identity. In South Africa, questions of race, culture and class are highly entangled, and have to be considered in the light of social history, as racial issues are inextricably mixed with every other. We are similarly obliged to consider race issues through a filter, as it were, of class or location in a sociopolitical hierarchy. Just as elites are mostly White, eating disorder patients are too; and the socially disadvantaged position of Black people in White-dominated countries (industrialised, developing, or South Africa) conversely is associated with a low incidence amongst Black women (Dolan, 1991). Theoretically, the principal link between the concepts of class struggle and the attitudes or beliefs of cultural groups is the concept of ideology, in this case ideologies of race.

As in other post-colonial societies, Black South Africans have a history of dispossession and exploitation, racial discrimination, and ongoing educational and economic disadvantage. Their bodies were regarded as an expendable labour resource, and social ills such as hunger and poverty are widespread. The destruction of African economies, cultures, and bodies is sometimes seen as linked to gradual devastation in self-esteem and cultural pride. In postcolonial and urban-dominated societies, traditional values and attitudes are eroded, there is a weakening of cultural identity, and in its place a tendency to identify with the aggressor by idealising and over-conforming to alien standards of the dominant culture.

Theories of ideology or hegemony from Marx, Engels and Gramsci onward have usually claimed that ideologies serve primarily to control and subdue the working class. However, this has been recently, and persuasively, disputed. Abercrombie, Hill, and Turner (1988) argue that the primary function of ideology is in fact to facilitate the coherence of the dominant classes, and in support of this claim they point to the Church of the Middle Ages, which far from being an opium of the masses, was largely ignored by the masses whilst exerting huge influence over members of the aristocracy. These authors would presumably agree that disordered eating occurs amongst members of privileged groups because they are the most adapted to dominant ideals of body shape and size (Dolan, 1991; Gordon, 1990). Amongst less privileged groups, problems of obesity and junk food are more likely to become a public health problem when food is available. Wadden *et al* (1990) found that nearly 50% of Black American women are obese, with adolescence appearing to be a critical period for developing obesity. For Smith, (1993) this is an effect of ideologies of consumption in the absence of traditional capitalist/Puritan values of restraint or abstinence in the interests of greater profits. Ideologically, the eating-disordered woman or girl is trapped between these two great ideological structures.

Feminist writers such as Diamond (1985) suggest that attributions of intelligence, social success, wealth and self-control, even spirituality, have thinness has come to symbolise in Western culture". In South Africa, this has important implications for the well-being of young Black women.

"Western culture" here is a blanket term in need of closer definition. It does not include cultures of antiquity, the early religious age, nor the European Renaissance. Although these were Western cultures and produced numerous anorexia-like female cases (Brumberg, 1988), we cannot assume that the mindset of today's anorexic, bulimic or generally weight-preoccupied young women much resembles medieval saints or Victorian dyspeptics. Even in Western societies definitions of "too fat" and "too thin" have historical specificity, as is illustrated in a study by Garner, *et al* (1980) which used centrefold photographs to demonstrate a significant trend to a thinner outline over 20 years in the US. What is common is the human need to create meaning out of living in a culture which from its early origins has transmitted confusing, contradictory, and punitive messages to women, delimited narrow ranges of acceptability for female roles and behaviour, and in particular has exerted ideological control over female bodies and feminine independence. Where contemporary self-starvers differ is that they live in an age where female roles, cultural messages and social controls are vigorously contested and in which there can be high expectations of female achievement in potentially conflicting arenas such as social life and education. High and conflicting expectations are most likely in affluent or socially aspiring families, who are able to secure good educations for their daughters (Gordon, 1990).

Smith (1993) introduces a necessary dimension of class struggle in his account which suggests that we consider the full spectrum of eating disorders from self-starving to self-gorging in relation to traditional capitalist values of profit seeking and frugality on the one hand, and late capitalist demands for consumption on the other. He states that media messages to both eat and starve simultaneously are received differently by differing social classes (p. 95). Yet it is possible that some young women who reject body fat are communicating a wish to resemble groups they perceive to have economic power. Furnham & Alibhai (1983) in a study of Kenyan Asian immigrants to Britain, found just this tendency to overconform and overvalue the norms and standards of the dominant culture in which their respondents were trying to find a place.

However, class-based explanations fall short of completeness. The lower incidence amongst Afro-American women has also been attributed to *cultural* differences in ideals of beauty (Abrams, Allen & Grey, 1993). These authors argue that restrictive eating disorders amongst Black women are related to the degree of assimilation to "mainstream" culture and to idealisation of values and beliefs associated with White identity, together with rejection of those associated with Black identity - not necessarily class eating and weight concern amongst women, but this is often not true of other literature in the eating disorders, in which social-theoretical frameworks or assumptions are seldom explicitly mentioned, but usually involve the assumption of causal "factors" in the environment (e.g. Garner *et al*, 1983, and most other medical studies quoted here). As AN and BN are seen as psychiatric disorders, most of the information about them comes from medical or psychiatric sources.

Contemporary medical literature on the eating disorders reflects the prevailing view that their aetiology is "multidimensional" - i.e. several factors are working together. Garner (1993) classifies the principal risk factors as individual, familial, and societal. Within this broader framework, clinicians and theorists usually ascribe greater significance to one of the sets than to the others. The immensely popular sociocultural view (e.g. Abrams, Allen & Grey, 1993) emphasises society-wide factors such as gender, culture and class. Yet frequently the individuals whose behaviour is under discussion are treated in these accounts as passive victims or recipients of influence from the structures which order society along gendered, cultural, and class lines. It is the structures and systems of the wider society or culture which are conceptualised as the agents of change. This approach is out of step with current social philosophies that emphasise both rational individual choice and the irrational, and is certainly inconsistent with the beliefs of most psychologists. The challenge is to develop a theory of change in society and culture which allows individuals to be the authors of their own stories and yet remain capable of rendering a plausible account of overarching structures.

One reason why we need more plausible accounts of social process in writings about the eating disorders is because of their apparent increase in recent years. The "slimming diseases" of AN and BN were once thought rare, but they are now public health concerns. Most urban health services now provide specialist treatment units, including in Johannesburg. Aetiologies must explain this "epidemic" phenomenon, and it is usual to find heavy emphasis on sociocultural factors, whether in popular accounts (such as magazines or newspapers), feminist accounts (e.g. Elks 1994), or medical accounts (e.g. Garner, Olmsted & Garfinkel, 1983). There is good reason for this. Analyses may vary, but each of these narratives takes its cue from epidemiology - the study of times, places, and types of person affected by an illness. AN and BN were documented mainly after World War II, in affluent and developed communities, amongst females, amongst the young, and amongst social elites or high achieving families. For a psychiatric syndrome, this is a very specific profile. Pate, *et al* (1992:802) describe eating disorders as "the only form of psychopathology in which culture plays a major part in determining prevalence", and conclude that "it is therefore probable that a rise in their prevalence could follow from a wider adoption of the ideal that

Philosopher Jacques Derrida offered a critique of the Symbolic Order, commenting on three aspects - the primacy of rationality (logocentrism), the unitary drive toward a single and supposedly attainable goal (phallocentrism) and dualism, or the pattern of dividing experience up into binary oppositions (Tong, 1989). Post-modern feminists dislike "isms" and prefer not to be called feminist or to define the meaning of feminism. However, their work offers women (and, one presumes, men) a glimpse of freedom from oppressive thoughts and ideas. Irigaray in particular has argued that Sameness or the suppression of difference obstructs imagination, especially about our bodies and selves (Tong, 1989). Although a psychoanalyst herself, Irigaray gives as an example of Sameness the Freudian theory of female sexuality, i.e. woman as a reflection of man except in her sexuality, which is then conceptualised as a lack.

Irigaray felt that a woman experiences herself in "the little structured margins of a dominant ideology" (Tong, 1989), and thus experiences important parts of her nature as "waste" or "excess". Trapped in a patriarchal 'imaginary' she becomes unable to imagine herself outside of this framework. For these writers, the female body is particularly important as a final statement of Otherness or difference, which is continually subject to efforts to reduce it to Sameness.

Feminist writers and clinicians have long been interested in issues surrounding the female body, and particularly the eating disorders Anorexia Nervosa (AN) and Bulimia Nervosa (BN). Like other illnesses of women, such as "hysteria" of the late 19th century, these disorders are often seen by feminists as silent but powerful testimony to (and protest over) female oppression. One such clinician is Susie Orbach, author of the well-known book *Fat is a Feminist Issue* (1978, 1988). Like many feminist thinkers, Orbach sees women as "socialised" into a particular view of self and body that places importance on size and shape, demanding that women both blend in and stand out (Orbach, 1988:17). Orbach's clinical interest is compulsive eating, which she characterises as "an individual protest against the inequality of the sexes" (p. 195).

Diamond (1985) takes issue with Orbach in her article "Thin is the Feminist Issue", in which she shows how a binary opposition between fat and thin appears to be the chief problem for feminists - yet Orbach has accepted it without challenge, and has even embarked on her own unitary project towards the goal of "natural" eating and self acceptance. In this article, Diamond applies post-modern feminist ideas to popular culture as well as to her critique of Orbach. Following her construction, we can say that the female body itself has been polarised, with its fat parts becoming "abject". Feminist writers such as Diamond are concerned to understand the processes of construction of meaning which lie behind the development of disordered

1. SOCIOCULTURAL APPROACHES IN THE EATING DISORDERS

1.1 SOCIOCULTURAL THEORY AND EATING DISORDERS

There are several academic disciplines which address themselves to the interrelations of nature, culture and society - psychologists, sociologists, social philosophers and social anthropologists all have a contribution to make, and often their interests in theory and research diverge widely. Yet there is at least one critical issue which stands at the centre of this complex interrelationship, and that is the fact of human embodiment - that we live in and through a physical body. The body has appeared in social theory down the ages as both limitation and potential, as restricting humanity to the needs of an animal species, but also providing us with rich experiences of the world, with powerful symbolism, and with creative sexual, emotional and intellectual energies.

Social theories at one time tended to exclude the physicality of "Man" from their analyses, because they typically opposed nature against culture (Turner, 1991). Like economics, the social sciences stressed action, particularly rational actions of individuals or institutions, in accounting for stability or change in social structures. Recently, there has been a shift in theory towards a "sociology of the body", with new attempts to understand the ways in which human bodies are presented in a "social space" (Turner, 1991). The influence of feminist theory played an important role here, because gender issues cut across neat classifications and problematise social constructions of the female body in particular.

There are many different feminist approaches, for example liberal, socialist, radical, marxist, and so on. One highly influential approach has been that of French post-modern feminism. These writers are influenced by psychoanalysis, and exploration of what Julia Kristeva has called "the abject" - early experiences with one's own infant body and the body of the mother (Turner, 1991). Kristeva argues that the abject becomes associated with aspects of the culture or society which are marginalised, silenced or oppressed. As children pass through the Oedipal crisis (essentially an encounter with patriarchy) they are forced to give up the abject, and to enter the Symbolic Order (corresponding to Freud's superego). This involves repressing and repudiating disorder, whether perceived within or without, and anything that is not part of the Symbolic Order is experienced as disorder, including plurality, difference, or that aspect of femininity in particular which de Beauvoir called Otherness.

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ABSTRACT

In recent years there has been great interest in studying the energy-restrictive eating disorders within sociocultural contexts. Patterns of change in the incidence and prevalence of these disorders appear to reflect social processes involving gender issues and shared cultural values around the female body. South African society is experiencing rapid sociocultural changes, and this raises questions about disordered eating and values in our own society.

This study investigated body figure preferences and attitudes and behaviours related to eating and body weight. The sample consisted of 125 White pupils and 61 Black pupils in three high schools in urban and periurban areas of Gauteng, South Africa. The schools represent different socioeconomic environments. One is a private school, one is a state school with partial provincial subsidy in an affluent suburb, and one is a community school which is subsidised mainly by donor funding and serves a periurban community.

Black and White pupils reported similar body ideals and levels of discrepancy between their reported actual body figures and their ideal figures, but Black pupils showed significantly greater tolerance of different body figures, both thin and fat. Despite this increased tolerance, however, their scores on the Eating Disorders Inventory were similar to those of the White pupils and exceeded White pupils on perfectionism and maturity fears measures. Amongst Black pupils in the three schools, EDI scores were similar but State school pupils showed more body dissatisfaction and Community school pupils showed more perfectionism and maturity fears. This suggests that pupils in more disadvantaged school environments are weight-concerned and could still be at risk of disordered eating. The finding is contrary to expectations that private school pupils would show the most disordered eating and weight concern.

EDI scores were closely related to body figure preferences, and especially to real-ideal discrepancy which was shown to be a simple but effective measure. A high-scoring subgroup was isolated and this was found to include 14 Black pupils and 22 White pupils. The findings have implications for preventive efforts and for further research.

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Declaration: I declare that this research report is my own, unaided work. It is being submitted for the degree of Master of Arts (Clinical Psychology) at the University of the Witwatersrand. It has not been submitted before for any degree or examination at any other university.

Sally Davies

S. Davies
11.12.95

BLAME IT ON BARBIE: BODY FIGURE PREFERENCES AND DISORDERED EATING AMONGST ADOLESCENT SOUTH AFRICAN FEMALES, A CROSS CULTURAL STUDY

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A research report submitted to the Faculty of Arts, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of Masters of Arts, (Clinical Psychology).

Johannesburg, 1995

This study uses the terms 'White' and 'Black' to define the two main race groups, but both are controversial. It also avoids using the terms as nouns, because this usage has come to feel racist, at least to South Africans, though it is often found in the American literature.

The experience of racist ideologies in our past and present social life - whether located amongst White or Black racists - has also sensitised research respondents and is likely to be a source of strong feelings when we try to investigate cultural issues. This is particularly true of a society in the process of political transition and cultural change. We may feel uncertain about what 'culture' is, about whether the content or form of our thinking can or should change through new experiences, and even about our own values - what, if anything, is worthwhile in life. For the young female respondents in this study, these questions are rendered even more complex by issues of gender and cultural transition that are, and have been, occurring within both Western and African cultures in relation to gender roles and family life. Consumer society gives strong but conflicting messages to women (and men) about how they should look and be in the world, as feminist accounts have pointed out (e.g. Orbach, 1988). Amongst adolescents, there is likely to be a varying awareness of these issues and thus a varying sensitivity to them, but in South Africa Black children have been at the forefront of sociopolitical transformation and it is probable that awareness levels are high. Few South African children have been sheltered from the impact of our racial past and its ideologies.

In spite of inherent difficulties, research has a role to play, especially feminist-orientated work that is responsive to issues of gender, culture, class and race. Unfortunately, much cross-cultural research in the field retains a crude, essentialist view of gender and culture, and (as previously explained), an oversimplified account of sociocultural change. Naive ideas about social progress (liberal) or class struggle (Marxist) can be set aside in favour of a flexible, accommodating model such as that of Bourdieu. Yet, whatever its theoretical and political limitations, the current body of research has raised key questions and concerns which feminists in particular might follow up.

2.2 DISORDERED EATING IN NONCLINICAL GROUPS

Most empirical, quantitative studies are found in medical sources, and as a result they inhabit the limited discourse of the medical model. One example of such limitation is the pathological/normal duality which creates a need to sort "disorders" into identifiable categories of known pathological status. During the 1980's research amongst nonclinical community samples led to a call for greater complexity and to protests against the limitations set up by disease-centred models.

2. CHAPTER TWO: SURVEY OF RELATED RESEARCH

2.1 INTRODUCTION

If, as various authors have claimed, there is an "epidemic" or dramatic rise in the incidence and prevalence of eating disorders related to sociocultural conditions (Gordon, 1990), then it follows that social transition could lead to more of these problems in groups where prevalence has seemed low. The change process loosely described as Westernisation is a prime example of such a transition - a complex evolution in which the ideas, values and beliefs that people hold come to resemble those of Western consumer culture.

In South Africa, cultural transition is complicated by former massive State attempts to fence off human cultures into enclaves. As is well known, this included efforts to limit areas where people were permitted to live, work and play as well as to prevent social interaction. An ideology of cultural purity was promoted, not only between White and Black but also between various African ethnic groups, in an effort to turn back the tide of integration which had developed over centuries of encounter.

Culture is not a finite entity - human cultures have always demonstrated qualities of growth, adaptation, and blending, as well as those of conservation and xenophobia. Cultures seem to join and divide people in equal measure, and cultural material may be utilised, it seems, in either direction. In South Africa deliberate attempts to produce division and prevent change give rise to an opposing desire to subvert the apartheid discourse by discovering and celebrating common ground, especially when we believe that the function of racist ideology is to deny Black people the right or opportunity to appropriate and enjoy profitable and prestigious aspects of 'white' culture.

It would be a particularly sad irony, then, if cultural integration were to produce some of the obnoxious signs of cultural deterioration that Verwoerdian racists predicted, and liberal consciousness were then compelled to ignore the issues. The problem is that culture is drawn into socioeconomic and ideological struggles which liberal views tend not to acknowledge. For liberally minded researchers, the acute sensitivity of cross cultural research seems off putting, and this may be one reason for a lack of South African studies to investigate racial differences in this field, despite great interest amongst psychology and life sciences students in the disorders which so often affect the students themselves or their friends. Another reason for the gap may be a history of unequal and segregated provision of health care, which often hampers comparative clinical research. In cross-cultural research, even terminology can be difficult or intrusive as an issue.

richer and more flexible understanding of what is going on in the eating disorders without recourse to simplistic notions of "causative factors" at the sociocultural level. We can also attempt to understand how women become involved in struggles for thinness and against fat, as well as the ways in which this might lead them to be 'predisposed' for eating disorders.

At a sociocultural level, however, this understanding is difficult to develop, because social structures are large-scale and so slow to change, and because (if Bourdieu is accurate) once the process of establishing ideologies is complete they become invisible and their workings are no longer available for observation. Given this situation, it seems possible that societies such as urban South Africa, which are undergoing massive and relatively rapid change or transition, provide special opportunities because at these historical points the "workings out" of texts and ideologies are still found at the centre of the historical page - they have not yet been marginalised or made invisible. An adequate theoretical account of change in sociocultural processes helps to frame empirical investigations of how individual social agents involve themselves in these processes.

Given these findings, it is a major limitation that the clinical discourse, which of necessity revolves around its two poles of normality and abnormality, has remained so dominant in discussions of weight, eating, and body issues in psychology and elsewhere. Weiss (1995) comments that medical or expert talk about eating disorders is self-perpetuating, and Gordon (1990) has referred to the role of professional discussion in these terms in promoting the adoption of these disorders by troubled individuals who need a culturally sanctioned way to express their conflicts and distress. Whilst the discourse has an important place, no doubt, in clinical treatment, its relevance to nonclinical populations is open to question, despite attempts to frame disordered eating as a continuum.

Yet "normal" anxiety over weight and shape is clearly the context in which risky and costly strategies will be adopted (Hill, 1993). It must also be a matter of concern that those who seem most willing to adopt the strategies are young, and not yet physically or emotionally able to manage these struggles. Childress *et al* (1993) have shown that even young children are proficient in discourses of fat and thin, but this does not mean that they are able to embark safely on a struggle against fat whilst they are still maturing physically. In addition, young people face many other conflicts in their lives, for which the eating struggle can all too easily become a life-threatening substitute, creating a cost in terms of loss of development as well as in its own right. Therefore, it is a useful exercise to investigate the strategies at a personal level, but also together with their cultural context as internalised by individuals. Only thus, it seems, can we begin to identify points at which the power of the texts can be subverted.

1.3 CONCLUSION

It seems likely that in every culture the female body has the potential to become a symbol of "the abject" but the forms of struggle under consideration here have a characteristically Western and consumerist flavour. Just as the physical body exists theoretically at a juncture of nature, culture, and society, so disordered eating and weight concern appear to reflect some kind of juncture in women's consciousness between their aesthetic tastes and values (representing a dominant ideology), and their personal struggles for power and recognition. Thus the female experience within social processes of domination and conflict remains riddled with contradictions.

The increased prevalence of eating disorders amongst women of a particular social stratum has confronted medical and paramedical "experts" (including psychologists) with material that we are not accustomed to thinking about or theorising academically, and this has resulted in a great deal of naive sociocultural speculation. Yet intellectual tools have been developed in other fields such as women's studies and sociology, which can help to develop a

Olmsted and Garfinkel (1983) who found no clear parallel between the continua of weight concerns in well individuals and the symptoms of eating-disordered individuals, even though it may seem plausible to argue for a family resemblance between the sets of behaviour. In terms of a Bourdieu framework, the family resemblance results from the use of similar strategies and a common perception of what is socially desirable or ideal. It is the strategies themselves that are worthy of further investigation, and the strategies which might be made the target of subversive efforts once their meaning is more fully elaborated.

Whatever the theoretical orientation or value perspective, subversion as a counter-strategy is likely to appeal to anyone who is concerned about women's well-being. Even if there were health benefits to the extensive modification of the body that is going on, and generally there are not, the strategies of fat avoidance account for much misery and deprivation amongst women, for what amounts to a goal that is cosmetic and (often) unrealistic.

Fairburn and Cooper (1984) found that nearly 90% of their female sample wanted to weigh less than the population mean weight. Moses, Banlivy, and Lifshitz (1989) found that exaggerated concern with obesity in adolescent females was unrelated to actual body weight or nutrition knowledge, and that girls who were of normal weight or even underweight were dieting and weighing themselves frequently. Moore (1988) found that his adolescent respondents tended to desire an excessive or inappropriate weight loss, and commented that many of the younger girls appeared to be attempting weight control without having an accurate perception of what is normal (that is, in medical eyes, presumably. These can be little doubt that these teenagers know what society defines as desirable). Fallon and Rozin (1985:102) carried out an interesting study which involved women and men students, and found that "Men think women like a heavier stature [in women] than females report they like, and women think men like women thinner than men report they like. Overall, men's perceptions serve to keep them satisfied with their figures, whereas women's perceptions place pressure on them to lose weight". This is interesting in terms of arguments that it is men (per se) that subject women to a demand to be thin. Based on these observations, it might be that whilst men place demands on women to be physically attractive, it is primarily women themselves who define attractiveness as thin and marginalise fatness. If so, then given the Bourdieu framework, they are probably doing so because they are trying to gain recognition in a context where traditional femininity has a low status or a narrowly defined role - but unable to change these perceptions of femininity, women "play the game" by redefining themselves physically as well as socially in more "masculine" ways.

normal eating". Their argument is that many so-called normal eaters are displaying characteristics of eating disorder pathology and "should be treated accordingly" (p. 635.) Hendren, Barber, and Sigafoos (1986) make similar claims.

Medical literature such as the above appears increasingly to be taking the view that disordered eating forms a continuum from the "worried well" (or the well whom professionals should be worrying about) through increasingly severe restricting and purging practices, to preoccupation with weight loss and dieting, and eventually to eith[illegible] imia or anorexia. This view is neatly aligned with sociocultural theories [illegible] emphasise structures or texts as the operative factors, with individuals variously "immersed" in these texts. For example, Casper and Offer (1990) reported that most of the female adolescents in their study were "preoccupied with weight and dieting", and that this in turn was associated with depressed mood, greater overall symptomatic distress, and dissatisfaction with the self. In a recent review, Fairburn and Beglin, (1990) found that the reported frequency of behaviours such as binge eating, self-induced vomiting, and strict food restriction ranged to well over half of the women surveyed, although the "true" incidence of eating disorders was only 1%. The [illegible]chological consequences of dieting involve loss of eating restraint which promote binge-starve cycles (Polivy & Herman, 1987), cognitive distortions, and even impaired performance on information processing, memory, and reaction-timed tasks (Hill, 1993)

Neimeyer and Khazoum (1985) found that eating restraint was related to feeling more out of control of eating habits, anxious, physically uncomfortable, disappointed, guilty, negative, panicky, self-critical and depressed. This type of picture is also familiar to psychotherapists working with women. They link these characteristics to the psychological features of eating disorders. Hill (1993:221) argues that "there are sufficient common themes in the origins and repercussions of dieting and eating disorder to imply causality...changes in the promotion and perceived acceptability of dieting will result in a change in the levels of eating pathology". Hill thus claims that normal dieting is linked in a regular and predictable way to the expression of eating disorders and that "the cases identified and treated are only the tip of the iceberg of eating pathology" (p. 221). Gillberg (1994) confirms this claim when he points out that nonclinical population studies have often identified quite seriously eating-disordered individuals who have not sought medical attention.

The theoretical framework adopted here admits these findings and arguments, but without necessitating reference to notions of either "pathology" or "causality", terms which are required by the limits of the medical discourse in particular. In fact, the so-called "continuum hypothesis" of eating disorders may be quite misrepresentative, as suggested by Garner, techniques of purging and weight loss, suggesting that in this way bulimia in particular has spread "like a brush fire" across American campuses.

Disordered eating therefore occurs in a social context where people tolerate extreme and even hazardous behaviour in the pursuit of thinness, but where fatness is hated and stigmatised. At the same time, as Smith (1993) points out, food is powerfully marketed and glamourised, promoting intense conflicts for those who tend to gain weight easily. Stigma against fat people can become concrete in terms of discrimination in educational and career settings (Gordon, 1990), as well as socially, and this sets the scene for weight preoccupation and fear of fatness even more securely. Yet not all who engage in these struggles develop an eating disorder. It seems that the intensity of the struggle for an individual, and perhaps also the extent to which the struggle for thinness and against fatness comes to displace other essential struggles (e.g. for independence, relationships outside the family, or for a coherent personal identity) may determine who will develop a clinical disorder by adopting strategies extreme enough to attract medical attention. Weiss (1995) points out that even in Western settings, eating disorders are not only struggles about being thin, and other aspects are well described in the clinical literature (e.g. Garner, 1993).

1.2 EATING DISORDERS AND DISORDERED EATING IN THE MEDICAL LITERATURE

As an individual becomes overwhelmed by her struggles, she may well adopt pathology as a culturally sanctioned method of protest. This is the premise of cross-cultural psychiatry, and as Gordon (1990) and others point out, it is also the danger of "informing the public" about eating disorders - a role that professionals usually regard as part of their job. Increasing acceptance of these conditions as medical disorders, together with offers of cure and care, may have contributed to their apparent increase. However, this again raises the issue of how a supposedly "normal" level of weight preoccupation, diet restriction and fat avoidance might relate to eating disorders.

Industries have grown up around the fat/thin polarity, not only in food, beauty and fashion, but also in paramedical fields such as nutrition, psychology, and in medical publication. Numerous professionals and paraprofessionals are now advising about food - its correct preparation and consumption, and about changing one's eating habits. This has generated comprehensive texts linking food consumption and health. Health professionals gain recognition from identifying, describing, and advising modifications for what is seen as abnormal or unhealthy. The extension of expert discourse in the eating disorders to the everyday world is neatly illustrated by Polivy and Herman (1987) who speak (albeit in deliberately subversive terms) about "the pathology of the norm" and the "diagnosis of

Bourdieu further contends that taste becomes embodied and made apparent in body size, volume, demeanour, ways of eating, sitting, walking, speaking, or making gestures (Featherstone, 1987, quoted in Frank, 1991:67). Bourdieu sometimes refers to these attributes as "physical capital", a notion which is subsumed under the broader concept of "cultural capital". Cultural capitals are always to be reinvested, for example in marriage ("catching a man") or in employment. For Bourdieu advantage accrues to individuals in the form of recognition and power to dominate others.

Individuals take their personal struggles for recognition into all kinds of social terrains, including education and peer group relations, and they do so through *active* attempts to acquire and utilise the dominant cultural material. Those who can do so fluently enough - without showing effort - will gain recognition, although pretenders may be despised. For social constructivists, the cultural material to be displayed with ease and naturalness is text material. Bourdieu uses the term "strategy" to describe the ways in which complex social practices (e.g. around dieting and weight loss) express an individual's personal "feel for the game". Strategies are not necessarily conscious or even rational, but in game theory terms they need to make sense for the agent.

Class distinctions are very important here. A child of the upper social classes starts out with a better "feel for the game" by virtue of early immersion in it. As far as eating disorders are concerned, this "game" is about gender roles and the female body. As women diet and exercise to gain recognition in a society where the thin, taut body is the dominant ideal, fatness is increasingly marginalised, and a vicious spiral forms between their actions (disordered eating) and the recreation of the text (culturally mediated complex of images, values, and associations). This theoretical framework creates possibilities for explaining the emergence of eating disorders and a "dieting ethos" without setting up individual actors as passive victims of culture or biology. Instead, the "factors" that have been documented become important contexts for strategy adoption, rather than taking the role of a social actor and leaving individuals as the acted upon.

As well as efforts to become and remain as thin as possible, the struggle for recognition in this particular arena requires that women (and, increasingly, men) will avoid displaying fat, and that fatness will be stigmatised. Given a split between fat and thin, even mild degrees of overweight can become the object of strategic efforts to remove or conceal. Childress *et al* (1993) have documented how readily young children make negative fat-related attributions to themselves and others. Polivy and Herman (1987) point out that in North America the "dieting mentality" has become normative amongst women. Gordon (1990:112) describes how female college students share correlates with assimilation into our 'thinness-conscious' culture ... An interesting, yet largely unexplored area relates to protective factors that tend to prevent the expression of eating disorders".

Although these accounts diverge, they both share the assumption that individuals respond to cultural or media bombardment in a passive, automatic way, expressed in terms such as "falls into", "inundation", "natural pushes", and "assimilation". Brumberg (1988) similarly argues that young women are "recruited" into body preoccupation and socially sanctioned attempts to alter weight or shape, and that a subset of these women go on (for other and complex reasons) to become eating disordered. This idea is useful insofar as it shifts the typical psychological or psychiatric focus from inner conflict and personal relationships to social dynamics. Yet her language also implies that the agent is a passive, neutral bundle of 'natural' responses to stimuli - nowhere is a space allowed for human agents to *act* and to construe meaning. It seems that there is a strong need for sociocultural models to become more sophisticated and flexible in their accounts of social structures and the individual agents who are responsible (collectively) for producing and reproducing them. As Diamond puts it, the social structure reveals itself in "what goes said or unsaid" in cultural texts that pose fat as the problem and thin (or thinner!) as the solution (1985:45), and it is individual and collective people that produce and reproduce these texts.

A contrasting approach has been articulated by French social theorist Pierre Bourdieu (1984), in a theory which is capable of including all the valuable aspects of the approaches described so far yet without loss of elegance. Frank (1991) sees Bourdieu as pre-eminently a theorist of the "mirroring body". This concept refers to the ways in which the human body reflects that which is around it and "the objects made available for it" (p. 61). The mirroring body therefore tends to become homogenous (or Same) across social strata. For Bourdieu, consumption is a central feature of the "social space" in which bodies are presented. Bourdieu is modernist (rather than postmodernist) in that he emphasises social class as a determining variable and demystification of class relations as a political praxis. Bourdieu sees social domination occurring in the context of wholesale, widespread consumption. Frank (1991:66) describes Bourdieu's position as follows: to be dominant is to be able to determine that what a society values as having distinction will be those same qualities which members of the dominant group are able to display, thus reproducing their own domination as good taste or legitimated distinction. These values or tastes are internalised by individuals such that they come to appear completely natural, and Bourdieu refers to the internalised values as "habitus". The process by which valued attributes are acquired and displayed is concealed however, and appropriation of dominance is denied - if there is a dominant ideology, it is in the belief that there is no ideology.

comprehensively to a glamour-look that is slender, tall, and features straightened, extended, and even bleached hair. Distinctively African features are downplayed so that the dark skin appears as an exotic feature of the anodyne Caucasian barbie doll.

Powerful vested interests are involved in the Black beauty business, and though depressing these trends are hardly surprising - as there is little profit to be made if people are content with the way they look naturally. However, it should also be noted that the shift back to the dominant ideal coincided with a more conservative, restrictive and harsh political climate. It therefore may be simplistic to associate changing body ideals purely with marketing strategies. Whatever type of shift takes place, and at whatever rate, it is clear that discourses of bodily appearance are markedly influential. They include verbal and visual texts about beauty, fashion, health, fitness, and of course gender and sexuality - a heady mixture that apparently motivates people to deny themselves the powerful gratifications and comforts available through food. The evidence that thousands of women change their eating behaviour and regularly deprive themselves of available and desirable food is all around us. Their widespread, totally voluntary and self motivated effort is in sharp contrast to public apathy when official and advertising attempts are made to influence sexual behaviour in the interests of saving lives.

To recognise the existence and power of cultural shifts, is also to raise the question of just how social agents (individual women or girls in this case) come to be part of them and thus to produce them, and it highlights the dangers of attributing powers of agency to social structures. How do individuals become involved in wider "structural" variables such as culture, class, and education, or more specifically in cultural discourses around body fat? Often, this is taken for granted. In medical discussions, feminist texts, and marxist analyses alike, one finds notions such as "social pressure", and ideas are expressed in grammar that ascribes agency to impersonal social forces or "the system". The implication often seems to be that if only little girls could be weaned off Barbie and play with trucks instead, we would not have these agonising problems with our body fat. Elks (1994:18[illegible]), a feminist writer, gives an example of this thinking in her description of the "Barbie doll factor". "From age 3, girls receive (and fanatically play with) a fashion doll with no waist, no hips and pencil-thin legs that go on for ever. When the girl is 10 or 11 ... she immediately falls into the ambient dieting ethos. This is enhanced by the inundation of ads from the highly remunerative diet product and food industry and the photos of the anorexic models in magazines, as well as the natural adolescent pushes from increased concerns about appearance and peer pressure". David Garner (1993:1633), international medical authority on eating disorders, expresses a more sober but similar approach: "Recognition that cultural pressures on women to diet contribute to anorexia nervosa has had a fairly recent history ... Disordered eating vantage point. In traditional rural societies, including those of Africa, thinness is not highly regarded; rather, people value fatter, heavier bodies as a sign of health and economic well being in the wider context of energy scarcity. Amongst women in particular, fatness has been taken to symbolise health, strength, fertility, and prosperity; for example Gordon (1990) discusses the African tradition of a fattening ceremony in which young girls prepare for adulthood and marriage. Such practices may lag behind social trends, and as a cultural milieu they exert their own influence on behaviour, attitudes, and values. For a young, urban, Black South African, they could form a confusing context for the construction of meanings around thin and fat - the values of her parents and grandparents, for example, may come into conflict with those of her friends in school or those embodied in popular media.

Once an opposition between "fat" and "thin" has been constructed, and meaning ascribed to it by an individual agent, she then may or may not begin to map it onto her own body in the form of a self image, and she may or may not begin to attribute vices and virtues to herself in the light of it. Depending on the conclusions reached, she then may or may not form goals and actively pursue a thinner, more socially desirable appearance (or to capitalise on it if she already has this image).

Furnham and Alibhai (1983) showed that shifts in aesthetic values and personal behaviour can occur quite rapidly. They found that Kenyan Asians (that is, people whose families originated in the Indian subcontinent but had been living in Kenya) who emigrated to Britain were *more* extreme than a British group in their preference for thinner figures, whilst Kenyan Asians in Kenya still preferred the fatter figures - even though the emigrants had been in Britain no more than four years. It may have been because their subjects emigrated under stressful conditions that the transition seemed so rapid. Pate *et al's* (1992) reference to a rapid rise of anorexia in Japan is another example of cultural assimilation, also arguably linked to social stress.

Attempts to undermine dominant ideals of beauty or bodily appearance have tended to fail under the onslaught of powerful texts. In South Africa (as elsewhere in the world), a bland Caucasian standard seems to dominate today, following a brief trend two decades ago in favour of the "black is beautiful" philosophy emphasising natural skin and hair appearance. Not coincidentally, this cultural move developed (in the US) in a time of some concern for social issues, where social controls were being relaxed, there was economic recession, and discourses around Black consciousness and power were in the public ear and eye. It seems a far cry from the underclass despair and middle class indifference associated with the contemporary collapse of the "American Dream". By contrast, today's media image makers for Black females such as fashion models and TV presenters seem to subscribe gradually become linked in Western culture to masculine or anti-female body ideals (Brumberg, 1988) and are readily attainable by women only insofar as they deny their bodily appetites, and suppress physical markers of femininity such as body fat. It is logical given the above accounts, that such ideals might predominate in members of more affluent social groups who are free from a daily struggle for provision or survival, but it is also possible that for aspiring group members, the attributions may contribute to a powerful dissatisfaction with one's appearance and a strong motivation to look thinner, wear fashionable clothes, and project the correct image.

Thus the context in which cultural meanings are mapped onto the body is the (politically) dominant culture, and it has been mainly successful female members of this culture that develop eating disorders. We can also say that in situations of cultural transition where people seek acceptance within a dominant culture, the potential exists for an individual agent to become eating-disordered at some level, although not necessarily clinically disordered. Indeed, a number of commentators have noted that the former epidemiological picture seems to be changing. Pate *et al* (1992) state that the prevalence of disorders may be increasing dramatically among all social classes and ethnic groups in the US, as well as in a number of other countries with diverse cultures. Gordon (1990) says that in the 1980's the number of Black patients in both America and the UK began to increase. A similar pattern has been noted at the Eating Disorders Unit of Tara Hospital, Johannesburg (Szabo, 1995, unpublished manuscript). However, the change process is slow, and the peer group plays a role (Pate *et al*, 1992; Abrams, Allen, & Grey 1993). The critical issue seems to be the rate at which the *popular* culture becomes less diverse and conforms more to a Western, consumerist model. Change is expedited when people experience mass education, multinational marketing techniques, and Western dominated media. Interestingly, there seems to be something specifically Western about this consumer culture, perhaps along the lines of Smith's discussion of production and consumption in relation to late capitalist social structures (1993). For example Pate *et al* (1992) claim that traditional Japanese culture is highly ascetic, yet a rise in clinical eating disorders was not documented until recently with a concurrent rise in consumerism. (The actual form of the disorders may vary, however, as Lee *et al*, 1993, have described - see below).

African case studies point to the role of education, competition, and upward social mobility in the development of eating disorders amongst Black Africans (Buchan & Gregory, 1984; Famuyiwa, 1988). Clearly, these factors are primarily sociocultural. Yet processes of cultural transition are not straightforward, because as Diamond (1985) argues, they are also processes of constructing meaning, and as Turner (1984) and Smith (1993) have said, they take place in a context of social conflict and vary according to social

The AB model comprises a personal, individual description of respondents' own thoughts, feelings, and behaviours around eating and weight concern. The Aesthetic model comprises an evaluation of different body figures, in which respondents are invited to appraise and label the figures according to pre-existing value sets. Further details of the dependent variables are given below under the discussion of research instruments.

3.2 DESCRIPTION OF RESPONDENT GROUPS

The groups comprised Standard 8 or Standard 9 female scholars from three high schools in the Northern Johannesburg area. All available pupils were presented with questionnaires with no randomisation or selection amongst the classes available. Respondents participated voluntarily in the study during their Guidance lessons, and the data were collected over four different days, two for each class at the State school, and once each at the Private and Community schools. Prior to administration of the questionnaire, respondents were introduced to the researcher by their teachers, and procedures were explained, with emphasis on the voluntary nature of the task, anonymity of respondents, as well as the need to give each other sufficient space and privacy to complete the questionnaire. During administration, the researcher was available for further clarification, which was minimised and as far as possible given in a neutral, standardised way. On completion of the questionnaires, time was allowed for debriefing, questions about the research, and for respondents to ask more general questions about the profession of psychology, in which some were interested. There was also a strong interest in the subject of the research, and it became evident that respondents who had initially resisted the task and not taken it seriously had had their interest engaged. Ten questionnaires were returned unused, suggesting that a few pupils felt comfortable in exercising their right of nonparticipation.

3.2.1 SAMPLE SIZE AND COMPOSITION

More than half of the respondents (54%) attended the State school (n = 108). Private school pupils comprised 32.5%. (n = 65). Community school pupils comprised 13% (n = 26). Due to poor data quality, two questionnaires were discarded at the outset (one from a Chinese respondent and one from a French-speaking Black respondent), and a further 11 scores from 'Asian' respondents were then set aside to avoid complicating issues of race and culture even more than is already the case. This left an overall N of 186: 6[illegible] Black and 125 White pupils.

3. CHAPTER 3: METHODOLOGY

3.1 VARIABLES

3.1.1 INDEPENDENT VARIABLES: RACE AND SCHOOL

The independent variables in this study are Race or ethnicity and School. 'Race' falls into two main categories, Black and White. Some Asian pupils (8 Chinese, 1 Korean, 2 South African Indian) also participated in the study but for analysis their scores have been left out.

'School' falls into three categories - Community, State and Private. The Community school is not integrated racially and has only Black pupils, but the other two schools included pupils of all races. To further the aims of the study, data relevant to processes of cultural assimilation amongst Black pupils was needed. To this end, as well as to obtain a spread across social classes, the schools were chosen to represent not only three different environments in themselves but also social groups that differed in specific ways. The Private school represents a fully urbanised, sophisticated environment where most (though not all) parents are affluent and where high academic standards prevail. The State school, which is geographically very close to the Private School, represents a typical South African government school in transition, where parents pay limited fees and there is an attempt to integrate Black pupils from nearby townships. These Black pupils represent an urbanised African culture. The Community school has donor support as well as a Government subsidy, but is classified by the Government as a farm school, and thus represents a sphere of South African education which is deprived of resources (though less so than farm schools on private farms). Some pupils come from township areas but most live in periurban shack settlements or farms. The Community School is thus both semi-urban and semi-rural.

These three schools, for the Black pupils attending, form a crude cross section of Black South African education and delimit three different positions on a gradient of sociocultural transition. For White pupils there is also a social gradient between the State school and the Private school.

3.1.2 DEPENDENT VARIABLES: TWO COMPLEMENTARY MODELS

The dependent variables are organised into two models, the Aesthetic model and the Attitudinal-Behavioural or AB model. Together they represent a view of sociocultural change processes, as described in previous chapters.

strategies (e.g. fasting) may have very different meanings for different cultures. The role of schooling, especially demands to achieve academically in White-dominated school environments, is shown to be important. The sociopolitical position of a particular group, and particularly their access to Western food, media and health care, are also critical. Lastly, case study evidence strongly suggests that a sense of cultural dislocation or even rejection of one's own traditional cultural values seems to expose women to a greater risk of developing an eating disorder.

A reading of the nonclinical and cross-cultural research suggests that we can expect to find relationships not only between race or culture and actual cases of eating disorders, but also that milder levels of suffering over body weight, food, and eating will be similarly related and are important in this context. Cautions, however, emerge regarding the interpretation of inventory items and the possible existence of different forms of eating disorder in non-western people.

It also appears that there is a need to build bridges between the dominant medical discourse and texts that aim to be more broadly based, whether the aim is to be more inclusive of different cultures, or more inclusive of so-called "normal" weight loss behaviour. Although medical talk has devised concepts that increase its range, this does not go far enough to satisfy an essentially feminist concern about the ways in which women of all ages, ethnic groups, and social classes might come to engage with these issues that are so central to women's lives.

In the next chapter, a research plan is presented which raises the relevant questions for a South African cross cultural study, and shows a method by which answers can be obtained.

introduced in a case history is poignant, re-introducing a sense of person that is absent from surveys. Buchan and Gregory (1984) describe a 22 year old Zimbabwean woman whose personal history included a transfer to Britain in early childhood, separation from her mother, a return to Zimbabwe at age six, and subsequent teasing and rejection by other children in the quiet Shona speaking rural area to which the family returned, including about being fat. There were high parental expectations of school achievement and frequent beatings. The patient was educated at a private, multiracial boarding school and having done well, went to study medicine in Britain - as the only Black student on her course and one of only three girls, she felt very lonely, isolated and homesick, as well as fearful for her family living in a war zone. During her second year, the patient became depressed and stopped eating, later developing a bulimic pattern. She was sent home to Harare, and by the time of admission weighed 42 kg. Following hospital treatment and the intervention of a traditional healer, this patient recovered well and began another course at the local university, seeking the support of a psychologist in order to cope with stressful situations. Her case shows how a person can become isolated from their culture, disorientated emotionally, and also that anorexic or bulimic strategies can help a patient deal with feelings of overwhelming anxiety and depression.

Whilst anorexia nervosa and bulimia typically develop in an "ideology of slimness", it is quite possible that in other cultural contexts, other forms of eating disorder may emerge. For example, Lee *et al* (1993) describe numerous cases of anorexia amongst Chinese women that involved no fear of fat, and therefore would not be diagnosable according to Western systems, even though other features were present such as examination stress, loss of relationships, or parental conflicts. The patients themselves explained their fasting as the result of epigastric bloating or lack of appetite (this sounds similar to the Victorian patients described by Gull or Lasegue). An Indian report also found that a clear body image disturbance or fear of becoming fat is hardly ever seen amongst their anorexic patients (Weiss, 1995). Weiss argues that it has now become a priority to "clarify professional concepts and local meaning of these disorders" (p. 549), and calls for further study of "the epidemiology and experience of eating disorders" in other cultures (p. 550).

2.4 RELEVANCE TO THE PRESENT STUDY

A survey of recent literature (e.g. Gillberg, 1994) shows that there is a need for more studies involving nonclinical samples. This research needs to be more wide-ranging in its focus than clinical symptoms of eating disorders, and it needs to take into account the findings of cross cultural research: that we should expect to find disordered eating and weight concern amongst Black respondents although Whites will generally show more, that cultural assimilation is a potentially important issue, and that apparently similar purging behaviour was found than had been previously reported - 41 % of Black boys, 61 % of Black girls, and 77% of White girls were dieting. There was also a significant tendency for Black girls to use laxatives and diuretics to purge, whilst White girls were more likely to use vomiting. Boys of both races were similar in their dieting and purging behaviour.

Abrams, Allen and Grey (1993) examined differences in the nature of "disordered eating behaviours" for black and for white female college students. White females demonstrated significantly greater disordered eating attitudes and behaviours than black females, for whom disordered eating was related to actual problems with overweight - for the white students this was not the case. They claim that this study is "the first to provide evidence that restrictive eating disorders among black women are related to the degree to which they assimilate to mainstream culture" (p. 50). Cultural assimilation was rated using a racial identity attitude scale which allowed for four "conceptually independent" stages of racial identity consciousness. Assimilation according to this measure has four "substages": "pre-encounter", "encounter", "immersion" and "internal". They found that eating variables such as restraint, fear of fat, and drive for thinness were significantly positively correlated with "pre-encounter" scores, but not with the other subscales. The pre-encounter stage is supposed to reflect "idealisation of values and beliefs associated with white identity and rejection of values and beliefs associated with black identity" (p. 51).

Unfortunately, the authors do not quote supporting data for this measure which appears seriously to oversimplify the issues. The report gives the impression that African-American psychology students could somehow be treated as though they were a remote jungle tribe that had not yet "encountered" whites. This is especially ironic, given that Black American identity has been forged out of just such an encounter, one whose outcome was slavery and second-class citizenship. However, the pattern they found is in harmony with Furnham and Alibhai (1983) who found that rejection of former values amongst immigrants seemed to place their subjects in a position of greater vulnerability. Although this finding is interesting, in the South African context it is probable that assimilation will be experienced differently. It also seems possible that what was measured in both these studies reflected a general self-rejection that was being expressed in both disordered eating and rejection of racial identity.

Finally, in addition to quantitative studies we also have several reported case studies of specifically African eating-disorder cases. Case histories highlight the difficulties of adapting to a new or dominant culture, and an "exaggerated over-identification with aspects of that culture, in this case an overvaluation of slimness as desirable" (Dolan, 1991: 73). They also show issues of acculturation very clearly. Sometimes the personal dimension increase in admissions during the five previous years, the majority of whom came from upper class families. Norris commented on the lack of non-white cases, but given the apartheid health policies operating at the time it is highly unlikely that any non-white patients would present anyway. The personality and demographic characteristics that Norris described are similar to those identified in North America and Europe, i.e. adolescents of above average intelligence, shy and compliant, showing psychosexual naiveté or guilt, with a close intact family that denies conflict, emotional enmeshment with a parent, and so on. Other African studies include Hooper and Garner (1986) who utilised the Eating Disorder Inventory to study a group of black, white and mixed race schoolgirls in Zimbabwe. They found that binge eating was present in all groups but most especially in the mixed-race group. Anorexic type behaviour was more common among white and mixed race schoolgirls than in the black group. Nwaefuna (1981), quoted in Pate *et al.* published a case report from Nigeria, a 22 year old woman with a six year history of anorexia nervosa with onset during a first pregnancy. This woman had experienced peer group teasing due to early physical maturity. The reviewers conclude that "As Western society's influence augments the conflicts over issues such as the female's role in society, physical appearance and attractiveness, and impulse gratification and consumption, the impact on biologically or psychologically susceptible individuals potentially increases" (p. 807).

Szabo (1995, unpublished) has reported on an increase of referrals at Johannesburg amongst groups which previously had a very low incidence of eating disorders, including Black patients and patients from lower socioeconomic groupings. Szabo comments that since studies such as that of Hooper and Garner (1986) were published, the situation seems to have changed. In addition, it is probable that South African Black groups are less 'traditional' and more 'westernised' than those in countries such as Zimbabwe and Nigeria (personal communication).

Some studies have compared Black females with Black males, as well as with Whites. Ca[illegible] Offer (1990) found that Black female adolescents were less likely to think about their weight than were white female adolescents, although (interestingly) this was not true of males, with Black males more concerned about caloric burning than white males. They also noted that Black adolescents from an inner city school (the study was done in Chicago) were more weight conscious than those from suburban areas, but did not offer an explanation for this finding, which seems to cut across class stereotypes.

Emmons (1992) investigated "dieting and purging behaviour" in a large sample of high school pupils from Cleveland, Ohio, including Black and White pupils, and boys as well as girls. A higher prevalence of dieting and society and in a number of diverse cultural settings" - other than in "achievement-oriented, upper and middle class individuals in Western countries". References in the section below are quoted from Pate and colleagues. These authors show a sophisticated approach in that they describe the thinness ideal in symbolic terms (self-discipline, control, sexual liberation, assertiveness, competitiveness, and affiliation with higher socioeconomic class, as well as attractiveness). One American community study found a high proportion of individuals from lower class backgrounds in the sample, and raised the issue of the importance of food in particular cultures - Jewish and Italian respondents seemed more vulnerable to eating disorders. An increase in numbers of Black patients referred in North America is attributed to "changing referral patterns, greater awareness, and improved case detection, along with increasing use of the health care system by blacks [sic] ... changing socioeconomic demography with increased exposure to the pressure related to upward social mobility...and a wider adoption of expectations about body shape and appearance ... In other words, it is possible that thinness is becoming as valued by black culture as it is by Caucasian culture" (p. 803).

Patterns of acculturation seem very important. Silber (1986 - quoted in Pate *et al*) studied a series of seven adolescents with anorexia nervosa, including five Hispanic and two Black teenagers. The Black adolescents were both "enrolled in highly competitive, predominantly Caucasian, schools in which there was no black peer group" (p. 803). Although previously considered physically attractive by others, the girls expressed negative attitudes towards their "big" bodies, seen by others as athletic; they also apparently felt responsible for "correcting the image of blacks" (p. 803.) All the Hispanic women had recently arrived in the US and suffered homesickness as well as loss of a peer group, extended family and familiar culture. Silber thought it possible that they felt different, had low self esteem and a powerful need to be accepted, and that they sought to increase their integration through an extreme adoption of new social standards, especially of appearance. Yates (1989) described a similar dynamic in Native American girls whose families had recently moved from reservations, and whose extreme weight loss seemed to be "a repudiation of the image of the traditional woman on the reservation" (p. 803). Rosen *et al* (1988) found that most of a sample of Native American women were trying to lose weight, and most of the dieters were employing hazardous methods. Pumariega (1986) found a significant correlation between acculturation and higher EAT scores in his Hispanic group, and suggested that greater adherence to the Western culture increased the vulnerability of individuals towards developing eating disorders.

Pate et al (1992) also report on eating disorders research from Africa and the Middle East. Norris (1979) published a study of 54 admissions to the adolescent and family unit in Johannesburg, which documented a 20 fold

These researchers found, in support of Abrams *et al's* (1993) tentative claim, that Asian girls from traditional families were at *greater risk* than those from the more Westernised families, in contrast to the Egyptian study. It may be that when certain non-western cultures collide with consumerist or Western ideology, a greater risk for eating disorders is created than would be produced by Western culture alone. It also seems more likely that this might occur when there is a strong patriarchy and women's behaviour is subject to intense monitoring and control. A different example might be the rapid rise of eating disorders that has been noted in Japan and some Chinese cultures - incidence of AN doubled in Japan between 1976 and 1981. Dolan however cautions that due to methodological limitations such as reliance on self-report measures and student populations, generalisation is problematic and therefore only "tentative statements of the incidence of eating disorders in non-whites should be made" (p. 70).

British case studies of bulimics found that the ratio of blacks to whites was at least ten times less, and the non-white bulimics were more likely to report gross emotional deprivation, including prolonged separation from the mother and incestuous abuse. Problems with racial identity were prominent, as four of the five cases had been cared for by white women (p. 73). A similar racial identity problem was recorded in a case study (Buchan & Gregory, 1984, see below) and Dolan quotes Furnham and Alibhai (1983) as a study that illustrates "how attitudes to weight and shape may change with immigrant status in ethnic groups where plumpness is considered attractive and thinness is undesirable" (p. 75).

It seems that in Western countries, referral via emergency services is more frequent in non-white patients, and it may be that even serious eating disorders are more likely to go unnoticed in ethnic minorities (over and above those who are presumably concealing the problem from other people successfully). Dolan links this finding to sociopolitical factors i.e. delivery of substandard or insensitive health care services to ethnic minorities, but in countries such as South Africa illness is often construed differently and people may prefer traditional herbal or spiritual solutions to the problem - either instead of, or in addition to "allopathic" interventions. In any case, the outcome is that there may be many cases of eating disorder that do not "present", and this could contribute to the apparently low prevalence rates amongst non-white populations. Dolan concludes that cross-cultural research is useful in terms of highlighting the impact of "sociocultural pressures" in the aetiology of these disorders, and in highlighting the pressures faced by young women of all cultural groups "to conform to ideals of Western society" (p. 76).

Pate *et al* (1992:802) reviewed cross-cultural patterns, commenting that "it now appears that these disorders may be increasing in other sectors of

By using ideas of "continuum" and "subclinical", health researchers have been able to take account of the overall morbidity (i.e. distress, unwellness, unhappiness) that disordered eating involves, and to be critical of accounts based only on clinical case presentations. Yet although the concepts are helpful for a profession which primarily ministers to those seeking help in clinics and surgeries, they can never be satisfactory to feminists attempting to develop an understanding of grassroots issues that illuminate the situation of women in sociocultural structures. Nor is much light shed on the role that different cultures might play.

2.3 CROSS CULTURAL STUDIES AND REVIEWS

Cross cultural studies which in the main compare Black and White groups, are of interest in that - like Black South Africans - Black populations in the developed world are usually thought to have a low incidence of anorexia and bulimia, and to be more prone to obesity. Recently, though, researchers have noted an apparent increase in the numbers of minority group members being diagnosed (e.g. Dolan, 1991). Dolan reviews case studies, surveys and clinical case reports. Her review is worth considering in some depth, as she has covered a large area of the available literature. All references in the following section are quoted from Dolan.

Initially, Dolan discusses the earliest figures reported for Black eating disorder patients. The first "non-white" anorexics discussed were part of a New York case series between 1960 and 1971; one of these women was Chinese. Garner and Garfinkel reported that their specialist Canadian treatment centre had not seen any Black women prior to 1979, but later on, 4 out of 124 referrals were black, and three of these came from upper middle class backgrounds. Another survey of case registers estimated that the case incidence rate of anorexia nervosa was eight times less than that for white women up until 1976 (Dolan, ibid:68). A British survey of nine schools in 1976 also produced no non-white anorexics. Two surveys in the US specifically included Black women, and found that black and white college students were equivalent in dieting and binge eating, but not in self-induced vomiting, or purgative use. This might suggest (taking the developmental/continuum view) that Black women were beginning to enter onto the slippery slope that leads to serious eating disorders, but had not yet reached the point of dangerous weight loss initiatives.

Dolan's report also ranged beyond North America. Egyptian students in Cairo and London were compared: the London group (which was much more Westernised) contained six bulimics and the Cairo group none, although there were some high Eating Attitudes Test scores due to dieting. Asian schoolgirls in Bradford, UK, had significantly *higher* EAT scores than Caucasians, with an equal number of anorexics and more Asian bulimics.

associations with general psychiatric morbidity - e.g. parental pressure to eat more, exercising to lose weight, stress at home, and a family history of anxiety or depression. It goes without saying that out of any given sample of young people, some are likely to be confused, hurting, angry, driven or have an external locus of control. The authors are implying that some of these vulnerable individuals will turn to food, body weight, and eating as vehicles to express their feelings or act out their conflicts - a view that concurs with the cross cultural psychiatry approach described in the previous chapter. This aspect means that we cannot assume an automatic link between "social pressure" and disordered eating - the strategies adopted by those wanting mainly to be thin may also be used by those engaged in other struggles, perhaps along the lines of those described in many clinical accounts.

Story *et al* (1991: 994) focus on chronic or repeated dieting as a "screening marker" for "more severe eating disorders", because of associations between repeat dieting and behaviours such as induced vomiting, or abuse of purgatives. Yet as Polivy and Herman (1987) have argued, "yo-yo dieting" (in which large amounts of weight are lost and then rapidly regained when the "diet" ends) is increasingly the norm, and it tends to set up a pattern of chronicity due to interference with cognitive and biological feedback mechanisms. It seems that with each diet cycle, the body improves its inherent ability to store fat and conserve energy. Overestimation of one's body size (Heilbrun & Friedberg, 1990) and underestimation of ideal body weight (Moses *et al*, 1989) may also serve to perpetuate dieting, and these appear to be common. The conclusion, increasingly admitted even by some parts of the slimming industry, is that dieting tends to be ineffective at best, and sometimes its long-term result can be weight gain and a slower metabolism. Some writers also claim that chronic dieting permanently impairs health, even when an individual does not purge or fall grossly below normal body weight in the process (e.g. Brownell & Rodin, 1994).

It thus appears that epidemiological research (e.g. Fairburn & Beglin, 1990) has found small numbers (around 1%) that fulfil stringent clinical criteria for diagnosis, and much larger numbers (anywhere from 5 to 30%) who are excessively weight preoccupied, and/or admit to "symptomatic" eating or purging behaviours. Similar patterns were reported from Japan by Kiriike *et al*, (1988). Of those who might be diagnosed as having a partial or even a full syndrome, it seems that a substantial number somehow cope with their problem without the help of doctors or clinics. This research has drawn attention to a complexity and scope of disordered eating that goes far beyond the limited clinical models, and some (e.g. Brownell & Rodin, 1994) also argue that these phenomena constitute a health problem for many people, thus bringing disordered eating in the wider sense into the ambit of the medical professions.

this study had never been medically treated at all, and this subgroup as it turned out was larger than the subgroup that had been hospitalised.

Childress *et al* (1993) investigated the extent of "problem eating" in children aged from 10 to 13 years. Of 375 children that took part, researchers found that over 40% (and more girls than boys) thought they looked fat or wanted to lose weight. These authors also found risky weight control behaviours including dieting, fasting, and use of diet pills, again more so amongst girls. Studies such as this, by focusing on children, manage to avoid the normalising talk that emerges in work amongst older people, where dieting is expected behaviour. Somehow, people seem to find the thought of prepubescent girls and boys of normal weight trying to 'slim', more disturbing and shocking than when thinking about adults. Childress *et al* (1993) found that White children were more likely to report dissatisfaction with their weight and eating disordered symptoms, yet Black children also reported problems: "The degree to which black subjects endorsed eating disorder items in this survey was surprising" (p. 848). Thus it seems that the perception still exists that weight loss behaviours are normal for White people but not for Black people, who might be stereotyped as prone to and indifferent to obesity (if not actually finding plumpness more attractive than thinness).

Other epidemiological studies creating a broader framework include Hendren *et al* (1986) who found that about 18% of their upper middle class female adolescents reported "at least one symptom of an eating disorder". Moore (1988:1114) found that "dissatisfaction with body weight and shape, and eating behaviours such as dieting, binge eating, fasting, and vomiting, are common in adolescent girls, many of whom are attempting weight control without an accurate perception of what is normal". Moses *et al* (1989:393) surveyed adolescent girls and found that there was an "exaggerated concern with obesity", which was found "regardless of their body weight or nutrition knowledge" - in fact, over half of *underweight* girls in this study described a great fear of being overweight. These authors conclude that, "the data suggest that fear of obesity and inappropriate eating behaviours are pervasive among adolescent girls regardless of body weight or nutrition knowledge" (p. 393). Research therefore portrays a pervasive *suffering* over body size and weight in the social groups involved (young Western women and girls) in which inner discomfort about one's appearance regularly reaches such a level that physical suffering (hunger, nausea, and the side effects of purgatives) seems to be more bearable.

Johnson-Sabine *et al* (1988) who speak about a "partial syndrome of eating disorder" throw an interesting sidelight onto this matter. Using a cross sectional study of three cohorts of state schoolgirls from London, they found that some commonly accepted risk factors for eating disorders are also

One means of protest was by introducing the idea of a continuum or a spectrum of eating disorders ranging from normality to severe pathological states. Scarano and Kalodner-Martin in a review article of 1994 describe a continuum model for bulimia as follows: normal eaters, weight-preoccupied persons, chronic dieters, purgers, subthreshold bulimics, bulimics. According to them there is an incremental increase along the continuum in behaviours such as binge eating, self-induced vomiting, drug use, or fasting; as well as in weight preoccupation and body dissatisfaction. Feelings of self esteem diminish as severity of eating disturbance increases. They also suggested that this model could be used to frame the *development* of eating disorders - a consequence of this could be that weight preoccupation and chronic dieting are regarded more seriously by health workers and educators and are less normalised. Support for the continuum concept has continued to develop, but the concept itself seems flawed, as shown by Garner, Olmsted and Garfinkel (1983 - see previous chapter). Yet even though the continuum concept may in some ways be a nonsense, it has served the useful function of encouraging discussion of a wider range of issues, and arousing curiosity about disordered eating and weight concern beyond the connection to clinical eating disorders.

Another way in which medical discourse can take account of a wider spectrum is by talking about "subclinical" eating disorders. The concept implies excessive weight concern, potentially dangerous weight loss or food intake behaviours or a combination of these symptoms that still falls short of diagnostic criteria. Button and Whitehouse, (1981:509) suggested that about 5% of post-pubertal females could develop a subclinical form of anorexia nervosa, and they conclude that whilst strict diagnostic criteria are useful in research, these criteria can set up a misleading framework for an overall discussion of serious problems of eating and weight concern. Fairburn and Beglin (1990) argue that prevalence studies have limited clinical significance and probably underestimate the prevalence (of bulimia nervosa) because of factors such as the tendency of sufferers to hide their problems (including in anonymous questionnaires), and the reliance on strict, narrow diagnostic criteria.

Various researchers have arrived at the conclusion that only a small subgroup of those with eating disorders is actually in clinic treatment at all, and this subgroup - on which so much research has depended - may be atypical in a number of respects. Gillberg (1994:209) identifies the lack of population studies and unquestioning reliance on clinic samples as primary deficits in the "immense volume" of literature on anorexia nervosa and bulimia. For example, he quotes a population study which found that only 15% of anorexic subjects had received inpatient treatment. This suggests that hospital samples in particular represent only the most severely and/or chronically ill. Gillberg also claims that a few of the most "deviant" cases in relationship between P and Ineffectiveness also suggests that feelings of inadequacy or low self-worth play a bigger role in Ineffectiveness than do control issues. MF has generally been found to be a weaker measure, including in the present study amongst the White respondents, and it appears to lack depth and complexity. This may account for its tendency not to correlate with other subscales. In general, the high levels of intercorrelation in apparently diverse subscales suggest that the notion of the EDI as a "psychological profile" of the eating-disordered individual is viable.

The strongest intercorrelation ($r = 0.67$) is found between Ineffectiveness and Interoceptive Awareness, and suggests that these two subscales share a common element, for example an external locus of control. I also seems closely related to Interpersonal Distrust at $r = 0.55$, perhaps for similar reasons. Drive for Thinness and Body Dissatisfaction co[illegible] at $r = 0.60$ and may be closely related; DT may represent a more generalised form of BD, for example. It is also possible the BD could be found as a precursor to DT, which would offer support to some of the feminist approaches e.g. Diamond, (1985). DT also correlates strongly with Interoceptive Awareness at $r = 0.51$. These two subscales do not appear logically linked, but this finding gives support to the thesis of Polivy and Herman (1987) that dieting behaviour tends to disrupt internal awareness and appetite controls.

Finally, Bulimia is strongly related to Ineffectiveness ($r = 0.51$) and to Interoceptive Awareness ($r = 0.50$). This suggests that women who tend to feel out of control around food are also more likely to feel generally ineffective and to be uncertain of their own internal states - again, this makes intuitive sense as bingeing and purging is likely to exert an effect on interoceptive awareness, and equally may arise when interoceptive awareness is lacking.

3.6.7 DISADVANTAGES OF THE EDI

The instrument is subject to the same limitations as any other self-report inventory, in that distortions can easily emerge in the form of response sets and differences between respondents about the meaning of words and statements. This latter problem is especially acute when using the inventory untranslated amongst second-language English speakers. Issues of cultural relevance also emerge, for example statements such as "I feel inadequate", or "My parents have expected excellence of me" - and many other items in the EDI. However, it may be that such confusions were not significantly less amongst the original samples, despite concerns about culture and language. Concepts such as "binge" are very likely to be difficult to interpret in subjective reports as one person's idea of a binge may differ widely from another's. It seemed that at the time of administration all three interpersonal relationship that Western (and White) cultures lack, and therefore it is, perhaps, not too surprising that this scale proved unreliable for Black pupils. Bulimia and Maturity Fears were found by Schoemaker *et al* (1993) to be unreliable, but unlike their sample, Perfectionism is adequate amongst White pupils even at the higher Alpha level, and Interoceptive Awareness amongst both race groups.

In summary, reliability for the Black sample is generally lower than for the White sample except for MF, but is basically acceptable at Cronbach alpha level of 0.6 with the exception of the ID subscale and cautions regarding Bulimia scores amongst Black pupils and Maturity Fears amongst White pupils. It was decided not to identify and remove items showing low item-total correlations, because of the need to maintain the integrity of the scale and to enable comparisons with other samples. As with the Dutch sample of Schoemaker *et al* (1993), there are likely to be many differences between both South African samples and groups tested in other countries, and these differences will limit the psychometric effectiveness of instruments such as the EDI. Nevertheless, with the reservations described reliabilities are satisfactory, particularly for critical variables such as Drive for Thinness and Body Dissatisfaction.

Efforts to validate the EDI suggest that it generates useful and relevant data in the area of eating behaviour and attitudes, and that it has sufficient specificity to measure degrees of "abnormality" as well as to identify respondents who have eating or weight concern issues, even when they are not clinically ill. Although other instruments have been developed, most notably the Eating Attitudes Test or EAT (Garner & Garfinkel, 1979, Garner *et al*, 1982), this test has been found to have a low predictive validity when used in the general population (Gillberg, 1994). Thus the EDI, with its longer track record and inclusive psychological profiling, was the instrument of choice in the present study.

3.6.6 INTERCORRELATION OF EDI SUBSCALES

There are numerous significant intercorrelations between the EDI subscales, based on the present study. In fact, ALL correlations were significant except for Perfectionism/Body Dissatisfaction, Perfectionism/Ineffectiveness, Maturity Fears/Drive for Thinness, MF/Bulimia, MF/Body Dissatisfaction, and MF/Perfectionism.

Lack of relationship between P and BD is especially interesting as it suggests that BD relates to a specific form of body image disturbance which does not necessarily require a psychological background of perfectionism. Lack of

3.6.5 PSYCHOMETRIC PROPERTIES OF THE EDI IN THE PRESENT SAMPLE

The present study obtained information regarding the reliability of the EDI in this research setting. Internal consistency coefficients (Cronbach Alpha) and average inter-item correlations were obtained for each Race group, and are shown below in Table 3.1.

TABLE 3.1. Internal Consistency and Item-Total Correlations - EDI

	BLACK		WHITE	
EDI	ALPHA	I/I CORR	ALPHA	I/I CORR
DT	.6767	.2453	.8490	.4859
BD	.8151	.3381	.9154	.5694
Bu	.5802	.1078	.7438	.3372
P	.6488	.2318	.7737	.3758
I	.6270	.1498	.8907	.4644
IA	.6934	.1922	.7916	.2833
ID	.4699	.1273	.8385	.4368
MF	.6391	1842	.5661	.1438

* I/I Corr = Average inter-item correlation
Note: For details of the EDI subscales, refer to Section 3.6.2.

For the Black sample, reliabilities are generally lower, although only one scale - Interpersonal Distrust amongst Black pupils - appears excessively low based on a rule of thumb of 0.60. Anastasi (1961) has suggested that reliabilities around 0.6 are acceptable for research purposes, although they would be considered too low for clinical purposes. In addition, Bulimia reliability is low (though arguably still acceptable) amongst Black pupils, and Maturity Fears amongst White pupils. This latter finding is rather surprising given the overall high reliabilities amongst White pupils, and may be the result of asking the same question too many times, possibly causing the respondents to think these were "trick" questions and respond inconsistently. At the debriefing sessions, several respondents complained about this subscale in particular for asking the same question over and over. Black respondents may have been less suspicious.

Regarding the Interpersonal Distrust scale, it has become a truism that traditional African cultures have strong assumptions of shared identity and

Shore and Porter (1988) examined the reliability of the EDI in a sample of male and female youth aged 14 to 18 years. Reliability was considered adequate if a coefficient of 0.70 was obtained. With the exception of the Bulimia and Maturity Fears subscales, alpha coefficients of above 0.70 were obtained for all subscales for the female sample. Shore and Porter contend that Bulimia and Maturity Fears items are more relevant to adults, given the typically later onset of BN and the notion of 'returning to the security of childhood' which is central to the MF subscale - this, they think, accounts for lower reliability amongst adolescents.

Schoemaker, Van Strien, and Van der Staak (1993) translated the instrument into Dutch. They also used an internal consistency score of 0.70 as a cut-off, and found that internal consistencies were somewhat lower than those reported by Garner and Olmsted (1984). Using the recommended scoring method, they found that Cronbach Alpha coefficients were unsatisfactory for Bulimia, Perfectionism, Interoceptive Awareness, and Maturity Fears.

c) VALIDITY. Two groups of subjects were used to validate the EDI. One group (N = 129) had primary anorexia nervosa at various stages of treatment. Fifty-six of these young women were identified as having a 'restrictor' subtype of the disorder, i.e. had relied mainly on fasting to lose weight; and 73 were classified as 'bulimic', i.e. they had also (or even mainly) relied on purging. As a comparison group, three independent subsamples of 770 female psychology students in first and second years of study were recruited. The original 146 items were administered, and an item was retained if, and only if, it demonstrated a significant differentiation between the anorexic and comparison groups, *and* showed a higher correlation with its own subscale than with others. A final cross-validation sample of 271 college women and 155 anorexics was then recruited, and the reduced scale was administered.

To establish criterion validity, patient profiles were compiled and these were satisfactorily compared with clinical accounts of the patient's psychological presentation.

Garner, Garfinkel and Polivy (1983) described further validation of the EDI. They established convergent and discriminant validity for the subscales, by administering the Inventory to other comparison groups, such as male college students, normal weight bulimics, and formerly obese women who had recently lost weight. The instrument proved capable of distinguishing between these different groups. It was also shown that clinically recovered anorexics had scores similar to the 'female comparison' group on all subscales.

freely expressing their own feelings. This area of inner life is therefore available to be drawn in to role-based conflicts.

8. MATURITY FEARS (MF) This comprises a negative response to the demands of adult life, and the corresponding wish to retreat into the security of being a child again. Various writers, such as Crisp (1980) have suggested that psychological maturity (independence) and physical maturity (changes in size, shape and sexual characteristics) are experienced as frightening by anorexics. From the feminist point of view, this is a direct consequence of the devaluation and oppression of women in society, such that a girl on the verge of adulthood readily becomes aware that her future as an adult could be beset with difficulties and dilemmas.

3.6.3 ADMINISTRATION AND SCORING

The inventory is easily administered and takes about 20 minutes to complete. Subjects rate each item on a 6 point scale. The scoring method assigns the most typically "anorexic" response a score of 3, the second most extreme scores 2, the next scores 1, and the three remaining responses all score zero. This method of scoring maximises the inventory's discrimination between groups, but may render it less sensitive and skewed towards zero.

3.6.4 PSYCHOMETRIC PROPERTIES OF THE EDI

The EDI has often been used in research amongst clinical and nonclinical populations, e.g. Larson (1991) who studied high school girls, and Hooper and Garner (1986) whose focus was schoolgirls of different race groups in Zimbabwe.

The authors drew on the experience of various clinicians who had been treating anorexic patients and were familiar with current research. From an original pool of 146 items, the eight present constructs were isolated as meeting basic requirements for reliability and validity (Close Conoley & Kramer, 1989).

b) RELIABILITY. Garner and Olmsted (1984) set a requirement for subscales to have reliability coefficients above 0.80 for their anorexic samples, and this was achieved in all subscales except Interoceptive Awareness and Maturity Fears, to which additional items were added that increased relibability to the desired levels. Item-total correlations were required to be above 0.4 and all but three items fulfilled this requirement, with an average item-total correlation of 0.63.

4. INEFFECTIVENESS (I). This subscale assesses feelings of general inadequacy, insecurity or worthlessness, and feelings of not being in control of one's life. It seems to include some aspects of Locus of Control but also involves negative self-evaluation. Personal ineffectiveness is strongly associated with anorexia nervosa by Harding and Lachenmeyer (1986). Feminine ineffectiveness can be viewed as a consequence of role conflict and perhaps of patriarchal family and societal relations.

5. PERFECTIONISM (P). The measure represents excessive personal expectations of superior achievement. A characteristic theme in writings about anorexia, perfectionism is seen as an 'overcompliant adaptation' by analytic writers such as Bruch (1978) an adaptation which is thought to break down when subjected to the increasing demands of adolescence. Garner, Olmsted and Polivy (1982) relate P to a dichotomous, all or nothing cognitive style in the context of cultural or familial emphasis on success and achievement. As with ineffectiveness, perfectionism can be linked to role conflicts and the feeling sometimes articulated by women that they need to perform perfectly in order to overcome gender prejudices. Feminists might also relate the trait to high expectations of compliance and conformity that parents may have of female children. As suggested above, a strong desire to succeed in a patriarchally defined arena may increase the psychological splitting of the physical self into its fat and non-fat parts.

6. INTERPERSONAL DISTRUST (ID). This construct refers to a sense of alienation and reluctance to form close relationships. Various writers have identified it as important in the natural history of anorexia nervosa. The difficulty with close or intimate relationships is not paranoid but is related to discomfort in sharing emotions and being vulnerable with others - again this could be exacerbated by cultural factors. Interpersonal Distrust is a trait that runs counter to the traditional female role as provider of intimacy and dependency needs for other people, and may at some level represent a rejection of this role. It may also reflect experiences of being hurt, betrayed or exploited in close relationships, including by mother figures.

7. INTEROCEPTIVE AWARENESS (IA). IA represents the ability to recognise with accuracy an internal signal, whether this is hunger/satiety, or an emotion. Anorexics, along with other psychosomatic patients, often show deficits in interoceptive labelling (alexithymia), i.e. they may have difficulty in identifying emotions and bodily states accurately or timeously. Some forms of Western culture are particularly denying or marginalising of feelings and sensations, and this is just as likely to be a problem of males as of females. However, females may be more expected to deny their own feelings and needs in order to focus on those of others, and may feel wrong or selfish in

identifying 'abnormal' eating (Johnson-Sabine *et al*, 1988). The EDI, however, provides a scenario or ideal type of a (Western) eating-disordered person's inner world, which given the aims of this research, is felt to be more important here. In the present research, the EDI has two main functions. In the first place, it provides an interlinked set of measures that depict a respondent's inner, individual world and her characteristic responses in this contested area of life. Secondly, as an instrument widely used in research and for which some norms are now available, it offers a useful opportunity to compare a South African sample with samples in other countries.

3.6.2 SUBSCALES OF THE EDI

The eight constructs that comprise the EDI are described as follows by its authors (Garner & Olmsted, 1983). In each case, an interpretation of the construct follows, presented from a sociocultural or feminist perspective.

1. DRIVE FOR THINNESS (DT). This construct represents excessive concern with dieting, preoccupation with weight, and "entrenchment in an extreme pursuit of thinness". Items include both positive checks e.g. a strong wish to lose weight, and negative checks such as a fear of weight gain. This relates directly to the argument that "thin is the feminist issue" (Diamond, 1985).

2. BULIMIA (Bu). Bulimia represents a tendency to eat uncontrollably (binge) with or without impulse to induce vomiting. The tendency may be present with anorexia but has also been described in women with no prior history of anorexia. Bingeing has been linked to social restrictions placed on women's appetites and also to the availability and aggressive advertising of processed foods (Smith, 1993). The Bulimia scale thus represents struggles for control around food and eating.

3. BODY DISSATISFACTION (BD). This measure targets parts of the body which normally enlarge at puberty and thus become associated with increasing 'fatness', i.e. hip, thigh and buttock. Garner and Garfinkel (1981) related it to other body image disturbances in anorexic patients. It has been suggested that attempts at weight loss in women of normal weight may often be a response to particular dissatisfaction with these body parts. Feminists relate it to anti-female discourses which promote feelings of disgust towards the mature female body, as well as to the societal restriction of women to childlike, dependent appearance and roles. Shore and Porter (1988) found that Body Dissatisfaction increased dramatically between the ages of 13 and 14 in girls, at the time when major bodily changes generally occur.

3. Are the South African samples (Black and White school pupils, nonclinical) similar in their EDI profiles to comparable samples from other countries? If not, in which ways do they differ?

4. Are there significant correlations between the Aesthetic and AB models?

5. Which races and schools are represented in a group of respondents scoring above an anorexic mean score on Drive for Thinness?

3.6 INSTRUMENTS USED IN THIS STUDY

3.6.1 EATING DISORDERS INVENTORY - A BROAD BASED MEASURE

The Eating Disorders Inventory (Garner & Olmsted, 1984) is a measure of attitudinal and behavioural dimensions relevant to anorexia nervosa and bulimia, which can be used from age 12. The self-report inventory has 64 items which make up 8 subscales. These subscales represent eight cognitive, behavioural and emotional constructs based on observations about eating-disordered patients. Three subscales (Drive for Thinness, Body Dissatisfaction and Bulimia) assess symptomatic patterns of eating behaviour. The other subscales (see below for details) assess psychological traits associated with the development of eating disorders, particularly AN (Schaaf & McCanne, 1994). As a whole, the inventory represents a summary of several decades of clinical experience in the eating disorders, and especially of the perspective of David Garner and his colleagues that eating disorders are 'multidimensional' (and not just about wanting to be thin). The inventory therefore includes cognitive, sociocultural, behavioural and psychodynamic factors which are relevant in the aetiology of eating disorders. In *The Tenth Mental Measurements Yearbook* of 1989, edited by C. Conoley and Kramer, the Inventory is described and reviewed.

Initially, the EDI was recommended for use as a screening device, or in typological research, of which Garner, Olmsted & Garfinkel's 1983 study identifying a 'weight preoccupied' group is an example. However, because the instrument offers a broad approach, it has been favoured for a variety of applications. Amongst clinical instruments in the field, the EDI has been distinctive in taking into account psychological traits which seem to pave the way for disordered eating to assume pathological proportions in individual cases. Other instruments, such as the Eating Attitudes Test (Garner & Garfinkel, 1979) focus more on symptomatic attitudes and behaviours. This makes them potentially more precise than the EDI for screening and scores reflecting disordered eating and weight concern, and five reflecting important background features of the eating disorders.

3.4.2 AESTHETIC MODEL

The Aesthetic model was based on a Body Figure Preference Test in which respondents were presented with a array of stylised body figures ranging in shape from skeletal to obese. The array was adapted from a research report by Furnham and Alibhai (1983). The model represents what Toro, Salamero & Martinez (1994) have called the "aesthetic body shape model". "Aesthetic" refers to discriminative judgement, preference, or taste, and in this case the judgement concerned the amount of body fat visibly present in any one of the given array, and the effect of this on the attractiveness of that figure.

Variables comprising the Aesthetic Model are either taken directly from responses or are indirectly derived from responses. They include the respondent's ideal body figure (Ideal), a forced choice between the two extremes for the worst figure (Worst), a self-representative figure ("most resembles your own body shape"), Real-ideal Discrepancy or R-ID which is the difference between ideal and self-representative figures, and Tolerance Range which is the number of figures falling between the first figure marked "unattractively thin" and the first figure marked "unattractively fat". Upper and lower limits of the tolerance ranges were also of interest, as these provide information about where on the array the range was placed.

3.5 RESEARCH QUESTIONS

Research questions were formulated, relating to the aims of the study stated above.

1. Are there significant differences between the two main race groups (Black and White pupils) on any of the dependent variables? If so, in what direction do they lie?

2.a) Are there significant differences between Black pupils in the three different school groups? If so, in what direction do they lie?

b) Are there differences between White pupils in the two different school environments where they are present? If so, in what direction do they lie?

3.3.4 RELATIONSHIP OF THE TWO MODELS

Relationship or lack of relationship between the models also has a bearing on understandings of sociocultural process in the field of interest. Investigating this was the fourth aim.

3.3.5 HIGH-SCORING GROUP

The fifth aim was to isolate a group scoring at or above the mean raw score (15 out of a possible 21 points) of a Canadian anorexic group on Drive for Thinness (Garner, Olmsted & Garfinkel, 1983). This high scoring group is described further in terms of race, school, and aesthetic model data. This information should be of interest to medical readers whose primary interest is in those respondents who appear to have serious difficulties and could be at some risk of an eating disorder. (This cutoff point is more than one standard deviation above the mean scores for the present sample).

3.4 DEPENDENT VARIABLE MEASURES

The dependent variables comprise responses given to two research instruments, and as described above they have been organised into two corresponding models, the Aesthetic Model and the Attitudinal-Behavioural or AB model. The Aesthetic model reflects culturally-defined preferences for particular body figures. The AB model reflects eating- and weight-related attitudes and behaviour, i.e. a level of individual embodiment of the issues at stake in (culturally-defined) ways. As explained in Chapter 1, cultural phenomena are assumed to exist only insofar as they are produced and reproduced by agents, and in this case they are being reproduced in the research context by specific evaluating and labelling activities. The relationship between the models represents a somewhat crude analogy for the complex relationship between agency (individual) and structure (social) as forces for social stasis or change.

3.4.1 AB MODEL

The AB model was based on the Eating Disorders Inventory or EDI (Garner & Olmsted, 1984). It comprised the eight subscales of this Inventory - Drive for Thinness (DT), Body Dissatisfaction (BD), Bulimia (Bu), Perfectionism (P), Ineffectiveness (I), Interoceptive Awareness (IA), Interpersonal Distrust (ID), and Maturity Fears (MF). The EDI is described in greater depth below. Together, these eight constructs are conceptualised as providing a psychological profile or "mindset" of an eating-disordered, weight preoccupied individual in the Western context. This profile includes three

3.2.4 BODY WEIGHT

Pupils were also asked to report their body weight, which most did ($n = 175$). Black pupils reported weighing on average 59.2 kilograms, and White pupils reported weighing on average 56.1 kilograms. This difference is less than might have been expected given that the Black sample is older, and is nonsignificant ($t = 1.392$, $p = .166$). This information is useful in that it indicates that the two race groups are roughly on a par in terms of real body size

3.3 AIMS OF THE STUDY AND EXPECTED FINDINGS

3.3.1 RACE DIFFERENCES

The primary aim of the study was to investigate differences between Black and White groups on the dependent variable models. It was expected that differences similar to those quoted in the American literature would emerge, i.e. that Black pupils would score low on the Attitudinal-Behavioural model compared to White pupils. It was also expected that they would prefer larger figures, and be more tolerant of larger figures, than White pupils, in line with reports in the literature regarding body preferences.

3.3.2 SCHOOL DIFFERENCES

The second aim was to determine whether there were differences between Black pupils educated in different school environments. This question is of interest because of its bearing on cultural assimilation, and because researchers in the Northern hemisphere (e.g. Hendren, Barber, & Sigafoos, 1986) have suggested that Black pupils in more elite environments have similar attitudes to their White classmates and could therefore, according to the sociocultural account of eating disorders, be similarly considered a high-risk group for the disorders. It was also expected that White pupils in the elite Private school environment would show higher scores than those in the State school, because of evidence that elite school environments incur a higher risk for eating disorders.

3.3.3 COMPARISON OF SOUTH AFRICAN SAMPLE WITH OTHER NORM GROUPS

The third aim was to compare scores obtained on the Attitudinal-Behavioural model with comparable groups of young females from other countries available in the literature.

3.2.2 AGE

As is common in South African schools due to disruption of education, there was an age difference between the race groups, even though most scholars were at Standard 8 or 9 level. The average age of the Black pupils was 16 years 7 months. The average age of White pupils was 16 years 2 months. The average age in months of the two groups is significantly different ($t = 3,54$, $p = .001$). Black pupils also showed a wider range, from 14 years 2 months to 20 years 9 months - three fourteen year olds took part who presumably were not in Standard 8 but perhaps accompanying older girls at the time. Their scores have been included. The State school group had a mean age of 16 years 7 months, the Private school of 16 years 1 month, and the Community school of 17 years, 4 months. These age differences may have affected responses, but most respondents are in a similar developmental stage, i.e. middle to late adolescence, and are at a similar point of social development, i.e. completing secondary education. The overall mean age was 16 years and 5 months.

3.2.3 RACE AND SOCIAL CLASS DISTRIBUTION.

Black South Africans made up 30% of the sample ($n = 61$). Two respondents were Black Africans from other countries. White South Africans of English or Afrikaans parentage made up 49% ($n = 98$), and a further 13.5% of the White group ($n = 27$) belonged to ethnic minorities such as Portuguese, Greek, Lebanese, Italian, and Yugoslav.

For classification of parental social class, respondents were asked to state the occupation of both parents, and the higher of two responses was taken. Occupations were divided into five groups: professional, business management, "white collar" or lower status professionals, "blue collar" or semiskilled workers, and unskilled workers. This classification proved difficult to apply, especially as respondents seemed to be protective of their family's social status and inclined to present their occupations favourably. As far as can be ascertained, 24.5% ($n = 49$) appeared to fall into the 'professional' group, 27.5% ($n = 55$) into business management, 26% ($n = 52$) into white collar occupations, and 12.5% ($n = 25$) into blue collar occupations. 7.5% ($n = 15$) were reported as unskilled workers, e.g. peasant farmers. These figures suggest that the sample is biased towards the middle classes and that proletarian families are under-represented, but given the small scope of the study the sample is sufficiently diverse.

average Black pupils indicated ranges of five to six figures and White pupils indicated three to four figures. Table 4.4 and Figure 4.3 (overleaf) show the probability of each body figure being included in the tolerance ranges of the two race groups.

TABLE 4.4 Probability of each figure being included in range of tolerance.

	A	B	C	D	E	F	G	H	I	J	K	L
White %	0	4	15	64	92	100	64	18	7	4	2	0
n=125	0	5	19	80	116	125	80	23	9	5	2	0
Black %	0	28	33	74	96	100	86	56	40	28	26	1
n=57	0	16	19	42	55	57	49	32	23	16	15	1

These results show that Black pupils are significantly more tolerant than White pupils of body figure extremes, whether thin or fat, and especially are more tolerant of fatness. This finding conforms with predictions that Black pupils would be more fat-tolerant. However, the finding that they are also more tolerant of thin extremes was unexpected. The puzzling question is, why did so many Black respondents (24%) exclude only the two most extreme figures, giving a range of 10 figures? Alternative explanations for the finding include possible misunderstanding of the instructions, yet this seems doubtful - the test is fairly simple, certainly more so than the EDI subscales on which this group obtained satisfactory reliabilities. It may also be that Black pupils were more resistant to, or uncomfortable with, this task than White pupils were - discomfort due, perhaps, to a dislike of applying pejorative labels to human figures, or to embarrassment or distaste for the naked body figures.

Another possibility is that the group giving this response simply did not relate to the task, and so they obliged the researcher by excluding the two most extreme figures (as the instructions appeared to require) but included the rest. This may not have been due to misunderstanding at all, but might point instead to a group that is not engaged in any kind of struggle around body shape and size at this externalised level, and who have not come to believe in the "preformed social opposition" of fat and thin that is so prevalent in Western culture. Consequently, it is possible that for this group neither fat nor thin is an (aesthetic) issue.

b) LOWER TOLERANCE LIMITS. Table 4.5 shows the percentages from each race group who set their lower tolerance limit at a given figure. The lower tolerance limit represents the first figure not to be identified by a respondent as "unattractively thin". For example, if a respondent stated that

TABLE 4.3. Forced choice between Figures A and L (row percentages)

	A	L
White n=125	40%	60%
Black n=62	19%	81%

A significant difference was found between the two race groups in their choice of a "worst" figure - significantly more Black pupils than White pupils rejected the obese figure (Chi-Squared 7.97, $p < 0.005$). Again, this finding was unexpected given the hypothesis that Black pupils traditionally value fatter figures and therefore are more likely to show distaste for thin, bony figures. It may be that the forced choice had the unintended effect - given the overall nature of the research - of alerting pupils who are aware of eating disorders such as AN to the issues at stake. If so, it is possible that this result reflects awareness, especially amongst White pupils, that (blameworthy) conditions of self-imposed starvation or "dieting gone mad" can exist, conditions which these pupils are opposing by rejecting the emaciated figure. Conversely, it may be that pupils who are less aware of such conditions might view the emaciated figure as a hapless victim of poverty. For these pupils, the obese figure might appear more blameworthy and deserving of rejection. If this reasoning is correct, it seems possible that White pupils feel more helpless in regard to gaining weight, and Black pupils in regard to losing it - a reflection of economic conditions. However, the argument depends on the assumption that respondents are making their "worst" judgement on grounds which are not purely aesthetic but contain an element of social acceptability.

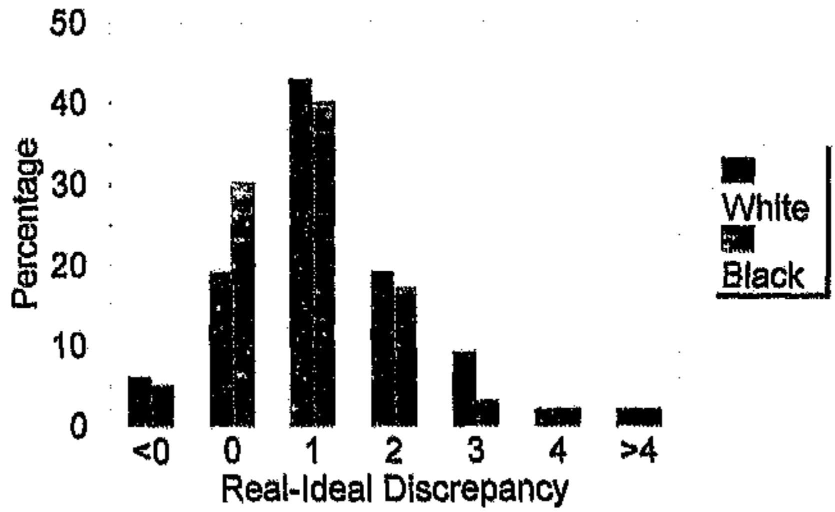
4.1.4 TOLERANCE

All figures not excluded by a respondent as either "unattractively fat" or "unattractively thin" were regarded as aesthetically tolerable to that respondent. Data obtained about tolerance include the size of the range (how many figures were included altogether), and also its upper and lower limits.

(a) TOLERANCE RANGE. As expected, respondents excluded figures from both extremes of the array as being unattractively thin or fat. A highly significant difference ($t = 5.9$, $p < 0.0001$) emerged between the Black group (Mean 5.55, SD 2.83, $N = 60$) and the White group (Mean, 3.72, SD 1.38, $N = 125$) in the number of figures in their tolerance ranges. On

Figure 4.2

Frequency distribution of RID



4.1.2 REAL-IDEAL DISCREPANCY (R-ID)

R-ID is the number of figures by which the ideal body figure is removed from the self-representative figure. Again, no significant difference was found between the race groups (Mann-Whitney $U = 3556.5$, $p = .36$). Based on this measure, 20.5% of the whole sample felt that they were at their ideal body size, 8% saw themselves as thinner than the ideal, and 69% felt that they were fatter than the ideal. Eleven per cent (11%) of the whole sample indicated an R-ID of two or more figures too large - which probably means that any efforts to resemble the ideal are unlikely to succeed. Table 4.2. shows the R-ID percentages for each race group. Figure 4.2 (overleaf) shows these in chart form. Less than zero indicates that a respondent perceives herself as thinner than the ideal, zero indicates at the ideal size, and positive values indicate that a respondent perceives herself as too large.

TABLE 4.2. Real-Ideal Discrepancies - percentages of each race group scoring at a given level

R-ID	<0	0	1	2	3	4	>4
White	6%	19%	43%	19%	9%	2%	2%
n=125	7	23	54	24	11	3	3
Black	5%	30%	40%	17%	3%	2%	2%
n=59	3	18	24	10	2	1	1

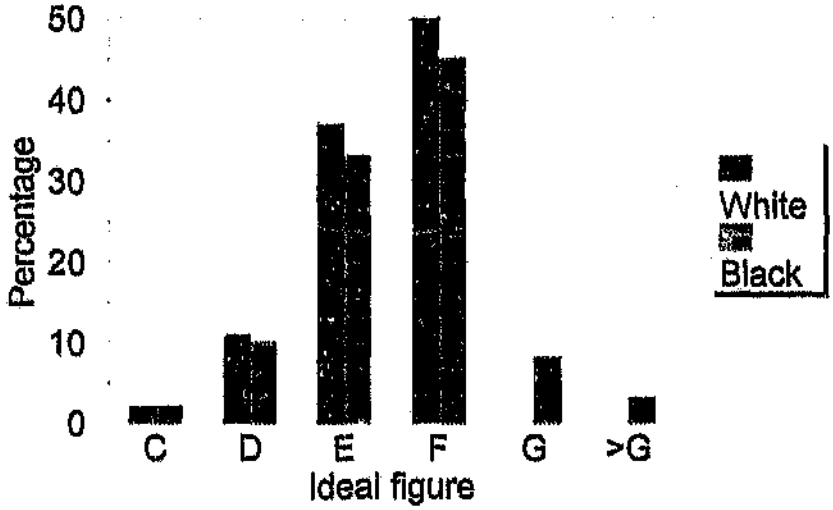
These findings show that 65% of Black pupils and 75% of White pupils feel that they are too fat, i.e. their reported discrepancy is one or more figures above zero. A higher percentage of Black pupils were satisfied with their own body (R-ID = 0), but clearly the potential exists for many individuals of both race groups to experience themselves as too fat in relation to their body ideals. A similar, small proportion of both groups felt that they were thinner than their reported ideal figure.

4.1.3 "WORST" OR REJECTED FIGURE

The forced choice between figures A and L for the 'worst' figure produced a significant race difference, with Black pupils significantly more likely to reject the obese figure L and White pupils to reject the emaciated figure A. Table 4.3 shows a cross-tabulation for the forced choice.

Figure 4.1

Frequency distribution of Ideal figure



4. CHAPTER FOUR: RESULTS AND DISCUSSION

As discussed above, the dependent variables in this study are divided into two models of disordered eating, the Attitudinal-Behavioural or AB model and the Aesthetic model. The former includes all EDI subscales, and the latter includes all data obtained from the Body Figure Preference Test. The two independent variables are Race and School.

4.1 COMPARISON OF RACE GROUPS - AESTHETIC MODEL

Findings are presented that are relevant to body ideals (ideal figure, real-ideal discrepancy, and forced choice for the 'worst' figure). Thereafter, findings relevant to tolerance are presented.

4.1.1 IDEAL BODY FIGURE.

Table 4.1, and Figure 4.1 (overleaf) show the percentages from each race group who chose a given figure as their ideal. (Note: Due to missing data, numbers of cases vary slightly from table to table).

TABLE 4.1. Choice of ideal figure on Body Figure Preference Test

	C	D	E	F	G	>G
White	2%	11%	37%	50%	0	0
n=125	3	14	46	62	0	0
Black %	2%	10%	33%	44%	8%	3%
n=61	1	6	20	27	5	2

White and Black pupils were very similar in their modal preference for Figure F, although a large minority of both samples preferred E. There was no significant difference between race groups in their choice of ideal figure (Chi Squared 0.81, $df = 1$; Mann-Whitney $U = 3763.5$, $p = .62$). However, there is a noticeable difference between the race groups in that no White pupil reported an ideal higher than F, whereas 11% of Black pupils chose G or an even larger body figure as their ideal. Whilst this was clearly a minority group, it is sizeable and may represent respondents who hold a more traditional attitude to body shape. Interestingly, similar proportions of Black pupils and White pupils selected C or D as an ideal, and these Black respondents may resemble those found by Furnham and Alibhai (1983) who seemed to be overconforming to the dominant values they encountered in their cultural transition.

The schools represent three differing locations in the South African social structure and also represent a process of cultural change o[illegible]ssimilation for Black pupils. From this perspective it is a cross sectional study. Pupils were grouped according to their race or ethnicity, as either Black or White. The race groups represent two different cultures. Whit[illegible]ls are already "Western" in their attitudes towards the female body, [illegible] are already considered a risk group for AN and other eating disorders. Black pupils are undergoing a process of cultural transition and have an unknown level of risk, although it has generally been considered low. The two Race groups and the three School groups were compared and hypotheses about the differences between them were tested.

The existence of differences between the race groups was not expected to shed light on their respective risk status for eating di[illegible]s, information which cannot be reliably established within this desi[illegible]ther it was intended to demonstrate the extent to which their a[illegible]ic judgements and/or inner worlds as these relat[illegible] disordered eating and weight concern were similar or dissimilar. Differences in the expected directions between the School groups, for Black pupils at least, would constitute indirect evidence that processes of cultural assimilation are leading them to develop disordered eating and weight concern profiles resembling those of their White classmates.

3.7 STATISTICAL ANALYSIS

3.7.1 COMPARISONS OF GROUP SCORES

Student's t-tests were carried out as a basic procedure to compare the two race groups on their AB model mean scores. One-way Analysis of Variance was used for three-group comparisons (the School group comparisons for the Black pupils). Chi-squared goodness-of-fit tests or Mann-Whitney U tests were used to compare the two race groups on their Aesthetic model scores, which were in the form of frequency counts and ranked data. Student's t-tests were also used to compare South African scores to scores obtained from other groups and reported in the literature.

3.7.2 CORRELATION

Scores from the two models were correlated to highlight relationship (and lack of relationship) between them. Spearman Rank Order correlation coefficients were used, because data from the *BFPT* is ranked data. In computing the rank-order correlations, missing data was pairwise deleted.

3.7.3 DESCRIPTIVE

Some findings were presented in the form of frequency distributions or percentages for an easily accessible comparison between groups. Graphical presentation was also used.

3.8 SUMMARY OF RESEARCH DESIGN

A post-hoc design was used in which sampling is nonrandom and there is no control group. Therefore, generalizations are limited and cause-effect relationships cannot be demonstrated.

A questionnaire comprising two research instruments, a Body Figure Preference Test and the Eating Disorders Inventory, as well as demographic information was presented to Standard 8 and 9 pupils in three diverse schools. These two instruments were used to set up two models for understanding disordered eating and weight concerns from a sociocultural perspective. One model is more personal and focuses on respondents' inner worlds, the other is more sociocultural and attempts to elicit externalised attributions and aesthetic judgements.

3.6.11 DISADVANTAGES OF THE BFPT

The main strength of this test, its simplicity, is also its greatest limitation. Respondents are being asked to produce an externalised judgement about the figures, but we have no way of knowing whether their judgements are affected by personal factors such as their own body image.

The concept of 'body image' is not consistently defined in the eating disorders literature and is often taken for granted. Brodie, Bagley, and Slade (1994) attempted to define it, concluding that the concept is complex and has psychological, psychiatric, somatic, and neurological aspects. Thus the term 'body image' could refer to any or all of a large set of perceptual, cognitive, and emotional phenomena. It is clear that bodily experiences have strong effects on body image, and this would include developmental changes (such as puberty), sexual experiences, and traumatic experiences including child physical and sexual abuse. Writers such as Bruch have emphasised the role of emotional abuse (being belittled and humiliated because of bodily appearance) in the subsequent development of eating disorders. In the post-test debriefing sessions, many of the respondents reported that they had been so teased, mainly by male relatives. The chief downfall of the BFPT, then, is that we have no way of knowing just how much these personal perceptions have influenced the respondent's choices. Because there are so many personal factors that might affect assignation of labels such as 'best', 'worst', and 'unattractive', the validity of the test as a measure of aesthetic values cannot be conclusively established.

Another potential disadvantage was that the drawing represented adult women, whereas the respondents were adolescents. In designing the test it was decided to use the adult array as the only other one available (from the study by Childress *et al*, 1993) contained figures of prepubertal children. The adult figures definitely did cause discomfort or embarrassment to some respondents, which may have made some of them unwilling to complete the BFPT (there is more missing data for the BFPT than for the EDI), but most seemed able to identify with the figures. Only one respondent stated that none of the figures resembled her own body.

A perhaps more serious conceptual problem is that the BFPT itself represents the prevailing discourse around fat and thin, including the "preformed social opposition" of the two, and thus it tends to preclude alternative constructions of the body figures which might be forthcoming were the test to be administered in another way. One Black respondent, for example, objected to the obese figure L because it was "too wrinkly"! It is possible, therefore, that respondents who do not relate at all to the fat/thin/unattractive text may find the task meaningless, leaving their responses open to interpretation.

3.6.9 ADMINISTRATION AND SCORING OF THE BFPT

The test is simple and quick to administer and formed the first part of the questionnaire, after demographic data had been collected. Each figure is assigned a rank from A to L. This ranking system follows Furnham and Alibhai's (1983) method. Although variability could be increased by providing a continuous numerical scale, it was felt that the test should be kept as simple as possible to minimise confusion, especially since the EDI (as the other major component of the research) is complex and potentially confusing, and at the design stage it remained uncertain how well respondents would cope with it. For scoring purposes each rank is numbered from A = 1, to L = 12.

Respondents were asked to report the following: which figure looks the best, which looks the worst, which most resembles your own body shape, which figures (out of the whole array) look unattractively fat, and which look unattractively thin. Data were then derived regarding the range of tolerance, the upper and lower limits of tolerance, the results of a forced choice (which approximates to Diamond's "preformed social opposition"), the location in the array of an ideal figure, and the Real-ideal Discrepancy.

3.6.10 INTERCORRELATIONS WITHIN BFPT SCORES

Spearman Rank Order correlations were used to determine the extent of intercorrelation between scores.

Ideal Body Figure correlates strongly (and negatively) with the Lower Limit of tolerance (rho = -0.51). Thus, the higher this limit is, the thinner the choice of ideal is likely to be. On the surface this is puzzling, but it probably reflects the nature of the lower limit. A low lower limit could represent increased tolerance, and a high lower limit could represent rigidity and a narrow range of acceptable figures. In the latter case, respondents would be likely to choose a thin body ideal if the theory of an homogenising tendency is correct, whereas the more tolerant individual might well choose a fatter ideal.

Ideal Body Figure also shows a strong negative relationship with Real-Ideal Discrepancy (rho = -0.46). This is a logical relationship - the thinner the ideal figure is, the more likely a woman's actual figure is to be discrepant from it.

not require respondents to delve into their own experiences of incoming messages (with or without insight), but merely to *project outwards*, onto the presented figures, the set of aesthetic values that is already there, disregarding the process by which they came into being. In doing so, they are also engaged in the reproduction of sociocultural structures and are transmitting these structures onto the text of the figure array.

As Diamond (1985) comments, social definitions construct ideas of fatness and set up a "preformed social opposition" between constructs like "fat woman" and "thin woman". The BFPT uses these definitions as a context in order to assess the extent to which a process of social construction of fat/thin/ideal is underway in the sample groups. Although the test cannot begin to explore the symbolic meanings that may be involved, nor elucidate modes of transmission, it can give a clear demonstration of aesthetic value sets.

Figure drawings have been used frequently in eating disorders research (e.g. Fallon & Rozin, 1985, Childress *et al*, 1993). Typically, the figures are presented in an array with very thin and obviously bony figures on one side, and very obese, fatty figures on the other. Fallon and Rozin (1985) used their array to explore notions of 'attractiveness' between sexes, asking respondents to give an estimate of their own figure from the array. Furnham and Alibhai (1983) investigated differences in 'idealized female shape' between Kenyan Asians born and resident in Kenya, and those born in Kenya but resident in Britain. Their research involved a repertory grid technique that enabled them to elicit complex attributions to the figures, e.g. "affectionate", or "assertive". Childress *et al* (1993) used an array of child figures to complement their self report inventory in a study of eating disorders amongst middle school age children.

The BFPT used in this study combines aspects of these different studies to produce a simplified measure that complements the EDI by attempting to gather information in the missing dimension of aesthetic values. It utilises the array of figures used by Furnham and Alibhai (1983), which comprise twelve figure drawings labelled from A (thinnest) to L (fattest). The array presents respondents with a dichotomy of thin and fat, notion of value (best and worst figures); of attractiveness and unattractiveness; and it invites them to identity their own body image with one of the figures. From this limited set of data it is possible to derive several interesting observations.

sample groups, regardless of school or ethnicity, tended to query similar words and items, such as 'ethnic', 'nervous', and 'inadequate'. The relatively high response rate obtained, even on protocols where other questions were left unanswered, suggests that most respondents felt themselves competent to attempt answers, and they all appeared to do so in the time allotted i.e. 20-30 minutes.

It has also been shown in at least one cross cultural study (Lee, Ho, & Hsu, 1993), that the psychological backdrop to disordered eating and the actual symptoms, even of acute anorexia, may not be as readily articulated as Western researchers (including the present researcher) have tended to assume. Their study demonstrated that fear of fatness was *not* present in over half of Chinese anorexic patients. Yet typical Western features such as intense fear of fatness have been included, perhaps prematurely, in the very definition of disorders such as AN. In the present study these clinical features are of interest only insofar as they might point to a Westernisation of perceptions or attitudes. However, such findings warn against interpreting the EDI or other Western instruments as straightforward indicators of risk status for eating disorders in non-Western groups.

3.6.8 THE BODY FIGURE PREFERENCE TEST

The BFPT was adapted from an article by Furnham and Alibhai (1983). The test is displayed in the Appendix (Questionnaire Format). The aim of using such a measure is to focus on aspects of what Toro, Salamero and Martinez (1994) have called the *aesthetic body shape model*. Whilst many other writers on the subject have taken for granted the link between social/peer "pressure" to have a slim body and women's' efforts to become slim, a view of the problem based on theories of social and cultural change such as that of Bourdieu (See Chapter 1) implies that the process involves both transmission of the aesthetic body shape model through a variety of social agents, *and* an active and to some extent conscious signing up of the individual agent to that set of aesthetic values.

The BFPT indirectly investigates the transmission side of this transaction. Aesthetic values may be learned or acquired through a number of routes. According to research done by Toro *et al* (1994) on cultural transition in Spain, the factors involved are influence of advertising, influence of verbal messages to lose weight, influence of social models, and influence of social situations. Yet in each case, the cultural values involved are being produced or reproduced by individual human agents - copywriters, health advisors, friends, and so on. Clearly the overall process of transmission is not straightforward, but the attraction of a simple preference test is that it does

4.4.2 SELF- REPRESENTATIVE FIGURE

Correlations showed strong relationships between the three scales that deal directly with disordered eating (drive for thinness, body dissatisfaction and bulimia), but not with the other EDI subscales. This suggests that being large or perceiving oneself as overweight may lead to disordered eating and weight concern, but not necessarily to the other components of the eating-disordered profile.

4.4.3 TOLERANCE RANGE

Tolerance range is significantly related to bulimia and body dissatisfaction scores, but not to drive for thinness or background factors. It may be that, for many women, body dissatisfaction is in itself a reason for disordered eating, and given the generally higher levels of body dissatisfaction amongst Black pupils, it is possible that a process evolves whereby a general sense of body dissatisfaction gradually coalesces into a more specific drive for thinness as a goal for body improvement.

4.4.4 UPPER AND LOWER TOLERANCE LIMITS

Lower tolerance limits do not show strong relationships with EDI subscales, but there are strong negative correlations between the upper tolerance limit (representing, specifically, fat tolerance) and all EDI subscales except perfectionism and maturity fears. If perfectionistic respondents reported very narrow tolerance ranges, there is unlikely to have been much variation in their upper or lower tolerance limits. Fat intolerance as measured by upper limits is an especially strong predictor of drive for thinness, bulimia, and body dissatisfaction, i.e. those subscales directly concerned with disordered eating. It seems likely that fat intolerance, specifically, is more important here than general intolerance. Relationships with "background" variables such as ineffectiveness, interoceptive awareness and interpersonal distrust however tend to validate these constructs as part of an overall psychological picture of disordered eating and weight concern - perhaps what Brownell and Rodin (1994) refer to as the "dieting mind-set".

4.4.5 REAL-IDEAL DISCREPANCY

Real-ideal discrepancy was shown to be a strong predictor of several EDI variables, including drive for thinness, bulimia, body dissatisfaction, ineffectiveness, interpersonal distrust, and interoceptive awareness. Interestingly, perfectionism is not a good predictor of R-ID although it is approaching significance. This suggests that whether or not respondents tend to think perfectionistically, they are equally likely to perceive a real-ideal discrepancy; R-ID also appears to be associated with discrepancies in inner awareness and uncertainty around trusting others as well as the self. The results offer striking confirmation of the value of this simple measure as an indicator of disordered eating and weight concern, because it correlates

TABLE 4.11. Rank order correlations between Aesthetic model and Attitudinal- Behavioural model - whole sample

	Ideal Figure	Self Figure	Real-Ideal Discrep.	Tolerance Range	Lower Limit	Upper Limit
DT	-.24 .0007** n=192	.30 .0000** n=191	.43 .0000** n=191	-.13 .0694 n=189	.09 .2411 n=189	-.25 .0005** n=189
BD	-.11 .1282 n=188	.48 .0000** n=187	.52 .0000** n=187	-.21 .005** n=185	-.02 .776 n=185	-.32 .0000** n=185
Bu	-.23 .0018** n=187	.26 .0005** n=186	.42 .0000** n=186	-.15 .0362* n=184	-.01 .8599 n=184	-.24 .0011** n=184
P	-.15 .0444* n=191	-.005 .9504 n=190	.12 .1046 n=190	-.05 .5042 n=188	.01 .9094 n=188	-.07 .3067 n=188
I	-.13 .0705 n=181	.13 .0848 n=180	.25 .0007** n=180	-.04 .6138 n=178	.17 .0220* n=178	-.18 .0147* n=178
ID	-.21 .0041** n=193	.002 .9726 n=192	.16 .0298* n=192	-.02 .8326 n=190	.16 .0241* n=190	-.16 .0303* n=190
IA	-.18 .0155* n=186	.08 .3022 n=185	.25 .0005** n=185	-.03 .7048 n=184	.14 .0619 n=184	-.17 .0246* n=184
MF	-.12 .1010 n=189	.001 .9887 n=188	.07 .3074 n=188	.07 .3649 n=186	.11 .1460 n=186	.01 .9046 n=189

4.4.1 IDEAL BODY FIGURE

Pupils choosing thinner body figure ideals also have a higher drive for thinness, bulimia, interpersonal distrust, interoceptive awareness, and perfectionism. Interestingly, there was a poor correlation between ideal figure choice and body dissatisfaction. This suggests that even when individuals do not have unrealistically thin body ideals, they may still feel dissatisfied with their bodies in other ways. The tendency to prefer a thinner ideal body figure is thus related to two of the disordered eating subscales and three background subscales.

our own society, and that these may have an affect on disordered eating and weight concern.

Amongst Black pupils, the Private school pupils were, in fact, less perfectionistic, less body dissatisfied, and less fearful of maturity that pupils in other groups. It appeared to be the State school pupils who were the most body dissatisfied and the Community school pupils who showed the most perfectionism and maturity fears. It may be that these pupils have a more intense experience of relative deprivation, resulting in feelings of self-dissatisfaction (including body dissatisfaction) and perhaps also more investment in outward appearances. The differences between State and Private school pupils suggest that the key factor is not exposure to Western culture in itself, but the type of experience an individual has within that cultural environment, and the types of st. ggle on which she might consequently embark. Findings for the White pupils also offer some support for this view, suggesting that for them too the issues need to be contextualised in specific sociocultural issues.

4.4 RELATIONSHIP OF THE TWO MODELS

Correlations between the Aesthetic model (Body Figure Preference Data) and the Attitudinal-Behavioural model (Eating Disorders Inventory) used ranked-data cor tions because the Body Figure Preference Test produced ordinal rather than interval data. Table 4.11 shows the correlations between the two models. Spearman's rho and probabilities are given for each correlation.

TABLE 4.10. Comparisons of White pupils in two school environments.

	Private			State			t	p
	x	SD	n	x	SD	n		
DT	6.69	6.09	49	8.37	6.22	75	1.48	0.14
BD	13.76	7.56	49	15.38	8.53	73	1.04	0.30
Bu	2.41	2.99	49	3.39	4.15	75	1.38	0.17
I	4.83	6.10	48	6.23	6.26	73	1.19	0.24
ID	4.54	4.41	49	5.36	4.57	75	0.95	0.34
IA	4.72	5.33	48	7.13	5.43	74	2.35	0.02
MF	4.54	3.02	49	4.09	2.55	74	-0.87	0.39

The predicted tendency did not emerge, and groups were generally similar. Although group differences are not significant on most variables, two are approaching significance and one is significant at the 5% level.

State school pupils showed a higher drive for thinness ($p = .14$), more problems with control around food (Bulimia, $p = .17$) and more difficulty with recognising inner sensations and emotions (Interoceptive Awareness, $p = .02$). This suggests that as others have commented (e.g. Szabo, 1995, unpublished) there has been a shift in the social distribution of disordered eating, with loss of a tendency for anorexic-type attitudes and behaviours to be restricted to private schools or affluent families. It may also be that White pupils at the State school are affected by pressures or tensions within their school related to processes of sociocultural transition or feel themselves to be disadvantaged in some way, thereby becoming involved in more intense struggles around food and body weight. White South Africans are not well prepared for loss of their historical privileges and may well find processes of racial integration threatening on many fronts, particularly in Model C schools where Black pupils are not preselected by their families' ability to afford high school fees.

In summary, it appears that disordered eating and weight concern do vary in different educational environments, and that there are more differences for Black pupils than for White pupils. In both cases, however, the predicted pattern (Private school highest, then State school, then Community school) did not emerge, and of the three school environments the State school appears to be the most potentially problematic for both race groups. Community school pupils (Black) also have their share of difficulties. It appears that in addition to the dynamics reviewed in the first chapter, South African school pupils are also experiencing struggles and tensions specific to but only at a level approaching significance ($p = .13$ at 0.10 level of significance recommended by Scheffé - c.f. Howell, 1992).

Although it might have been expected that Private School pupils would show the most perfectionism, given their more high-achieving academic environment and parental investment in their education, it appears that the Community School pupils show the high ... levels of perfectionism. Given the South African situation, this is an interesting finding and probably reflects the high priority given to education by Black South Africans in the light of previous denial of educational opportunities. It may be, therefore, that young people from disadvantaged backgrounds are under as much or more pressure to do well at school as those from the elite, and that this type of pressure to achieve is experienced more intensely in schools with fewer resources. It is also interesting that State School pupils who are in some sense competing with more advantaged population groups at school, are not more perfectionistic.

Community School pupils showed significantly more Maturity Fears than the State school ($p = .004$ on Scheffé test). Community school pupils also appeared significantly more fearful of entering adulthood than Private school pupils, although the difference between Private and State schools was not significant ($p = .72$). It seems possible that Community school pupils experience a stronger sense of social disadvantage, and that this may lead them to lack confidence in their ability to cope as adults, whilst feeling more pressure to achieve educationally. In this respect, it is probable that apartheid ideology has undermined the confidence of Black people by preventing their access to educational resources. A high level of Maturity Fears promotes disordered eating and weight concern (according to the theoretical model described in Chapter 1) because individuals must reinvest the "cultural capital" that they have, and are likely to place all the greater emphasis on outward appearance if they experience themselves as lacking in educational or intellectual resources that they will need in the future.

b) WHITE PUPILS. White pupils in Private and State schools were compared. The expected pattern of scores was that Private school pupils would tend to score higher than State school pupils, based on reports of social-class and private school education as factors in eating disorder development. Table 4.10 shows a comparison of White pupils at the two schools.

c) IDEAL FIGURE. No significant differences were found amongst either race group on their ideal figure choice which for all groups fell on average between figures E and F.

d) REAL-IDEAL DISCREPANCY. No significant differences were found amongst either race group on the extent of real-ideal discrepancy that they reported which averaged between one and two figures above the ideal level. This is in itself a useful finding as it suggests that processes of social transition (insofar as these are relevant) seem to have spread beyond racial and social divides. There may be a tendency for Black Private School pupils to indicate higher positive discrepancies (State School mean .90, Community School mean .92, Private School mean 1.8) but these differences are not statistically significant ($F = 1.33$, $p = .27$). It may be that with a larger sample and a more sensitive measure a clearer tendency could be established.

4.3.2 SCHOOL EFFECTS IN ATTITUDINAL-BEHAVIOURAL MODEL

a) BLACK PUPILS. Analysis of variance showed some significant interactions between school environment and the EDI subscales of Body Dissatisfaction, Perfectionism, and Maturity Fears. Comparisons between Black pupils in the three schools are shown in Table 4.9.

TABLE 4.9. Comparisons of Black pupils in three school environments.

	Community		State		Private		F	p
	x	n	x	n	x	n		
DT	8.70	23	10.76	21	6.93	14	2.24	0.116
BD	8.04	24	14.39	18	12.73	15	4.80	*0.012
Bu	2.85	20	3.05	20	2.71	14	0.04	0.960
P	9.57	23	6.68	19	6.33	15	3.15	*0.050
I	6.21	19	4.29	17	3.79	14	1.59	0.215
IA	7.27	22	7.35	20	4.92	13	1.00	0.376
MF	10.20	20	5.30	20	6.53	15	6.44	**0.003

* = Significant at 5% level ** = Significant at 1% level

Significant differences were found on Body Dissatisfaction, Perfectionism, and Maturity Fears. Post-hoc comparisons (Scheffé tests) showed that pupils from the State school were significantly more body-dissatisfied than those from the Community school ($p = .018$), but not significantly different from the Private school pupils on body dissatisfaction ($p = .79$). Private school pupils were more body-dissatisfied than Community school pupils.

b) FORCED CHOICE. Table 4.8a shows a cross-tabulation of the Black pupils' forced-choice rejections. Pupils rejecting Figure A saw the emaciated figure as the "worst", and those rejecting L saw the obese figure as the "worst".

Table 4.8. Forced-choice: Black pupils in 3 school environments

	State	Private	Community	Total
Rejects A	3 (14%)	7 (47%)	3 (12%)	13
Rejects L	18 (86%)	8 (53%)	22 (88%)	48
Total	21	15	25	61

A highly significant difference between Black pupils was found on the forced choice selection of a "worst" figure, with the proportion rejecting the obese figure being highest at the Community School and lowest at the Private school (Chi-squared 7.65, $p = < .05$ at $df = 2$). This appears to support the interpretation offered in 4.1.3. above, that the forced choice is (unintentionally) tapping into an awareness of eating disorders at least at the Private and State schools. Although Black pupils appear to have a generally higher tolerance of both fatness and thinness, this task required them to reject one or the other, but not specifically on aesthetic grounds, and this creates space for other considerations to influence their choices - such as assignation of responsibility or blame for being over- or under-weight. Table 4.8b shows the forced choices of White pupils in two schools.

Table 4.8b. Forced choice - White pupils in two school environments

	Private	State	Total
Rejects A	18 (37.5%)	32 (41.5%)	50
Rejects L	30 (62.5%)	45 (58.5%)	75
Total	48	77	125

Compared to the Black pupils, White pupils showed very little difference in their forced choices (Chi-squared 0.21, nonsignificant at $df = 1$).

patterns that have been associated with eating disorders. Maturity Fears, which showed a highly significant difference, needs further investigation. The subscale is a relatively simple one in which the same question (i.e. would they rather be a child or an adult) is asked in various ways - something the respondents complained about at the debriefing sessions. Thus, we can say that Black pupils seem to fear maturity or independence more than White pupils, but are not able to suggest reasons why this might be so. Racist and sexist ideologies in South African may have led this group, in particular, to lack confidence in themselves, and the ongoing transition from a community-centred "ubuntu" society to an individualistic, capitalist-dominated and anomic one may also play a role in promoting unrealistic educational aims and fear of coping independently in the world.

4.3 SCHOOL EFFECTS FOR EACH RACE GROUP

Hypotheses around the roles played by different levels of cultural assimilation (Black pupils) and a more elite school environment (White pupils) were tested by comparing the different school groups. As explained previously, Black pupils were present in all three schools, but White pupils were present only in the Private and State schools.

4.3.1 SCHOOL EFFECTS IN AESTHETIC MODEL

a) TOLERANCE. No significant differences were found between White pupils in their two schools on the Aesthetic model (State School mean, 3.63 and Standard Deviation 1.51; Private School mean 3.86 and Standard Deviation 1.15; $t = -0.889$, $p = .376$). This suggests that cultural norms and values are widely disseminated across class and ethnic boundaries amongst the White sample.

No significant School effect was found for Black pupils either, although there may be a tendency for Tolerance to reduce with increasing social status of the school, such that Community School pupils were more tolerant than State School pupils, who were more tolerant than Private School pupils (Means Community School 6.29, State School 5.45 and Private School 4.43, $F = 2$, $p = .145$). Given the small sample sizes, it is not possible to conclude from this data that real differences exist due to cultural transition, but this possibility cannot be ruled out. It seems that approximately 30% of the Black pupils in less privileged environments show the larger range of tolerance (10 figures, excluding only the two most extreme) - or alternatively, might be said to lack the aesthetic framework for judging bodies as better or worse on the basis of shape alone. It could be that the relevant cultural process here is an homogenising of taste, with the end result being an aesthetic body shape model that is very similar to that of White pupils.

TABLE 4.7. Race differences - AB model

	Black			White				
	x	SD	n	x	SD	n	t	p
No Difference								
DT	9.02	5.44	58	7.70	6.20	124	1.376	0.170
BD	12.64	8.07	57	14.73	8.16	122	-1.345	0.181
Bu	2.86	3.20	54	3.00	3.75	124	-0.200	0.841
I	4.69	4.46	50	5.67	6.21	121	-0.873	0.384
IA	6.53	5.16	55	6.17	5.50	122	0.350	0.727
Black>White								
P	7.39	4.56	57	5.23	4.55	124	2.487	0.014
MF	7.36	4.36	55	4.27	2.75	124	5.060	0.0001

Significant differences between group means were found, but the direction of the differences is not consistent. It was found that Black and White pupils scored similarly on all EDI subscales except for Perfectionism and Maturity Fears. On these subscales Black pupils scored significantly higher than White pupils at the 5% level of significance. It therefore appears that Black and White pupils are similar in their drive for thinness, body dissatisfaction, sense of being in or out of control around food (bulimia), feelings of ineffectiveness, and ability to recognise emotions and sensations (interoceptive awareness). Black pupils however are more perfectionistic in their attitudes to school achievement and show more fears about growing up.

The implication is that insofar as the EDI scores indicate commitment to a struggle around eating and body weight, and insofar as this struggle is associated with the eating disorders, Black pupils are at least as much at risk of developing an eating disorder as White pupils are, especially as the three subscales which directly address disordered eating patterns (Drive for Thinness, Body Dissatisfaction and Bulimia) show that Black pupils are level-pegging with White pupils. Whilst the Bulimia scale showed a lower reliability amongst Black pupils (see Chapter 3 for details), the Drive for Thinness and Body Dissatisfaction subscales appeared to be reliable for both groups.

Perfectionism and Maturity Fears were found to be less reliable (see Chapter 3) and therefore error may account for some of the differences found. However, it seems possible that these scores reflect different attitudes and experiences. It may be that in affirming items such as "only the best is good enough in my family", Black pupils are reflecting a sense of family pride and the high value that Black South Africans have traditionally placed on education. It does not necessarily imply the dichotomous, rigid reasoning

TABLE 4.6. Upper limits of tolerance on Body Figure Preference Test

	F	G	H	I	J	K	L
White	34%	46%	13%	3%	2%	2	0
n=125	42	58	16	4	3	2	0
Black	14%	30%	16%	12%	3%	23%	2%
n=57	8	17	9	7	2	13	1

Overall, more than half of the whole group was not prepared to tolerate any figure larger than H, and nearly half of the White sample was not prepared to tolerate any figure larger than G. The higher tolerance of Black pupils for fatter figures is very striking, with a minority group opting for K (the same group that chose B as a lower limit). One Black pupil stated "none" in answer to the item asking which figures were seen as unattractively fat.

In summary, it appears that White pupils' ranges are more homogenous than those of Black pupils, and White pupils tended to reject both extremes of the array. Of this group, 19 pupils (15%) appear to find either B or C not unattractive. Amongst the White pupils there is more tolerance for thin extremes than for fat extremes - 15% included B or C, but only 4% included J or K. Black pupils showed more variety in the placement of their tolerance ranges within the array. Although most Black pupils chose similar lower limits to those of White pupils, a substantial minority of 29% were willing to include B or C. Black pupils were also, however, more likely to choose a figure larger than H as their upper limit (39 % of Black pupils as compared with 6% of White pupils), suggesting that racial contrasts in tolerance are more apparent at the high extreme of the array - White pupils showed some tolerance for the thinner figures, but almost no tolerance of fat at all, whereas Black pupils showed approximately equal tolerance for fat and thin extremes. A majority of Black respondents included H, and substantial minorities also included I, J, and K in their ranges. To some extent, then, the prediction that Black pupils would not reject the fatter figures is confirmed, but not, it seems, in the sense of showing a preference for them. Rather, they are more tolerant across the board.

4.2 COMPARISON OF RACE GROUPS - ATTITUDINAL-BEHAVIOURAL MODEL

The mean scores of each race group was compared for each of the EDI subscales except Interpersonal Distrust (due to low reliability). It was anticipated that White pupils would score more than Black pupils on these subscales, but this did not prove to be the case. The findings are shown in Table 4.7.

figures A, B, and C were "unattractively thin", then her lower tolerance limit is set at D.

TABLE 4.5 Lower limits of tolerance on Body Figure Preference Test.

	B	C	D	E	F	>F
White	4%	11%	49%	30%	6%	0%
n=125	5	14	61	37	8	0
Black	28%	5%	40%	23%	2%	2%
n=57	16	3	23	13	1	1

If we take Figure D as representing the lower limit of the normal weight range, it can be seen that 15% of White pupils would extend their lower limits below this level, i.e. presumably would not consider these levels of underweight to be unattractive. Black pupils are even more likely to include underweight figures in their ranges of tolerance, contrary to predictions that they might reject the thinner figures. The 27% selecting B as a lower limit represent, in the main, that subgroup of Black pupils that reported a wide overall tolerance range of 10 figures, excluding only A and L. Substantial groups of both Black and White pupils reported ranges of three or four figures, starting at D. Those few pupils who gave E or F as their lower limit typically had very narrow ranges that included only their ideal figure, or that figure and the figure immediately above or below it.

c) UPPER TOLERANCE LIMITS. Table 4.6. shows the percentage of each race group who set their upper tolerance level at a given figure. The upper limit of tolerance represents the last figure to be included, i.e. one figure below the first figure described as "unattractively fat". Thus if a respondent stated that figures H to L were "unattractively fat", her upper tolerance limit was set at G.

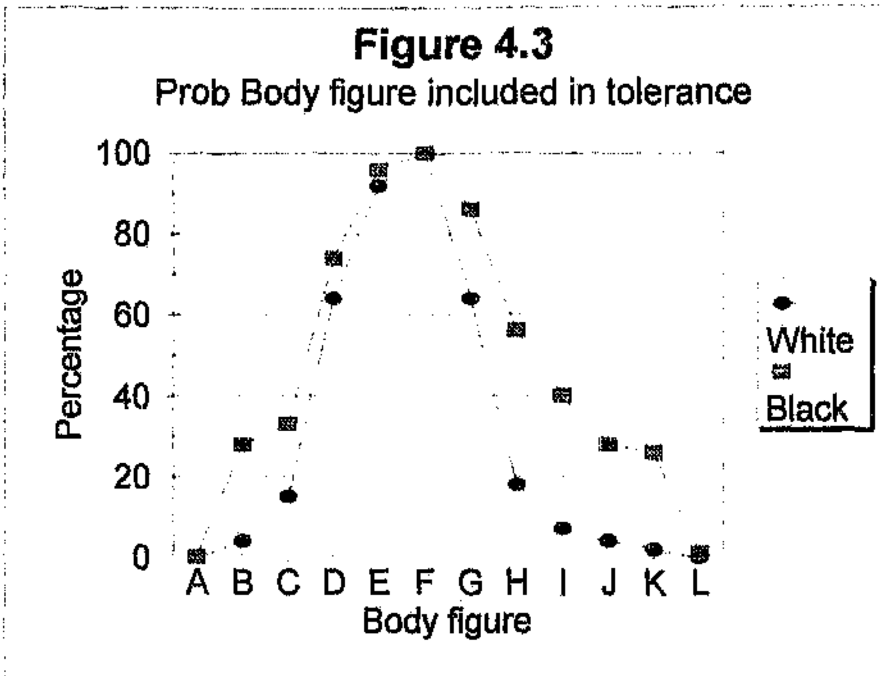


Figure 4.3
Prob Body figure included in tolerance
100
80
60
40
20
0
Percentage
A B C D E F G H I J K L
Body figure
White
Black

ıdicate a need for caution in assuming that promotion of tolerance as such would have any impact on disordered eating or weight concern.

b) ATTITUDINAL-BEHAVIOURAL MODEL. Given the prediction that White pupils would outscore Black pupils on the Eating Disorders Inventory, and the finding that Black pupils were more tolerant of different body shapes, the lack of difference in the group scores is striking. White pupils did not significantly outscore Black pupils on any of the subscales, and Black pupils had significantly higher averages than White pupils on Perfectionism and Maturity Fears. The results indicate that Black pupils are just as engaged (or just as psychologically ready to become engaged) in struggles over eating and body weight as White pupils are. They appear to have higher ideals of achievement at school (although not necessarily in a typically "driven" way) and also appear more insecure about taking on an independent, mature adult role. It may b.. therefore, that the psychosocial scene is set for these adolescents tc uevelop serious eating disorders, just as this seems to have happened amongst White adolescents.

Black pupils in the relatively disadvantaged Community school showed higher levels of Perfectionism and Maturity Fears than Black pupils in the other schools, suggesting that these pupils are exposed to high demands for achievement, perhaps to transcend the poverty and social disadvantage of their families. It is also interesting, though, to note that Black pupils in the State school were by far the most body-dissatisfied, and also showed a higher drive for thinness (though this is not statistically significant, it is approaching significance).

Differences between the Black pupils suggest that these young women are experiencing different types of demands and different struggles within their educational and perhaps social environments. Whilst a simplistic view of sociocultural factors would dictate that the Private school pupils (the most socialised into Western attitudes by virtue of their relative success in the social system) would show more disordered eating and weight concern, as well as being under the most pressure to achie e, it appears that State school pupils have more problems with eating and body weight, whilst Community school pupils have more problems with finding a place in the world. It may be that some State school pupils, integrated perhaps hastily and problematically into a formerly rather elite White school environment (bearing in mind that the "tate school services an affluent part of the city), are responding to the situation with an overcompensation, or overvaluation of the dominant ideals, and are therefore at risk in the same way as those women whose experiences of rapid cultural assimilation are described in the medical literature (e.g. Furnham & Alibhai, 1983, Buchan & Gregory, 1984).

not reject the skeletal figure because they associate it straightforwardly with involuntary weight loss due to hunger - and not with inexplicable and disturbing self-starvation in the midst of plenty. White pupils, and some Black pupils (especially the group in the Private school) are aware that conditions of self-starvation exist and wish to express disapproval of them.

If it is the case that anorexia is in some sense an illness of our times, and an expression in particular of female conflicts, then rejection of anorexics is particularly sad and ironic. Yet so often it seems to be women who are women's harshest critics, and anorexia is not the only disorder affecting women which attracts a negative, rejecting response - depression, especially postnatal depression, might elicit a similar reaction from other women. If the responses described here are related to knowledge of eating disorders, then it is also notable that awareness of eating disorders does not appear to protect individuals from disordered eating patterns and weight concerns of their own.

The data on tolerance also suggests that the Black sample represents, in some sense, a process of cultural transition. Tolerance range was found to be significantly different, with White pupils reporting narrow ranges of only two or three figures on average. Black pupils reported wider ranges of between four and five figures on average. However, the averages were influenced by a relatively large group that excluded only the two most extreme figures, and even this might have been in response to a perceived demand of the task that at least one figure on each end of the array be excluded.

Variation in tolerance range is a particularly interesting and useful finding, as it has not been reported before in the literature. Both feminists and other observers have often argued that a central problem in the eating disorders is cultural intolerance or non-acceptance of natural body diversity amongst women, with body ideals and norms becoming ever more narrow and oppressive. This study presents what appears to be a small freeze-frame of this process in action, especially as a trend for tolerance to reduce with increasing school status was observed amongst Black pupils.

It may well be that increased general tolerance, especially for fatter figures, compensates for the more individualised sense of dissatisfaction and body concern that Black pupils reported and may therefore work to protect Black women from developing clinical eating disorders, helping to explain why the actual incidence of these disorders has remained low, at least for now. If this is so, then we can certainly expect an increase in disorders as more Black urban women adopt narrow ranges of tolerance. However, the findings of disordered eating and weight concern in the presence of increased tolerance

5. CHAPTER FIVE: SUMMARY AND CONCLUSIONS

5.1 DIFFERENCES BETWEEN RACE AND SCHOOL GROUPS

a) AESTHETIC MODEL Data obtained for this model show that the two race groups are very similar in their ideal body figure, preferring figures on the thin side of centre in the figure array presented. Differences in variation were observed, however, with the White sample showing greater homogeneity in that no White respondent offered an ideal higher than Figure F, whereas a small minority of Black respondents chose G or an even larger figure. It thus appears that the Black sample is divided between respondents who are "Westernised" and similar to White pupils, and respondents who are apparently more traditional in their tastes. A similar minority (12%) chose very thin body ideals, and it may be that this group represents a point in cultural transition at which the dominant ideals are taken to the extreme.

These findings indicate that the Black pupils represented in this sample are relatively varied in their body figure preferences. Most resemble their White colleagues, but some are more extreme and may be overconforming in some way to a perceived ideal of the dominant culture. Others do not conform at all to this ideal, and show what might be interpreted as more traditional African values about body ideals. The suggestion, therefore, is that the results reflect a process of cultural transition in aesthetic values or tastes.

Black and White respondents were also similar in their Real-ideal Discrepancies, with self-representative figures averaging between one and two figures above the ideal. A majority of both groups (64% of Black pupils and 75% of White pupils) saw themselves as larger than their ideals.

A significant race difference was found in the forced choice between the two most extreme figures, with Black pupils more likely to reject the obese figure. As Black pupils seemed generally more tolerant of fatness, this could reflect an awareness of eating disorders amongst White pupils in particular and therefore a rejection of self-starvation as a strategy. The questionnaires were relatively transparent regarding the underlying interest in eating disorders, and respondents may have been eager to demonstrate disapproval of anorexics.

A major influencing factor to be considered here is the pervasive poverty in Black South African communities, especially rural and farming communities. Some of the younger children attending the Community School appear poorly nourished, and it may be that respondents from this environment do women (black or white) are protected by their culture from developing similar levels of disordered eating or excessive weight concern to those found in overseas samples. In fact, it may be that some factors thought to serve a protective function may not do so, or alternatively are serving in a limited way (e.g. increased tolerance of body figures or selection of a realistic body ideal). It may even be that other features of South African society (ongoing racism, the legacy of apartheid education, poor security in the community and overvaluation of intellectual or academic achievement, for example) may place South African women at a greater risk in some respects.

show more body dissatisfaction. Both South African groups appear to feel more out of control around food and eating (bulimia) than the Canadians.

As can be seen some significant differences emerged on the comparisons, and generally both South African samples tend to have scores at least as high as groups from these Western countries. On Maturity Fears, the Black South African group scored higher than the anorexic patients. Although this does not necessarily mean that they have the same kinds of maturity fear (the scale is very unspecific and appears to establish only that a respondent would or would not prefer to remain a child than to be an adult), it does suggest that South Africans have particular difficulties in this area.

The differences may be due to errors in responses, especially on the Bulimia scale which is lower in reliability and has been described as less appropriate for this age group (Schoemaker *et al*, 1994). Yet amongst Black pupils the Drive for Thinness, Body Dissatisfaction and Maturity Fears subscales showed adequate reliability and these scales also show a trend for South Africans of both race groups to outscore the other nonclinical samples. Further more, Schoemaker's rationale here may be faulty, as they reason that the later onset of *clinical* bulimia nervosa makes it less likely that young respondents will score highly on this subscale. However, the bulimia subscale is not a checklist of diagnostic criteria, but rather focuses upon a more general feeling of being out of control around food, which might well be present for a long time before a person becomes fully bulimic.

It is also possible that the Black pupils' scores are exaggerated by a tendency to over-report symptoms or adopt negative response sets. Whilst this cannot be wholly ruled out, the inventory contains several reverse-score items which should help to compensate for this. All in all, it seems likely that South African pupils - both Black and White - are at least as troubled by weight concern and disordered eating as so-called "Western" groups. There also seem to be high levels of background difficulty such as perfectionistic attitudes to achievement, sense of ineffectiveness, and fears for the future which could create a psychodynamic climate for eating disorders to develop. Some of these difficulties may relate to a culture which is still relatively chauvinistic and experiencing conflicts around female independence, others to past and present sociopolitical developments. It is not possible, for example, to rule out the effect of living in a tense and crime-ridden society such as urban Johannesburg on ineffectiveness or interpersonal distrust - poor security also has an impact on female independence and feelings of being able to cope as an adult in the world.

In summary, the comparisons along with a breakdown of the high-scoring subgroups suggest that there is no reason to believe that South African

The groups compared are as follows: Canadian, college female comparison group (Garner, Olmsted & Polivy, 1983); Canadian, school females 11 - 18 years (Shore & Porter, 1990); Dutch, school females 13-20 years (Schoemaker, van Strien & van der Staak, 1994); Canadian, patient sample with anorexia nervosa, bulimic and restricting subtypes (Garner, Olmsted & Garfinkel, 1983).

Figure 4.4 shows these comparisons. Figure 4.5 shows the raw scores from Table 4.11 transformed to standard scores with a mean of 50 and a standard deviation of 10, by using the formula T = 10 x [(Mean - Benchmark [illegible]n)/ Benchmark Standard Deviation] + 50. The samples described abov[illegible] [illegible]hen plotted against the benchmark of a sample of anorexic patients (c.f. Garner, Olmsted & Garfinkel, 1983).
Comparisons between the two South African samples (White SA n=125, df 356, and Black SA n = 58, df 257) and Shore and Porter's Canadian school sample showed some significant differences which are shown in Table 4.14. The scales compared are Drive for Thinness, Body Dissatisfaction and Bulimia - the three scales directly concerned with disordered eating. Only the nonclinical Canadian sample is compared, as it is clear from the above tables that the Dutch schoolgirl sample scores much lower than either Canadian or South African pupils on these scores, and because this sample represents a nonclinical sample of schoolgirls similar to the present South African group - unlike the other Canadian groups which are either clinical samples or college-aged groups.

TABLE 4.14. Comparison on disordered-eating measures between two South African samples and a sample of Canadian school pupils (Student's t and probability for each comparison *).

	Black SA		White SA	
	t	p	t	p
DT	2.0	.05*	0.72	NS
BD	0.77	NS	2.4	0.01**
Bu	1.49	.05*	2.09	.05*

* Note: Means and standard deviations for those groups appear in Table 4.13.

The comparisons indicate that Black South African pupils show a greater drive for thinness than Canadian pupils, whereas White South African pupils

Figure 4.5

SA standardised against AN group

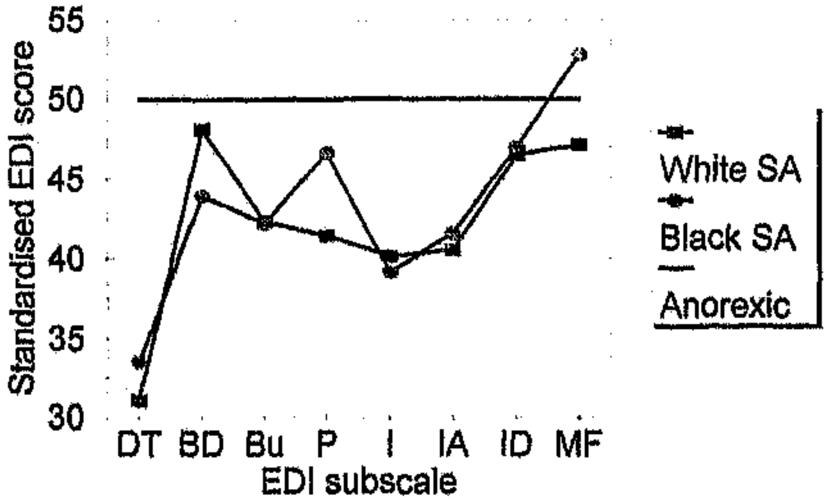
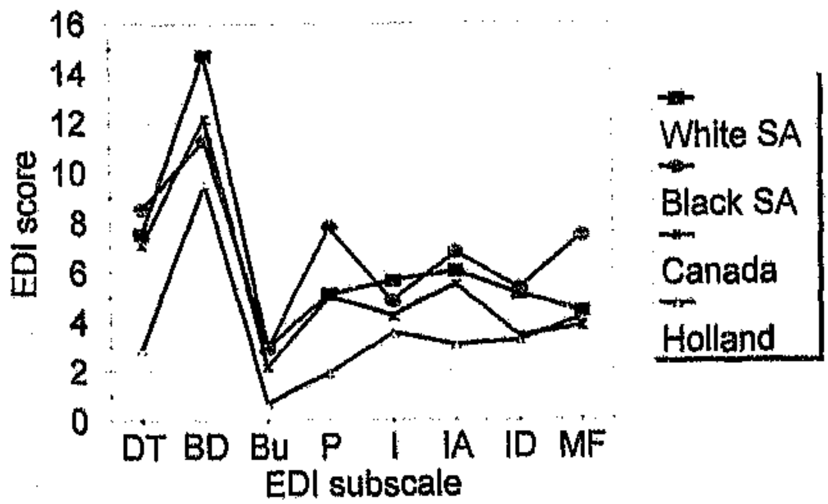


Figure 4.4

Group comparison of EDI



the implication is that respondents with a low tolerance range may be more likely to show disordered eating and weight concern, but that having higher levels of tolerance does not protect an individual in this respect. The results demonstrate that cultural or aesthetic values have limited protective value in terms of weight concern and disordered eating at the attitudinal-behavioural level.

4.6 COMPARISONS BETWEEN SOUTH AFRICAN SAMPLES AND OTHER GROUPS

Table 4.13 and Figures 4.5 and 4.6 (overleaf) illustrate comparisons on EDI scores between the present sample (Black and White pupils) and four other groups, three from Canada and one from the Netherlands. Table 4.12 shows means and standard deviations for White/Black South African and Dutch school pupils and three Canadian samples - school pupils, college students, and a third group made up of patients with anorexia nervosa.

TABLE 4.13. Comparisons between South African and other group means and standard deviations (SD)

	White SA	Black SA	Canada College	Canada School	Holland School	Canada A.N.
N	125	58	770	231	735	49
DT	7.53 (5.24)	8.50 (4.47)	5.09 (5.30)	7.09 (5.94)	2.90 (4.20)	15.10 (4.00)
BD	14.74 (7.99)	11.28 (7.36)	9.80 (3.10)	12.14 (8.65)	9.50 (8.30)	16.30 (8.30)
Bu	2.97 (3.65)	2.89 (3.38)	1.80 (3.10)	2.17 (2.84)	0.70 (1.80)	8.00 (6.60)
I	5.60 (6.14)	4.80 (4.26)	2.10 (3.60)	4.20 (4.89)	3.50 (3.80)	13.70 (8.20)
P	5.06 (4.51)	7.75 (4.67)	5.60 (4.00)	4.97 (4.10)	1.90 (2.40)	9.50 (5.20)
IA	5.98 (5.46)	6.75 (5.33)	2.30 (3.50)	5.46 (5.43)	3.00 (3.00)	12.80 (7.20)
ID	5.06 (4.41)	5.29 (3.30)	2.30 (2.90)	3.36 (3.56)	3.20 (3.20)	6.80 (5.00)
MF	4.35 (2.91)	7.42 (4.89)	2.30 (2.40)	3.76 (3.08)	4.10 (2.90)	5.90 (5.40)

show weight concern or disordered eating. Yet the Black State school pupils tended to show more body dissatisfaction and the Community school pupils showed more perfectionism and maturity fears. White State school pupils averaged a higher drive for thinness, body dissatisfaction and bulimia than White Private school pupils, and appeared significantly less able to label and describe inner feelings and sensations (interoceptive awareness), and this may have been influenced by the presence of several high scorers amongst this group.

4.5.1 AESTHETIC MODEL DATA FOR HIGH SCORING SUBGROUP

a) IDEAL FIGURE. High-scoring White pupils had a mean ideal figure of 4.95 (SD = .995), which is lower than the general White mean of 5.3. High scoring Black pupils selected similar ideal figures to the general Black sample (Mean = 5.3, SD = 0.947). Of the White high-scorers, 5 reported D, and 2 reported C as their ideal. Of Black high-scorers, 3 reported D but none reported C. Both D and C might be regarded as underweight and probably represent unrealistic ideals, especially as respondents enter adulthood and become heavier.

This again suggests that respondents are reproducing a shared and fairly consistent cultural value. Having an underweight ideal may lead to disordered eating, but it also seems likely that assent to less extreme ideals does not protect from weight concern or disordered eating at a personal level.

b) REAL-IDEAL DISCREPANCY. Real-ideal Discrepancies were also similar to the general scores - the discrepancy averages one to two figures above the ideal. Amongst the White high-scoring group, one respondent reported no discrepancy, and amongst the Black high-scoring group, 3 respondents reported no discrepancy. This suggests that a sense of being at one's ideal weight also does not protect the individual from weight concern or disordered eating.

c) TOLERANCE. The White high-scoring group had a mean tolerance of 3.36, i.e. they averaged between three and four figures in their ranges. The Black high-scoring group had a mean tolerance of 4.2, compared to the general Black mean of 5.6. This suggests that the high scoring Black group, whilst appearing more tolerant on average than White pupils (high-scoring or otherwise), are perhaps less tolerant than other Black pupils. Amongst the high-scoring Black group, four respondents reported ranges of only one or two figures, but two reported the ten-figure range (B-K) described above and suggested to represent a more 'traditional' response to the task. Again, body weight and dieting, and fear of becoming fat. Garner and colleagues utilised the mean DT score of their anorexic group (raw score of 15) as a cut-off to identify "weight preoccupied" respondents. (The maximum raw score for DT is 21 points). Amongst the present sample, respondents scoring over 12 points on DT would satisfy a cut-off level of one standard deviation above the mean for both race groups - so those scoring 15 or more are very likely to represent potentially problematic weight concern or disordered eating. In the present study 35 White and Black respondents scored at or above this level on DT - 21 White pupils and 14 Black pupils. Table 4.12 shows the race and school characteristics of this group.

TABLE 4.12. Pupils scoring at or above 15 points on Drive for Thinness.

DT	Black (n=14)			White (n=21)		Total
	CS	SS	PS	SS	PS	
15	2	4	0	3	1	10
16	0	2	2	5	1	10
17	0	1	0	3	0	4
18	0	0	0	2	1	3
19	0	2	1	2	0	5
20	0	0	0	2	0	2
21	0	0	0	0	1	1
Total	2	9	3	17	4	35

Note: CS = Community School, SS = State School, PS = Private School.

It appears that of this group, 14 (40%) are Black pupils. Nine of these are at the State School, 2 are at the Community School, and 3 are at the Private School. This represents a high proportion (50%) of all Black respondents at the State School.

The presence of 14 Black pupils in this group suggests that Black South Africans do experience disordered eating and weight concern, and may therefore be at risk for harmful dieting activity and/or eating disorders. There was no significant difference between the proportions scoring high on DT overall for each race group (Chi-squared = 0.1166, df = 1, p = .733), but as the White pupils in this group comprised only 17% of the White sample, it may be that some Black pupils are even more vulnerable to becoming eating-disordered than the average White pupil is. It is also interesting that most of the high-scoring Black pupils attend the State school rather than the private school - as described in the opening chapters, the elite status of the Private school and the implied higher level of Westernisation for private school pupils led to an expectation that these pupils would be the most likely to substantially and more than other measures with five of the eight EDI subscales, including all three disordered-eating subscales. A strong relationship with ineffectiveness suggests that being too different from one's body ideal (perhaps such that the ideal is practically unattainable) is likely to be associated with feeling ineffective generally.

4.4.6 SUMMARY

The two models are strongly related, and these findings confirm the value of the Body Figure Preference Test (and especially Real-Ideal Discrepancy) as an indicator of disordered eating and weight concern. However, an important question is raised about the nature of the relationship overall, specifically that differences in aesthetic taste and particularly tolerance, do not seem to be strongly related to lower EDI scores.

The implication is that whilst having a thinner body ideal, and especially having a large difference between actual shape and ideal shape is associated with disordered eating and weight concern, being more tolerant or accepting of different body shapes in a general, aesthetic way does *not* seem to protect an individual from having worries about her own body weight or shape, and difficulties in managing food and eating. Thus, whilst tolerance might seem to be a good thing in itself, and might be beneficial in all kinds of ways, it cannot be regarded as a failsafe guard against disordered eating. If it is possible to have tolerant preferences but still show disordered eating and weight concern, then it is at least possible that the process of developing disordered eating and weight concern could take the opposite direction - people might increase their admiration for thin body shapes because they themselves are already struggling to become thin! Yet narrow tolerance is correlated with higher EDI scores - and particularly body dissatisfaction - to some extent, and therefore it would appear that tolerance of different body shapes might usefully be discussed and promoted amongst young women.

Strong relationships between the models suggest that as individuals begin to think in more limited terms around body figure ideals and become less tolerant of difference, they are also likely to play out these ideals at an attitudinal-behavioural level, although it might also be that as people feel more dissatisfied with their own bodies, they become more stringent in their aesthetic preferences.

4.5 HIGH SCORING SUBGROUP

Because of the background interest of this study in eating disorders, it seemed useful to identify those profiles which could reflect problematic or potentially pathological attitudes towards eating and the body. This was done by using the Drive for Thinness subscale as an index, following the approach of Garner *et al* (1983). The scale measures preoccupation with

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food available. Such tolerance probably needs to include not only different body sizes and shapes, but also different colours, hair types, and skin types. Ideally, a number of strong discourses about the body would be undermined, with efforts to promote tolerance, self-acceptance and affirmation of one another's physical appearance as acceptable. A sense of being accepted and affirmed by other women may do more to mitigate disordered eating and weight concern than any number of nutritional programmes.

Subversion of the dominant texts, it seems, could most constructively involve promotion of alternatives. However, there are other factors to take into consideration. If struggles around eating and body weight become exaggerated due to lack of recognition in other arenas, then there is a clear *implication that long-term prevention of eating disorders may* best be served by wider attempts to empower and equip young women for competence and independence in the world - rather than by unintentionally promoting disordered eating in which the physical body becomes a powerful channel for distress and anger.

It may not be possible to prevent or discourage the entry of young women into struggles and strategies that have already been defined within the dominant culture. The texts are too powerful and all-encompassing for that. But by increasing awareness of just how intolerant and limited we are becoming, and by working actively for greater self- and other- acceptance, we may be able to lessen the intensity of those struggles. For those working amongst young Black women such as those in the community school, there may yet be opportunities to challenge dominant ideologies of physical appearance which may place them at risk, but at the same time it will be necessary to help them explore their own sense of body dissatisfaction and their own struggles to find a place in the world. Where schools are racially integrated, opportunities exist for Black and White pupils to learn from and about one another, and to use this experience of each other to develop greater tolerance and acceptance of each other's physical appearance. In our very differences, perhaps it is still possible to develop ways of imagining ourselves and our bodies differently.

could be valuable both in themselves (e.g. having therapeutic value) and for research purposes, considering not only body size and shape but also, perhaps, other physical features which could be subject to a Sameness trend, such as skin and hair. Feminists in particular may be interested in this type of work, from both theoretical and practical viewpoints.

Areas not necessarily associated with eating disorders but raised by the present study include the Maturity Fears scores - clearly, young South African women and especially Black women are facing adult roles with trepidation, but the reasons for this are not clear and are not elicited by this limited questionnaire. Such questions could be very important if it is the case that eating disorders are primarily culturally determined responses in situations of overwhelming conflict or distress. Related questions about body ideals might also be of interest, particularly with Black adolescents - this study considered body size and shape, but it may be that other aspects of the "ideal" are worth investigating and contribute to unrealistic appearance goals.

5.5 PREVENTIVE EFFORTS

These findings suggest that efforts to prevent eating disorders and promote wellness in the area of body weight could be important and should not be delayed. Yet clearly, this is no straightforward task. Mere awareness of the issues does not seem to help, and "health education" in the usual sense may even serve to make matters worse. Some of the present findings, however, could help to point the way for interventions at individual, group, or even community level.

If the present findings are a reliable guide, it appears that a key problem is the "centralising" or "homogenising" tendency which leads to narrow and limited tolerances and perhaps also to devaluation of typically African (and other) features in favour of typically Western body features. In other words, the problem is not that we are adulating Barbie (in plastic or in flesh), but that we increasingly do not accept alternatives to her bland, impossible outline. Some efforts in this direction are already being made (differently shaped or coloured dolls for girls, for example, or the shunning of excessively thin models by some women's magazines), and the present findings would support their value even though offering a note of caution about the complexity of the issues. Once the habit of evaluating bodies via a polarity of thin and fat has set in, this concept of tolerance is probably the best available defence.

It is unlikely that people can turn back the clock and rearrive at an age of innocence in which fat and thin have no meaning aside from the amount of and time-consuming, to try and create a translation of the EDI - as was done by Schoemaker *et al* (1994) in Holland. Translation of the BFPT could also have been done and might have helped improve the response rate on that test. Some simple questions could have been added to the EDI, for example about whether respondents were currently dieting, or about how often they weigh themselves, and this would probably have been more useful than the demographic detail that was collected.

A further limitation is that sampling was nonrandom, and this raises doubts about the generalisability of the data in either race group.

Although not practical in a study of this scope, it may be useful to know the actual weight and height of respondents, in order to see how this relates to patterns of disordered eating and weight concern. This is open to debate, however, as respondents might well experience these measures as intrusive, thereby increasing their resistance and reducing their willing co-operation.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

This research had a number of logistical limitations, specifically the small size of the Black sample and possibly also the lack of sociocultural variation amongst Black pupils in particular, but the findings presented here confirm the need to explore this area further. It is suggested that further research could be helpful in two particular areas. There appears to be a need for a more comprehensive "epidemiological" approach that would survey large numbers of young women and measure levels of disordered eating and weight concern as well as specific eating disorder symptoms. Such research is costly and difficult to implement but with growing levels of concern about eating disorders amongst Black South Africans in particular, at least one such large-scale study is presently being planned in Johannesburg (Szabo, personal communication). Clinicians and educators need this information.

A second area of research that is more accessible to interested students with limited resources involves qualitative techniques. This is very important in terms of developing a richer and fuller understanding of the processes that might lead young women into the so-called "dieting ethos" without reifying cultural influences into causal factors in that process. The present research demonstrates that sociocultural transactions between individuals and the dominant texts of their culture are likely to be complex and yet well worth trying to understand more deeply. Areas that have emerged from the present study as needing further elucidation include the meanings ascribed to fatness and thinness in the different race groups, and the question of body dissatisfaction, especially for Black respondents - what is the source of dissatisfaction, and does it represent some kind of rejection of racial identity, for example. Group-based work around issues of body figure preference

Preoccupation with dieting and weight loss appears to develop its own momentum (Casper & Offer, 1990), perhaps along the way involving more damage to self-esteem, more insecurity and increased efforts to gain recognition. Clearly, a struggle for control around food and eating can result in feeling more out of control (Neimeyer & Khazoum, 1985). It is also possible that the promotion of dieting and diet food plays into this dynamic, and factors such as this may be more crucial in promoting such responses as drive for thinness or body dissatisfaction than the promotion of thin body images in the popular culture.

If women commence dieting because of such cultural pressures and an as yet vague sense of dissatisfaction with themselves and their bodies, they may then experience an increase in dissatisfaction. This could then gradually coalesce into a more fixed objective of becoming thinner. At that point, hatred of fat could begin to develop, slowly becoming more extreme and accelerating the process of cultural shift by which women come to have similar mindsets about these issues. It is suggested that a process such as this could be occurring amongst the Black pupils in the present sample, explaining the more varied locations of Black pupils in terms of aesthetic values (ideals and tolerance) and disordered eating. However, it seems that the probl...s of cultural transition, and especially rapid cultural transition, have less to do with integrated schools than with the overall sociocultural location of young Black women.

5.3 STRENGTHS AND WEAKNESSES OF THE STUDY

The study has succeeded in showing that Black and White school pupils are not substantially different in their tendency towards disordered eating and weight concern, even though there are differences in their aesthetic values, particularly tolerance. This finding has both clinical and theoretical implications. Furthermore, the study was economical, involved little difficulty in collecting data, and offers a useful contrast not only between Black and White respondents but between Black pupils in different sociocultural locations. This has not been explicitly attempted before, and therefore addresses a gap in the literature. In administering the questionnaires, the enthusiastic support of teachers from all three schools was a great asset, as was the evident enthusiasm and co-operation of the respondents, which can be seen in the low numbers of missing data and questionnaires that had to be disregarded. This means that numbers for both race groups are sufficiently lar... to provide interpretable data, and to be suggestive of possible gen...alisation beyond this limited context.

There were, however, a number of limitations. The instruments are both open to criticisms about their reliability and validity, despite attempts to gather data about reliability. It might have been better, although more costly

White pupils, although the process may involve a shift from a more "traditional" view that is either opposed to dominant values or simply not proficient in the language of fat and thin (predominating at the Community school), to a possibly "overconforming" view that expresses high levels of conflict (predominating at the State school), and finally to a mindset that closely resembles that of White pupils (predominating at the Private and State schools).

The findings imply that in up to 25% of Black respondents there may be no fat/thin opposition to frame meanings. Conversely, it appears that such a framework does exist in up to 75% of the Black respondents, creating the possibility of weight concern and disordered eating.

It is also possible that the problematic aspects of sociocultural transition are not "Western" education, competition or upward social mobility in themselves, but rather the conflicts and confusions that these may produce at an individual level - such as feeling inadequate to cope with academic demands or to compete with more affluent classmates who demonstrate an easy "feel for the game". In their own way, each school represented here is White dominated - even the consciously progressive and nonintegrated Community school, insofar as it must adhere to a state-imposed syllabus or utilise English in the teaching of subjects. It appears that the critical issue could be disadvantage within a particular academic environment - a disadvantage likely to accrue from the sociopolitical location of respondents in relation to that of their school.

Another problematic aspect could be rejection of Black identity at a physical level, a strategy that suggests Abrams *et al's* (1992) so-called "pre-encounter" stage of cultural change. No apparent differences existed between the race groups on "cultural differences in definitions of beauty" (Abrams *et al,* 1992) but differences were found in tolerance of different body figures, especially the fatter figures, and it may be that this is more important: intolerance of fat, for these pupils, may represent a rejection of traditionally valued Black body shapes and especially those of the older generation which tend to be heavier - including around stomach, breasts, and buttocks which are singled out in the Body Dissatisfaction subscale. Case history reports, e.g. Buchan & Gregory (1984) have emphasised the role of identity problems and of devaluation of one's own racial identity. It is interesting to note that in this respect, the presence of a larger Black peer group (at the State and Community schools) did not seem to help. Perhaps previous State efforts to divide Black communities and set people against one another have had the effect of undermining Black pupils' ability to support one another in terms of cultural pride and racial identity.

a high drive for thinness, but for White pupils low tolerance is associated more with drive for thinness. This illustrates the point, made above, that for different people the struggle may be differently expressed. Since Black pupils showed a much greater overall tolerance than White pupils, but not a lesser overall level of disordered eating and weight concern, it may also be suggested that their higher tolerance is not a protective factor when it comes to appraising their own body size and shape.

5.2.1 PREVALENCE OF DISORDERED EATING AND WEIGHT CONCERN

The findings of this study, tentative as they are, support the view that disordered eating and weight concern is increasingly crossing former social barriers (real or apparent). At least in terms of the Eating Disorders Inventory constructs, Black pupils from these three urban schools appear to be at least as much at risk as White pupils, and in some cases more so. Black pupils are also well represented in the high-scoring subgroup described here. Not only do Black respondents show high levels of Drive for Thinness and Body Dissatisfaction, they also report high standards of achievement, difficulties in identifying inner feelings and sensations, and strong fears of becoming adult. These difficulties may enhance their struggles around eating and body weight.

Reports of eating disorders amongst Black women in the Northern hemisphere are emerging into the literature (e.g. Pate *et al*, 1992; and Emmons, 1992). Therefore, it appears to be important (including in South Africa) that professionals concerned with the well-being of young women, such as teachers, doctors, dieticians and psychologists, should dispel the perception that weight loss behaviours are normal for White people but not for Black people, and are not likely to become problems for Black people (Childress *et al*, 1993). If there is some kind of a "slippery slope" involved in the development of disordered eating, perhaps leading to serious eating disorders, then young Black South Africans - insofar as they are represented by the present sample - could be on it already, since they are reporting concerns with dieting, food control, and purging as well as body dissatisfaction and other related issues. Furthermore, based on the data presented here, there is no reason to assume that young urban South African women of either race group show less weight concern or disordered eating than groups from developed, Western countries with known incidence of eating disorders.

5.2.2 EFFECTS OF SOCIOCULTURAL TRANSITION

Evidence for a process of cultural transition amongst Black pupils was found, but it is not conclusive. Nor does it appear that this transition is directly associated with School environment or educational integration with

In summary, it appears that neither South African sample is much different from Northern Hemisphere comparison groups, except where scores tend to be higher and are comparable in some cases with groups identified as being already worryingly preoccupied with body size and shape, e.g. ballet or modelling students (Garner *et al*, 1983). Using Bourdieu's terminology, it seems that South Africans of both races could be highly invested (even if for different reasons) in those issues or struggles around weight and the body which appear to form the background to clinical illness.

5.2 RELATIONSHIP OF THE TWO MODELS - THEORETICAL IMPLICATIONS

The close relationship of the two models demonstrates that aesthetic values in the form of body preferences or tastes are indeed translated into action at the level of attitudes and behaviours. The usefulness of the Body Figure Preference Test is also confirmed, especially measures of tolerance and real-ideal discrepancy, which are so simple to obtain and yet deliver so much information. A particularly striking finding was that White pupils but not Black pupils comprehensively reject all body fat in their ideals, and the less their fat tolerance, the more they report disordered eating and weight concern.

Questions still remain, however, about the interpretation of this test by some of the Black pupils. It may be that for the group who chose a tolerance range of ten figures, the task as set was essentially meaningless - *not* because respondents could not understand the instructions, but because they are not familiar with the discourse that is represented, i.e. the "preformed social opposition between fat and thin" (Diamond, 1985). If an individual does not have a cognitive schema for this, then when asked to deselect figures that are "unattractively thin" or "unattractively fat", they are likely to simply co-operate by cutting off one figure from either end of the array - without, however, necessarily holding any opinion about whether that figure is "unattractive" or not. One Black pupil from the Community school gave a clue to this puzzlement when she wrote on her questionnaire, "because she's too wrinkly" - a judgement not about fat but about the state of the skin. Pupils for whom fat/thin is not the primary aesthetic issue may well have felt sorry for the emaciated figures, or not wanted to make such judgements about any human being, finding it difficult to accept the notion of an impersonal "type" that is divorced from human feelings and morality - a further assumption of the Body Figure Preference Test.

The strong relationships between the models confirms that "Same" or phallocentric thinking at an aesthetic level is related to disordered eating and weight concerns at a behavioural level. For Black pupils, a narrow range of tolerance is more likely to be associated with a high body dissatisfaction than

Comparisons between attitudes and behaviours of the two main race groups thus tended to dispel the notion that Black pupils are less vulnerable to eating disorders than White pupils, and did not follow the expected pattern of racial differences. Comparisons between attitudes and behaviours of Black pupils in the three schools tended to dispel the notion that the highly socialised Private school pupils would be more at risk, and to support the argument (set out in Chapter 1) that we have to take into account the particular sociocultural circumstances and an individual's choice of strategies within that. In this context, it is also interesting that White pupils at the State school similarly reported more difficulties with eating and body weight, though the differences were less striking. It may be that as the major social struggle in South Africa moves from the arena of race to that of class, it is individuals whose class position is uncertain who may experience greatest conflict, including over their gender roles, self-esteem and body image.

5.1.1 COMPARISON WITH OTHER FINDINGS

Both White and Black South African samples appear to have mean scores that are either equivalent to or are higher than those reported from similar samples abroad. Dutch scores appear to be lower than either Canadian or South African scores, which is interesting and suggests that there may be sociocultural differences - perhaps in what Smith (1993) has called the "production-consumption dialectic". However, the Dutch study used a translation of the test and this may have played a role. South African scores generally resemble the Canadian scores but tend to be higher for both South African groups. On one subscale, Maturity Fears, Black South Africans outscored an anorexic patient group, which suggests that Black South Africans have quite severe problems with facing adulthood - although not necessarily the same struggles as those experienced by Western anorexics. White South Africans were more body dissatisfied than other groups.

A comparison specifically with Canadian schoolgirls shows that Black South Africans tend to show more drive for thinness, and White South Africans more body dissatisfaction, whilst both groups appear to feel more out of control around food and eating. There may be different reasons for this, to do with the different social location of White and Black South African women both in terms of other South Africans, and in terms of relationship to the struggles that Canadian women might be experiencing. For example, it might be that South Africa is still a more chauvinistic and patriarchal society than Canada, resulting in greater controls being exercised over women and their bodies, or a stronger focus for South African women on struggles around the body - different struggles, quite possibly, for Black and White women.

60. I feel that I am a worthwhile person	Always	Usually	Often	Sometimes	Rarely	Never
61. When I am upset, I don't know if I am sad, frightened or angry	Always	Usually	Often	Sometimes	Rarely	Never
62. I feel that I must do things perfectly, or not do them at all	Always	Usually	Often	Sometimes	Rarely	Never
63. I have the thought of trying to vomit in order to lose weight	Always	Usually	Often	Sometimes	Rarely	Never
64. I need to keep people at a certain distance - I feel uncomfortable of someone tries to get too close	Always	Usually	Often	Sometimes	Rarely	Never
65. I think that my thighs are just the right size	Always	Usually	Often	Sometimes	Rarely	Never
66. I feel empty inside, emotionally	Always	Usually	Often	Sometimes	Rarely	Never
67. I can talk about personal thoughts or feelings	Always	Usually	Often	Sometimes	Rarely	Never
68. The best years of your life are when you become an adult	Always	Usually	Often	Sometimes	Rarely	Never
69. I think that my buttocks are too large	Always	Usually	Often	Sometimes	Rarely	Never
70. I have feelings I can't quite identify	Always	Usually	Often	Sometimes	Rarely	Never
71. I eat or drink in secrecy.	Always	Usually	Often	Sometimes	Rarely	Never
72. I think that my hips are just the right size	Always	Usually	Often	Sometimes	Rarely	Never
73. I have extremely high goals	Always	Usually	Often	Sometimes	Rarely	Never
74. When I am upset, I worry that I will start eating	Always	Usually	Often	Sometimes	Rarely	Never

The last question asks you to express your own opinion. Please think about your answer and write it down in not more than 10 lines.

Many people feel that their bodies are either too big (too fat or tall), whilst many others feel that they are too small (too thin or short). Most of the people who think their bodies are too big are female, and most of the people who feel too small are male. Sometimes people feel so desperate about it that they adopt dangerous methods to change size, such as starving themselves to lose weight or abusing drugs (anabolic steroids) to make themselves bigger.

75. Why do you think it is that women so often worry about being too big or fat?

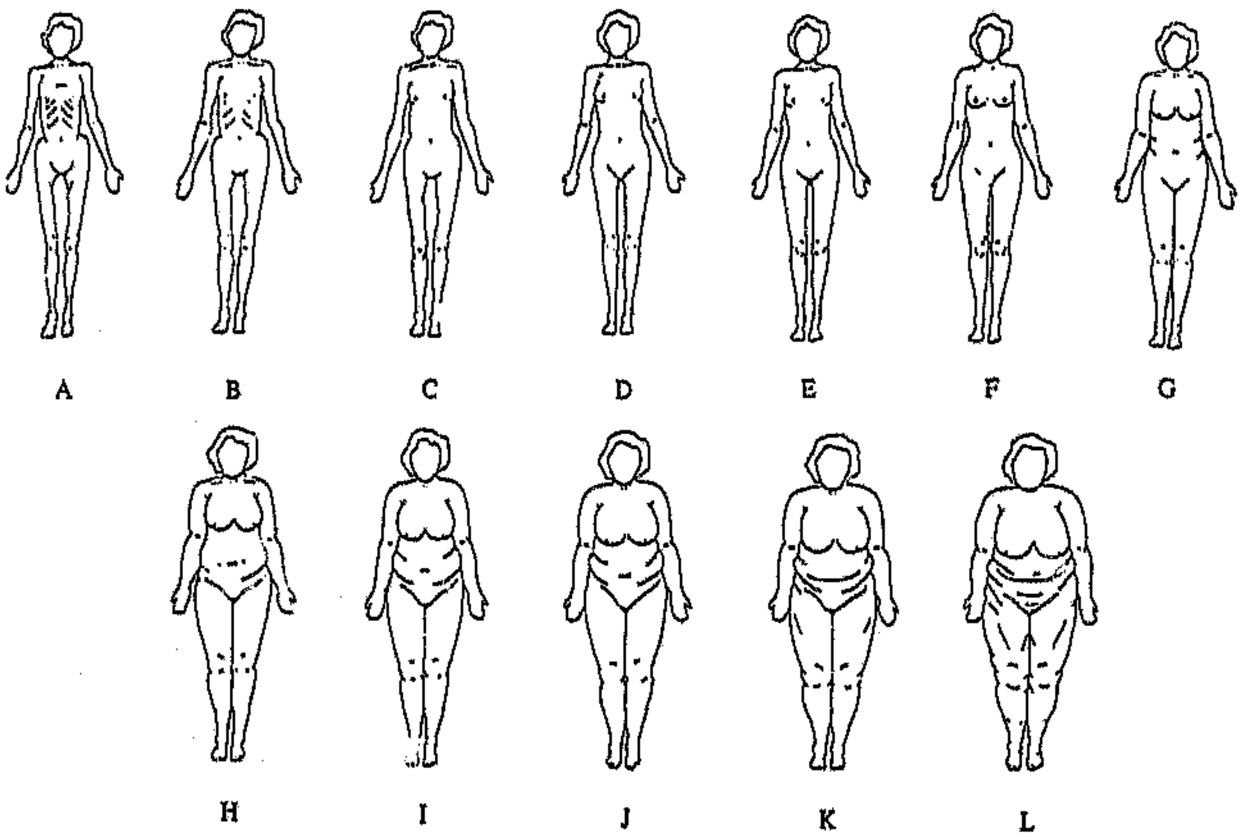
36. I can clearly identify what emotion I am feeling	Always	Usually	Often	Sometimes	Rarely	Never
37. I feel inadequate	Always	Usually	Often	Sometimes	Rarely	Never
38. I have gone on eating binges where I have felt that I could not stop	Always	Usually	Often	Sometimes	Rarely	Never
39. As a child, I tried very hard to avoid disappointing my parents and teachers	Always	Usually	Often	Sometimes	Rarely	Never
40. I have close relationships	Always	Usually	Often	Sometimes	Rarely	Never
41. I like the shape of my buttocks	Always	Usually	Often	Sometimes	Rarely	Never
42. I am preoccupied with the desire to be thinner	Always	Usually	Often	Sometimes	Rarely	Never
43. I don't know what's going on inside me	Always	Usually	Often	Sometimes	Rarely	Never
44. I have trouble expressing my emotions to others	Always	Usually	Often	Sometimes	Rarely	Never
45. The demands of adulthood are too great	Always	Usually	Often	Sometimes	Rarely	Never
46. I hate being less than the best at things	Always	Usually	Often	Sometimes	Rarely	Never
47. I feel secure about myself	Always	Usually	Often	Sometimes	Rarely	Never
48. I think about overeating	Always	Usually	Often	Sometimes	Rarely	Never
49. I feel happy that I am not a child anymore	Always	Usually	Often	Sometimes	Rarely	Never
50. I get confused as to whether or not I am hungry	Always	Usually	Often	Sometimes	Rarely	Never
51. I have a low opinion of myself	Always	Usually	Often	Sometimes	Rarely	Never
52. I feel that I can achieve my standards	Always	Usually	Often	Sometimes	Rarely	Never
53. My parents have expected excellence of me	Always	Usually	Often	Sometimes	Rarely	Never
54. I worry that my feelings will get out of control	Always	Usually	Often	Sometimes	Rarely	Never
55. I think that my hips are too big	Always	Usually	Often	Sometimes	Rarely	Never
56. I eat moderately in front of others and stuff myself when they're gone	Always	Usually	Often	Sometimes	Rarely	Never
57. I feel bloated after eating a normal meal	Always	Usually	Often	Sometimes	Rarely	Never
58. I feel that people are happiest when they are children	Always	Usually	Often	Sometimes	Rarely	Never
59. If I gain a kilogram of weight, I worry that I will keep gaining	Always	Usually	Often	Sometimes	Rarely	Never

(EATING DISORDERS INVENTORY)

Please read the following questions and circle the answer which applies best for you. Please think about each question very carefully and make sure to mark your answer on the right line (you could use a ruler if you have one).

11. I eat sweets and carbohydrates without feeling nervous..........	Always	Usually	Often	Sometimes	Rarely	Never
12. I think that my stomach is too big..........	Always	Usually	Often	Sometimes	Rarely	Never
13. I wish that I could return to the security of childhood..........	Always	Usually	Often	Sometimes	Rarely	Never
14. I eat when I am upset..........	Always	Usually	Often	Sometimes	Rarely	Never
15. I stuff myself with food..........	Always	Usually	Often	Sometimes	Rarely	Never
16. I wish that I could be younger..........	Always	Usually	Often	Sometimes	Rarely	Never
17. I think about dieting..........	Always	Usually	Often	Sometimes	Rarely	Never
18. I get frightened when my feelings are too strong..........	Always	Usually	Often	Sometimes	Rarely	Never
19. I think that my thighs are too large..........	Always	Usually	Often	Sometimes	Rarely	Never
20. I feel ineffective as a person..........	Always	Usually	Often	Sometimes	Rarely	Never
21. I feel extremely guilty after overeating..........	Always	Usually	Often	Sometimes	Rarely	Never
22. I think that my stomach is just the right size..........	Always	Usually	Often	Sometimes	Rarely	Never
23. Only outstanding performance is good enough in my family..........	Always	Usually	Often	Sometimes	Rarely	Never
24. The happiest time in life is when you are a child..........	Always	Usually	Often	Sometimes	Rarely	Never
25. I am open about my feelings..........	Always	Usually	Often	Sometimes	Rarely	Never
26. I am terrified of gaining weight..........	Always	Usually	Often	Sometimes	Rarel	Never
27. I trust others..........	Always	Usually	Often	Sometimes	Rarely	Never
28. I feel alone in the world..........	Always	Usually	Often	Sometimes	Rarely	Never
29. I feel satisfied with the shape of my body..........	Always	Usually	Often	Sometimes	Rarely	Never
30. I feel generally in control of things in my life..........	Always	Usually	Often	Sometimes	Rarely	Never
31. I get confused about what emotion I am feeling..........	Always	Usually	Often	Sometimes	Rarely	Never
32. I would rather be an adult than a child..........	Always	Usually	Often	Sometimes	Rarely	Never
33. I can communicate with others easily..........	Always	Usually	Often	Sometimes	Rarely	Never
34. I wish I were someone else..........	Always	Usually	Often	Sometimes	Rarely	Never
35. I exaggerate or magnify the importance of weight..........	Always	Usually	Often	Sometimes	Rarely	Never

9. Look at the following set of figures which are marked A, B, C, D, E, F, G, H, I, J, K and L.



a) Which figure do you think looks the best? ....

b) Which figure do you think looks the worst? (NB: Choose only ONE figure) ....

c) Which figure do you think most resembles your own body shape? ....

NB: For the next two items, please write down ALL the letters which you want to include in your answer.

d) Which figures do you think look unattractively fat?

e) Which figures do you think look unattractively thin?

10. NB: The following questions are important information for the research; remember your answer is anonymous so please be honest! But if you really don't know the answer, don't try to guess.

a) What is your present weight? ....

b) What clothing size do you take at present?............................

b) What is your present height? ....

1. NAME OF SCHOOL: ....

2. AGE: Years .... Months ....

3. GENDER: Male Female (PLEASE CIRCLE)

4. LANGUAGES AND ETHNICITY

a) What language was spoken at home when you were very young? ....

b) What language do you mainly speak to your friends? ....

c) If you were to identify yourself with an ethnic group (for example: Zulu, Portuguese, Tamil) which would it be?

5. PLACE OF BIRTH

City or suburb Rural area Township Shack settlement or camp

6. FAMILY BACKGROUND

Father's occupation .... Mother's occupation ....

Paternal grandfather's occupation .... Maternal grandfather's occupation ....

7. EDUCATIONAL BACKGROUND

a) What grade mark or percentage did you achieve in your last exams in the following subjects? (Mark N/A next to a subject if you do not take it)

English Language .... Maths .... Science........... History ....

b) What was your best mark in the las exams you took? Subject .... Grade/percentage mark ....

c) Do you take lessons outside of school in any of the following (PLEASE CIRCLE):

Music Ballet Horse riding Gym Drama/speech Other (Please specify)

8. This question asks you for your own opinion. Please think about it carefully and write your answer down in not more than 10 lines.

What personal qualities do you think are important in order to be happy and successful in your future life?

7. APPENDIX: QUESTIONNAIRE DETAILS

ABOUT THE QUESTIONNAIRE

This questionnaire measures a variety of attitudes, feelings, and behaviours. Some of the items relate to food and eating. Others ask you about your feelings about yourself. There are also questions about your family and schoolwork.

Your name will not appear on this questionnaire, and therefore no one can trace your answers back to you; students from different schools will be helping in this research, and the privacy of all respondents is respected. There are no right or wrong answers, so try very hard to be completely honest. Read each question and either fill in your response, or CIRCLE the answer which applies best for you.

This research study will help us to understand the way young South Africans in different schools and from different backgrounds feel about themselves.

Participation in the study is voluntary, and you are free not to participate or to stop at any time. After your group has completed the questionnaires, time is allowed for any questions you might have about the research study. If you feel worried about any of the questions and would like to talk pr..ately to someone, please contact your school counsellor who will listen to you in confidence.

Thank you for your time.

Sally Davies
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