Abstract

Objective: To demonstrate that recent attempts to equate anorexia nervosa with any form of voluntary self-starvation are not justified. Method: Three arguments are critically reconsidered: That weight phobia was not part of early case reports on anorexia nervosa, that weight phobia should be eliminated from the diagnosis of anorexia nervosa, and that there is a continuity of forms of extreme fasting since the late Middle Ages. Results: A critical approach to the history of eating disorders by interpreting historical sources makes the emergence of anorexia with weight phobia in the middle of the 19th century probable. Criteria for establishing psychiatric diagnoses and the differences between historical types of extreme fasting also support the historical novelty of anorexia nervosa. Discussion: The etiological implications of the historical specificity of anorexia nervosa are limited. Research should be directed to better understand self starvation without weight phobia.
On the uses of history in psychiatry: Diagnostic implications for anorexia nervosa

Anorexia nervosa (AN) and bulimia nervosa (BN) with their apparent link to fashionable dieting have been considered distinctly modern and culture-bound disorders. This popular notion received substantial support from cross-cultural (e.g., Nasser, 1997) and historical research (e.g., Habermas, 1989, 1992a). Others have argued for the universality of BN and especially AN, referring to the historical and cultural ubiquity of binge eating (bulimia) and of self-induced emaciation. In a previous review of cross-cultural and historical research on eating disorders I argued that the clinical feature which renders both disorders distinctly modern and Western is the overvalued idea of being too big when at normal body weight which serves as the primary conscious motivation for restricting food-intake (Habermas, 1996).

This paper focuses on recent arguments regarding the historical dimension of the debate, leaving cross-cultural specificity aside. Although in recent years no essential new historical sources have been reported, safe details on anorexic behavior and cognition in Queen Elizabeth of Austria (Vandereycken & Abatzi, 1996), controversy has continued to revolve around the following questions:

- Are AN and BN historically invariable?
- Should diagnostic criteria be modified to reflect a supposedly less ethnocentric or superficial view of a more general core syndrome of self-starvation?
- Is there continuity between religious and secular interpretations of self-starvation?

The first, historical argument leads up to the central nosological issues, which are followed by a reconsideration of the secularization of motives for extreme fasting. All three proposals will be discussed by clarifying the logic of the argument and the methodology of the interpretation of historical sources, as well as by describing some of the neglected historical sources and by testing their historical and sociological validity. The most extensively argued universalistic position by Pamela Keel and Kelly Klump (2003) will serve as the main proponent for critically discussing the history of eating disorders.

**Are AN and BN Historically New Syndromes?**

The answer to the question whether AN and BN are historically new syndromes or have always existed, depends on whether psychological criteria of the diagnosis are abolished or not. The crucial psychological criteria are phobia-like attitudes towards normal body weight, body-volume or body-fat, which motivate a restrictive food-intake and a variety of purging behaviors as well as, in the case of AN, a denial of the dangers of emaciation and purging. In the current version of the DSM, three of five criteria for the diagnosis of AN are psychological. Besides a body weight below 85% of the norm and amenorrhea, the psychological criteria are the “refusal to maintain body weight at or above a minimally normal weight”; “intense fear of gaining weight or becoming fat even though underweight”, and a “disturbance in the way in which one’s body weight or body shape is experienced, undue influence of body weight or shape on self-valuation, or denial of the seriousness of the current low body weight” (APA, 2000, p. 589).

Ascertaining psychological phenomena in patients requires clinical experience, empathy, and cognitive and communicative skills for observing and talking with the patient. Similar behaviors may have a variety of motives and meanings which can be crucial for understanding the condition of the patient. The possibility to understand and diagnose a patient is severely limited both if the patient cannot be interrogated and if the patient not only speaks a different language, but also thinks in different cultural categories. In epidemiological research based on case registers or medical records, researchers have to rely on the reporting doctor’s diagnostic ability and his criteria for what is clinically significant enough to be reported. In historical research the methodological problems are even greater than in epidemiological research, since the reporting doctor’s criteria for diagnosis, clinical significance and reportability from the researchers’ criteria also on a historical dimension.

Are AN and BN invariable?

The diagnosing clinician and the historian alike need to go beyond mere appearance, both need to take into account the perspective of their sources, and thereby the sources’ limits and partiality. In their recent review of historical, epidemiological, and cross-cultural research on eating disorders, Keel and Klump (2003) conclude that AN is a universal phenomenon while BN is historically new and culture-bound. The following scrutiny of their and others’ argument aims at revising this conclusion on the basis of three points. The first two will be dealt with in this section, the third point in the subsequent section: a) taking historical reports at face value without taking into account the source’s perspective and biases may lead to erroneous conclusions, b) taking selected secondary sources of other researchers on the history of eating disorders at face value in a review of historical case reports, instead of analyzing primary sources, may lead to erroneous conclusions and makes it difficult to find criteria for favoring the historical interpretation of one secondary source over another, and c) contrary to expressed intentions, the authors apply modern diagnostic criteria to one disorder (BN), but not to the other (AN).

**Why Historical Case Reports Should Not Be Taken At Face Value**

Those who argue for the historical continuity of AN tend to rely on historical authors’ diagnostic judgments of clinical relevance. For example, Keel and Klump (2003) point out that diagnostic uncertainty has plagued epidemiological studies, as may be seen from the fact that “incidence rates differ more across studies than across time” (Keel & Klump, 2003, p. 749). They point out that relying on diagnoses in case registers may track changing diagnostic habits rather than historical changes in incidence. Nevertheless Keel and Klump include these third-hand reports in their meta-analysis of historical epidemiological studies of incidence-rates. Although there are only a few historical epidemiological studies on eating disorders, both the methodologically more sound ones and the reports which doctors were instructed to diagnose in accordance with modern diagnostic criteria, as well as the remaining studies seem to indicate a rise in the incidence of AN between the 1930s and the 1970s (Hoek & Hoeken, 2003). Still, when reviewing epidemiological studies, one should have a close look at the criteria used in these studies. Lucas, Beard, O’Fallon and Kurland (1991), for example, claim to be using modern diagnostic criteria, but do not require psychological criteria for a diagnosis of AN.

In their review of research on historical case reports of AN and BN, Keel and Klump (2003) point out that historical case reports of extreme fasting or survival without food do not mention weight-concerns, as was the case in the reports by Gull (1874) and Lasègue (1873), this should be taken as straightforward evidence for the lack of weight phobia in these patients. To support their interpretation, the authors quote a passage by Winslow (1880) in which he mentions young women who ruin their health by voluntary fasting because they believed themselves too plump. And according to the authors, “Charcot emphasized the role of weight phobia in the etiology of self-starvation among his patients”. They conclude that “the work of both Winslow and Charcot would have been available to Gull and Lasègue, suggesting that both men could be aware of this possible explanation for self-starvation” (Keel & Klump, 2003, p. 754).
This line of reasoning is open to four counter-arguments. (a) Winslow published in 1880, that is seven and six years respectively after Gull and Lasègue published their reports. Charcot appears never to have published anything about the “idée fixe d’obésité” as the motive for losing weight in AN. Rather, Charcot’s oral comments were reported by Pierre Janet only in 1907. Also, in contrast to Janet, neither Lasègue nor Gull practiced in Paris nor worked closely with Charcot. Thus Gull and Lasègue could not have known about the fear of being too thick from either Winslow or Charcot when publishing their reports in 1873 and 1874.

(b) However, Gull and Lasègue probably could have known about the beginning fashion of dieting among girls. In the early 1860s, Queen Elizabeth of Austria suffered from an intense fear of becoming overweight, which she counteracted by a strict restriction of food intake and physical exercise resulting in severe emaciation (Rainbaud & Eilacheff, 1989; Vandereycken & Abatzi, 1996). Overweight became a popular preoccupation in the 19th century first for men. Banting’s letter on how he was cured of overweight (1864) provoked a rush on fasting-cures offered by medical men and private clinics (e.g., Kisch, 1888, Schindler-Barnay, 1882). In the second half of the 19th century medicine began to pathologize even moderate degrees of overweight, which were more and more judged by reference to statistical tables such as those by Worthington and Quetelet. We know from one medical source that in the 1880s French schoolgirls sought to outdo each other in controlling their body weight by drinking vinegar and restricting their food-intake (Wallet, 1892).

The traditional technique for forming the female appearance had been and still was in the late 19th century the corset. Apparently it was slowly superseded by fasting as a technique with more lasting effects between maybe the middle of the 19th century and WW I. Several case-reports describe this transition from corset to fasting. Gasne (1900), Tarris (1910) and Noguès (1913, case #16) report that their anorexic patients not only fasted but also practiced excessively strict lacing of their corsets. Brisseau and Souques (1894) described an anorexic patient who could no longer carry a corset due to a local sensitivity: “Once without corset, she declared to feel even thicker than before”. These two motives for not eating were considered as weight phobia.

However the first to mention weight-control as a motive for extreme fasting in the medical literature was Worthington in 1875, followed by Azenfeld and Huchard (1883), Sollier (1891), Sepilli (1892) and others. The first description of weight-phobia as a motive for extreme fasting in a specific case was published by Rist in 1878, followed by Féré (1892), Gungl & Stichl (1892), Wallet (1892), Brisseau & Souques (1894), Kissel (1898), Janet (1898) and many more (cf. Habermas, 1899, 1992a).

Lasègue might indeed have known of fasting for reasons of controlling body weight among girls and young women. However, in the early 1870s it may not have been everyday knowledge that girls, and not only overweight girls, fasted in order to reduce. Even with this knowledge, extreme emaciation is a far cry from normative dieting in young girls. It is especially difficult to imagine that extremely emaciated women still fast to control their body weight, especially if they deny eating little or deny at least any intention to eat little, as was typical for AN before it became popularly known in the 1970s. Thus if patients tended to deny intentional fasting and fearing normal body weight, and if the doctors did not know of fashionable dieting among girls, or at least did not know of this specific motive for not eating despite underweight, then it must have been difficult to detect weight phobia. One striking example for the possibility of overseeing even the intentional character of not eating and thus misunderstanding AN is provided by the misdiagnosis of cases of AN as suffering from Simmonds’ disease which prevailed for decades.

(c) A further argument against an uncritical reading of case reports is that the historical publications of cases of extreme emaciation with fasting and weight phobia and the publications of cases of extreme emaciation without fasting or without weight phobia are not randomly spread across times and countries. Rather, the meaningful pattern of who did report weight phobia before WW I and who did not is sufficiently explained by four factors (Habermas, 1991): working within a tradition that values clinical description, as was the case in French psychiatry in the 19th century, an interest in the psychological aspects of mental disturbance, as was the case in the French tradition leading up to Charcot, and an interest in nutrition, which, combined with an interest in the psychology of their patients, made German doctors of internal medicine sensitive to motives for not eating. The fourth factor is working in a tradition which has already discovered weight phobia, as was the case especially with doctors working in Charcot’s Salpêtrière. Other authors who fulfill one or two of the first three criteria have not reported weight phobia in anorexics because of any one of three further reasons: they were not working with neurotic patients, such as many psychiatrists, or they were working in private practice which prevented them from seeing severely emaciated patients, such as psychoanalysts, or they were biased by the conviction that cases of AN were really suffering from an internal disease such as Simmonds’ disease. An especially interesting case is how AN was treated almost exclusively as an internal disease in Germany between 1914 and 1945. Even some psychologically minded authors insisted on the somatic etiology of emaciation, for reasons of proving their holistic conceptions of psychosomatic medicine (cf. Habermas, 1994).

The most convincing explanation of this systematic pattern of reporting or lack of reporting weight phobia in cases of extreme emaciation is that weight phobia was difficult to detect and was not reported if doctors were not alerted to it, were not attuned to detailed clinical, psychological description or focused on nutrition, or if the doctor held preconceptions which contradict weight phobia as a motive for fasting.

(d) Finally there are no competing motives for not eating that have a comparable organizing and explanatory power. Typical aspects of AN, such as an intense interest in food, extreme fasting, selective eating aiming at reducing weight-gain and hunger at the same time (e.g., by filling oneself with soup), the positive value of weight loss, a high level of physical and mental activity which is highly atypical for underweight, and a denial of the seriousness of their underweight can be understood if the individual is thought to fear normal body weight. No other motive not to eat is compatible with this pattern of phenomena. No other motive not to eat is specific for AN (Habermas, 1996). Conversely, when retrospectively diagnosing historical cases with the criterion of weight phobia, only in very rare cases can one find weight phobia such as a supportive motive for profit from the state of emaciation with a denial of illness or denial of the state of physical exhaustion as evidenced in overactivity” (Habermas, 1989, p. 262), no cases from before 1870, but a growing number of cases from then on may be diagnosed as cases of AN (Habermas, 1989; 1992a). Van Deth and Vandereycken (2000), using equivalent criteria for the retrospective diagnosis of cases from the 19th century, only include few earlier cases from after 1850, but no earlier case (cf. van Deth & Vandereycken, 1992).

The field of the history of psychological and psychiatric phenomena the same care should be taken to estimate possible biases in sources as historians do with their sources. If historical reports are not taken at face value, this opens the possibility that phenomena may not have been reported because the historical observer’s expectations did not prepare him to see them. Thus weight phobia probably emerged in single individuals some decades before it was first described in the 1870s. This permits (a) retaining important insights into the dynamics of AN, i.e. the role of weight phobia, (b) extending the history of AN to the first reports using this or a similar term, namely to Lasègue’s (1873) and maybe also Gull’s (1874) report, (c) accounting for surprisingly great national and chronological differences in medical publications in which AN is retrospectively discernible.

**Why Historical Statements Should Nevertheless Be Based on Primary Historical Sources**

Research on the history of eating disorders presents competing conclusions regarding the historical continuity versus discontinuity of AN and BN. The disagreement is mostly created by differing views on the reliability of historical sources and on whether weight phobia should be used as a central criterion for differential diagnosis also in historical research. Since these issues are treated differently by different researchers, any review of the history of eating disorders should rely on the primary sources. Keel and Klump (2003) acknowledge this necessity by excusing themselves for using secondary sources for cases from “prior to the mid-19th century. […] Although this section
of the review” on the history of AN “is vulnerable to the interpretations of the secondary source, many of the cases were reviewed by multiple authors with differing theses, thus allowing a reasonably comprehensive presentation” (Keel & Klump, 2003, p. 749).

However, Keel and Klump (2003) do not discuss differing diagnostic interpretations of historical cases by different authors. Nor do they rely on primary sources for cases from after the middle of the 19th century. They report some research on ascetic-mystic fasting saints of the late middle ages, on the miraculous fasters since the 16th century, and on sitophobia, that is food refusal in the asylums, but most of the literature on continental miraculous fasters (Vanderyecken & van Deth, 1994) is left out as well as most of the continental sources on AN from the 19th and 20th century. Also, analyses of van Deth and Vandereycken (1992, 2000), showing that fasting girls and patients described as sitophobic differ from anorexia nervosa, are not mentioned.

The argument that AN as defined today emerged some time in the middle of the 19th century is based on positive explicit evidence of weight phobia as the motivation to fast in AN in several descriptions and seven general descriptions of AN in the latter quarter of the 19th century. Six of these case descriptions were published in French, one in German. Between 1900 and 1917 seven more case descriptions mention the wish to control body weight as a motive for extreme fasting in AN, again five of which published in French, two in German (Habermas, 1989, 1992a). Although it is known that the evidence for weight phobia is to be found in French and German historical case reports, Keel and Klump (2003) do not mention it. Therefore it is not surprising that they conclude that weight phobia is only a recent phenomenon in self starvation. If a motive for not considering primary sources from the European continent is the language barrier or scarce availability of printed sources on the American continent, this should be stated and taken into consideration when drawing conclusions.

Reliance on secondary sources may lead to imprecise statements. For example, a study by Pope, Hudson and Miale (1985) is cited, who identify four cases with binge eating in the second volume of Janets Les obsessions et la psychasthénie” (1903). Had Keel and Klump read Janet, they would have discovered extensive clinical description and theorizing about weight phobia. One of the four patients mentioned by Pope, Hudson and Miale (1985) is famous Nadia. Janet described this bulimic anorexic on eight pages in 1898 and on six pages in 1903.

Nadia had started fasting at age 20. She ate very little and preferred tea, soup and vinegar: “out of the fear to gain weight” (Janet, 1898, 34). Janet used Nadia to differentiate what he termed true anorexia from hysterical anorexia. True anorexia, as in Nadia, leaves hunger intact. In fact, Nadia frequently forgot herself to devour anything edible within reach. Also, she passed hours with thinking and reading about food. She was eager in her work, and walked all her ways by foot in order to reassure her mother of her health as well as to lose weight. “The refusal of food is only the consequence of an idea, a delusion (délire). This idea, if you look at it superficially, is obviously the fear to gain weight. Nadia fears to become as big as her mother; she is eager to remain skinny (maigre), pale, only that pleases her, is in harmony with her character; from this stems a continuous agitation, she fears to have an inflated figure, to bulge, to have big muscles, to have a better complexion” (Janet, 1898, p. 37). Janet goes on to describe in detail how the body and bodily activities like eating are the central objects of Nadia’s shame and fear. Five years later, in the second volume, Janet again described Nadia under the heading “delusion of thinness through obsession of shame of body” (délire de maigreur par obsession de la honte du corps; Janet, 1903, p. 368).

In the same volume in which Janet first described Nadia, he also mentioned Red, a second female patient whom he explicitly likened to Nadia because both were dominated by the idea that they should be very thin. She was seen first at the age of 14, as reported by Brissaud and Souques in 1894 under the name of Julie R., and two years later again by Janet (1898, p. 87f.). Besides fasting Red., also induced vomiting. Brissaud and Souques detail the development of the idée fixe de la maigreur, starting at the age 13 or 14 when she was slightly overweight and was teased by peers. “The desire to lose weight had to emerge in her mind, so as to avoid her peers’e teasing. All the more she was quite coquette. To realize her desire, the safest and simplest measure was not to eat and to vomit what she had eaten” (Brissaud & Souques, 1894, p. 336).

The two patients of Janet’s were briefly presented to convey a sense of how explicitly renowned French psychiatrists described weight phobia as the central organizing idea in AN. These and many other reports were ignored in the review by Keel and Klump (2003).

Even when Keel and Klump (2003) refer to a translated primary source, their detailed discussion is sometimes not supported by the facts. They try to discredit Habermas’ (1989) historical analyses by finding fault in several details of his reference to Wulff’s (1932) case report on bulimia when compared to Stunkard’s (1990) translation of parts of that text on bulimia. None of the alleged differences holds. Habermas did not classify the four cases as examples of BN, but stated that “none of the patients would appear typical today, but they share many features with BN” (Habermas, 1989, p. 267), not only three but all four patients had alternating phases of binging and fasting. Wulff did also report on the motive to fast in AN in seven male patients, and patient A’s periods of fasting were not always last several months, but were later reduced to “shorter periods of time, sometimes only for a few days, even for only one day” (Wulff, translated by Stunkard, 1990, p. 265). Finally, Stunkard used the term ‘bulimia’ not in the broad sense of binge eating, but to denote BN, as he specified only one year later: “bulimia as binge eating with associated body image disturbance and purging behavior is of relatively recent origin. […] T he 1932 paper by Wulff […] may well be the first description of the latter disorder” (Stunkard, 1991, p. 1274).

A similar misrepresentation is that “Habermas (1989) review of Briquet revealed a case of apparent BN” (Keel & Klump, 2003, p. 760), while actually it said that “some earlier case histories give room for speculations without providing essential evidence such as the one by Briquet (1859, p. 255)” (Habermas, 1989, p. 267).

To sum up, both taking historical sources by the letter and relying on secondary instead of primary sources introduces more ample room for error than necessary. Methodological standards of historical research in psychiatry require a more critical stance towards sources.

**SHOULD THE CURRENT DIAGNOSTIC CRITERIA BE USED FOR RETROSPECTIVE HISTORICAL DIAGNOSES?**

The perspective on the history of eating disorders depends largely on the choice of diagnostic criteria. Two points shall be made: a) stating that BN is a new, but AN an old, universal disorder implies an inconsistent use of diagnostic, b) the proposal to drop weight phobia does not preserve the nosological specificity and clinical homogeneity of AN.

**Two Different Standards For Two Related Disorders?**

Keel and Klump (2003) summarize their review of cross-cultural and historical evidence suggesting “that BN is culture-bound and that AN is not”, declaring little later that they “chose to follow the DSM-IV conceptualization of these syndromes because it has the greatest empirical support.” (2003, p. 762). However, their summary is a direct consequence of using the DSM-IV criteria (including weight concerns) for identifying BN, but eliminating weight phobia from the DSM-IV criteria for AN: “Thus excluding the criterion of weight concerns, AN appears to represent a similar proportion of the general and psychiatric populations in several Western and non-Western nations” (Keel & Klump, 2003, p. 755).

This apparent contradiction could be resolved by assuming that the authors hold the tacit assumption that only behavioral and somatic criteria of DSM should be used for diagnosis. This seems to follow from their reasoning about the criteria for comparing historical forms of fasting with AN, namely “ovet behaviors, consequences, course, and affected population” (Keel and Klump, 2003, p. 761). Historical comparison of historical forms of binge eating with BN is based on the combination of binging and purging behaviors. From the relative rarity of this combination of behaviors before the 20th century they infer that BN in normal weight women “may not emerge in the absence of weight concerns” (p. 761). Here again the authors do not analyze the positive
arguments for dismissing weight-related cognitions and motives as diagnostic criteria of an eating disorder not otherwise specified (EDNOS) makes up 30% to 60% of all eating disordered patients, and that many of these are not distinct from cases of AN (e.g., Andersen, Bowers & Watson, 2001; Crow, Agras, Halmi, Mitchell & Kraemer, 2002; Favaro, Ferrara & Santonastaso, 2003). Similarly, Lee (1995) proposed that many self-starving patients in China did not present weight phobia but did not differ otherwise from anorexic patients with weight phobia. When dropping weight phobia as a diagnostic criterion, the consequence is that states of self-starvation which are motivated by other psychopathological states such as depression, gastric complaints, phobic and hypochondriac obsessions, paranoid delusions of being poisoned, or hysterical vomiting would all be included in the new diagnostic category. If these other conditions of food refusal were explicitly excluded from a new diagnosis of self starvation, then it would remain merely a residual category of ‘other forms of self starvation’ and lose both its homogeneity and distinctness.

For instance, Rieger, Touyz, Swain and Beumont (2001) suspect that one of the non-fat phobic self starvers presented by Lee (1995) was suffering from depression. In later publications Lee sought to explicitly exclude depression when describing non-fat phobic self starvers (Ngai, Lee & Lee, 2000, p. 315). However the second patient presented as non-fat phobic (case 4) raises suspicions whether she simply denied the voluntary character of not eating by justifying food refusal with epiphanic pain in order not to be made responsible for not eating. The statement that “she was comfortable with being nicknamed ‘fat little girl’ and was satisfied with her body weight” (Ngai, Lee & Lee, 2000, p. 315) seems not very plausible, but rather to provide a plausible motive for starting to diet at age 13. No information is provided about the attitude of the patient towards her losing weight or towards her body. Also, it is not clear whether the data were collected at age 13 or rather nine years later when the authors saw the patient. The fears of fatness exhibited by the patient several years later may as well have first developed at age 13 but were only admitted later.

The other non-fat phobic patient presented by Ngai, Lee and Lee (2000; case 3) indeed seems to differ from the typical AN patient to the extent that she “loatched at the sight of food which she ‘loathed’ and became a voracious eater” (p. 315) and avoided meat and fat. Thus in contrast to typical cases of AN she was not attracted by food and thus did not have to fight the constant temptation. Also, she selected food not according to suspected non-fattening effects. These differences in motives and attitudes, I would argue, probably go together, not only in this particular patient, with an absence of binge-eating, purging behavior, overactivity and hiding of how little she eats. The better prognosis should be based on the different motives for not eating: When underweight is only a by-product of other, not body-related motives not to eat, then regaining weight is not feared in itself and is not avoided as an end in itself.

However internal case reports are for understanding and formulating the typical features and internal logic of syndromes, a test of the homogeneity and distinctness of diagnostic categories has to rely on greater numbers of patients. Several studies compare AN and subthreshold AN as well as BN and subthreshold BN on measures of depression (BDI) and anxiety (STAI; Ricca et al., 2001), the Yale-Brown-Cornell Eating Disorders Scale (Crow et al., 2002), (BDI) and the EDI (Danzyger & Garfinkel, 1995). Some suggest that the existing criteria of severity do not succeed in defining clearly distinct groups (Crow et al., 2002; Ricca et al., 2001; Turner & Bryant-Waugh, 2004).

Other studies find that the criterion of amenorrhea for a diagnosis of AN is not warranted since patients with all anorexic features except amenorrhea do not differ significantly from cases of AN on measures such as the EDI, BDI, or the psychopathology-subscale of the MMPI (Cachelin & Mahler, 1998; Garfinkel et al., 2001; Andersen, Bowers and Watson (2001)) therefore propose to abolish the criterion of amenorrhea and to mitigate the weight criterion.

More to our point are comparisons between AN and self-starvation without weight phobia. A substantive minority of emaciated self-starving patients denies any weight-related concerns, for example 13% of all AN-like patients with the diagnosis of EDNOS in a British sample (Turner &
Bryant-Waugh, R. (2004). Of all patients who fulfilled all diagnostic criteria for AN except, possibly, weight phobia, 21% did not state weight-related concerns in a sample from San Francisco (Strober, Freeman & Morrell, 1999), 22% in a German sample (Willenberg & Krauthauser, 2000) and 28% in a sample from Hong Kong (Lee, Chan & Hsu, 2003). In a sample including adolescents and children, eating disorders were phenomenologically even more diverse. Besides AN and BN, they included functional dysphagia, selective eating, a so-called food avoidance emotional disorder and a pervasive refusal syndrome (Nicholls, Chater & Lask, 2000).

Four studies have addressed the phenomenology of the AN diagnosis compared to other forms of self-starvation. Ramacciotti and colleagues (2002) divided a mixed group of eating disordered patients with diagnoses of AN, BN and EDNOS into a group of 59 individuals with high values on the Drive for Thinness Subscale of the EDI (cutoff seven points) and a group of 12 individuals with values low seven which they label ‘atypical ED’. Among these were five out of 22 patients with AN, seven of 44 patients with BN and one of three patients with EDNOS. Patients in this ‘atypical’ group showed less severe symptoms. In a second sample of 106 patients with AN, 18 had values of less than seven on the Drive for Thinness Scale of the EDI. The authors conclude that “weight phobia should not be viewed as critical to the diagnosis of ED and drive for thinness could be a culture-bound dimension” (Ramacciotti et al., 2002, p. 206).

However, although the authors claim to have used the DSM-III-R and DSM IV-criteria for diagnosis, they also claim that over 20% of all patients with AN in both samples lacked weight phobia. Therefore what is to be concluded from the study is not the non-uniquity of weight phobia in AN but rather the lack of reliability of either the clinical diagnosis or the EDI in this study.

Three studies compared patients with AN with patients fulfilling all diagnostic criteria for AN except for weight phobia or a denial of emaciation. Willenberg and Krauthauser (2000) compared 42 patients with AN with 12 comparable patients except for weight phobia. Patients with AN were more dominant on the Giessen Test, a German personality test. Four studies have addressed the specificity of the AN diagnosis compared to other forms of self-starvation. Ramacciotti and colleagues (2002) divided a mixed group of eating disordered patients with diagnoses of AN, BN and EDNOS into a group of 59 individuals with high values on the Drive for Thinness Subscale of the EDI (cutoff seven points) and a group of 12 individuals with values low seven which they label ‘atypical ED’. Among these were five out of 22 patients with AN, seven of 44 patients with BN and one of three patients with EDNOS. Patients in this ‘atypical’ group showed less severe symptoms. In a second sample of 106 patients with AN, 18 had values of less than seven on the Drive for Thinness Scale of the EDI. The authors conclude that “weight phobia should not be viewed as critical to the diagnosis of ED and drive for thinness could be a culture-bound dimension” (Ramacciotti et al., 2002, p. 206).

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However, although the authors claim to have used the DSM-III-R and DSM IV-criteria for diagnosis, they also claim that over 20% of all patients with AN in both samples lacked weight phobia. Therefore what is to be concluded from the study is not the non-uniquity of weight phobia in AN but rather the lack of reliability of either the clinical diagnosis or the EDI in this study.

Three studies compared patients with AN with patients fulfilling all diagnostic criteria for AN except for weight phobia or a denial of emaciation. Willenberg and Krauthauser (2000) compared 42 patients with AN with 12 comparable patients except for weight phobia. Patients with AN were more dominant on the Giessen Test, a German personality test.
transition in the interpretation of not eating, from fasting girls to AN, however, cannot be attributed to a change of perspective in the historical source, because both were reported by doctors. Also, it cannot be attributed to the emergence of the specialty of psychiatry in the 19th century, since the majority of reports on AN before WW I were written by doctors of internal medicine or pediatrics.

Not surprisingly, the medical literature on AN of the late 19th and early 20th century neither contains references to religious reports of alleged inedia nor to religiously motivated ascetic-erotic fasters. The one exception is Giovanni Brugnoli (1875) who referred to his colleague Becarri of the 18th century who had written a medical expertise on the possibility of inedia for Pope Benedict XIV’s book on the criteria for canonization (cf. Habermas, 1992b). More surprisingly maybe, and in contrast to the opinion of Keel and Klump (2003), not many, if any at all, of the early reports contained references to the fasting girls. The major shift in the cultural interpretation of not eating in the 19th century was from a focus on claims of prolonged survival without food to a focus on emaciation due to voluntary abstinence from food. inedia was no longer considered to be possible.

**Discontinuities Between Religious And Non-Religious Motives For Extreme Fasting**

The transition from the first to the second type of extreme fasting at the beginning of the 16th century was accompanied by a change from religious to secular sources. To which degree the motives for extreme fasting reported in historical sources were influenced by this change in sources remains unclear. The next historical transition took place in the 19th century. Alleged inedia ceded to AN, in which not eating is hidden rather than exhibited. This transition appears to mark the final secularization of fasting, not only in the eyes of medical doctors, but also of the fasting women themselves. Accordingly, in the case reports on AN up to WW I there is frequent talk of patients having been teased by peers about their chubbiness, being on a diet, and their wish not to become as big as their mothers. Religious and ascetic motives, in contrast, are only very rarely mentioned in these reports. These few reports will therefore be reviewed in more detail in order to demonstrate the historical discontinuity between religiously motivated extreme fasting and AN.

Ascetic practices are described in two patients who somehow resembled anorexics. Nougès (1913, case #14) reports a patient who flagellated herself, lived ascetically and ate very little so that she lost weight. She believed to have the devil in her body and to be feeding him with every bite she ate. Thus she did not eat out of a paranoid delusion. Also Ludwig Winswanger (1909; cf. Habermas, 1991) described a patient with severe autopunitive and ascetic practices. Apparently fasting served more as a means for self-mortification than to systematically reduce her body, since she fasted for entirely different reasons in order to do penance for her delusional sins. Only once fasting had provoked binge-eating did she start to try to systematically control her food-intake, but never with the effect of becoming underweight.

Religiosity is described in four patients. Young Red., who was mentioned as a case of AN above, was quite religious. However she fasted explicitly in order to lose weight, not for religious motives. Religious means such as holy waters from Lourdes, in contrast, did serve her to try to get away from not eating (Brisaud & Souques, 1894; Janet, 1898).

In two other cases there may have been religious motives for fasting, although the reports are not explicit about this point. Kissel (1896) mentioned an emaciated girl of 11 years of age whom he saw in his clinic in Moscow in 1893. One year earlier she had become very religious, obsessively bowing in front of a saint’s statute. Little later she “developed the conviction, as she herself said, to be eating too much, and she aimed at giving up eating” (p. 387) although she was hungry. She felt ashamed of eating too much. In spite of her progressing emaciation she felt well all the time. The report leaves the possibility, that the girl had religious ideas of sinfulness about eating, open.

Brugnoli’s (1875) probably anorexic patient Guendalina described her illness and the dangers of her emaciated state, loved extremely long walks despite her malnourished state, and preferred to eat lots of soup, which may have served to create a feeling of fullness without gaining weight. A variety of motives were discussed, but Guendalina only declared that she wished to enter a monastery. Some time later the parents gave in, Guendalina went to a monastery in Rome where a sister of her was a novice. However, Guendalina died three months later. As in the case presented by Kissel, it remains uncertain, whether, and if so, how religiosity and fasting were connected.

The only clear case of AN in the context of and motivated also by ascetic religious beliefs is Renata (Schnyder, 1912). Born to an old, very religious Catholic family in a small French town, she finished school at age 16. Little later she began to eat very little and to voluntarily vomit what she had eaten. She was overactive: “I was never more happy than when I had made 40 km on bike” (Schnyder, 1912, p. 204). At age 25 she was sent to the clinic of Paul Dubois in Berne, who himself had published on AN (1904), but was treated by Louis Schnyder. Renata ascetically restrained herself from satisfying hunger, thirst, need for rest and warmth, and curiosity: “Feeling in every way forbidden” (p. 15). She dictated these and other words in English in a dissociated state to Schnyder. In the evenings she explained these words. For example she explained that the words sin, thinking, talking, doing, feeling, which she had dictated in the morning, meant that the four activities were hampered by a fear of committing sins. Commenting on the words woman-skame-fat she said “I was ashamed to be a woman, because of the shape of my body. […] I was humiliated to be a woman and ashamed to feel that I was looked at. Being fat seemed especially humiliating to me, because it rendered the shape of the body even more perspicuous” (Schnyder, 1912, 218f).

Renata was torn between the prospects of marrying or becoming a nun. She linked ascetic, religiously inspired abhorrence of any sensual satisfaction with the more specific concern to weigh too much: “She eats little and vomits voluntarily from time to time, because her fear to gain weight stops her [eating]” (Schnyder, 1912, p. 247). When Schnyder pressed her to explain her fear of gaining weight (répugnance de grossir, literally: to become big), she answered “I could never get used to the feeling of full of forms, to the excitation of the flesh that I would prove in every part of myself. Also I don’t want to provoke in others the feelings which I experience myself, to be for them an object of desire” (Schnyder, 1912, 248).

An additional argument for the discontinuity between religiously inspired extreme fasting is that Janet never compared his patient Madeleine to any of his anorexic patients, only to another food-refusing, but not anorexic patient of his (Janet, 1911). He treated the stigmatized mystic Pauline Lair Lamotte (Maitre, 1993), called Madeleine, for over 20 years and wrote the two-volume book De l’angoisse à l’exstase on her Janet, (1926). Madeleine for periods of time refused food, she fought any sensual temptation, tried to increase her suffering, and even once tried to stop breathing (Janet, 1898, p. 284f., 338f). However, Madeleine, like many of the fasting girls, was normal weight. Although Madeleine seems to resemble many of the cases of alleged inedia, Janet did not think that she resembled anorexics.

The evidence reviewed shows three types of historical interpretations of extreme fasting: Religious interpretations of extreme fasting as signs of a virtuous life dedicated to God, not to worldly pleasures, furthermore medical interpretations of inedia considered possible but nevertheless to be often based on fraud, and finally medical interpretations of emaciation due to eating very little.

The three corresponding types of extreme fasting described in historical sources appear to be equally distinct. Late-medieval religious fasting was integrated into a system of ascetic and self-mortifying practices, was often accompanied by mystic gifts, and many of the fasting women lived in religious institutions. The miraculous fasting girls from the 16th to the 19th century remained in their families, were ill or handicapped, and claimed not to be eating anything, although most of them were not emaciated. Girls with AN rather try to make believe they were eating normally, and provide a variety of medical, somatic or aesthetic reasons not to eat. The fasting girls differ strongly from both the ascetic-mystic and the anorexic fasting women. Van Deth and Vandereycken (1992) compare the fasting girls to AN and found many more differences than similarities. Bellin (1999), like Bynum (1987), stresses the differences between religious late medieval and private anorexic fasters. And Gayral (1989) finds more differences between inedia and AN than commonalities.
Similarities Between The Three Historical Types Of Extreme Fasting

Despite these differences, there are also continuities and gradual changes. Thus some of the modern fasting maidens continued to claim religious motives for their refusal to eat. While some of the ten fasting maidens of the 16th century mentioned above publicly exhibited their miraculous inedia for money, such as Barbara Kremers, the girl from Cologne and Margaretha Ulmer, others were said to be very religious. Anna Lamenitta and Eva Flugel were held in high regard by the local religious and intellectual elite, while Katharina Binder and Appolonia Schreyer, living in rural areas, were sought for religious advice by the local people (Habermas, 1990). Also some of the later miraculous fasting girls were religious and fasting served as penitence, whereas others apparently were not religious or did not motivate not eating religiously (e.g., Molly Fancher from Brooklyn, Hammond, 1879; or Anne Marie Kinker from Osnabrück, Germany, Consbruch, 1800; Gruner, 1800).

Also, within the realm of the Catholic Church, in the 16th century some young women continued to follow the ascetic-mystic model of extreme fasting, but the response of the church became ever more negative. Of the fourteen Italian women analyzed by Zarrí (1980), who in the early 16th century were admired as saints during their lifetime and who followed the ascetic-mystic model of female saintlihood, five were suspected of a pact with the devil and black magic, one was denounced, and another one even judged as a witch. As late as in the middle of the 17th century a young Italian woman from a rural area near Bergamo followed the ascetic-mystic model of extreme fasting, was admired as a holy woman due to her alleged inedia, and was condemned by the Holy Inquisition for “pretense of saintlihood” (fictionalized by Tomizza, 1981; cf. Carroll, 1998). Several French women apparently followed the ascetic-mystic model of extreme fasting within the Catholic church, such as Marie Guyart in the 17th century (Maître, 2000), Louise Lateau (Hammond, 1879) and Thérèse of Lisieux (Harrison, 2003) in the 19th century. Even in the 20th century Simone Weil (Eliachef & Raimbaud, 1989, Maître, 2000), Therese von Konnersreuth (Steiner, 1977) and Gemma Galgani (Bettini & Mazzoni, 2002) appear to have been still following this late medieval model of saintliness and fasting.

Thus the transition from the first to the second type of extreme fasting was not abrupt but gradual and also incomplete. In addition, the secularization of the motives for fasting and of the self-interpretations of fasters is also less than totally accomplished. Although only one of the about three dozen case-reports on AN before WW I explicitly refers to religious motives for fasting, there continue to be published some few reports on AN in the context of strong religiosity. Morgan, Marsden and Lacey (2000) report that 81% of their patients with AN in whom the body took on negative religious meanings, so that self-starvation was experienced as a means of expiation. In one, probably two of the cases the religious interpretation of starving was secondary to the onset of AN. Banks (1992) interviewed a woman who in her adolescence in the 1970s had been anorexic and a middle-aged chronic anorexic woman, both coming from a conservative to fundamentalist Christian background. They interpreted fasting in an ascetic religious vein as a way to achieve purity. Finally Garrett (1998) reports that most participants in her study described their recovery from AN as a spiritual process, which did not necessarily take a religious form.

Other studies looked at religiosity and religious practices in groups of anorexics. A questionnaire-study of members of a British self-help organization, mostly recovered anorexics, indicates that religiosity was related to a lower minimum BMI ever reached and that religiosity increased in the course of AN (Joughin, Crisp, Halek & Humphrey, 1992), as already suggested by the case reports of Morgan, Marsden and Lacey (2000).

Based on questionnaires of 20 eating disordered patients, of whom 16 suffered from AN, Graham, Spencer and Andersen (1991) find that the onset of the eating disorder changed religious practices depending on their expected effects on body weight, thus decreasing participation in the communal and religious feasts, but increasing participation in religious fasting. A study of sub-threshold eating disorders symptomatology among 44 Spanish nons living in open communities suggested that they showed comparable degrees of weight concerns and disordered eating (Macias & Lell, 2002).

These few studies show that even nowadays religious ascetic motives may be present in AN, although it is fair to say that they are far from being typical. Thus Renato (Schnyder, 1912) was not the only or last woman with AN whose asceticism, and more importantly, also weight phobia was cast in religious terms. Weight phobia and a religiously motivated asceticism are not mutually exclusive.

To sum up, Keel and Klump’s (2003) thesis that the miraculous fasting girls followed the ideal of historical ascetic-mystic fasters such as Catherine of Siena may be correct for some, but definitely not for all or even a majority of miraculous fasting girls. Their other thesis that psychiatrists at the end of the 19th century judged fasting girls and anorexies as clinically similar could definitely not be corroborated. However, Keel and Klump (2003) are correct in pointing out that religious interpretations of fasting are not confined to the first two types of extreme fasting.

DISCUSSION

Whether AN and BN are universal or restricted to specific historical phases (and cultures) has been shown to depend on two main factors, namely on the methodology of historical research and on the diagnostic criteria chosen. First, it was demonstrated that the universal nature of AN can only be claimed by treating primary and secondary sources at face value and interpreting them literally instead of following historical methodology by taking into account the probable factors that have influenced the sources and by changing current diagnostic criteria.

Then three arguments for abolishing weight related concerns from the diagnostic criteria of AN are refuted. The conception of psychiatric diagnoses as defined by reference to somatic criteria is criticized as not feasible. A review of the few existing studies of the homogeneity and specificity of clinical groups defined with or without specific criteria showed that dropping amenorrhea and keeping weight phobia succeed in creating homogeneous and specific groups. And it was argued that only the current criteria with weight phobia allow to write a history of AN with a minimum of contradictions.

Finally arguments and additional evidence for a typology of three different historical forms of extreme fasting were reviewed. Basic, also diagnostic differences were restated, but partial continuities and overlaps between the three types were also specified (cf. van Deth & Vandereycken, 1994).

The argument for weight phobia as a necessary criterion for the diagnosis of AN should of course not obscure psychological similarities between different forms of ascetic reactions to sexual maturation in puberty, which had been emphasized, among others, by Arthur Crisp (1980). The focus on weight phobia has the limited aim of defining a group of phenomena which follow a similar dynamic, which is created by weight phobia and the ensuing underweight.

Finally the arguments for AN as a culture-bound syndrome should not obscure differences in the cultural influences on AN and BN. While AN for a long time has been individually ‘invented’ by each woman afflicted by it, the diffusion of BN since 1980 seems to be much more influenced by unconscious and conscious imitation of a cultural model of misconduct (Habermas, 1994).

With their historical and cross-cultural review, Keel and Klump (2003) intend to find evidence for the relative weight of cultural versus genetic etiological factors. However, they concede that both universal syndromes may also be due to cultural factors and that culture-bound
syndromes may also have a genetic diathesis. Thus genetic research profits little from information about the universality or culture-boundedness of syndromes, if it is not looking for non-universal genetic diatheses. Research into cultural conditions of syndromes, in contrast, may indeed use information about culture-boundedness of syndromes as indications for possible etiological factors.

The study of the history of eating disorders has seen its heyday in the 1980s and early 1990s. Nevertheless the diverging opinions about the history have remained. The debate about history could be based more on evidence if historical case material was more physically and linguistically accessible. Also, a more systematic quantitative analysis of historical case reports could be attempted, using a manualized diagnostic approach controlled by measures of interrater-reliability. The related debate on diagnostic criteria could be further advanced by defining better how to tap psychological criteria of weight concerns and ego-syntonicity and by designing studies similar to those by Strober, Freeman and Morrell (1999) and Lee, Chan and Hsu a (2003), in which clinical features and prognosis of groups defined with competing sets of criteria are tested on their relative homogeneity and specificity.

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