disorder Unit, she participated in the bulimia programme (Szabo et al., 1995).

2.1.3. Case 3

Case 3 concerned a 24-year-old university student who had attended a private school. Apart from eating issues, she presented comorbid mood and personality problems, including depression, suicide attempts, interpersonal conflicts, mood swings, impulsivity, and distrustful and destructive patterns of relational interactions. Despite having lost her appetite as a result of depression, she reported regular episodes of binge eating and purging, which had been going on since her teens after various failed dieting attempts. She was extremely concerned about her weight and food intake (Szabo et al., 1995).

The patient’s father was a general practitioner and her mother a nursing sister. She was closer with her mother than with her father, whom she described as ‘emotionally distant’. After examination she was diagnosed with bulimia nervosa, borderline personality disorder, and major depression. She was prescribed outpatient psychotherapy combined with the psychopharmacological drug ‘fluoxetine’ (Szabo et al., 1995).

2.2. Discussion

The cases hereinabove describe clinical pictures of non-Western eating disorders. It is important to acknowledge their distinct pathologies, as they may well be culture-specific and thus require an adjusted treatment plan. Of particular interest here is the absence of weight phobia, because it raises questions on to what extent such phobia is a core feature in eating disorders and how that may impact misrepresentations in prevalence rates. Also, the role of traditional healers must be
considered for individuals not finding their way to a medical facility for treatment (Szabo et al., 1995).

Unfortunately, only in this article cases were precisely delineated. Other works on eating disorders in black South Africans summarised the methods and findings, which is valuable to examine common trends and concerns, but they did not describe case studies on their own. The cases hereinabove described by Szabo et al. (1995) are illustrative and meaningful on their own, but they must be placed in bigger comparative research to be able to draw more general conclusions. Also, it can be useful to consider how the people surrounding these girls view, judge, and explain their behaviour.

3. The case of Miss Kagiso Matlala

Kagiso Matlala, a black South African woman who at the time of writing is 26 years old, uploaded a video onto her YouTube channel ‘Kagiso Matlala’ (Matlala, n.d.) called ‘How I survived my eating disorder #24 || South African vlogger’.

To date (July 23, 2018), Kagiso’s channel is followed by 81 subscribers. She monthly uploads new videos. Her channel includes several playlists: ‘Self-Care’, ‘Thought Pieces’, ‘Tags’, ‘Travel Diary’, and ‘Weekend Diaries’. The video on her eating disorder was put under ‘Self-Care’, reflecting a positive attitude towards recovery. Other videos in this playlist include a self-care routine, a video on working as an ambassador for Berea-Hillbrow Home of Hope for Girls (i.e. a charity that focuses on rescuing girls from abusive environments and sex trafficking environments, https://www.hopehome.org.za/), a 2018 welcoming, a Valentine’s day celebration, and a video on how to end the cycle of negative coping mechanisms.

In most of her videos, Kagiso uses the tagline ‘The BrownGirl Experience’. When asked about it, she explained:
“The BrownGirl Experience is what I named my YouTube vlog. The whole point is talk about issues pertinent to the experience of being a brown woman. I use the word brown to make it inclusive, I’m talking to all women who aren’t white. I think women of colour around the world share the same experiences and that our struggles are universal. I’m able to speak to a woman of colour in Paris and find that our experiences and struggles are identical” (Matlala, 2018).

In addition, Kagiso started a social club for women of colour:

“The BrownGirl Social Club is a social club I started in Joburg [Johannesburg]. It’s basically a platform for women to come together and share in our experiences. Once you find other people who are going through the same struggles as you, your burden becomes lighter and healing can start. So, the themes of the different sessions I hold range from self-care practices to growing in career and business. I always have a professional come in and address the girls. I facilitate the discussion. The BrownGirl Social Club also works as a networking platform for members. It’s mostly attended by professional women from my close and extended friendship pool who are between the ages of 25-30. I typically have plus minus 50 people attend” (Matlala, 2018).

Kagiso’s engagement can be seen in the light of Afrocentrism, as she encourages brown women to unite and embrace themselves and their identity. Afrocentrism was also found in other videos dealing with natural hair, the problem of skin lightening among women of colour, brown sisterhood and relationships, nurturing young black female entrepreneurs and supporting black businesses, and colourism within the black community. In some videos, she is wearing what appears to be traditional clothing.

The following paragraphs analyse her YouTube video on her eating disorder as well as different chat conversations we had after getting in contact with her on Instagram.
3.1. YouTube video

Kagiso’s eating disorder video was uploaded on April 24, 2017. In the description, she wrote “I talk about dealing with an eating disorder and dispelling the myth that only white girls suffer from them” (Matlala, 2017). This description makes clear that she is well aware of the stereotype of racial exclusivity when it comes to eating disorders. Furthermore, using the past tense ‘survived’ in the title implies that she considers herself being recovered. In the following paragraphs, some themes will be discussed that came along.

3.1.1. Views on eating disorders

In the beginning of her video, when she announces the content on which she will speak, Kagiso describes eating disorders as follows:

“So, eating disorders, that is just when you do not have a healthy relationship with food, when your eating habits are unhealthy, whether you are starving yourself, whether you are overeating, whether you are binge eating, whether you are throwing up. There are just many different ways around having an eating disorder. It’s an illness (…) that has (…) symptoms, that has… not necessarily cures but there are medicines available, there is treatment available” (Matlala, 2017).

In this description, Kagiso focuses on unhealthy eating habits. She does not mention a desire for weight loss, which contradicts the stereotype. With regard to treatment, she later mentions psychotherapy:

“There is therapy that you can (…) just speak to someone who can help you understand where you are in your life, why it is that you have the feelings that you have. You can speak to someone who can just sort of guide you in the right direction when it comes to why it is that you have an eating disorder or what is it that has affected your eating and your eating habits” (Matlala, 2017).
She also raises attention to the myth that eating disorders are only common in white girls:

“What I want to get in to is just the whole myth that only white girls suffer from eating disorders, well, that any sort of mental health illness (...) is only prone to white people as opposed to black people and that we don’t suffer from those things and we don’t go through those things. That is completely false and that is completely wrong” (Matlala, 2017).

Later, she elaborates that eating disorders “are all sort of related to self-esteem and the way an individual sees their body. And you know what, self-esteem and the way we see our bodies as women is not (...) based on skin colour” (Matlala, 2017).

Kagiso then turns to her own experiences with an eating disorder, that started when she was around 22. She does use the term ‘eating disorder’, but believes that “what you see on tv, which is anorexia, bulimia, in my head I knew it wasn’t that” (Matlala, 2017). Later, she says: “I’ve never purged, I never thought that I had a disorder but not eating is an eating disorder. It’s not healthy and it’s not a healthy relationship that you should have with food because obviously our body relies on fuel” (Matlala, 2017). In the chat conversations, Kagiso clarified that she did not identify as anorexic, as she related anorexia to wanting to be thin and she herself did not express such wish, yet that she definitely had an eating disorder (Matlala, 2018, see V, 3.2.3.).

She further explains that in the beginning, it was difficult for her to understand what was going on, as there was little to no information available on eating disorders in blacks:

“Every time I had seen any sort of education on it on tv, it always felt so removed from my (...) immediate reality, my everyday existence. So, I didn’t know that I was going through an eating disorder. All I knew was that I couldn’t eat anymore. (...) I didn’t know what it looked like, I didn’t know what it felt like and therefore I sort of just got lost in it.” (Matlala, 2017).
In the conversations we had, it became clear that this made her feel very confused and isolated, and that according to her, eating problems in blacks must be brought to attention.

3.1.2. On having an eating disorder

Kagiso’s eating disorder started as a result of depression:

“I was just going through a point, a phase in my life where I was so depressed, I was super anxious all the time, that I stopped eating. The idea of food really just made me nervous. (...) I can never really pinpoint the relationship between those two but depression leads to (...) having aversions from food or not wanting to eat because your mind is so preoccupied with whatever it is that’s going on in your life that (...) there’s no desire to eat” (Matlala, 2017).

She further explains that after having not eaten all day at campus, she would go back home and nearly pass out on the streets. Only on these crash moments, she realized what she was doing to herself. Looking back, she adds that “besides being unhealthy it’s dangerous to be so vulnerable in spaces that might not necessarily be safe for you as a woman” (Matlala, 2017).

As a result of not eating, she lost lots of weight: “I looked very unhealthy. You know you get skinny skinny and then you get sick skinny. (...) I genuinely looked sick skinny” (Matlala, 2017). This indicates that she did not show any distortions regarding body percept (see II, 2.1.3.); she was very well aware of her unhealthy appearance.

Considering the impact on her mood, she says:

“Not eating, it really (...) messed up a lot in my life because I wasn’t thinking straight. You know how they say you’re not yourself when you’re hungry? Or (...) when you get moody because you’re hungry? So, you’re just (...) not yourself if you haven’t eaten” (Matlala, 2017).
3.1.3. Community reactions

Many people started judging Kagiso for being so skinny. They “would start making comments. (…) I’d always come across that really harsh comments about my weight and how (…) disgusting it looked. (…) It was really a hard time and really hard to process because people can be insensitive when it comes to weight” (Matlala, 2017). She also elaborates on how the black community perceives changing bodies:

“You know, it’s like in black families as well where if you do lose weight or if you do gain weight it is subject for discussion (…). It’s a reality that we’ve all been through and that we’ve all faced and we all know this as brown women” (Matlala, 2017).

As a result, she made up excuses for her not eating at social gatherings:

“I remember every time I would have to go out for lunch or dinner or just meet up with someone over food, that was so stressful for me because I knew that I was not going to eat. Before getting to the restaurant, I knew I wasn’t going to eat. Whilst looking at the menu, I knew I wasn’t going to eat. Whilst ordering from the menu, I knew I wasn’t going to eat. And then I’d get my food and just play around with it, maybe take two bites. And just to save myself embarrassment I would say “Oh let me take a doggy bag because I’m full now” (Matlala, 2017).

Such reactions are quite different from the ones Western anorexic girls get. At least in the beginning of the disease, when people start to notice you lost weight, it often is perceived and meant as a compliment because being thin is a something of a cultural norm. Also, as dieting trends co-occur with many food temptations, being able to do so is considered an act of perseverance. This is actually dangerous, as sufferers can think of these comments as confirmations that they have a strong mind and look better being slim. It enhances their self-esteem and may induce a fear of not being acknowledged if they would improve their eating or gain the weight back (www.proud2bme.nl, consulted on July 31, 2018).
Kagiso ends her video advocating for self-love and being healthy. She also encourages fellow sufferers to seek help or reach out to her. “I am here for you guys because I’m a brown girl as well, I’m a brown sister, and it’s all about helping each other out” (Matlala, 2017).

3.2. Chat conversations

After having watched Kagiso’s video, an email was sent to her which contained a call for case studies and a resume of the issues being researched. She replied affirmative to cooperating in the study. The first contact took place on April 28, 2018 via Instagram chat. In the subsequent months, several conversations followed. Here, too, the relevant themes will be discussed.

3.2.1. Psychopathology

As she discussed in her video, Kagiso’s eating disorder started as a result of depression: “I got really depressed in 2014 and lost a lot of weight. Only later was I able to identify that during that period I had actually developed an eating disorder” (Matlala, 2018). Her depression was caused by some adjustments she went through. After she had been to Paris, she came back to Johannesburg feeling very anxious and unsure. In the same year, she was sexually assaulted and went through a bad relationship (Matlala, 2018). When asked about her eating habits during the time of her eating disorder, Kagiso answered:

“I completely avoided food. The smell of it cooking nauseated me. I immediately felt sick when I saw food or smelt it. I was very intimidated by it. There were times when I hadn’t eaten all day I could feel myself about to faint” (Matlala, 2018).

Kagiso never expressed a wish to be skinnier. “There was never a desire to be slim like Western beauty standards dictate” (Matlala, 2018). Instead, not eating became “a self-harm that I impose on myself. Instead of confronting my issues I’d rather go into self-harm mode” (Matlala, 2018).
3.2.2. Familial situation

Kagiso was born in Pretoria. Her father is Pedi and her mother Swati. There are no specific eating habits in either cultures that she knows of. Also, her parents “weren’t very strict about traditional practices at home” (Matlala, 2018). When she’s asked about her ethnicity, she always replies Pedi, although she does not relate much to it: “[I] don’t speak the language. Our society is patrilineal so I automatically assume my father’s culture. Nothing more than that” (Matlala, 2018).

At the time of her eating disorder, Kagiso was living in Johannesburg while her parents stayed in Pretoria. She avoided her family because she could not explain what was going on. Contact with them is much better now (Matlala, 2018).

3.2.3. Feelings of isolation due to lack of knowledge

At different times, Kagiso mentions that she felt isolated because no one understood what she was going through, as there was no culture of knowledge on eating disorders in blacks. When she first got ill, she too was not able to understand why she struggled the way she did. The following quotes very well express her loneliness.

“The biggest issue for me was not knowing what was wrong with me. Not being able to point out that I had an eating disorder because at no point was I trying to lose weight” (Matlala, 2018).

“I never identified as anorexic because to me that’s the desire to be skinny” (Matlala, 2018).

“I felt so lonely! I didn’t know anyone going through it because at the time I couldn’t even articulate what ‘it’ was” (Matlala, 2018).

Kagiso could only point out in retrospect that she had an unhealthy relationship with food, when she was searching online for similar experiences. “As soon as I came across ‘eating disorder’ and its definition, it resonated with me and I was able to
identify with the term” (Matlala, 2018). She says that “putting a name on what I went through was very liberating because I could finally identify it” (Matlala, 2018). She did however not identify as anorexic, as she mainly came across (stereotypical) accounts of anorexic women unwilling to eat because they wanted to be thin, and she could not relate to that. Indeed, that is often the image of anorexia portrayed in the media, but as we discussed earlier, its aetiology is much more complex (see I, 4.).

Later, she confirmed that she always understood anorexia nervosa to be resulting from a poor body image:

“Anorexia is an unhealthy obsession with food and the desire to lose weight to attain a certain body image. (…) I’ve always understood the cause to be the desire to be skinny. Thinking one is overweight or perhaps a trauma that has triggered one to find acceptance through looking a certain way. That has always been my problem with identifying as anorexic because I think eating disorders are quite nuanced. I believe anorexia and bulimia are just two types of eating disorders and don’t account or all forms of unhealthy eating habits. In my case I’ve never felt societal pressure to be thin, my cultural environment dictates otherwise. The current trend is thicker women with bigger bums” (Matlala, 2018).

3.2.4. The role of black culture

Generally, black African culture favours a big appetite and a full figure (see III, 1.1.). Eating little and losing a lot of weight thus made Kagiso not ‘fit in’. Moreover, anorexia is perceived as a white woman’s problem. The comments she received made her feel even more isolated.

“I would get a lot of body shaming comments from friends and family and that made me even more ashamed. As black person I should automatically always like food. So, people thought it was very unusual that I could be so skinny. I’d get super nervous eating around people because I knew I couldn’t stomach more than three bites of my food. So, my anxiety would soar around
others because I knew somebody would always point out that I’m not eating” (Matlala, 2018).

“I don’t think black people talk about these issues and have managed to mystify eating disorders as a white woman’s problem” (Matlala, 2018).

When asked if she referred to a specific black ethnicity, or rather black culture in South Africa, or black culture in general, she said black culture in general. But within that, she explained, “some cultural settings may be more conservative in their approach than others” (Matlala, 2018). She then told how the Congolese uncle of a friend once said to her that her weight made him uncomfortable, and that in African culture someone who is that thin is poor. “He then asked if I needed money” (Matlala, 2018).

Also, she said, “to this day I’m told I’m better off dating a white man because they appreciate thin women. Someone said I’m not the ‘ideal’ type for a black man” (Matlala, 2018).

Kagiso spontaneously referred to colonisation with regard to differences in Western and African beauty ideals:

“Beauty in the black community carries the baggage of history. For centuries black people had their culture erased through the project of colonisation. Being told our features were not appealing and that the European standard is the ideal. In essence you could say that the celebration of bigger women in the black community is a way of reclaiming power” (Matlala, 2018).

In addition to her thinness being rejected, her eating attitudes were, too.

“It’s offensive to not finish your food as a guest in an African house. It’s considered rude. It implies you’re too good to eat their food. That was definitely pressure. (...) [What I did was] do the best I can to finish at least one thing on the plate then make an excuse about having had a late lunch. Or having eaten not too long ago” (Matlala, 2018).
3.2.5. Treatment

With regard to treatment, Kagiso mentions having seen a psychologist for about two months. However, it never worked for her because “she was a sixty something year old Afrikaans lady. I didn’t think she could relate to me or my lived experience” (Matlala, 2018). This calls for the therapist-patient relationship to be considered (see V, 4.3.).

Kagiso was the best helped by a personal trainer at the gym, who made gym plans and suggested guidelines for eating.

“She was a young black girl in her twenties who had also battled with depression. We sat together and worked out what my goals in the gym were. My primary goal being to get back to a healthier body weight. (…) The gym works to clear my head. Before entering the gym, I know I have to eat otherwise a workout is impossible. It’s the structure of gym which helps me improve my eating habits” (Matlala, 2018).

“My gym routine is based on building muscle mass and toning. (…) I like the way [being toned] looks on me. It looks healthy” (Matlala, 2018).

“At present I am comfortable with my body as long as I’m treating it right. Treating my body right means at least 3 meals a day and 5 days of gym a week. My main priority is being healthy” (Matlala, 2018).

“There are days when I miss the gym and I’m ok with that. But if I skip two consecutive days or more, I don’t feel good. The feeling I get from gym is a clear mind. And a sense of wellness with regards to how I see my body. I’m more positive about myself after a session. (…) I feel guilty if I don’t [work out] because it means I’m not putting in effort to take care of myself. (…) [Not working out] will deteriorate my mental health… which will affect my body when I have no inclination to eat. I will look too thin and unhealthy” (Matlala, 2018).
Kagiso explained her way to recovery as follows: “The underlying theme of my story was that this was something I had to figure out, and learn to live with. And I think it’s an experience that many black people have to live, where we have to figure it out because there are limited resources available to us. Personally therapy with a psychologist failed me. So, I found an alternative means of healing through exercise” (Matlala, 2018).

When asked about how to improve access to care for blacks, Kagiso said that “the black community needs information and education on mental health. Healthcare is already an issue and the only way to survive is by getting expensive health insurance or using government hospitals which lack” (Matlala, 2018). Therefore, raising awareness is the key. Concretely, “providing information on mental health care and how to get help. There are so many ways to be mentally unhealthy and people don’t know that. South Africa needs more education on how to deal with living with a mental disorder” (Matlala, 2018). She would distribute such information on the internet, but not everyone has data to watch a full 15-minute YouTube video. She mentions that the national broadcaster could do more to raise awareness through TV and radio. Furthermore, high schools and university campuses should provide information on mental health.

4. Reflections

The cases described by Szabo et al. (1995) reflect eating disorder pathologies largely similar to those known from Western accounts (see I, 1.). The woman in case 1 severely restricted her food intake in a stressful period and used herbal laxatives and appetite suppressants to lose more weight. During restriction periods, she also suffered from occasional binge eating. However, she did not express weight concern, nor did she show any body image distortion, which contradicts the stereotype.

Case 2 involved a woman displaying alternate episodes of restricting and binge-purging. This patient expressed weight concerns and did not consider herself too thin, despite being underweight.
In case 3, the patient suffered from an eating disorder and comorbid depression and personality disorders. She too expressed weight concerns. Thus, these girls showed varying degrees of body dissatisfaction and weight issues. They attributed to their distorted eating habits meanings of exam pressure, a family history of dieting, and depression, which can also be found in Western cases.

Kagiso Matlala (2017, 2018) never expressed a desire to be slim or weigh less. In fact, she only displayed body dissatisfaction when she had already lost a lot of weight. To her, not eating was a method of self-harm when confronted with issues of depression.

The cases described by Szabo et al. (1995) did not consider specificities on being a black eating disorder patient. In this regard, the study only confirms that blacks do suffer from eating disorders; it does not pay attention to how these patients experience their illness in relation to culture. The interview with Kagiso Matlala (2018) focused more on her individual experiences. The following themes of her story may need further attention: feelings of isolation, access to care, the therapist-patient relationship, the interpretation of therapy, the interpretation of being healthy, and her identification as a black woman.

4.1. Isolation

Kagiso found herself feeling isolated as a result of two stigmas. First, it is thought that eating disorders do not occur in people of colour, but this is not true. Also, according to her, mental illness is not easily talked about in the black community. Second, in black culture, being thin and eating little is rejected because of standards that favour full-figured women with big appetites (Matlala, 2018).

4.2. Access to care

Kagiso says that for black people, there is only limited access to care. This can be linked to what we earlier discussed, namely, that during apartheid health care was not evenly distributed between whites and people of colour (see III, 2.3.2.). This imbalance may still be visible in contemporary South Africa. Also, help-seeking
behaviour is influenced by financial limitations, because health care is expensive (Matlala, 2018).

4.3. The therapist-patient relationship

In Kagiso’s case, a good therapist-patient relationship was hindered by two main factors: age and cultural background. Kagiso found that her psychologist, who was an elderly white Afrikaans lady, could not relate to her experience as a young black eating disorder patient (Matlala, 2018).

Tseng (2001) investigated parameters that may be crucial in the therapist-patient relationship. By definition, he says, “the status assigned is unsymmetrical – with one person offering service and the other receiving care. As for the roles played, the therapist is expected to have special knowledge and experience, while the patient is expected to follow the treatment suggested as well as he can in order to benefit from it” (Tseng, 2001, p. 435). Apart from this, there are many cultural variations.

First, the power relation between therapist and patient may be hierarchical or egalitarian. Second, the communication between them may be asymmetrical – “the therapist offers explanations and instructions unilaterally and the patients listens and follows passively” (Tseng, 2001, p. 435-436) or symmetrical, whereby they both voice their ideas. Third, “the commitment may be explicitly expressed and agreed upon or subtle and flexible” (Tseng, 2001, p. 436). Fourth, the patient may be expected to fully cooperate, or may be free to make his own choices, without sticking to the therapist’s suggestions. Fifth, the reward for the therapist may be established in advance, or “carried out in an informal way, based on his contribution and the patient’s appreciation” (Tseng, 2001, p. 436). It is important for therapists to be aware of such differences, especially in intercultural settings where their patients might not share their own cultural background. If not, misunderstandings can take place, for example, when the patient is considered noncompliant due to conflicting expectations (Tseng, 2001). When defining the criteria of culture-bound syndromes, Ritenbaugh (1982) took this notion one step further, stating that successful treatment can only be accomplished by participants of the same culture (see II, 1.1.).
Following Ritenbaugh, it may be argued that black eating disorder patients best be helped by mental health workers of their own culture. This is however not a simple matter. Tseng (2001, p. 437) writes that “such matching may not only be impractical, but, clinically, it does not necessarily guarantee successful therapy”. The success of therapy depends on various factors, including the professional competence of therapists and their individual ability to establish a positive relationship with their clients. In addition, says Tseng (2001), therapists with the same ethnic or racial background as their patients may sometimes bring about unwanted effects, for instance, “if the patient does not want to reveal his background to therapists with the same background” or when “the therapist does not offer a proper figure for ethnic identification” (Tseng, 2001, p. 437).

Therefore, a second suggestion is to include in the therapeutic process anthropologists who take on a relativistic viewpoint, and thus try to locate where such intercultural misunderstandings come from.

Obviously, the therapist-patient relationship is also influenced by interpersonal variations, such as the patient’s mode of presenting complaints, the patient’s style of communicating information about illness, the therapist’s format and skill for inquiring about needed information, the therapist’s listening skills, and the therapist’s mode of communicating information about disease (Tseng, 2001). Furthermore, differences exist with regard to orientation toward and expectations of therapy, and with regard to the congruence of values between therapist and patient. Finally, there are cultural variations in considering the role of the family in therapeutic interactions (Tseng, 2001).

4.4. The interpretation of therapy

Apart from limitations in access to care and shortcomings in the therapist-patient relationship, ‘therapy’ can be interpreted in different ways. Each culture has its own ways of dealing with mental health. For comparison, Rwandan genocide survivors created a dance troupe to ‘chase away traumatism’ (Plancke, 2018), which differs from the talking therapy that the West praises to deal with trauma. Thus, when establishing therapeutic practices in African communities, one must be careful not
to be Eurocentric (Sikkema et al., 2018). However, therapeutic interventions should not only culturally be adapted, but also individually, because each sufferer has a unique story. In other words, caregivers should handle a patient-centred approach (see I, 2.2.).

In Kagiso’s case, she found recovery in going to the gym and being understood by a personal trainer. She calls this an “alternative means of healing” (Matlala, 2018) out of necessity, because there are limited treatment resources for blacks available. This suggests that Kagiso does not view going to the gym as ‘real’ therapy but rather as a compensation for it.

4.4. The interpretation of being healthy

For Kagiso, ‘being healthy’ means a regular eating pattern of three meals a day, and a workout routine in the gym five days a week. When she misses two consecutive days of sports, she feels uncomfortable and wants to make up for it (Matlala, 2018). In the West, therapists may consider such rigid gym routine pathological, because anorexic patients tend to compulsively exercise (see I, 2.1.). In this regard, Kagiso reminds of the current hype of ‘fitgirls’ noticed in Western countries who praise clean eating and obsessively go to the gym in order to be ultra-fit and get the perfect body. Recovering eating disorder patients are vulnerable to such trends and may find in this ‘fitness and healthy eating hype’ a socially acceptable way of being overly concerned with weight and body issues. According to eating disorder activists, it is often so that they claim to be recovered, but have in fact replaced their symptoms by a new obsession (Proud2Bme, 2015, 2016).

Kagiso herself does not consider herself such ‘gym bunny’ (Matlala, 2018), she mentions that it goes much deeper than that. For her, working out is a way to clear her mind and not fall back into the traps of depression that can lead her to stop eating again. She does however feel “guilty”, “irritable”, and “sluggish” (Matlala, 2018) when she does not work out, and admitted it feels like an obligation. To further elaborate on this, questions were asked that gauged cultural standards on doing sports. According to Kagiso, her activity levels do not exceed those of her peers. She also knew of girls who “are far more pedantic with their gym schedules”
(Matlala, 2018). However, she nuances that most girls just don’t have the money to pay for a gym membership. When asked about cheaper ways of doing sports, Kagiso mentioned running and informal soccer clubs, but she does not clarify whether she finds herself being more preoccupied with working out than those who engage in such sports. Considering her views on the impact of her body if she does not work out, she fears that the progress she has made on her body will be gone and she will be less toned (Matlala, 2018). To her, looking healthy equals being toned and having muscle definition, which suggests that, though she mentioned earlier that she was never concerned about looking a certain way, she does value body image, not to get skinny but to be toned. Clearly, further research is needed to examine to what extent extensive exercise in South Africa is linked to eating disorder mindsets.

However, Kagiso added and emphasized that not working out will also affect her mental health:

“I’ll get super depressed. (...) I feel in order to keep this dark cloud (of depression) away I need to go to the gym. Otherwise the cloud starts growing bigger and gets darker. I’m so scared of falling back to that place where everything feels hopeless. (...) [Not working out] will deteriorate my mental health, which will affect my body when I have no inclination to eat. I will look too thin and unhealthy. (...) Going to the gym is an act of self-love because after my session, I’ve worked up an appetite. (...) My old destructive habits meant I skip breakfast, I don’t get any exercise and I don’t eat anything for the rest of my day. So, self-love is an act of preservation” (Matlala, 2018).

This indicates that to her, exercising to ‘be healthy’ is not just about remaining in shape, but also about preserving mental peace. In this regard, her view on ‘health’ is holistic.

With regard to her eating habits, Kagiso describes ‘eating healthy’ to include drinking lots of water and consuming fruits and vegetables. She also mentions that eating healthy is expensive in South Africa and that “the majority can’t afford it” (Matlala, 2018). This is confirmed by Temple and Steyn (2011), who found that in South
Africa, as in other countries, nutrient rich foods like oats, beans, fish, lean meat, fruits, and vegetables generally cost more than energy-dense foods that are lower in nutritional value, such as fast food, jam, and refined cereals. This can be linked to what Bourdieu (1979) called the ‘taste of necessity’ of the lower classes, who buy cheap products that are familiar because of lack of financial means, as opposed to the broader ‘aesthetic taste’ of the higher social classes. As a result, low-income people will be pressured to select foods that are less healthy in terms of micronutrients (Temple & Steyn, 2011).

It can be argued that this helps explain why restrictive eating disorders are more prevalent in urban South African settings, as people in those areas generally have higher incomes (http://www.etu.org.za/toolbox/docs/development/poverty.html, consulted on August 2, 2018) and thus can afford to select only healthy foods to eat. Indeed, as we saw earlier (see II, 4.2.), eating disorders appear to be more prevalent in people whose food choices are relatively abundant.

4.5. Identification as a black woman

When asked if Kagiso felt less of an African being so thin and thus not responding to the cultural ideal, she replied negative: “I am an African, that’s a fact. It’s something no one can ever take away from me” (Matlala, 2018). However, the embracement of her African identity definitely got stronger in recovery. In the year preceding her mental health problems, she had been to Paris. When coming back to Johannesburg, she felt very unsure about herself. Now, the content of her YouTube channel shows otherwise: she preaches self-love and self-care, warns others about mental health issues, shows nature and culture in South Africa, and advocates for the rights of people of colour. She also made one video in which she contested the act of skin lightening as an African woman, and another in which she supported the natural hair movement. Also, she established The BrownGirl Social Club for people of colour to unite and talk about their experiences (see V, 3.). In this regard, her keys to recovery are similar to those carried out by eating disorder therapists in the West (Netten, 2017), namely, practising self-care and embracing one’s own core identity.
PART VI: DISCUSSION

1. The role of culture

This research raised some interesting questions regarding the role of culture in anorexia nervosa and eating disorders in general. To start with, attention was brought to the culture-boundedness of the disease. While at first anorexia had been thought to only occur in the West, that thesis has now been contested. Not only are there reports of anorexia in non-Western societies, the strict cause-effect linking of Western culture to anorexia nervosa must also be nuanced. In this regard, it is valuable to distinguish between Di Nicola’s (1990) notions of culture as cause, trigger or envelope in the aetiology of anorexia (see II). With regard to cultural factors (see I, 4.2.), it can be argued that culture acts a cause. With regard to biological and sociopsychological factors (see I, 4.1.), culture may be present too, but rather as a trigger or an envelope.

Di Nicola (1990, see II, 4.1.) contested the notion of anorexia nervosa as a culture-bound syndrome by focusing on anorexic reports found in non-typical populations. Specifically, he mentioned cases in migrants and in cultures undergoing rapid socioeconomic change. Therefore, he speaks of ‘culture-change syndromes’.

Di Nicola’s notion of culture-change syndromes allows for a more nuanced view on the link between anorexia nervosa and culture. It asks for the official DSM classification to be reviewed. Di Nicola (1990, p. 272) questions whether “diagnostic schemas [should] include an atypical group for orphan cases of anorexia nervosa when all the symptom criteria are met but the sociocultural context is anomalous”.

The notion of change may as well be useful to reconsider anorexia nervosa in the West. As anorexia nervosa appears to be most prevalent in periods of transition (personal as well as transitions in society) (see I, 5.; II, 2.1.), it can be argued that ‘change’ is a common factor of both typical Western anorexia nervosa and other forms. ‘Transition’ can thus be understood quite broadly, either as a personal transition such as puberty or life events (Fischer et al., 2010), or sociocultural, such as acculturation stress following migration or sociocultural evolution (Di Nicola,
Clearly, those forms are not distinct from one another; an individual may well be triggered by both personal and sociocultural forms of transition.

Similarly, Njenga (2011, cited in Ndetei & Szabo (eds.), 2011) writes that in periods of rapid sociocultural change, particularly associated with cultural uprooting, there tends to be a sharp increase in psychiatric conditions among young people. This is the case in many present-day peri-urban parts of Africa, where residents have lost their rural roots but have not acquired full citizenship of the city yet.

Tseng (2001) suggested ‘culture-related syndromes’ (see II, 4.2.). In his view, some syndromes previously assumed to be culture-bound can be prevalent in various cultures that share specific cultural traits, rather than occurring only in one particular cultural system. As globalisation causes cultures to become increasingly interconnected, varied forms of restrictive eating disorders may appear across the world. Their specific manifestation will differ in every culture, which can be referred to as ‘glocalization’, a specific blend of global and local cultural aspects (Daouk-Öyry et al., 2016).

With regard to this interconnectedness, Szabo (2009, see III, 3.) recalls the process of acculturation. He says that acculturation revolves more around milieu and cultural setting, such as an urban context, rather than ethnicity or race. This view asks for the idea of white exclusivity when it comes to eating disorders to be reviewed, because it shows that black people in an urban setting can just as well suffer from an eating disorder. This is the case in South Africa, that after apartheid became increasingly racially integrated, resulting in mutual influences between blacks and whites in urban contexts, albeit with a dominancy of the white Anglophile ethos (Szabo, 2009, see IV, 2.1.).

2. A patient-centred approach

In this thesis, it became clear that when understanding and treating eating disorders, it is important to handle a meaning-centred approach (Di Nicola, 1990, see II, 3.). Such an approach does not focus on clinical symptoms as such, but rather on what
those symptoms mean to the sufferer in a specific sociocultural context. Obviously, next to acknowledging such cultural understandings, therapists should also consider individual differences. After all, even within cultures, sufferers experience their illness in a unique, personal way.

In this regard, Banks (1992) advocates for the proper consideration of the patient’s own subjective understandings and motivations: “While [anorexic] symptoms are related in complex ways to biological dysfunctions caused by starvation and weight loss (...), they are also given meaning by the anorectic. The anorectic consciously understands and gives meaning to her symptoms using culturally explicit and objective symbols, beliefs and language” (Banks, 1992, p. 868). Such meanings held by patients may differ from the ones held by diagnosticians, medical practitioners, and even other anorexics. Therefore, it is important to not homogenize sufferers and always start from the individual’s own unique story (Banks, 1992). Eating disorder pathology might look alike, but patients experience their symptoms in different ways.

This has some crucial implications for treatment. Treatment plans that generalize patients are more likely to fail (Jacob, 2014). Unfortunately, this happens a lot. In many clinics, hospitals, and ambulant settings, patients attend the same therapy sessions, get standard meal plans, and are subjugated to the same rigid rules, such as having to maintain a certain weight to keep privileges. There is something to be said for this approach, as eating disorders have a will of their own and can make patients unaccountable for themselves. The stronger an eating disorder gets, the weaker its host will become and the more the eating disorder will try to isolate the individual and undermine its identity (Netten, 2017). When this happens, the voice of the eating disorder takes over and determines the patient’s decisions.

However, when therapists acknowledge the person behind the illness and listen without judgment to her individual dreams and conflicts, true solace can happen, making the eating disorder no longer needed as a coping mechanism. In this view, treatment plans that are multidisciplinary, holistic, and individually customized have more chance of success.
3. Restrictive eating in South Africa

Restrictive eating disorders in South Africa are on the rise (see IV, 1.). It is hard to pinpoint the exact causes of it, though some of the factors are clear. First, the socio-political situation in post-apartheid South Africa caused society to become increasingly racially integrated (see III, 2.). As a result, black and white cultures were not that strictly segregated anymore, which lead to cultural societal systems becoming mixed. Specifically in urban school systems, there appeared to be a tendency among black students to incorporate Western values, because the white ethos was still dominant (see III, 1.).

In this regard, it would be logical to explain the emergence of eating disorders in black South Africans as a simple result of Westernization. There are however some problems with this assumption. First, as we discussed before (see I, 5., VI, 1.), eating disorders are not only caused by a dominant Western beauty ideal. This is supported by various reports of anorexia nervosa in non-Western cultures, where sufferers do not appear to express weight concerns or fat phobia (Lee et al., 1996; Becker et al., 2009, see I, 2.3.). However, such cases are not completely separated from Western culture and in some cases, Western thinness does play a role (see IV, 4.2.). Rather, they appear be the result of a complex mixture of individual and cultural identity conflicts (see IV, 2.). Some sufferers do not emphasize thinness as such, but rather what thinness represents in their society, such as upward mobility and prosperity of whites (see IV, 2.2.).

Second, acculturation appears to be not unilateral in the sense that the more blacks adopt Western values, the greater a risk they encounter to develop an eating disorder. In Chapter IV, 4.2.2., we saw that local traditions just as well can play a role, for instance, when the Zulu habit of purging before breakfast is extended to purging after breakfast to get rid of the food (Morris & Szabo, 2013).

When thinking about Western acculturation, it would be interesting to compare eating disorders in blacks during (when they were still largely separated from white culture) and after apartheid. Unfortunately, the only reported accounts were described after apartheid (see IV, 1.), because during apartheid, psychiatric care for eating disorders was reserved for whites (see III, 2.3.). As a result, we do not know
whether at that time eating disorders occurred among blacks. If they did, it may question the role of Western acculturation in the development of eating disorders in black South Africans.

4. Recommendations for research

According to the author, further research on the topic of anorexia nervosa and culture must consider the following considerations. First, we saw that applying a universal diagnostic system (DSM-5) and Western based self-report questionnaires (EAT-26) in different cultures neglects local meanings of identical symptoms (see I, 2.2., IV, 3.). Two suggestions are proposed, namely, including anthropologists in psychiatric research, as they try to understand processes on a local cultural level, and adding follow-up interviews to such questionnaires (see IV, 3.1.). Such interviews may clarify whether eating attitudes that would be considered distorted by Western research are actually the result of a pathological eating disorder. For instance, Le Grange et al. (2004, see IV, 3.1.) found that a high EAT-26 score on preoccupation with food was not in all cases caused by an eating disorder, but rather by poverty-related hunger. Similarly, purging behaviour was linked to cultural taboos on certain foods rather than to a typical eating disorder.

Furthermore, there can be no universal standards of ‘normality’. For instance, in the case of Zulus purging before breakfast (see IV, 3.1.), such a habit is culturally accepted as normal. In the West, however, this behaviour would be considered abnormal, because we do not hold such practices. Here, too, the socioeconomic situation plays a role, for example, when skipping meals is not the result of an eating disorder, but rather of lack of food — and thus can be considered ‘normal’ or logical in that particular context. Therefore, cultural studies on eating disorders should reason from local standards of normality and abnormality. Also, one should be careful to apply standard eating disorder labels. For instance, Kagiso Matlala said that she definitely had an eating disorder, but did not identify as anorexic, because she linked anorexia nervosa to a desire to be thin and she herself did not express such wish (Matlala, 2018; see V, 3.). In this regard, the author suggests to leave aside the traditional subclassification of eating disorders and only distinct between
‘restrictive’ and ‘non-restrictive’ eating disorders. Such a differentiation leaves room for specific cultural interpretations of eating disorders.

Also, the findings in this research call for the DSM to include the proper cultural consideration of every disorder, because diseases are to some extent always influenced by the sociocultural context in which they appear (see II, 4.2.).

Lastly, the author recommends ethnographic fieldwork to be conducted. In-depth interviews with assumed eating disorder patients in non-Western settings may clarify if and in what way they consider their behaviour to be abnormal. In such interviews, attention must be brought to cultural and individual meanings of thinness and dysfunctional eating.

5. Recommendations for therapeutic practice

Regarding therapeutic practice in a cross-cultural setting, a few suggestions are made here. First, we must step aside from the idea that blacks cannot suffer from eating disorders. Even though these eating disorders may be manifested in a way different to the ones in the West, they still deserve therapeutic attention. If such disorders are not recognised in the black community, sufferers may feel isolated, which makes it even more difficult to recover (Matlala, 2018). Additionally, they also must be recognised by physicians working in intercultural settings in order for those patients to get treatment and for therapists to adjust that treatment in a culturally appropriate way (see V, 4.3.).

Second, black people should be informed on eating disorders. As Matlala (April-July, 2018; see V, 3.) said, lack of knowledge is a real problem and results in sufferers not knowing what they are going through. Therefore, information should be distributed on a local level such as in school systems or at hospitals. Also, if traditional healers were informed on eating disorders, they may be able to contribute to treatment in their own way. However, this hypothesis should be further examined.

Third, culture gaps in treatment must be addressed. According to Tseng (2001, see V, 4.3.), therapists should be aware of the cultural background of their clients. Two
ideas were discussed. First, to only match patients with therapists of the same culture (Tseng, 2001; see V, 4.3.). However, this appeared to be impractical and does not necessarily guarantee successful treatment. Also, the author suggests to include anthropologists in the therapeutic process in order to get to local meanings of symptoms.

Fourth, what it means to be recovered and to ‘be healthy’ may differ across cultures, too (see V, 4.5.). Therefore, attention must be brought to cultural norms and views on health, recovery, normalisation of eating patterns, a healthy weight, and so on. If not, treatment is more likely to fail. For instance, regarding the case of Kagiso, it can be examined whether extensive exercise is considered culturally normal.

Fifth, different forms of identity issues seem to be a common factor in eating disorders both in the West and in South Africa (see I, 5.; IV, 2.). In treatment, enhancing someone’s core identity may help to combat the voice of the eating disorder. In this regard, it can be useful to focus on Afrocentric tendencies in black patients who consider themselves inferior in comparison to their white counterparts. When re-embracing their African identity and valuing the beauty of it, the eating disorder will no longer be needed to create a sense of self. This is however only a suggestion that needs to be further investigated. And, of course, attention must also be given to the individual needs of the patients, for instance, when someone’s eating disorder was triggered by the lack of a caring parent figure.
Conclusion

This thesis reconsidered the role of culture in anorexia nervosa. Culture-bound syndrome advocates (Swartz, 1985) strictly ascribe this disease to core aspects of Western culture (see II, 2.). In their view, anorexia is an illness that originates in modern-day pressures put on individuals, mostly women, in the West, the most obvious pressure being the thin beauty ideal combined with a dieting culture. However, such assumptions do not hold stand when considering non-typical forms of anorexia nervosa. Reports of the illness have been reported from as early as the 19th century (see I.3.) and outside the West (see I, 5.; IV, 1.). In many non-Western accounts, patients do not express weight or body concerns (see I, 2.3.).

Other approaches were carried out by Di Nicola (1990, see II, 4.1.), who proposed ‘culture-related syndromes’, and Tseng (2001, see II, 4.2.), who speaks of ‘culture-change syndromes’. Culture-related syndromes refer to diseases that are related to certain cultural features, rather than being bound to one particular cultural system. In this regard, anorexia nervosa can occur in different cultures sharing specific traits. The concept of culture-change syndromes is used to delineate cases of anorexia in people undergoing rapid socioeconomic or cultural change, such as cultural evolution or migration.

The author argued that the notion of ‘change’ can equally be used to reconsider anorexia nervosa in the West, because anorexia appears to emerge in various periods of transition – either personal or societal. In this regard, ‘change’ can be a common factor in the aetiology of anorexia nervosa across cultures.

Furthermore, this thesis looked at eating disorders in Africa. A differentiation was made between non-restrictive (see III, 1.) and restrictive eating disorders (see III, 2.). It appeared that it would not be accurate to call African symptoms of overeating and consuming non-foods ‘disordered’ only because such symptoms can also be found in binge eating disorder and pica occurring in the West. Rather, these behaviours should be understood within their own cultural context. In this regard, many Africans would not consider overeating to be abnormal, because a big
appetite is the norm. Similarly, in some African countries, it is common to eat clay, soil, or stones.

Restrictive eating disorders are thought to be rare in the African continent. Three possible explanations have been discussed for this: the idea that culture acts as a protective factor through differences in beauty ideals and worldview, the stereotype of Africa as a continent in misery where the focus is on survival rather than self-questioning, and challenges in African psychiatry. Nevertheless, cases of anorexia have been reported in some African countries (see III, 2.).

Of particular interest in this thesis were assumed cases of anorexia nervosa in black South Africans (see IV). Pioneering work was done by Prof. dr. Christopher Szabo (University of Witwatersrand, Johannesburg) in the 1990s. He found that the emergence of eating disorders in black South Africans co-occurred with the end of apartheid, suggesting that racial integration might play a role. Also, in the ‘new South Africa’, women have to straddle between traditional and emancipated female gender roles, which may evoke identity confusions.

Attention was brought to the validity of using Western-based self-report questionnaires in non-Western cultures. Le Grange et al. (2004, see IV, 4.) found that high EAT-26 scores do not necessarily reflect the presence of an eating disorder. Therefore, they suggest follow-up interviews that gauge the meanings of thinness and dysfunctional eating behaviours in such contexts. For instance, purging may reflect cultural food taboos rather than an eating disorder, and a preoccupation with food may be attributed to poverty-related hunger.

A final part of this thesis looked at existing case reports of anorexia nervosa, as well as the extended testimony of Kagiso Matlala, a young black South African woman who claims to be recovered from an eating disorder. Kagiso’s story in particular offered some crucial factors in her experience as a black eating disorder patient. On the basis of her story, a reflection was written that included different aspects of having an eating disorder as a black woman in South Africa (see V, 4.). These aspects need further attention.
In a discussion (see VI), the author noted that the role of culture in anorexia nervosa must be nuanced. In this regard, Di Nicola’s (1990) notions of culture as cause, trigger, and envelope appeared to be useful. Also, it was argued that therapeutic and theoretical approaches to anorexia nervosa should be patient-centred, rather than doctor-centred, and that attention must be given to the individual’s own understandings of her symptoms. Furthermore, it was discussed how the rise of eating disorders among black South Africans should be explained.

Lastly, recommendations were made for further research and for therapeutic practice. Considering research, extended fieldwork is needed, using in-depth interviews, and, ideally, consultations with anthropologists. Also, what is and what is not normal and abnormal behaviour should be defined not with general standards, but within each culture, because every culture has its own standards of normality. For researching non-Western eating disorders, the author suggests to leave aside the usual subclassifications and only differentiate between non-restrictive and restrictive eating disorders, because such a distinction leaves room for various cultural interpretations to be included.

Considering therapeutic practice, physicians as well as the black community should acknowledge the existence of eating disorders among blacks. Also, information should be distributed, for instance in high schools, to raise awareness. Furthermore, culture gaps in treatment must be assessed, and therapists should be aware of the cultural background of their clients in order to adjust treatment in a culturally appropriate way. It is also important to consider cultural interpretations of recovery, being healthy, and normalisation of eating attitudes. Finally, a suggestion was made for therapists to consider Afrocentric tendencies in the treatment of black patients who regard themselves as inferior to their white counterparts.

Limitations in this research include the absence of fieldwork and the near absence of relevant South African professionals giving their views on the occurrence and manifestation of eating disorders in the black population. With regard to patients, there was only found one woman to be interviewed about her experiences. Her story on its own is meaningful, yet more accounts are needed in order to identify trends or draw conclusions.
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Annexes

Table 1: DSM-IV and Lee's culture-free diagnostic criteria for anorexia nervosa

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<tr>
<th>DSM-IV</th>
<th>Revised &quot;Culture-Free&quot; Criteria</th>
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<tr>
<td>A.</td>
<td>A. Weight loss of 15% or more of weight expected for height.</td>
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<td>B.</td>
<td>B. Intense fear of gaining weight or becoming fat, even though underweight.</td>
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<tr>
<td>C.</td>
<td>C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.</td>
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<tr>
<td>D.</td>
<td>D. Amenorrhea in female or loss of libido in male.</td>
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Table 2: Overview of the contacted professionals in South Africa

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<td>Montrose Manor</td>
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<td>Treatment Centre</td>
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<td>Eating Disorders Anonymous</td>
<td>Recovery Website</td>
<td>Won’t release member’s details</td>
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**Therapists (www.findhelp.co.za)**

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<td>Social Worker, Cape Town</td>
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</tr>
<tr>
<td>Kirsten Meyer</td>
<td>Clinical Psychologist, Cape Town</td>
<td>“Unfortunately I have very limited experience working with non-white people suffering from anorexia. I can recommend talking to associate professor Jackie Hoare at Groote Schuur Hospital. She is the head of their consultation-liaison psychiatry division. I worked under her during my internship rotation there and was impressed with her knowledge and experience with eating disorders. It is also likely that she will have more diverse experience across socioeconomic and racial lines, given that she is working in a state setting, rather than privately. I hope this is helpful, and all the best with your very important and exciting research.”</td>
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<td>Cornel Verwey</td>
<td>Clinical Psychologist</td>
<td>Cape Town</td>
</tr>
<tr>
<td>Tasneem Van De Biezen</td>
<td>Counselling Psychologist</td>
<td>Parktown</td>
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<tr>
<td>Tracy-Ann Capitano</td>
<td>Clinical Psychologist</td>
<td>Parkmore</td>
</tr>
<tr>
<td>Renee Shearing</td>
<td>Occupational Therapist</td>
<td>Wynberg</td>
</tr>
<tr>
<td>Kim De La Harpe</td>
<td>Clinical Psychologist</td>
<td>Claremont</td>
</tr>
<tr>
<td>Jorgan Harris</td>
<td>Clinical Psychologist</td>
<td>Randburg</td>
</tr>
<tr>
<td>Lynne Radomsky</td>
<td>Clinical Psychologist</td>
<td>Milnerton</td>
</tr>
<tr>
<td>Bernadett Ferreira-Martins</td>
<td>Counselling Psychologist</td>
<td>Bedfordview</td>
</tr>
<tr>
<td>Name</td>
<td>Specialization</td>
<td>Location</td>
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<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Elzaan Cothill</td>
<td>Counselling Psychologist, Newton Park, Algoa Park</td>
<td>Brackenhurst</td>
</tr>
<tr>
<td>Melanie Anthony</td>
<td>Counselling Psychologist, Morningside</td>
<td></td>
</tr>
<tr>
<td>Olivia Dunseith</td>
<td>Clinical Psychologist, Parkmore</td>
<td></td>
</tr>
<tr>
<td>Saskia Wolfaardt</td>
<td>Clinical Psychologist, Newlands</td>
<td></td>
</tr>
<tr>
<td>Mandy Florence</td>
<td>Clinical Psychologist, Kyalami</td>
<td></td>
</tr>
<tr>
<td>Vaughn Parkhurst</td>
<td>Registered Counsellor, Klein Constantia</td>
<td></td>
</tr>
<tr>
<td>Rossella Meusel</td>
<td>Educational Psychologist, Wembley</td>
<td></td>
</tr>
<tr>
<td>Monika Macnaughton</td>
<td>Registered Counsellor, Kenilworth</td>
<td></td>
</tr>
</tbody>
</table>

“I thank you for getting in touch. Unfortunately I do not fall in the right category. I wish you luck.”

“Thanks for your email. I would like to help but am unfortunately not really seeing patients at the moment who would fit your description.”
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sian Green</td>
<td>Clinical Psychologist, Garsfontein</td>
<td></td>
</tr>
<tr>
<td>Phile Möller</td>
<td>Counselling Psychologist, Garsfontein</td>
<td></td>
</tr>
<tr>
<td>Jezebel Machado</td>
<td>Clinical Psychologist, Caremont</td>
<td>“Unfortunately I am unable to assist. I wish you best of luck.”</td>
</tr>
<tr>
<td>Michelle Lawrence</td>
<td>Counselling Psychologist, Blouberg, Parklands, Tableview, Milnerton, Melkbosstrand</td>
<td></td>
</tr>
<tr>
<td>Kelly Marcisz</td>
<td>Clinical Psychologist, Johannesburg</td>
<td></td>
</tr>
<tr>
<td>Debbie Marais</td>
<td>Counselling Psychologist, Pinelands</td>
<td>“Your research sounds interesting. As a first step, you might want to read some research I conducted a while ago on this topic: <a href="https://link.springer.com/article/10.1007/bf03324988">https://link.springer.com/article/10.1007/bf03324988</a>. There is a lot of similar research that has been conducted locally - I assume you are including this in your thesis? I would be happy to assist, but first I wonder if you could send me the ethics”</td>
</tr>
</tbody>
</table>
Any research that is conducted on local populations should have ethics approval both from your home institution and from a local research ethics committee.”

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Croxford</td>
<td>Clinical Psychologist, Parktown, Bryanston</td>
</tr>
<tr>
<td>Jennifer Ralph</td>
<td>Clinical Psychologist, Oranjezicht, Rosendal</td>
</tr>
<tr>
<td>Trust In Hope Recovery House</td>
<td>Treatment Centre, Garsfontein</td>
</tr>
<tr>
<td>Sharoni Tsarafi</td>
<td>Clinical Psychologist, Sandton</td>
</tr>
<tr>
<td>Candice Garrun</td>
<td>Social Worker, Parktown</td>
</tr>
<tr>
<td>Denzel Mitchell</td>
<td>Psychiatrist, Umhlanga, Ballito</td>
</tr>
<tr>
<td>Philippa Cameron</td>
<td>Clinical Psychologist, Rondebosch</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
</tr>
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</tr>
<tr>
<td>Vyvyan Bean</td>
<td>Counselling Psychologist, Gardens</td>
</tr>
<tr>
<td>Denise Mulder</td>
<td>Clinical Psychologist, Boston</td>
</tr>
<tr>
<td>Marilise Nel</td>
<td>Counselling Psychologist, Morningside, Fourways</td>
</tr>
<tr>
<td>Marina Zitanellis</td>
<td>Clinical Psychologist, Green Point</td>
</tr>
<tr>
<td>Judy Wynne-Potts</td>
<td>Clinical Psychologist, Hillcrest</td>
</tr>
<tr>
<td>Taryn Harverson</td>
<td>Clinical Psychologist, Wynberg</td>
</tr>
<tr>
<td>Nadine Knopfmacher</td>
<td>Clinical Psychologist, Sandton</td>
</tr>
<tr>
<td>Marcelle Stastny</td>
<td>Psychiatrist, Constantia</td>
</tr>
<tr>
<td>Tanya Oosthuyzen</td>
<td>Clinical Psychologist, Bergvliet</td>
</tr>
<tr>
<td>Vuyo Lekhelebana</td>
<td>Counselling Psychologist</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
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<td>---------------------</td>
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</tr>
</tbody>
</table>
| Georgie Le Roux     | Clinical Psychologist, Brooklyn               | “Your research in this area is vital. I see many young black girls that are obsessed with being thin. I have not seen diagnosed anorexics in my practice but think many are not treated. I am concerned about black girls that hardly eat or go for fast foods that in the future may cause serious physical problems. Historically black people that are overweight were seen as wealthy. The media is also getting to these girls who want to look thin. Just a few thoughts.
If you are interested I can give you a contact number of a psychiatric child and adolescent unit at Weskoppies Hospital.” |
| Bridget Westwood-Chetty | Clinical Psychologist, Lonehill, Skeerpoort |                                                                                                                                                                                                             |
| Darryn Costello     | Clinical Psychologist, Norwood                |                                                                                                                                                                                                             |
| Luziana Carvalho    | Registered Counsellor, Fourways               |                                                                                                                                                                                                             |
| Meindert Korver     | Clinical Psychologist, Johannesburg          |                                                                                                                                                                                                             |
Generally I work with people who have eating disorders, amongst to other disorders, but it's not an area of specialization for me. The person who's done a lot of work on eating disorders, from a psychoanalytic perspective, in South Africa, is Yael Kadish, a colleague of mine: yaelkadish@gmail.com.

You might also want to look at the South African Medical Journal which might have covered this from a more psychiatric perspective, but would probably carry more statistical data. I'm
not an expert in this area, but these are just some thoughts."

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinique Barnard</td>
<td>Clinical Psychologist</td>
<td>Kempton Park</td>
</tr>
<tr>
<td>Natasha Reddy</td>
<td>Counselling Psychologist</td>
<td>Brakpan</td>
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<tr>
<td>Dannita Borageiro</td>
<td>Clinical Psychologist</td>
<td>Rustenburg</td>
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<tr>
<td>Garth Newman</td>
<td>Clinical Psychologist</td>
<td>Brackenfell</td>
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<tr>
<td>Chris Rees</td>
<td>Clinical Psychologist</td>
<td>Rondebosch</td>
</tr>
<tr>
<td>Brad Kallenbach</td>
<td>Clinical Psychologist</td>
<td>Bryanston</td>
</tr>
<tr>
<td>Sune Naude</td>
<td>Counselling Psychologist</td>
<td>Bassonia</td>
</tr>
<tr>
<td>Sonika Badenhorst</td>
<td>Social Worker</td>
<td>Oakdene</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Location</td>
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<td>-------------------</td>
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</tr>
<tr>
<td>Saieda Desai</td>
<td>Clinical Psychologist, Melville</td>
<td></td>
</tr>
<tr>
<td>Vikki Kotton</td>
<td>Clinical Psychologist, The Gardens</td>
<td></td>
</tr>
<tr>
<td>Carla Dukas</td>
<td>Clinical Psychologist, Claremont</td>
<td></td>
</tr>
<tr>
<td>Craig Traub</td>
<td>Clinical Psychologist, Morningside Manor</td>
<td></td>
</tr>
<tr>
<td>Tracy McIntyre</td>
<td>Clinical Psychologist, Newton Park</td>
<td></td>
</tr>
<tr>
<td>Amy Dane</td>
<td>Clinical Psychologist, Tamboers-kloof</td>
<td></td>
</tr>
<tr>
<td>Debbie Bub</td>
<td>Occupational Therapist, Kenilworth</td>
<td></td>
</tr>
<tr>
<td>Oliver Fuchs</td>
<td>Clinical Psychologist, Gardens, Capri</td>
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<tr>
<td>Oasis Counseling Centre</td>
<td>Treatment Centre,</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Location/Role</td>
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</tr>
<tr>
<td>Gadija Roshan</td>
<td>Clinical Psychologist, Claremont</td>
<td></td>
</tr>
<tr>
<td>Lauren Bock</td>
<td>Clinical Psychologist, Bryanston</td>
<td></td>
</tr>
<tr>
<td>Ilhaam Solomons</td>
<td>Clinical Psychologist, Claremont</td>
<td></td>
</tr>
<tr>
<td>Elza Berk</td>
<td>Registered Counsellor, Klein Constantia</td>
<td></td>
</tr>
<tr>
<td>Christopher Kemp</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christopher Szabo</td>
<td>Professor and Psychiatrist at University Of Witwatersrand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only replied in the very last week of finishing this thesis. Confirmed that therapy must be culturally adapted but didn't add much new information.</td>
<td></td>
</tr>
<tr>
<td>Yael Kadish</td>
<td>Eating disorder expert</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has recently been seeing only a few eating disorder patients and none of them were black.</td>
<td></td>
</tr>
<tr>
<td>Anele</td>
<td>Works at Tara</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Message</td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>Fahima Adam</td>
<td>Psychiatric Hospital (Nutrition project in Cape Town, Registered Dietitian)</td>
<td>&quot;I'd love to help but I don't often deal with eating disorders unfortunately so I don't have a lot of insight into the experiences of black South Africans with eating disorders. The only form of weight issues we deal with is disease related weight loss, obesity and other diseases of lifestyle. I'll try and see if any of my other colleagues have some insight and get back to you. Good luck!&quot;</td>
</tr>
<tr>
<td>Tabitha Hume</td>
<td>Nutritionists and dietitians</td>
<td>&quot;Thank you for your email. Unfortunately due to the POPI Act we cannot give you access to our database. One way to request participation is to send a notice via our mailer. I've copied Jessica in and she will be able to help you with this should you which to proceed.&quot;</td>
</tr>
<tr>
<td><a href="mailto:info@adsa.org.za">info@adsa.org.za</a></td>
<td>Association for Registered Dietitians South Africa</td>
<td>“Thank you very much for making contact with ADSA. As Nicole already suggested, we will be able to place a notice about this in our weekly mailer which goes out to our database of about 1500 dietitians across South Africa. I have attached a template – please complete this with all the relevant information requesting dietitians to take part. If there is any other background information you would also like to share&quot;</td>
</tr>
</tbody>
</table>
with this notice, please send to me, and we can link it in the mailer.

The mailer goes out once a week on a Tuesday, so if you could get this information back to me by the close of business on Monday, I will be able to include it next week.

This sounds like a very interesting study, and we wish you all the best for your research.”

<table>
<thead>
<tr>
<th>Maryke Bronkhorst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estée Van Lingen</td>
</tr>
<tr>
<td>Lila Bruk</td>
</tr>
<tr>
<td>Kelly Schreuder</td>
</tr>
<tr>
<td>Kerry Hillerman</td>
</tr>
<tr>
<td>Dietitians Vaal Area</td>
</tr>
</tbody>
</table>

Jody Calitz, Heidi Lobel, Carol Murell, Michelle Lewis, Elenia Kolokotronis, Jean Sobiecki, Lynne Maccallum, Megan Bosman, Katherine Tudsbury, Anastacia Sampson, Kari Jonker, Claire Mchugh, Marie Petrelis, Lynne Brown, Diane Hill, Adele Pelteret, Cathy Grundy, Andrea Jenkins, Lesley Scott, General email to nutritionists.co.za
<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sara Bilbe, Elise Barron, Ashleigh Caradas, Megan Bailey, Marian Bryant, Margaret Ellis, Heidi Du Preez, Ingrid Regenass, Hannah Kaye, Kelly Lynch, Cath Day, Eleanor Knoesen, Nicci Robertson, Beatrice Rabkin</td>
<td>Registered Dietician</td>
</tr>
<tr>
<td>Anja Smant</td>
<td>Registered Dietician</td>
</tr>
<tr>
<td>Ruth Sithole</td>
<td>Registered Dietitian, Johannesburg</td>
</tr>
<tr>
<td>Nelly Silvis</td>
<td>Registered Dietitian, Pretoria</td>
</tr>
<tr>
<td>Elzette</td>
<td>Registered Dietician</td>
</tr>
<tr>
<td>Mindful Eating</td>
<td>Dietitian Consultancy</td>
</tr>
<tr>
<td>Conscious Healing SA</td>
<td>Nutritionist</td>
</tr>
<tr>
<td>Lisa Raleigh</td>
<td>Fitness, Lifestyle, Nutrition</td>
</tr>
<tr>
<td>Nutrition Society South Africa</td>
<td>Individual emails</td>
</tr>
<tr>
<td>Joan Matji: “Thank you for your message and congratulations on”</td>
<td></td>
</tr>
</tbody>
</table>
working on a research topic that is highly relevant and of importance in our region. Unfortunately at this moment in time I am overwhelmed with work related demands and will not be able to support your efforts. I would highly recommend that you reach out to Ms. Lynn Moeng who is working on a related research topic for her doctoral degree, her email is moengl@health.gov.za, Wishing you every success going forward."

<table>
<thead>
<tr>
<th><a href="mailto:info@dieticiansatwork.co.za">info@dieticiansatwork.co.za</a></th>
<th>Dietitians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynn Moeng</td>
<td>Conducting doctoral research on a related topic</td>
</tr>
</tbody>
</table>