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History of Anorexia Nervosa

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The term *anorexia nervosa* (AN) has been in use for the past 140 years (Gull, 1874). This designation has been criticized as a misnomer, because the syndrome does not necessarily involve a lack of appetite. Hilde Bruch (1973) suggested that the German term ”Magersucht” described better the distinctive psychopathological feature, an “addiction” to extreme thinness, termed variously “drive towards emaciation” (Selvini Palazzoli, 1963/1974) and “relentless pursuit of thinness” (Bruch, 1965), or, more adequately in stressing fear, “l’idée fixe d’obésité” (Charcot; cited by Janet, 1907), “weight phobia” (Crisp, 1970), or “morbid fear of being fat” (Russell, 1970). These terminological issues reflect how much AN has been disputed in history, and also how much its history is still at dispute.

Knowledge of the history of anorexia nervosa helps put into perspective current controversies which in some respects repeat past debates. History shows how some insights are over and over again forgotten or repudiated for ideological reasons. Finally history helps put into focus both the influence of cultural context and the our own biases. After considering the nature of evidence in historical research on syndromes, I will provide an overview of the history of extreme fasting and AN, and then propose ways in which ideological and theoretical preferences of doctors influenced their clinical reports. Then I will summarize some possible socio-cultural factors influencing actual changes in eating disorders prior to their identification as medical disorders as well as how medical conceptualizations have secondarily influenced the nature of eating disorders. For brevity’s sake, I will refer to the principal secondary sources which contain references to the primary historical sources.

Methodological and Ideological Intricacies of Writing the History of a Syndrome

Writing the history of a psychiatric syndrome mainly serves two purposes: Legitimize the writer’s present-day conception and learn about the syndrome itself, the discipline, or society. Syndrome histories may focus on the history of medical ideas, termed conceptual history by Berrios (1996), or they may reconstruct historical changes in the actual occurrence and form of the syndrome. Conceptual histories can legitimize the current state of knowledge by heralding founders and writing a history of the progress of knowledge. Such histories may also remind contemporary researchers and practitioners of forgotten insights into the nature and treatment of the syndrome, or point to past mistakes. “Natural” histories can be used to demonstrate that a newly defined syndrome has always existed, thereby justifying the new category. This strategy was used by Charcot when he analyzed medieval reports on witches using his modern concept of hysteria (Charcot & Richer, 1887). Histories that demonstrate the historical constancy of a syndrome may also be used to argue for its somatic nature. Histories of the variability of a syndrome may decry possibly responsible societal developments, or justify the call for the allocation of resources to new services and positions.

The history of AN has served all of these purposes, and no history can escape present-day implications. Therefore this chapter both spells out its methodological assumptions and argues for present-day implications. The epistemological stance towards psychological disorders and their history taken here may be termed realist and lies between idealist or post-modern positions and

positivist or naturalist positions.[1] Psychological disorders need to be described at the psychological level, because they are defined as disorders of thinking, feeling, and acting. They are influenced to varying degrees by biological and social factors. They are assumed to exist independent of the observing scientist, but are influenced by the observer. Observations, on the other hand, are influenced by the observers' theoretical and practical perspectives, which in turn depend on their personality, professional orientation, and wider cultural context. Both patient and observer share a cultural and natural environment, which influences the nature of the patients' suffering and their illness behavior, as well as the observers' systems of significance and practice.

These assumptions have implications for what is considered valid evidence when writing the history of a syndrome. When writing a conceptual history of the profession's thinking about a syndrome, it is sufficient to ensure that the sample of publications used is representative. Depending on the historical distance, concepts and even words used in the sources will be different from today's usage and therefore need to be reconstructed. Writing the history of a syndrome is more difficult than that of concepts, because its object is one step more remote from us. Both the historical gap to the phenomena of interest, that is, of the afflicted individuals, their thoughts, feelings, and actions, as well as the historical gap to the sources through which we gain access to psychological inflictions, need to be bridged. Thus sources need to be critically evaluated not only in terms of trustworthiness, which is influenced by the writers' interests and purpose in writing, but also in terms of the writers' mind set. What is noteworthy and what is reportable versus what is taken for granted or deemed insignificant may differ significantly from what we are interested in. Therefore the historian has to reconstruct the historical writers' mindset to interpolate what they may have actually seen. This may be close to impossible for individual writers' psychology, but might be approximated in terms of cultural and professional mindsets. This is the easier the more similar the historical period is to ours and the more we know about it.

The nature of AN renders writing its history even more difficult, because typically there is a denial of illness and therefore also of emaciation, and, to circumvent social pressure to eat and gain weight, there is also secrecy regarding the motive for eating little and moving much. Even nowadays this may pose a problem for diagnosis. This motivates some authors (e.g., Keel & Klump, 2003; Treasure & Campbell, 1994) to suggest deleting the central organizing motive of AN from the diagnostic criteria. This would, however, imply giving up understanding the specific psychopathological core of the syndrome. Nevertheless nowadays a combination of empathic interviewing and clinical observation makes diagnostic judgment possible at least over the course of some time. Historical writers, however, who did not have the modern concept of AN, had a hard time seeing and reporting in print those observations which we need to identify a case of AN.

Given these intricate methodological issues, the history of AN can only try to draw a more or less probable picture by attempting to fill the gaps. The two major ways to do this is by reconstructing the observers' world view and interests and by using indirect diagnostic signs of AN which still allow making a probable differential diagnosis even in the absence of any explicit report of weight phobia.

History of Extreme Fasting, Miraculous Abstinence from Food, and Anorexia Nervosa

Most research on the history of eating disorders was published in the 1980s. The most comprehensive work on extreme fasting and food refusal was published by Vandereycken and van Deth (1994), while the best-informed source concerning the history of overeating was published by Ziolko and Schrader

[1] I use the term "psychological disorders" and not "psychiatric disorders" here because I wish to refer to psychological phenomena independent of their medical classification.

(1985) (see chapter 3). Two relatively distinct historical types of intentional abstention from food were identified: ascetic-mystic fasting and miraculous survival without food.

Ascetic-Mystic Extreme Fasting

Ascetic-mystic fasting is motivated by religious ideas about the duality of body and spirit. Fasting aims at purifying the spirit by mortifying (i.e., subduing or deadening) the body. Fasting is only one among other ascetic practices that serve to liberate the mind from its dependency on bodily needs for food, drink, warmth, rest, freedom from pain, and freedom from longing for sensual pleasures. In addition, extreme fasting facilitates entering states of ecstasy and visions, which makes it a highly valued practice in mystic cults. These practices are reported, for example, by early Christian monks (Bemporad, 1997) as well as by medieval Chinese Daoist priestesses (Lo, Hsu, & Vandereycken, 2012).

Apart from few isolated medieval reports of young women who survived without eating and who were interpreted as being possessed by the devil (Habermas, 1986; Skrabanek, 1983; Vandereycken & van Deth, 1994), in the period leading up to the Reformation reports on cases of extreme fasting are dominated by ascetic-mystic fasting in the context of religious practices of pious people. Bell (1985) described a type of late medieval, typically Italian female saint who was famous for her extreme fasting, often living only on the host, entertaining ascetic practices, and experiencing mystic revelations. Saint Catherine of Siena is the most well-known. Bell likens many of their practices to those of modern day anorexics, speaking of “holy anorexia”. The striking similarities are extreme fasting that goes beyond normal ascetic practices; self-denial as a reaction of girls to adolescent sexual maturation; social withdrawal; and stubborn refusal to eat once the religious establishment, doctors, or the family begin to exert pressure.

Despite these similarities, differences abound (Bynum, 1987). Fasters intentionally cultivated and practiced their fasting religiously in a religious context, imitating the models of Christ and saints such as San Francisco (Davidson, 1999), and it was apparent to them and often to others that asceticism produced mystical experiences that brought them closer to God. Also they were offered institutional roles by the church hierarchy if only they moderated their fasting, which some of them accepted (Bynum, 1987). Their focus was more on not eating rather than on losing volume and weight. The church did everything to prevent these young women from gaining a fame for being able to live for a long time without eating in their lifetime, because “living saints” (Zarri, 1980) undermined the church’s authority. However if they did succeed not to be tried for possession by the devil by ceding to ecclesestial powers, some of them did play quite influential roles in their time. With the reformation’s (early 16th century) questioning of miracles and abolishment of saints, the Catholic counterreformation (mid-16th to mid-17th century) restricted the criteria for miracles and canonization of saints. The historical traces of ascetic-mystic fasters change from hagiographies to records of the inquisition (Zarri, 1980) and to medical publications, producing an altogether different appearance of extreme food restraint.

Secularized Miraculous Fasting

From the 16th century onwards the reported pattern of not eating changes in several respects. Not eating was embedded in physical illness and disability, often resulting from apparent hysterical conversion symptoms. These women were of socially modest background, passive, often still lived with their parents (not in a monastery), and parents mediated the contact with the secular public. None evidenced ascetic practices, although the young women themselves were very religious and were often sought-after as holy women by the public. It is difficult to tell to which degree this relatively sudden historical change is due to the change from religious, Catholic to secular, medical sources, and to the change from mostly Italian to mostly Germanic sources. It appears that the new

characteristic of not eating and pretended survival without eating was exceptional in Italy. This is indicated by two Italian medical writers who mention only two such Italian cases, but report at length many German and Dutch cases of the 16th century (for references, see Habermas, 1990, 2005; van Deth & Vandereycken, 1992). However, phenomena did not change as abruptly as the change of sources suggests. Secularization was a very gradual process also in Protestan areas, as historical anthropologist Waltraud Pulz (2007) showed. She analyzed in detail 7 of the 10 16th century cases known from German and Dutch areas, drawing on a rich array of mostly medical historical sources. The more detailed the stories, the more complex each appears, showing that secularization and the abolition of belief in miracles and saints was not a sudden effect of the Reformation and Counter-Reformation of the 16th century. Rather secularization and abolition of supernatural beliefs was a long process stretching between the 16th and the 20th century. Actually the process started even earlier, as the the church started refraining from officially acknowledging miraculous cases of not eating for extended periods of time (and also mystical experiences) already in the 15th century.

Similar cases were reported in North-Western Europe and also in the USA, especially in the late 18th and 19th century, such as Molly Fancher in Brooklyn and Sarah Jacobs in England (Brumberg, 1988), and Anne Marie Kinker in Northern Germany (Habermas, 1990). The English language secondary literature on this period has mostly been limited to English and American cases (e.g., Brumberg, 1988; Keel & Klump, 2003). Case reports from Catholic areas like Belgium (Louise Lateau), Italy (Palma Maria d'Oria; for both see Hammond, 1879) and Bavaria in the early 20th century (Therese Neumann; Seidl, 2008) focus somewhat more on traditional religious signs such as stigmata and mystic experiences. What most of these women appear to lack is the active ascetic zeal of ascetic-mystic fasters of earlier centuries. Instead there is a stress on passive suffering and, often, normal body weight! What unites these reports is the contention of living without food (being nurtured solely and miraculously by faith in God's grace), which is contested by medical and juridical professionals in the service of ecclesiastical and worldly powers.

Anorexia Nervosa

This section focuses on the reconstruction of the history of the phenomenon now called "anorexia nervosa" (AN). Thus, the history of medical *conceptions* of AN is the topic of the following section. For retrospective identification of cases I will use today's concept of AN, especially a fear of an abundance of body mass, which is the central organizing motive for the symptomatic actions aiming at achieving or maintaining an underweight body, such as eating food that promises little weight gain; physical and mental overactivity despite underweight conditions; denial of underweight and illness; and secretive actions to protect the subjects' liberty to fast. Most specifically it is weight phobia and the ensuing denial of emaciation and of illness which differentiates AN from what Hilde Bruch (1973) termed' secondary anorexia", that is, other forms of psychogenic malnutrition and fasting, as can be seen in depression, delusions of food poisoning, food phobic states, hysterical vomiting, globus hystericus, and gastric complaints. In none of these states is there a fear of normal body weight, but emaciation is a consequence of various other motives for not eating.

If the current definition of AN is used for writing a history of the syndrome, if historical descriptions are taken at face value, and if only English historical publications are analyzed, then it appears that AN was first described in the 1930s, by the British doctors Young* in 1931, Ryle* in 1936, and Nicolle* in 1938.[2] A few years later American doctors of internal medicine, influenced by psychoanalysis and interested in psychosomatics, published several articles also mentioning the fear

[2] Due to space limitations, medical sources on anorexia from between 1870 and 1945 for which references are listed in Habermas (1989; 1992a) are marked with a star* and not listed in the reference list.

of weighing too much as a motive in specific cases (Rahmann*, 1939, McCullough & Tupper*, 1940, Waller, Kaufmann, & Deutsch*, 1940).

This picture implies that prior to 1930 the concept of AN was applied to describe patients who nowadays would not be diagnosed with AN. This has not been established and, even if it were, it would need to be explained why the same concept was used so homogenously for different patients. Nevertheless, given the strong preference for a non-psychological, somatic definition of psychiatric diseases, it appears that the dominant view of the history of AN in the Anglophone literature is that we should define AN more broadly than we presently do to include any psychogenic food restriction, or at least any extreme fasting. This would mean that the history of AN begins with Lasègue* in 1874 and Gull* in 1873, and would imply that weight phobia became a new component in the 1930s in a malady that otherwise is 60 years (Casper, 1983; Russell, 1985) or even centuries older (Keel & Klump, 2003).

If, however, articles and books published in languages other than English are also included in the sample of sources, weight phobia emerges as a symptom in clinical descriptions of cases of AN case over half a century earlier. Searching German, French, and Italian psychiatric and medical journals between 1850 and 1950, I found weight phobia described in cases in several reports starting in 1878 (see Table 1). The list summarizes earlier lists in Habermas (1989; 1992a). Starting in the 1880s, many more texts mention the desire to lose weight as the motive for extreme fasting in AN, without providing case descriptions (cf. Habermas, 1898; 1992a). The relatively extensive case reports by Brissaud and Souques* (1894), Janet* (1902), Schnyder* (1912), and Binswanger* (1944; see Hirschmüller, 2003) provide ample evidence that these patients psychologically resembled current patients with AN.

Table 1

Clinicians describing weight phobia in case presentations in German, French, and Italian psychiatric and medical journals and books between 1878 and 1945

Year	Author(s)	Country of Residence	Language of Publication
1878	Rist	Switzerland	Italian
1883	Charcot (Féré)	France*	French
1892	Féré	France*	French
	Gungl & Stichl	Austria	German
	Wallet	France*	French
1894	Brissaud & Souques	France*	French
1898	Janet	France*	French
	Kissel	Russia	French (German, Russian)
1900	Ling	Estonia	German
1902	Ebstein	Germany	German
	Raymond	France*	French

1905	Girou	France	French
1909	Bérillon	France	French
1910	Tarrius	France	French
1911	Régis	France	French
1912	Noguès	France	French
	Schnyder	Switzerland	French
1914	Raimbault	France	French
1922	Lévi	France	French
1924	Möller	Denmark	German
1925	Souques	France*	French
1926	Faber	Denmark	German
	Ziehen	Germany	German
1927	Lafora	Spain	Spanish
1930	Aurimond	France	French
1931	Young	Britain	English
1932	Schottky	Germany	German
	Steinitz & Thau	Germany	German
1936	Benedek	Germany	German
	Bergmann	Germany	German
	Ryle	Britain	English
1937	Krause & Müller	Germany	German
	Kylne	?	German
1938	Nicolle	Britain	English
1939	Leibbrand	Germany	German
	Rahmann	USA	English
	Trefzer	Switzerland	German
1940	McCullough & Tupper	USA	English
	Waller, Kaufmann & Deutsch	USA	English
1941	Deutsch	USA	English
	Falta	Germany	German
	Wissler	Germany	German
1942	Feuchtinger	Germany	German
1943	Accornero	Italy	Italian
1944	Binswanger	Switzerland	German

Note. * Worked at the Salpêtrière in Paris.
References and more details are provided in Habermas 1989 and 1992a, except for Charcot (1883), which I found recently thanks to Gelfand (2000). Starting in the 1920s, German references are oversampled because of intensive research for a chapter on anorexia nervosa in Germany between 1916 and 1945 (Habermas, 1994, chapter 9).

A summary of a lecture by Charcot which had not been included in my previous publications demonstrates how early weight phobia was observed. Even this report on an 18-year-old young

woman summarized by Féré in 1883 includes the typical psychological aspects of AN. She had consulted Lasègue and Cornil before coming to Charcot in the summer of 1882. “It was a case of psychic anorexia. The patient systematically and energetically refused all food. [. . .] She weighed 29 kg [. . .]. For her, the beauty ideal was defined by excessive skinniness (*maigreur*).” Charcot goes on to describe an extended struggle with the patient for any food she was to eat, “the idée fixe not to eat [was] ever present. At times she hid the food in her towel, her pockets, her stockings, sometimes she even tried to keep it in her mouth [. . .]. She entered the watercure clinic of Passy in a state of great agitation. Her skin was cold and viscuous; she was incessantly tormented by the idea of gaining weight (*grossir*).” Half a year later, after being treated by water cure and a strict alimentary regimen, the patient was released with a body weight of 40 kg. Returned home, the young woman soon lost weight again, the mother refusing to put her back in the hospital, and the patient died within weeks (Charcot, 1883, p. 4).

A summary of another of Charcot’s lectures by Charles Féré and Fernand Levillain in the same year (1883) basically confirms Lasègue’s clinical description of 1873, stressing the lack of insight and the subjective gain from abstinence as well as overactivity, but falling short of mentioning anything similar to weight phobia both in the general description and in the case of a 21-year-old patient treated in 1881. Féré’s own three- page-case report published 9 years later again stresses the conscious project of losing weight, in this case to attract the attention of a man, over which at some point the girl lost control. This 15-year-old had laced her corset very tightly and secretly wore a strictly tied linen belt under her blouse. She did everything to prove that she was not ill.

Thus, because weight phobia was reported in anorexic patients beginning in the last quarter of the 19th century in French, German, and Italian language publications, the timing of the historical emergence of weight phobia in AN needs to be moved back 50 years, at least in regard to these three linguistic areas. However, if one does insist on the current diagnostic understanding of AN, the problem remains that there were other publications of alleged cases of AN which did not report weight phobia, including the two publications credited for introducing the concept of AN (Gull*, 1874; Lasègue*, 1873).

A critical approach to historical sources suggests that they need not be taken at face value. The writers’ interests, categories, and notions of reportability, as well as the journals’ policies and audiences need to be taken into account when inferring from a source what historical reality may have looked like. The next section explores some of these factors in more detail. The one to be mentioned here is that people with AN tended to hide their motivation to fast, including the fact that they were intentionally reducing their body weight by fasting and possibly by overactivity and purging. This secretive behavior was noted frequently in the literature. If historical writers were not expecting to find weight phobia, it was even more difficult to detect. Therefore it was often not reported, although it may have been present in the patients. Following Bruch (1973), I argue that two interrelated types of indirect specific evidence for AN are a denial of illness and denial of emaciation despite a state of severe malnourishment. This was mentioned by Lasègue* in 1873, but not so explicitly by Gull* in 1874. However, if indirect evidence such as denial of illness or overactivity is taken into account, some of the case reports that do not mention weight phobia can be argued to nevertheless probably describe actual cases of AN (Habermas, 1989; 1992a). Confirming the existence of weight phobia starting in the second half of the 19th century, Queen Elizabeth of Austria suffered from an intense fear of becoming overweight I the early 1860s, which she countered by strict fasting and physical exercise resulting in severe emaciation (Vandereycken & Abatzi, 1996).

From the 1930s onwards, publications started reporting case series with more than 20 patients. The number of publications began to increase more rapidly in the 1960s and 1970s. Available epidemiological evidence suggests that in Europe and North America the prevalence and

incidence of AN increased between 1940 and 1990, especially in the 1960s and 1970s, probably reaching a stable level since 1990 (Hoek, 2006).

Before moving on to the conceptual history of AN, two counterarguments against this view of the history of the phenomenon of AN need to be considered. One concerns the historical boundary between AN and religiously motivated and interpreted fasting, the other the boundary of Western AN with non-Western forms of food refusal. The only explicit reference in the historical literature on AN to religiously interpreted extreme fasting and surviving without food can be found in Brugnoli's report on two cases of possible AN from 1875. He refers to the illuminated Pope Lambertini's reform of the criteria for canonization in the 18th century and the appendix to the Pope's major text on canonization by Beccari, a medical doctor, which discussed natural versus supernatural causes of not eating (Habermas, 1992b). The few historical case reports of anorexic-like behaviors with religious motivation appear not to be actual cases of AN, with the exception of the one patient described in 1912 by Schnyder* (Habermas, 2005). There appears to be a relatively clear difference between religious motivations for ascetic fasting and the motivation for fasting in AN.

Cross-cultural comparison of forms of eating disorders, especially between Western and more traditional societies, might provide indirect evidence on the history of AN, if it is assumed that present-day traditional societies somewhat simulate earlier Western societies. Putting aside the weaknesses of this assumption for the sake of the argument, Lee's (1995) finding that the majority of anorexic patients in Hong Kong in the 1980s lacked weight phobia but presented otherwise comparable clinical features might be seen as a confirmation of AN without weight phobia. Accordingly, Lee argued for dropping weight phobia from the diagnostic criteria to render them, as he thought, more culture-neutral. However, systematic comparisons between samples of underweight patients with and without weight phobia do indicate that people with very low body weight who have eating disorders, but an absence of weight phobia, show less severe symptomatology (Carter & Bewell-Weiss, 2011) and have a better course (Lee, Chen, & Hsu, 2003; Strober, Freeman, & Morrell, 1999) than patients with AN. Crow et al. (2012) recently found that eating disordered patients with underweight without weight phobia had a higher mortality rate than those with weight phobia. However, weight phobia was assessed by questionnaire, so that it is not clear whether self-reported absence of weight phobia can be seen as authentic or as a sign of denial of illness. Actually AN has been increasing and atypical forms of eating disorders decreasing in frequency in the 1990s and 2000s in Hong Kong (Lee, Ng, Kwok, & Fung, 2010).

The Influence of Medical Thinking on the Description of Anorexia Nervosa

The history of theories about AN begins with the introduction of the terms *anorexie hystérique* in 1873 by Charles Lasègue* and AN by Gull* in 1874. The differences between the French and British traditions already show in these first two reports, inasmuch as Gull reports mostly physical and behavioural aspects, whereas Lasègue pays more attention to the psychological aspects of his patients.

A historical precondition for understanding extreme fasting as a psychological disorder was the firm conviction that humans could not survive extended periods of time without eating. The physiology of eating and digestion was advancing in the second half of the 19th century, but in 1876 Empereur still maintained that hysterical patients could live without eating! In 1890 Gilles de la Tourette and Cathélineau published their extensive laboratory studies of the nourishment of psychiatric patients, whom they had kept in a controlled environment for many weeks and months to control what was going in and coming out of their bodies. Even Janet (1926, pp. 159ff.) kept some of his patients for weeks in cages, to check why they maintained their body weight despite minimal food

intake. The Italian physiologist Luciani published a book on fasting in 1889, reporting his research on the hunger artist Succi, who was only one of many male hunger artists of the time. The change in attitude is exemplified by Luciani's severe and condescending criticism of the doctor who had written the report on the survival without food of the fasting maid Anna Garbero only 60 years earlier.

Analysis of the nationality, medical discipline, theoretical orientation, and professional interest of those historical doctors who described weight phobia in anorexic cases or probable cases of AN before the end of WWII enables us to identify some specific influences that helped these physicians see and report what nowadays are considered the defining clinical features of AN. For example, three factors explain why the French were so advanced in understanding AN and who within each national tradition was most predisposed to describe AN. These factors were: (1) a belief in the value of considering in detail symptoms and the history of each patient; (2) attention to psychological aspects of the patient and her subjective experience; and (3) an interest in nutrition. These three factors practically exclude British doctors and favor French psychiatrists, and, to a far lesser degree, German doctors, especially of internal medicine. Some doctors who did fullfill these criteria nevertheless did not publish case reports in which we can identify anorexia nervosa. They were either not interested in the neuroses or did not work in hospitals, in which it was most probable to see anorexic patients (for more detail see Habermas, 1991). In addition, Charcot's discovery of weight phobia in the early 1880s paved the way for other psychiatrists working at the Salpêtrière to author most of the early case reports that described weight phobia, like Féré* (1892), Wallet* (1892), Brissaud and Souques* (1894), and Janet* (1898).

Both the opinions of influential teachers and basic convictions about the nature of illness have strongly influenced how anorexia nervosa has been conceptualized and described up to this day. The German doctor Simmonds described an endocrinological disorder in 1916, which for the next 3 decades dominated the interpretation of unexplained underweight. A preference for somatic explanations in medicine reinforced this trend. Surprisingly those medical doctors who did believe in a role of psychological factors in disease, that is, proponents of psychosomatic medicine in the 1930s to 1950s, also tended to overlook the voluntary nature of fasting in AN, and instead attempted to explain weight loss with physical factors. A detailed analysis of German publications on AN between 1918 and 1945 (Habermas, 1994, chapter 9) reveals that in addition to the misapplication of the concept of Simmond's disease, it was actually a belief in a "holistic medicine" that hindered doctors' acknowledgement of the psychological nature of AN. They chose AN as a prime example of how psychological factors could influence the body and cause disease *without* voluntary actions directly affecting the body. The main proponents of psychosomatic medicine, von Bergmann, and psychoanalytic psychosomatic writers insisted on the endocrinological nature of AN. Only Viktor von Weizsäcker, who pursued an anthropological conception of medicine, understood the primarily psychological nature of AN and of intentional fasting as the cause of weight loss. An analysis of the editorial policies for accepting or rejecting manuscripts by the American journal *Psychosomatic Medicine* demonstrates that this was not an isolated German phenomenon of the 1930s. Rather the aim to belong to the medical mainstream by being as scientific as possible led to a focus on the somatic aspects of AN in the 1960s and 1970s (Mizrachi, 2002).

Finally, in the case of Nazi Germany political influences played a role in isolating the medical literature from the international discussion. Furthermore, quasi-intentional self-destruction could be dangerous in a Nazi Germany that systematically murdered also psychiatric and handicapped patients, which made it by far safer for patients to have their AN treated as a somatic illness.

Primary and Secondary Historical Influences on the Emergence and Form of Modern Eating Disorders

Primary Historical Influences

Thus modern AN must have emerged some time in the middle of the 19th century, while the modern form of bulimia with weight-concerns emerged over half a century later (Habermas, 1989,1992a; see chapter 2). AN increased drastically in the 1960s and 1970s, whereas the increase in bulimia nervosa (BN) occurred after its medical definition in the 1980s and 1990s. Several historical developments have typically been seen as responsible for the emergence of and increase in these modern eating disorders. The most popular explanation is the female body ideal, which became thinner in the 20th century, especially in the 1960s. However, there have been other periods in history in which slimness was the moral or fashionable ideal. Consequently, other factors may have played a role (see, e.g., Gordon, 1990; Habermas, 1990). These include:

- absence of famines from in Europe, beginning about 1850, which rendered fasting a way to distinguish oneself from others;
- de-ritualization and individualization of eating. Norms regarding eating historically began to shift in the late 19th century from regulating the form and amount of eating in social situations to prescribing long-term health and aesthetic effects on the body.
- the dominant cultural technique to adapt one's body to the socially prescribed form shifted in the second half of the 19th century from using external devices temporarily applied to the body (e.g., a corset), aiming at a manipulation of the social appearance of the person, to actions aiming at long-term internal modifications of the naked body (e.g., exercising and dieting for weight control).

The latter two changes can be conceptualized in terms of an extension of the theory of the process of civilization. Elias (1939/1982) described a civilizing process between 1600 and 1900 that was marked by an increase in self-control of impulses and emotions for the benefit of foreseeing the long term effects of one's actions. Elias conceived this civilizing process in terms of the diffusion of courteous manners which were then internalized so that violations of manners evoked shame. In the course of the 19th century self-control was extended to the private satisfaction of sexual bodily needs and aggressive impulses. As Wouters (2007) points out, the increase in self-restriction described by Elias changed into a process of informalization of affect controls in the course of the 20th century, liberalizing especially sexual, but also food-related behavioral standards, only to subject them to even stricter norms regulating their long term outcome. This general societal development describes historical changes in cultural techniques for shaping and disciplining the body as well as for eating.

Elias explained the civilizing process in terms of the necessity to increasingly foresee results of one's actions on others due to the growing interconnectedness of people through trade and communication. Given the relative exclusion of women from the pubic sphere in the West, their integration into societal systems of communication via schooling, work, and mobility accelerated more than that of men, putting additional pressure on them to acquire cultural techniques of affect control to be able to participate in these impersonal systems of communication (Habermas, 1990).

Learning how to diet so as to control one's body weight can be understood as an exemplary socializing practice in the transition to adulthood, training women to look ahead for the consequences of their actions. It is probably no coincidence that in decades of women's emancipation ideals of female appearance became slimmer and allowed less external aids, as was the case in the 1920s and the 1960s.

But AN is not identical to normative dieting; it is an exaggeration, a caricature. Apparently, the

normative adolescent socializing practice of dieting offers a totalizing defense against the threats of puberty, which come from within in the form of sexual urges and from without in the form of (male) objectification of girls' bodies (Selvini Palazzoli, 1963/1974). Anorexia nervosa is even more effective than early adolescent asceticism (Anna Freud, 1936) in defending against all sensual pleasure, because it establishes an emaciated body that physically is less capable of experiencing sensual pleasures (Bruch, 1973; Crisp, 1980).

Secondary Influences of the Psychiatric Conception of an Eating Disorder

Why did BN emerge later than AN? Sociologically, BN can be seen as a failure of internalizing the normative practice of dieting. Bulimia nervosa can be interpreted as an ethnic disorder as conceptualized by George Devereux (1956/2000; see also Gordon, 1990), because it (a) focuses on culturally central preoccupations; (b) uses important cultural techniques for defensive purposes; (c) negatively defines central social norms, in this case the norm of controlling one's body weight without impulsive breakthroughs; and (d) serves as a cultural models of misconduct (Linton, 1936), that is, as a model for how to be mentally ill in a culturally accepted way. Thus, I suggest that BN was introduced in Western societies successfully as a new psychiatric disorder once the cultural technique of dieting for weight control had been sufficiently established to expect the majority of female adolescents to comply with it (Habermas, 1994). Consequently, BN is a disorder which from its beginning also relied on the mechanism of imitation (Gordon, 1990). In the most straightforward sense this involved imitating the technique of self-induced vomiting from others to compensate for impulsive binging (Habermas, 1992c).

Anorexia nervosa, in contrast, was for a long time "invented" individually anew by each anorexic adolescent. According to Bruch (1973), AN offers, or at least historically offered, the psychological reward of uniqueness and superiority. Only once the concept of AN became known among adolescents, could they start imitating this somewhat glamorized disease. For this historical change in the mechanisms of AN Bruch (1973) invented the term "Me-too-anorexics". However, I believe that the main thrust of the imitation of AN produced BN rather than AN. Possibly only in the past decade did AN become a disorder in which imitation also played a homogenizing role by way of pro-ANA-sites (see chapter 26) and the socializing effect of specialized eating disorders units (Vandereycken, 2011).

Conclusion

The history of AN has several lessons to offer. It shows how malleable conceptions of a psychiatric disease are due to professionals' major convictions about the nature of mental disorders. In the case of AN, ignorance of patients' subjective point of view and a naturalistic somatic prejudice obscured the understanding and adequate recording of AN in the past, and these factors continue to trouble the field to this day (see Strober & Johnson, 2012). This shows in proposals to drop weight phobia as a diagnostic criterion, because it relies on patients' subjectivity and on psychological, but not somatic criteria. A similar preference for somatic criteria for defining psychological disorders must have motivated Keel and Klump (2003) to suggest that AN was a historically invariant disease once it is defined without reference to psychological criteria, only to conclude that genetic factors play a more dominant role than social influences in AN. Given that genes interact with environmental and social conditions (see chapters XX and XX), this conclusion only reveals an inadequate preconception that psychiatric disorders need to be defined in somatic terms.

In contrast, a methodologically informed approach to the history of eating disorders that critically takes into account the available historical evidence suggests not only that psychological

criteria are indispensable for defining the specific disorder of AN, but also that AN as well as BN are historically new syndromes. This, of course, in no way precludes genetic dispositions and somatic maintaining and aggravating conditions in AN.

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