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On the uses of history in psychiatry:  
Diagnostic implications for anorexia nervosa

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ON THE USES OF HISTORY IN PSYCHIATRY

#### 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 19<sup>th</sup> 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 has 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 reviewing additional nosological evidence. 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 phenomena 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 differ from the researchers’ criteria also on a historical dimension.

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 also 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 studies in which records were re-diagnosed or in 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 AN and BN, Keel and Klump (2003) are even less critical of their sources. For one, the only limit of reliability of historical sources mentioned is that allegedly “prior to the twelfth century, details become sparse, increasing the difficulty of interpreting these potential cases” (p. 753). Degree of detail, however, does not differentiate early from recent case-reports. The story of the Bavarian serf Friderada, for example, reported by monk Wolhard at the end of the 9<sup>th</sup> century in his book on the miracles attributed to holy Walburgis, was seven pages long (Bauch, 1979, p. 325-339). Wolhard cites many details of the case in order to prove the credibility of the miracle (which consisted in curing Friderada from her inability to eat – Bauch, 1979; cf. Habermas, 1986). In contrast, many of the medical reports of the late 19<sup>th</sup> and early 20<sup>th</sup> century are quite brief and contain little detail.

In accordance with the assumption that medical reports from after the 12<sup>th</sup> century are reliable, Keel and Klump (2003) argue that when historical 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 reduction of food intake and physical exercise resulting in severe emaciation (Raimbault & Eliacheff, 1989; Vandereycken & Abatzi, 1996). Overweight became a popular preoccupation in the 19<sup>th</sup> 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 19<sup>th</sup> 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 19<sup>th</sup> century the corset. Apparently it was slowly superseded by fasting as a technique with more lasting effects between maybe the middle of the 19<sup>th</sup> century and WW I. Several case-reports describe this transition from corset to fasting. Gasne (1900), Tarrus (1910) and Noguès (1913, case #16) report that their anorexic patients not only fasted but also practiced excessively strict lacing of their corsets. Brissaud 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, and the wish to lose weight became even more imperative” (p. 336).

However the first to mention weight-control as a motive for extreme fasting in the medical literature was Worthington in 1875, followed by Axenfeld 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), Brissaud & Souques (1894), Kissel (1898), Janet (1898) and many more (cf. Habermas, 1989, 1992a).

So Gull and 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 19<sup>th</sup> 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 or secondary symptoms related to weight phobia such as a “strong subjective 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 19<sup>th</sup> century, only include few earlier cases from after 1850, but no earlier case (cf. van Deth & Vandereycken, 1992).

In 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-17<sup>th</sup> 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 17<sup>th</sup> century. They report some research on ascetic-mystic fasting saints of the late middle ages, on the miraculous fasters since the 16<sup>th</sup> century, and on sitophobia, that is food refusal in the asylums, but most of the literature on continental miraculous fasters (Vandereycken & van Deth, 1994) is left out as well as most of the continental sources on AN from the 19<sup>th</sup> and 20<sup>th</sup> 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 19<sup>th</sup> century is based on positive explicit evidence of weight phobia as the motivation to fast in AN in seven case descriptions and seven general descriptions of AN in the latter quarter of the 19<sup>th</sup> century. Six of these case descriptions were published in French, one in German. Between 1900 and 1918 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 Mialet (1985) is cited, who identify four cases with binge eating in the second volume of Pierre Janet’ “*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 Mialet (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* from time to time 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 maigre 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 18, 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 maigre*, 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’ 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 bingeing and fasting, Wulff did also report on one male patient, and patient A’s periods of bingeing would 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. [...] The 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 “overt 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 bingeing and purging behaviors. From the relative rarity of this combination of behaviors before the 20<sup>th</sup> 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

evidence of weight concerns in historical case descriptions of binge eating, but seem to treat it as a hypothetical construct. Even more surprisingly, they exclude psychological criteria from diagnostic considerations in the field of psychopathology.

#### Why Arguments For Dismissing Weight-Related Cognitions and Motives As Diagnostic Criteria of AN Do Not Hold

Many authors dealing with the history of eating disorders tend to define AN simply as voluntary self-starvation on a variety of grounds. They tend to dismiss psychological criteria such as disturbed experience of weight or shape of body, denial of seriousness of low body weight, and intense fear of gaining weight. The crucial implication of such an approach to the history of food refusal is an anti-psychological revision of the diagnostic criteria for anorexia nervosa. This diagnostic question is at the heart of the debate. In addition to an earlier discussion of these proposals (Habermas, 1996) and from a different angle, three major motives for abandoning the current diagnostic criteria will be discussed.

Concept of universal disease categories. The first and most persistent argument is that psychiatric disorders in general, and therefore also AN, should be defined and understood in purely biological terms. A polemical example for this line of argument was provided in *The Lancet* by Bergh and Södersten (1998), who suggested that recovery-rates for AN have been terribly low in this century because of Janet's and Freud's entertaining and colorful psychological descriptions of AN. Only a purely biological understanding and definition, as provided by Gull, would promise to raise recovery rates to the level which Gull had claimed for his treatments.

In a similar vein, Keel and Klump (2003) refer to other authors' argument that weight-phobia "is not necessarily related to the disease that underlies AN" (2003, p. 749). They propose to take as "the core feature of AN [...] an intentional yet involuntary self-starvation" (p.754). Their argument against weight phobia is that the motives for food refusal may vary widely and that these "may not represent the true causes of self-starvation", but may be culturally meaningful attempts to understand "an affliction that leaves women feeling unable and unwilling to eat" (p. 754).

Of course conscious motives for food refusal are not natural causes of a disorder, but motives that give an aim and meaning to actions and organize how the individual understands herself and others. Thus weight phobia is not the cause of AN but its central organizing element. Like any overvalued idea, the motive for fasting is conscious and deliberate, but appears to be involuntary to others since no rational motive is discernible. Also, in each afflicted individual the body, its form, volume and weight have individual meanings, which have been formed through individual life experiences and relationships. They may arouse feelings of shame, guilt, disgust, passivity, helplessness, or estrangement. Individual motives for weight phobia may be, for example, fear of sexuality, fear of growing up, a need for control, or a need to accentuate body boundaries.

The designation *weight phobia* may appear to be not always a precise description, because volume, form, fat or weight may be feared. But since most often afflicted individuals test effects of fasting by weighing themselves, the name *weight phobia* is still the most appropriate for the motive for fasting in AN. It is descriptive enough to cover all more specific and less conscious motives.

If weight phobia is not considered to be the cause but a symptom, the centrality of weight phobia is also compatible with the statement that "the sociocultural pressure to diet is not always a crucial factor in leading to AN" (Ngai, Lee & Lee, 2000). Apparently, the cultural technique of dieting is used and perverted in AN, but only very few of those exposed to norms of dieting do develop AN.

Nosological specificity. Besides proposals based on the general preconception of psychiatric disorders as biologically defined diseases, two other arguments for modifying diagnostic criteria actually refer to criteria for the adequacy of diagnostic criteria. The second argument is nosological and requires diagnostic criteria to define a group of cases which is homogeneous with regard to the clinical features, course and outcome and distinct from cases not falling into this category. Some suggestions at revising diagnostic criteria of AN argue that the group of patients diagnosed with 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 epigastric 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 typical AN in that she "loathed the sight of food which reminded her of her father, 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. These differences in clinical features probably also imply a better prognosis, though admittedly not in this patient whose underweight became chronic. 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 important 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 (Danzkyger & 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 & Maher, 1998; Garfinkel et al., 1996). Andresen, 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, 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 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).

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-ubiquity 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.

More relevant differences resulted from two other studies. Strober, Freeman & Morell (1999) followed restricting anorexics and atypical self starvers without weight phobia over ten to fifteen years and found a better prognosis for the atypical group in terms of recovery, speed of recovery and development of binge eating. Similarly, Lee, Chan and Hsu (2003) followed patients with AN and self starvers without weight phobia over 4 years. Patients with AN and patients with later age at onset predicted poorer outcome. Sing Lee (1995) and George Hsu (Hsu & Lee, 1993) had been among the most fervent proponents for abolishing the criterion of weight phobia, also on the grounds that weight phobia introduced a cultural bias (Lee, 1995). Testing their thesis by looking at differences in prognosis they have revised their former reservations about weight phobia concluding that "the outcome profile of Chinese patients supported the cross-cultural validity of AN" (Lee, Chan & Hsu, 2003). The little nosological evidence available at this point clearly supports the importance of overvalued idea of overweight in AN.

Suitability for historical research. Besides a conception of psychiatric disorders as universal disease entities and the aim to maximize nosological specificity and comprehensiveness of the diagnosis, the third motive to revise the diagnosis of AN is historical and requires that diagnostic criteria include both patients described by the alleged historical discoverers of the syndrome as well as present day patients. Indeed it does pose a problem to the historiography of AN that what today is taken as the central criterion for differential diagnosis, weight phobia, is absent in the alleged first descriptions of the syndrome by Gull and Lasègue as well as by the majority of historical reports of cases that were labeled AN or with equivalent terms in the 19<sup>th</sup> and first fifty to seventy years of the 20<sup>th</sup> century. Only two interpretations seem possible. Either weight phobia is a new symptom, then AN in the 19<sup>th</sup> century was in the majority of cases a different syndrome, and AN as understood today was not discovered by Lasègue and Gull, but by other authors of the 19<sup>th</sup> century who did describe AN in the modern sense of the term (cf. Habermas, 1989, 1992a). Alternatively, AN should be defined without reference to weight phobia, then the currently prevailing understanding of AN, which goes back to Bruch (1973) and Selvini Palazzoli (1974), would need to be abolished.

As discussed above, the best solution is to make two assumptions. The first is that weight phobia may have been overlooked, the second that denial of the seriousness of the current low body weight due to a subjective gratification by losing weight may be taken as an indirect indicator of AN. Lasègue (1873) emphasized the denial of illness, whereas in Gull's reports (1874) overactivity on part of two of his patients could hint at a strong subjective profit from losing weight (Habermas, 1989).

Rieger, Touyz, Swain and Beumont (2001) have responded to the proposals by Lee (1995) to abolish the criterion "fat phobia" with the counterproposal to use "denial of illness in which extreme emaciation is not perceived by the patient as problematic but, to the contrary, is highly valued" (Rieger et al., 2001, p. 207). They argue that this keeps the diagnosis specific but includes earlier historical cases as well, namely the ascetic-mystic fasters of the late middle ages (Bell, 1985), but not most of the alleged cases of *inedia*, survival without eating food for prolonged periods, between 1500 and nowadays. This brings us to the last section on the similarities and differences between these three historical types of extreme fasting.

#### CONTINUITIES AND DISCONTINUITIES BETWEEN RELIGIOUS AND SECULAR EXTREME FASTING

One additional argument adduced for abolishing weight related concerns from the diagnosis of AN is the alleged continuity between religiously motivated and interpreted extreme fasting and modern AN. Keel and Klump (2003) state that fasting girls of the 18<sup>th</sup> and 19<sup>th</sup> century imitated the ascetic-mystic medieval saints and that in addition 19<sup>th</sup> century psychiatrists endorsed a continuity between fasting girls and AN (p. 752). I will take up an earlier argument (Habermas, 1996), offering evidence for a discontinuity in the interpretation by the cultural agents who dealt and deal with extreme fasting and wrote about them, namely clergymen and doctors, and for a discontinuity between the religious and secular motives for extreme fasting. Finally, looking at the continuing presence of religious interpretations and motives in extreme fasting, it will be conceded that the three historical ideal types of extreme fasting do not preclude continuities in some cases. This, however, is still no argument for abolishing weight phobia.

#### Discontinuities In The Cultural Interpretation Of Extreme Fasting

The sources from which we know about extreme fasting from before 1500 are religious. They were mostly concerned with proving the saintliness of the women in question (Bell, 1985). Most of the cases from the 12<sup>th</sup> to 15<sup>th</sup> century correspond to the Catholic ascetic-mystic model of fasting. From the time of the reformation onward the church made it much more difficult to become a saint (Zarri, 1980), reacting to the Protestants' criticism of the institution of saints. All of a sudden doctors began to report on cases of alleged *inedia*, sustained abstinence from food. Only two Italian cases of the 16<sup>th</sup> century were described in the medical literature, contrasting to ten cases from German speaking areas of Europe.<sup>1</sup> An analysis of these latter cases showed a stark contrast to the earlier ascetic-mystic holy fasters: these women started abstinence after an illness, many remained afflicted with illness, few were very active, some had religious visions, many showed conversion symptoms, but none showed generalized ascetic and self-punitive practices. The doctors were mostly called upon by secular powers to control the alleged miracle of prolonged *inedia*. They thus suspected it to be fraudulent and to be motivated by the wish for notoriety and by financial motives (Habermas, 1990, p. 55 ff.; cf. van Deth & Vandereycken, 1992). All of these miraculous fasting girls purportedly lived without eating. Similar cases, with or without religious motivation, have been reported until the 20<sup>th</sup> century (Vandereycken & van Deth, 1994). Being underweight was not a necessary or even typical condition for claiming *inedia*, as could still be seen 80 years ago in the well-fed, but allegedly abstaining *Therese von Konnersreuth* (Steiner, 1977).

The difference between late medieval ascetic-mystic extreme fasting and the modern, 16<sup>th</sup> to 19<sup>th</sup>-century miraculous fasting girls may depend to some degree on the secular perspective of medical men reporting on the latter, who focused on illness, not virtue. The second historical

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 19<sup>th</sup> century, since the majority of reports on AN before WW I were written by doctors of internal medicine or pediatricians.

Not surprisingly, the medical literature on AN of the late 19<sup>th</sup> and early 20<sup>th</sup> century neither contains references to religious reports of alleged *inedia* nor to religiously motivated ascetic-mystic fasters. The one exception is Giovanni Brugnoli (1875) who referred to his colleague Beccari of the 18<sup>th</sup> 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 19<sup>th</sup> 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 16<sup>th</sup> 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 19<sup>th</sup> 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 and interpreted extreme fasting and AN.

Ascetic practices are described in two patients who somehow resembled anorexics. Noguès (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 Binswanger (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 entire days on and off in order to do penitence 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 (Brissaud & 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 statue. 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* denied 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 unclear, 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-shame-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 concerns 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 *Marcelline*, another food-refusing, but not anorexic patient of his (Janet, 1911). He treated the stigmatized mystic Pauline Lair Lamotte (Maître, 1993), called *Madeleine*, for over 20 years and wrote the two-volume book *De l'angoisse à l'extase* 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., 338ff). 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 anorexic patients.

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 16<sup>th</sup> to the 19<sup>th</sup> 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 maids continued to claim religious motives for their refusal to eat. While some of the ten fasting maids of the 16<sup>th</sup> 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 Flegen* 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 16<sup>th</sup> 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 Zarri (1980), who in the early 16<sup>th</sup> century were admired as saints during their lifetime and who followed the ascetic-mystic model of female saintliness, five were suspected of a pact with the devil and black magic, one was denounced, and another one even indicted as a witch. As late as in the middle of the 17<sup>th</sup> 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 saintliness” (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 17<sup>th</sup> century (Maître, 2000), Louise Lateau (Hammond, 1879) and Thérèse of Lisieux (Harrison, 2003) in the 19<sup>th</sup> century. Even in the 20<sup>th</sup> century Simone Weil (Eliacheff & Raimbaud, 1989, Maître, 2000), Therese von Konnersreuth (Steiner, 1977) and Gemma Galgani (Bell & 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 three 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 communion and religious feasts, but increasing participation in religious fasting. A study of sub-threshold eating disorders symptomatology among 44 Spanish nuns living in open communities

suggested that they showed comparable degrees of weight concerns and disordered eating (Macías & Leal, 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 *Renata* (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 19<sup>th</sup> century judged fasting girls and anorexics 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 role of asceticism in AN and the resulting similarity not with miraculous fasting but with the religious ascetic-mystic fasting has been noted repeatedly (Huline-Dickens, 2000; Mogul, 1980, Rampling, 1985). Rieger and colleagues (2001) motivated their proposal to substitute the criterion of weight phobia by the ego-syntonicity of weight-loss with the similarity of late medieval fasters and modern AN, who would then fall into the same category. Indeed neurotic asceticism with unintended weight-loss is very similar to AN, but is probably still more similar to neurotic asceticism without weight loss (Habermas, 1996).

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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## Footnotes

- 1 – The ten cases are: Anna Lamennita, Aventinus, 1881; Margaretha Ullmer, Weyer, 1577; Margaretha Weiß, Bucoldianus, 1542; puella Delphensis, Forestus, 1602; Katharina Binder, Kolb de Vuartenberg, Loelmannus, Smetius & Theodorus, 1580; Barbara Kramers, Weyer, 1577; Eva Flegen, Hildanus, 1604; puella coloniensis, Hildanus, 1604; Appollonia Schreier, Lentulus, 1604, Hildanus, 1604; Joanna Balam, Citesius, 1604. The two Italian cases were described both by Imperiale (1668) and Licetus (1612).