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### Anorexia: A Western Culture-Bound Syndrome

When you hear the word “anorexia”, what is the first thing that comes to mind? For most, the answer is some variation of “eating disorder” because this is medicine’s current approach to anorexia. However, relying on precedent to describe anorexia as an eating disorder does not always lead to the most accurate conclusions. In fact, this leads to many “atypical” cases that are more accurately described as “exercise disorders” or “ascetic disorders” (O’Connor and Van Esterik 6). Those that over-exercise given the number of calories they ingest and those that abstain from food for the sake of a stronger connection to a higher power or to take control over their life are still engaging in the primary behavior that is characteristic of anorexia: self-starvation. Yet, current definitions fail to include them despite the same unhealthy nature of their practices.

Failure to include all types of self-starvation in the definition of anorexia, in part, leads to the development of inadequate treatment options. Despite the current emphasis on medicalizing anorexia, the treatment options available for those with other eating disorders are not met with high success rates. According to Terence Dovey, author of *Eating Behaviour*, “[u]p to 10 percent of patients will die within 10 years and another 10 percent will die within 20 years as a direct result of the condition” (152). Dovey cites this statistic from another author’s work published in 1997. Although this was twenty years ago, anorexia has been documented since the nineteenth century. The fact that we still have such high mortality rates as a direct result of this condition indicates that little progress has been made in addressing it. Medical professionals and patients

alike should be invested in redefining anorexia to make more accurate diagnoses and address treatability issues.

Although there are many options for treating eating disorders including cognitive behavioral therapy, pharmacotherapy, full-time inpatient clinics, interpersonal therapy, and family therapy, these options often do not apply to anorexic patients. Cognitive behavioral therapy, specifically when it comes to eating disorders, is focused on recognizing the triggers of disordered behavior (Dovey 162). Once recognized, the therapist will try to guide the patient to develop coping strategies that will prevent the individual from engaging in the disordered behavior (162). Although this strategy “is completely effective in about 40 percent of bulimics, and at least 80 percent will see a dramatic reduction in symptoms”, this treatment is not effective for anorexics because they often refuse cognitive behavioral therapy (163). In addition, “[o]f 5,512 studies identified to have used cognitive behavioural therapy, only six stand up to scientific rigour and of those only two showed any positive effect in anorexia nervosa” (163). Cognitive behavioral therapy is, therefore, not a viable option for many anorexic patients.

Similarly, the use of pharmaceuticals to treat anorexia is no more promising than other methods, despite their success in treating bulimia. According to Dovey, “[f]or bulimics...SSRIs [selective serotonin reuptake inhibitors] appear to be fairly effective, but they should be administered alongside psychological interventions to provide a combined therapy for them” (164). Yet, for anorexics, SSRIs have been tested with little success seeing as they “do not appear to work for anorexic patients...and may actually reinforce their propensity to lose weight” (164). Doctors must also be extremely careful when prescribing medicines to individuals at such

a low weight (164). Using this method of treatment for anorexics is, therefore, nonsensical and impractical.

Even full-time inpatient clinics, which are specifically designed for patients in dire need of help, are met with relatively little success. These inpatient clinics provide around-the-clock care for their patients, particularly those with the most severe forms of anorexia, since bulimic patients and those with other eating disorders rarely require that caliber of care (Dovey 164). However, this method of treatment is expensive and not practical for everyone who may need it. Considering that these “inpatient clinics are about 50 percent effective in terms of treatment and relapse”, this treatment may not be realistic for all patients either (165). This treatment option may be one of the most successful attempts, but a hospital environment and “real life” are nowhere near the same. Under the controlled care of others, the anorexic may feel further out of control, a known contributing factor to anorexia, and continue the behavior once out of treatment, so they can regain control of their life. Additionally, the triggers of daily life can be controlled for in a hospital, but not when the individual must resume their routine and actively make food choices again.

Interpersonal therapy and family therapy are also occasionally used to treat eating disorders, but have unknown or variable success rates. Interpersonal therapy is founded on the idea that with a therapist, a patient can determine the core themes in their life and devise their own solutions to their problems (Dovey 161). In the context of eating disorders, this is usually done alongside an outpatient program where the patient has the ability to decide what strategies are effective to use in their daily life (161). When used to treat bulimia nervosa and binge eating disorder, interpersonal therapy is said to have a success rate of approximately forty percent

(161). Dovey does not include the effectiveness of interpersonal therapy with respect to anorexia. It seems that there is not enough research to conclude its efficacy. Family therapy, which aims to address the role of the family in the individual's disordered behavior, is often offered alongside other therapies, so its role in treating eating disorders is unclear (Dovey 164).

All of the treatment options referenced above can be explored in more detail in Dovey's *Eating Behaviour*. Although Dovey's work is an older text, it provides a valuable introduction to one of the major issues with anorexia as an eating disorder: its treatability. Not all disorders are treatable, but it is worthwhile to ask whether or not anorexia should be placed in the same category as bulimia and binge eating disorder when there is almost no success in treating anorexia as opposed to other eating disorders. Treating anorexia is an end goal of medicalization, but if the end goal is failing, we should reflect on the foundation that these treatments are grounded in: categorization.

One study analyzed the categorization of eating disorders in the *DSM-IV*. Rebecka Peebles, Kristina Hardy, Jenny Wilson, and James Lock sought "to answer a primary research question of how *DSM-IV* diagnostic criteria predict medical outcomes" (e1194). Eating disorders not otherwise specified (EDNOS) was a category of eating disorder that existed before the current edition of the DSM, *DSM-V*, was released in 2013. The majority of those diagnosed with EDNOS did not fulfill the criteria of anorexia nervosa or bulimia nervosa fully, meaning, for example, that they were underweight but had not met the menstrual criteria for anorexia nervosa, or they binged and purged but not at the correct frequency for bulimia nervosa (Peebles et al e1195). Peebles et al categorized the many partial anorexia or partial bulimia conditions and

studied whether or not this “partial” diagnosis, or being considered to have an EDNOS, had any correlation with the severity of their medical comorbidities.

According to Peebles et al, “61.6% of patients with EDNOS met recommended criteria for medical hospitalization and were more compromised than patients with BN [bulimia nervosa] in most medical outcomes” (e1198). At the time of this research, EDNOS were automatically assumed by medical professionals to be less severe because they were not as clearly defined as anorexia or bulimia (e1194). If more than half of these patients fit criteria for hospitalization, then why is their diagnosis so vague? Why are they not treated with the same vigor as someone with anorexia or bulimia might be? This shows how categorization of medical conditions is not always matched with the severity of the condition. Medical categorization does not always parallel the need for adequate treatment.

Severe medical conditions with life-threatening consequences may arise from eating disorders, but categorization does not necessarily reflect these circumstances, particularly when it comes to EDNOS or partial diagnoses. EDNOS patients also “displayed similar disease duration and rates of weight loss...orthostasis, and hypokalemia as their full diagnostic counterparts” (e1198). Orthostasis is “a decrease in blood pressure that happens soon after standing” which is uncommon for people under 65 years-old, but often happens to young anorexics because of malnutrition (“Orthostasis”). This can cause patients to feel faint and lead to falling or other injuries. Hypokalemia, on the other hand, is a condition that results from extremely low potassium levels. If left untreated, this can be fatal (Campbell and Aulisio 628). These dangerous symptoms are present “despite that they [patients with EDNOS] weighed

significantly more than patients with AN [anorexia nervosa]" (e1198). Partial diagnoses do not reflect the medical severity of many patients' condition.

The weight criteria for anorexia as found in the *DSM-V* is not actually a useful diagnostic marker because these potentially fatal comorbidities are affecting other patients with a much higher weight. Peebles et al also found that "[o]f pAN [partial anorexia nervosa] subgroups, patients who had EDNOS and had lost >25% of their premorbid body weight...seemed more compromised than other subgroups of pAN and even more than patients with AN in some medical outcomes" (e1198). Again, "[t]his is the case despite being at a significantly higher, near 'ideal' body weight, reminding us that malnutrition is a complex disease with manifestations at multiple weights" (e1198). Partial diagnosis, despite seeming less severe because it is only "partial", should be taken seriously, and our system of classification should allow for that by not placing too much emphasis on the patient's weight. Weight also correlates with the presence of a menstrual cycle, but the weight at which an individual no longer experiences their menstrual cycle is variable. Presence of a menstrual cycle is, therefore, a problematic criteria for diagnosing anorexia. This criteria can be the difference between being diagnosed with anorexia and receiving a vague, partial diagnosis despite the fact that its presence or absence may not be indicative of the health of the individual. There must be a way to better categorize anorexia in order to create the foundation for better treatment options.

Better categorization and treatment options are critical for patients whose anorexia has become life-threatening. Like with many other life-threatening conditions, there is a choice of whether or not to use "aggressive treatment" (Campbell and Aulisio 628). Amy Campbell and Mark Aulisio evaluate the cases of "Alison" and "Emily", anonymous patients that refused to

take “aggressive treatment” measures after being disillusioned by medicine, from the legal and ethical standpoint. Here, however, I will simply share parts of their stories to emphasize what’s at stake. Alison was a 55 year-old patient that struggled with anorexia for over 40 years (628). She attended several inpatient treatment programs and took several types of medication in efforts to treat her condition, but each attempt was complicated by an underlying personality disorder (628). In the last year of her life, she simply decided that she did not want to try anymore (628). Since she did not have any history of suicide attempts and was found to be cognitively capable of making this decision, she was allowed to go into hospice care where she most likely succumbed to hypoglycemia or hypokalemia (628). According to the authors, “[f]or years, she had expressed a deep desire to get better, but now said that all medical treatment attempts had failed her” (628). Emily, on the other hand, did not express this same level of dissatisfaction with medicine. However, even though “she understood what was needed to improve her condition...[,] she was not willing to take those steps” (628). With over 25 years of suffering under her belt, Emily was also dissatisfied with her lack of improvement, and as a result, also went into hospice care. Cases like Alison’s and Emily’s should be more thoroughly investigated to explore why treatment attempts failed and what can be done to improve options for others in the future. In short, medical perspectives have failed to explain anorexia and to produce viable treatment options suited to complex individuals.

Sociology offers a new, more individualized approach to anorexia--that is not offered by medicine--which may allow for novel conclusions about this complex condition. Nicole Perez conducted a study “to get at the lived experience of eating problems as told by sufferers themselves” (1). She recognizes that “there has been an increasing medicalization of eating

problems with an emphasis on biology and genetics” which has not left much room for evaluating the individuals’ experiences with eating (1). Perez uses the phrase “eating problem” in efforts to avoid medicalization and “caus[ing] the participants to feel labeled or defined in any negative way”, coining the term after “many of the participants used [it]...themselves to describe their struggles with food and eating” (2).

Although Perez attempts to decrease stigmatization associated with medicalization by using the phrase “eating problem”, she perpetuates the stigma by calling her subjects “sufferers” throughout the report of her findings. In fact, as Perez notes in her discussion, “[s]ome [of her participants] referred to it [their eating disorder] as ‘not an eating disorder...just life’” (Perez 17). So what is anorexia from the perspective of the “sufferer”? Is it a lifestyle? Many of these so-called “sufferers” are actually part of an internet subculture called “pro-ana” (Perez 5). According to research by Nick Fox, Katie Ward, and Alan O’Rourke, “[i]nterviewees saw ‘pro-ana’ as a means to actively live with an eating problem in a society that seeks to treat their ‘deviant’ illness” (qtd. in Perez 5). This reflects Western values of individual determinism, allowing the supposed “sufferer” to take control over their life and “illness”.

Many of the blogs in this individualistic “pro-ana” subculture can be found on Tumblr. Superskinnygoals is one such blog. Careful analysis of Superskinnygoals’ post “After School Thinspo \*Don’t Read if You Get Triggered Easily\* Stay Safe”, originally written by Myanadiary, reveals much of what this subculture is about, and how it allows individuals to express culturally-instilled hyper-individualism. The post starts by saying, “[y]ou have started looking at thinspo for years, that is years you have wished to be skinny. You can’t take back those years, but you can make the next year's much better.” This claim marks the beginning of



the post which then details the method by which the reader can get there. Myanadairy tells the reader to avoid food by drinking plenty of water, taking a shower, or watching a YouTube video. Essentially, they suggest numerous distractions to prevent the reader from thinking about food. Then, Myanadairy reminds the reader of the reason why they would want to pursue this in the first place by stating: “Just imagine all the photos you will take. All the clothes you will wear. All the confidence you will have.” These “goals” give readers a purpose, making them feel that their self-starvation will be worth it for some loftier goal. Before ending the post, the author writes, “Remember, you’ll be thinner in the morning.” Each line of writing is reminiscent of the “voice inside your head”, mesmerizing the reader as they continue on.

Because of how well-written and persuasive Myanadiary’s post is, it may seem as if this is a natural process. However, this is anything but natural. Starving is not natural; it defies animal instincts. Humans, while distinct from other animals in many respects, still have the instinct to eat, and somehow this community has been bound together by the choices they make on their quest to defy it. Anorexia, according to this community, is a series of choices that the individual has the power to make. Myanadiary’s steps to achieve thinness all involve active choices. One should actively avoid food with water and tea. One should look in the mirror to see flaws that can be perfected by thinness. One should dream of what their body will look like once they’ve achieved their goal. If the habits and behaviors associated with anorexia involve a degree of choice, do they constitute a “disorder”?

Another interesting note about Myanadiary’s post is that it does not actually tell the reader what to do once they have their “dream body”. At that goal weight, should the reader start eating again or aim to get even thinner? When does the reader reach the end goal? Lack of an

endpoint could be evidence that this is not meant to be a short-term dabble into unhealthy behavior, but rather a lifelong quest for thinness. “Alison” and “Emily”, the hospice patients that died after decades of anorexia, were clearly experiencing this throughout their lifetime. Many of Nicole Perez’ research participants “considered their eating problems to be in the past, or referred to themselves as ‘recovering’ sufferers of eating problems, [but] still noted regular and overwhelming thoughts to participate in behaviors related to eating problems” (17). Anorexia is often a lifelong series of choices that may be more closely defined as lifestyle, rather than as an “eating disorder”. Understood as a series of lifestyle choices, anorexia is the epitome of Western values, particularly individualism. Our classification and categorization should reflect the role of cultural values in the development of anorexia.

Considering medicine’s failure to treat anorexia, medicine’s failure to accurately categorize eating disorders, and the “pro-ana” view of anorexia, it is time to redefine and recategorize anorexia. It should no longer be defined by weight percentiles and menstrual cycles, but rather as a series of symptoms that result from the undeniable weight of cultural values. Anorexia should be redefined and recategorized as a culture-bound syndrome.

The term “culture-bound syndrome” is typically applied to illnesses based on cultural values that Western medicine does not understand. Ghost Sickness, an illness found among some Native American tribes, particularly the Navajo, is a well-known example of a culture-bound syndrome. According to Amber Huack, Ghost Sickness affects individuals that are consumed by thoughts of death or particular deceased individuals (Huack). Culturally, Ghost Sickness is believed to be caused by the spirits of individuals that did not have proper burial or grieving rituals performed in their honor (Huack). If the spirits are not at peace, they will cause illness or

discomfort for the living (Huack). In particular, those individuals afflicted with Ghost Sickness can develop symptoms like anxiety, nightmares, weakness, dizziness, and sometimes depression among other symptoms that can only be relieved by rituals performed by tribe members (Huack). Since Western medicine cannot cure Ghost Sickness, this illness was categorized as a culture-bound syndrome. Despite its origin and prevalence in Western culture, anorexia can be categorized as a culture-bound syndrome as its treatment and cure has eluded Western medicine. It's time to change our perception of anorexia by reflecting on our own cultural values that create that illness.

The impact of Western values on the development of eating disorders is clearly shown by a case study in Fiji. Prior to Westernization, many indigenous peoples did not have rates of anorexia at all, including Fiji. Before contact with the West, Fijian culture held that “[a] robust, nicely rounded body is the norm for men and women” (Goode). It was complementary to be told that you had gained weight, and it was concerning if someone thought you were “going thin” (Goode). However, once television satellite signals began to reach the island, perception of weight and prevalence of eating disorders changed drastically (Goode).

The impact of access to American television on Fijian body image and eating disorder rates is well-documented. Dr. Anne E. Becker and her colleagues from the Harvard Eating Disorders Center of Harvard Medical School began to research eating disorders in Fiji in 1995 just one month after television satellite signals began reaching Viti Levu, the country's main island (Goode). The researchers used surveys to determine the prevalence of eating disorders and related disordered behaviors over time, particularly among high school-aged girls (Goode). According to survey results, the percentage of girls that used purging to regulate their weight

increased fivefold from 3 percent in 1995 to 15 percent in 1998 (Goode). Additionally, in 1998, “69 percent [of girls] said that at some time they had been on a diet. In fact, preliminary data suggest that more teenage girls in Fiji diet than their American counterparts” (Goode). The results of this study are often used to show the damaging impact of media on adolescent girls’ body image. However, these results also lead to conclusions about the damaging impact of Western values on adolescent girls. Media sends direct or indirect messages about societal values, such as equating thinness with goodness, which is the problem more than the media itself.

Western values that promote anorexia include hyper-individualism, thinness as morally good, and restraint. In general, most societies can be categorized as individualistic or collectivistic. Individualistic societies value independence, self-sufficiency and individual rights whereas collectivist cultures emphasize selflessness, family, and community. In many Western cultures, there is an overemphasis on the power of the individual. The “pro-ana” internet subculture is the perfect example of this ideal taken to the extreme. By refusing to allow medicine or, more generally, society define their behavior as “abnormal”, the “pro-ana” community reasserts their power to make behavioral choices and define themselves. They are expressing their individualism despite deadly consequences and, in a way, battling death for the sake of their individuality.

Evaluating anorexia as an expression of individualism explains the “distorted form of spirituality” described by many “atypical” anorexics (O’Connor and Van Esterik 6). According to Richard O’Connor and Penny Van Esterik, “Instead of adolescent girls literally dying for looks, we found youthful ascetics--male as well as female--obsessive over virtue not beauty” (6).

These individuals “had an experience of transcendence or grace” despite the fact that their “self-imposed asceticism developed outside established religious institutions” (6). Starvation continued because “their virtuous eating and exercising eventually became addictive” (6). In a society that values independence and uniqueness, the behavior ultimately becomes positively reinforced. There are few things that better demonstrate independence and uniqueness than transcending the boundaries of mortality. Individualistic tendencies of Western societies, therefore, breed societal norms that can lead to anorexia.

Western culture has also conflated virtue and “healthy foods”, making it difficult to separate eating from worthiness as a person. O’Connor and Van Esterik clearly demonstrate this value system when they say:

Witness the popular prejudice whereby fat people, seen as ‘letting themselves go’, are stigmatized as weak or even bad, while slim people perceived as strict with themselves exemplify strength and goodness. Or consider how people readily judge their own eating, speaking of ‘sinning’ with dessert, ‘being good’ with veggies, or ‘confessing’ a late-night binge. (8)

Although O’Connor and Van Esterik’s work was written eleven years ago, these phrases are still commonly used in our society today, especially since diet culture is on the rise. Think about the last time you had a “cheat day” or had a dessert because you “deserved” it. Moralizing food has become part of Western cultural norms, probably as a response to rising obesity rates. However, promoting the ideology that “the good person eat[s] sparingly and nutritiously, exercise[s] regularly, avoid[s] all health risks, and--as a matter of self-respect--keeps[s] a slim and attractive body” is pointing many individuals in the direction of the extreme: starvation (8). Extreme

reactions to the moralization of food are clearly shown by the impact of Western media on Fiji, where rates of eating disorders and related behaviors increased dramatically after seeing thin bodies on television.

Food is not the only commodity that has been moralized by the West; in an age of excess, there is still societal emphasis on reigning in this excess with self-control, discipline, and restraint. Historically, people were concerned with having just enough to survive or live comfortably, but now a large number of Westerners have achieved that standard of “comfort”. What comes next after achieving comfort? Excess. Yet, even in the face of excess, we are still told that we should stay humble to maintain social graces and that we should wait for the next best thing because there will always be something better. Excess creates internal conflict between instant gratification and delayed gratification, which is often applied to food. When there are so many delicious, unhealthy options out there, it becomes hard to make the healthy choice. So, what do people do? They “reward” themselves with the delicious, unhealthy foods after a hard day of “being good” by eating healthy, or they have “cheat days” on their diet plans. Some, however, take restraint to the next level, which often results in anorexia. Resisting “bad foods” until they need a reward becomes resisting all food until something has been accomplished which slowly becomes resisting food until they feel faint or they absolutely need it. When combined and taken to the extreme, individualism, food morals, and restraint breed the cultural conditions that sustain anorexia. These values represent the “culture-bound” principles that make up a culture-bound syndrome.

The word “syndrome” in “culture-bound syndrome” is also more representative of anorexia than “disorder”. According to Jen Kasten, a blogger for the National Center for

Learning Disabilities, “[t]he DSM V defines ‘mental disorder’ as follows: a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (qtd. in Kasten). While the *DSM-V* definition of disorder does include the word “syndrome”, it goes on to say that those with mental disorders have some kind of “disturbance” or “dysfunction” which implies a deviation from normality. Yet, as we have seen, not all anorexics perceive their behavior as an abnormality that negatively impacts their life, but rather an empowering lifestyle choice. In fact, their behavior is completely “normal”, understandable, and highly functional given Western cultural context discussed above. The “disorder” part of “eating disorder”, thus, does not accurately describe all cases of anorexia.

Recategorizing anorexia as a “culture-bound syndrome” would remedy this inaccuracy, especially when considering what a “syndrome” is. According to Dr. Kirtly Parker Jones with the University of Utah:

Syndromes are defined by a group of signs or symptoms. And you may not have to have all of them, but you might have two from one group and one from the other to have a syndrome....And there is no clearly understood process that pulls all the patients together into a group that has a single cause and a defined cure.... Sometimes a syndrome is a bunch of symptoms that we aren't smart enough yet to understand, and the underlying specific disease process and treatment has not been figured out yet. (“What Exactly Are Syndromes?”)

Anorexia is not well-understood by the medical community, just like Dr. Jones says of many other syndromes. Some research has been done into organic causes of eating disorders, particularly with genes known to be associated with appetite regulation, but there is no “anorexia gene” (Dovey 142-143). There are also many environmental factors that could potentially lead to anorexia. For example, individuals appear to be at an increased risk if they come from high-achieving families, but this may be a diagnostic bias since “[h]istorically, practitioners were likely to [incorrectly] diagnose malnourishment in people from lower social economic groups” (Dovey 139). There also appears to be a correlation between the rise of social media and an increase in eating disorders. Yet, there is no unifying cause of anorexia, and, as discussed earlier, there is also no clear treatment path that has a reliable success rate. Anorexia, by Jones’ definition of syndrome, is most definitely a syndrome.

Categorizing anorexia as a syndrome allows for a much more holistic list of symptoms, reducing the number of “atypical” cases. As a syndrome, the symptoms of anorexia could include some of the cultural values that oftentimes lead to anorexia. For example, spiritual transcendence of mortality could be listed in relation to hyper-individualism. Medical comorbidities could also be considered, like lack of menstrual cycle or low bone density, but they would not necessarily hold as much weight for diagnosis. Low weight percentiles could be listed, but could no longer be mandatory for diagnosis, leading to a more inclusive definition of anorexia. Overall, there would be less emphasis on the role of food and weight, which could allow diagnosis and treatment to become more personalized to the individual.

Redefining anorexia as a culture-bound syndrome would allow medicine to grow in its understanding and treatment of anorexia. Rather than simply treating the physical ailments



resulting from malnourishment, medical professionals could move forward towards helping the individual overcome the cultural pressures and values that lead them on that path in the first place. Better treatments could address the individual's concept of morality related to food and their overuse of self-restraint. This new understanding would also make it easier for "atypical" patients to seek help, since they would no longer be excluded because of their weight status or presence of a menstrual cycle in spite of starvation. Until the medical community is better able to understand anorexia, it should be labelled as a "culture-bound syndrome", so that all affected individuals can seek the help they need and see results they need.

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