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The Quantification of Gender: Anorexia Nervosa and Femininity

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Abstract

The ways in which Anorexia Nervosa (AN) has been described and explained has differed drastically over time although since it was first named in 1874 it has been primarily associated with women and girls it is argued in this paper that it came to be more fundamentally associated with femininity due to certain disciplinary changes in the psy sciences. The influential psychiatrist Hilde Bruch lamented the loss in clarity of the clinical picture that was the result of psychoanalytic interpretations, to remedy this she reformulated AN into a pathology that was the result of the individual being too determined by external influences. Bruch's changes increased the emphasis that psychiatrists placed on the relationship between women and their social context and the lack of individual autonomy that many felt. Feminist writers adapted Bruch's theory to suggest that patriarchal culture was colonizing the lives of women and that social rather than individual change needed to occur. Psychiatrists subsequently developed scales for assessing gender identity which switched the emphasis back onto individuals and rendered gender as an individualised, quantifiable, manipulable object. When reified and individualised in this fashion it became more legitimate to discuss femininity as causative of, and masculinity as a protection against, AN.

Keywords: Anorexia Nervosa, gender, psychiatry, objectification, gender identity scales, masculinity

The Quantification of Gender: Anorexia Nervosa and Femininity

Introduction

This paper is part of a larger project of writing a genealogy of Male Anorexia Nervosa (MAN), although the focus here is on Anorexia Nervosa (AN). Formulations of AN in the psy sciences¹, which are analysed here, are seen as a contribution towards the construction of the modern self by revealing human subjectivity in certain ways with implications for how people should be governed and how they should govern themselves.

The “discovery” and naming of AN will be briefly discussed and the differences between the initial clinical picture and that later developed by Hilde Bruch will be outlined. The feminist response to Bruch’s approach will be outlined focusing on how they made the individualising and victim blaming tendencies of the accepted clinical picture harder to maintain. The subsequent development of gender identity scales will be framed as a reaction by the psy sciences to the challenge from feminists and the anti-psychiatry movement. Gender identity scales, although initially developed in the 1930s, did not come into wide usage until the 1970s when they provided psychiatrists with a way of studying gender quantitatively and thereby seemingly sidestepping political considerations. The subjective, qualitative notion of gender thus came to be considered as an objective, quantitative phenomenon. When applied to AN gender identity scales accentuated an existing tendency towards perceiving femininity as causative of the condition. The seemingly objective data of the scales strengthened the relationship between femininity and AN and helped to position masculinity as a protective agent with femininity as a risk factor.

The Discovery of Anorexia Nervosa

AN was named and given an extensive clinical picture by William Gull in 1874. Gull was a physician and approached his conceptualisation in a manner appropriate for his profession; he observed the symptoms of emaciation and could not find any biological aetiology so deduced that it must be a mental disorder (Gull, 1894: 310-311). In the early twentieth century AN was diagnosed rarely and attracted limited scientific or academic interest with Gull’s conceptualisation remaining dominant until psychoanalysis grew in stature and it was reconfigured as a psychosomatic disorder. From 1940 to 1960 the psychoanalytic model of AN reigned, this was built on the notion that it was the result of phantasies² usually of oral impregnation (Lorand, 1941; Waller, Kaufmann & Deutsch, 1940). Psychoanalysts

¹ The phrase “psy sciences” is used here to refer to all of the disciplines that deal with the psyche such as psychiatry, psychoanalysis and psychology.

² Phantasy spelled with ‘ph’ is distinguished from that spelled with an ‘f’ as it always refers to an unconscious phenomenon and is not oppositional to reality but rather a permanent accompaniment to it (Akhtar 2009: 209). Fantasy is more commonly used to refer to something akin to a daydream. Usage is, however, inconsistent although ‘ph’ is usually used in the British context (Hayman 1989). The usage of the sources in this paper seems to be consistent with the description given in this note.

interpreted such phantasies in an oedipal manner and helped to produce a new relation between feminine sexuality and self-starvation while simultaneously making the clinical picture more complex and less standardised.

Hilde Bruch, probably the most influential writer on AN in the twentieth century, mourned the loss of clarity in the clinical picture of AN since psychoanalysis had taken hold (Bruch, 1962: 287). In order to regain some of the clarity of Gull's clinical picture Bruch proposed some persistent observable characteristics that occurred in AN patients, as behaviourists such as Watson (1913; 1970 [1924]) had been calling for since the early twentieth century. The move towards observable phenomena rather than the somewhat subjective and amorphous interpretation of psychoanalysis was gaining momentum across psychiatry in the 1960s (Horwitz, 2002) and would be codified into the "Feighner criteria" in 1972 (Feighner et al., 1972) and subsequently institutionalised with the introduction of the DSM III in 1980 (American Psychiatric Association, 1980). Specifically, Bruch reformulated the picture of AN as a relation between inside (psyche) and outside (society/culture) with the two in conflict. For Bruch, AN, and eating disorders in general, occurred in an individual who was 'deficient in his sense of separateness with diffuse ego boundaries, and will feel helpless under the influence of external forces' (Bruch, 1973: 56). Too much external influences was a theme latent in psychoanalytic accounts but was here reformulated from dependence on the family to dependence on social institutions and cultural products such as media texts.

Crucially for Bruch the neuroses are derived from the mother's failure to recognise and confirm the child's expression of independent needs which results in inner confusion manifest in perceptual and conceptual disturbance (Silverman, 1997: 4). The individual constantly judges themselves against external standards and has little ability to judge themselves on their own terms, body image disturbance is thus the result of taking on the cultural message that it is good to be thin and to be dieting but not balancing this with messages from their own body or senses that tell them that their body is too thin. The core of the pathology according to Bruch is, therefore, a weakening of individual autonomy in relation to socio-cultural influences, which is the result of deficiencies in the mother's parenting technique. The clinical picture developed by Bruch is profoundly gendered not just because the blame for the development of such characteristics is placed on the mother but because the latter have traditionally been associated with femininity. Saukko (1999: 42) proposed that Bruch's theory can be gathered around a set of binaries notably; autonomous/dependent, modern/traditional, genuine/artificial, austerity/frivolity, public/private with the former in each pairing considered to be positive and masculine and the latter negative and feminine. Classically, self-definition, autonomy and an objective outlook have been associated with masculinity, which has been related to solid boundaries of the self as opposed to the porous boundaries associated with femininity (Pronger, 1998; Thomas, 2002; Vincent, 2006). Similarly, the lack of objectivity which Bruch identified as part of the pathology of AN has long been culturally associated with femininity.

The Feminist Response

Bruch's position quickly became the standard way of conceptualising AN and coincided with the perceived rise in cases of AN (see Hof & Nicolson, 1996 for a critique of this increase) and with second wave feminism which quickly took an interest in AN. Feminists working in the psy sciences used Bruch's approach to AN but emphasised the relation between the psychological characteristics associated with AN and those expected of women generally in contemporary Western societies and dropped the blaming of the mother, although the relationship between child and mother remained crucial. Orbach, who was at the forefront of this movement, stated that:

The psychological requirements of successful femininity for the adult women today include three basic demands. The first is that she must defer to others; the second is that she must anticipate and meet the needs of others; and the third is that she must seek self-definition through connection with another (Orbach, 1985: 84).

It is clear that Orbach's formulation of the psychological basis for AN is similar to Bruch's. For Bruch, as for Orbach (1985: 7) '[...]the self-starvation in anorexia represents a struggle for autonomy, competence, control and self-respect'. Some feminist writers, such as Chernin (1986), saw a familial tension in the form of the daughter desiring to, but feeling guilty about, transcending the mother so some so AN was a way of recapturing the mother-daughter social bond through dependence.

AN came to be more closely associated with femininity and related problems rather than phantasies of oral impregnation or fear of taking on an adult role, it developed into a relation between contemporary experience, and social expectations of femininity. Traditional notions of femininity were not seen to be problematic in themselves only when they came into tension with new, more liberated ideas of what it meant to be a woman. For Orbach (1978), the dominant cultural values, primarily transmitted by the media, provided an ideal femininity defined by consumption, sexual attractiveness, pleasing men, etc. She simultaneously saw AN as a protest against this consumption although one that was defined in terms of those same media texts that valorise thinness and position it as indicative of control and power.

Orbach's (1978; 1986) broader critique has proven to be highly influential but more theoretically sophisticated critiques have developed that took some elements of Orbach's analysis and often combined it with a Foucauldian approach. The notion of the anorexic being unable, or unwilling, to resist the influence of certain damaging aspects of culture has nevertheless remained at the centre of feminist accounts and debates (Blood, 2005; Bordo, 2001; 2009; Gremillion, 1992; 2003; Guilfoyle, 2009; Lester, 1997; Malson, 2009; Saukko, 2000; 2009). There is not space in this article to fully explore this literature³, but, what is important to take from these accounts for the purposes of this paper is the way in which they took Bruch's position and subverted it. The feminist accounts retained the notion of a tension between individual and social/cultural forces but rather than placing the onus on the individual to be stronger, which nevertheless they would present as being important, they focused on changing social institutions, structures and processes. The feminists who wrote on

³ The epistemological significance of these debates will be explored by the author in a forthcoming paper.

AN, along with their counterparts who critiqued psychiatry generally, and those involved in the anti-psychiatry movement, made it difficult for the victim-blaming of individual women to continue; the rest of society had to take some responsibility. Psychiatrists had to deal with the feminist critique and some elements of it were incorporated into the psychiatric picture but it was, however, dangerous to the legitimacy of the psy disciplines, as commenting on society is not strictly within their remit. Psychiatrists may, therefore, have had their claims to defining AN undermined as, logically, social scientists may be more qualified to conceptualise it as a socially produced phenomenon. It is argued below that psychiatry adapted to the changes brought on by Bruch and the feminists through refocusing on to the individual, one way in which this was achieved was through the use of masculinity-femininity scales.

Gender Identity Scales

As discussed above AN came to be seen as a condition which was the result of a lack of individuation and autonomy by mainstream psychiatry and some feminists. There was a growing theoretical consensus that some relation between AN and femininity existed and this led to psychiatrists looking for experimental proof, most significantly by investigating correlations between gendered personality traits and incidence of AN or a related pathology. Rather than concentrating on the social and cultural forces that may be driving some women and girls to self-starvation many psychiatrists translated the perceived lack of autonomy and individuation that Bruch discussed into more psychiatric terms, namely that such individuals demonstrated high levels of adherence to personality traits associated with femininity. Gender identity scales gave psychiatrists a way of transforming the complex, dynamic, processual phenomenon of gender into a static, individualised, quantifiable one which in turn enabled femininity to be positioned as a risk factor in the development of AN.

It was thought by early pioneers of the psychology of gender, Terman and Miles, that it would be possible to quantify gender in a similar fashion to Binet's intelligence scale, this was to be done by 'accumulating test items on which males and females differed' (Morawski, 1992: 207). As a sociologist any such scale is immediately problematic as they reduce complex, dynamic, processual phenomena into static characteristics that seemingly exist within an individual. The process of producing gender scales 'consists of continued indexicality of constructs[...] The process in turn engenders objectification and ossification of the constructs' (Morawski, 1992: 216) with the traits associated with each gender seemingly fixed and reified:

The masculinity-femininity theorists, purportedly by detaching their conceptual work from social life, have tacitly defined normative objectives by way of reference to an idea of society and individual behavior within that society[...]The implicit objectives of the androgyny theorists mirror the virtues of corporate democracy where self-contained individualism and role flexibility (behavioural inconsistency) are desired (Morawski 1992: 217).

Early gender scales, such as the Attitude Interest Analysis Test (Terman & Miles, 1936) and the Masculinity-Femininity subscale of the Strong Vocational Interest Blank (Strong, 1936), tended to characterise masculinity and femininity as mutually exclusive, such scales were not

employed in investigations of AN, however, as the relation between femininity and AN was not strongly proposed until after Bruch's key writings in the 1960s and the first feminist writings on AN.

By the mid-1970s Constantinople (1973) and Bem (1974; 1976) had instigated something of a revolution in the use of gender scales. Inspired by feminist concerns they saw existing scales as tending towards aligning masculinity with psychological well-being and falsely presented gendered traits as mutually exclusive. Instead, Bem produced the Bem Sex Role Inventory (BSRI), which allowed for masculine and feminine traits to be present in an individual. Bem developed research tools which construed gender identity as existing on a sliding scale, rather than as oppositional, essential qualities. Her work was consistent with a wider political project among feminist writers who sought to de-conflate gender and sex (Gatens, 1996: 3-5). Androgyny tended to be seen as more positive for self-identity (Block, 1973; Spence, Helmreich & Stapp, 1975) than femininity and was certainly seen as a positive route to a liberated sexual identity by Bem (1976) as it undermined the notion that the characteristics often displayed by women were themselves pathological. Mednick (1978: 86) stressed the social-psychological approach of this movement in that they rejected the primacy of intrapsychic variables in favour of critiquing social institutions.

Bem developed the BSRI based on an inventory of characteristics that were judged to be desirable for a man or woman in American society. Although, it was differentiated from previous scales as it was 'designed to measure the extent to which a person divorces himself from those characteristics that might be considered more "appropriate" for the opposite sex' (Bem, 1974: 156). Rather than merely judging to what extent people conform to one set of characteristics or the other, gender identity is judged relationally. True to the political project outlined by Mednick (1978), Bem's scale is situated within a relational context and is born of critiques of the essentialism, and assumed universality, of gendered characteristics in previous masculinity-femininity scales such as the one used in the California Psychological Inventory. Other similar scales were developed around the same time as Bem's such as the Personal Attributes Questionnaire, through which it was acknowledged that it only assesses socially desirable masculine traits so it was later redesigned to include socially undesirable ones as well (Spence et al., 1975). When this trait approach was applied to AN such nuances would not be evident.

Gender Identity Scales and AN

Various gender identity scales have been used in studies of AN with the BSRI being perhaps the most popular. While androgyny research can be seen as progressive and potentially liberating as it does not posit gendered characteristics to be mutually exclusive and attempts to position androgyny, rather than masculinity, as psychologically healthy. Androgyny scales have, however, retained the categorical constructs of femininity and masculinity and the cultural values associated with them. Crucially, a feminist psychologist, Boskind-Lodahl (1976), first proposed that there may be a correlation between feminine personality traits and eating disorders although she did not seek to establish this in an empirical fashion. Many writers from across disciplines have suggested that there are connections between femininity and AN but as argued below this is done in a particularly

individualising and objectifying fashion by some psychologists and psychiatrists through the use of gender identity scales. Moreover, the use of such scales had facilitated the positioning of femininity as a risk factor in the development of AN.

Particularly since the early 1980s psychiatrists have investigated connections between gender identity and eating disorders with varying results. Hospers and Jansen (2005) found higher levels of body dissatisfaction in men who identified as homosexual and who had lower levels of masculinity as judged by the BSRI. Higher levels of body satisfaction were reported by adult men and women who were deemed to have higher levels of masculinity according to the Multidimensional Body-Self Relations Questionnaire in a study by Wilcox (1997). Higher levels of femininity, on the BSRI, were identified as a risk factor for the development of eating disorders, as judged by the Eating Attitudes Test, and masculinity as a protective factor in Meyer, Blisset and Oldfield's study (2001). A study by Hepp, Spindler, and Milos (2005) did not find a correlation between femininity and the core eating disorder symptomatology but did between femininity and 'lower levels of unspecific psychopathological symptoms related to ED' (Hepp et al, 2005: 230). As with other studies (Lancelot & Kaslow, 1994; Murnen & Smolak 1997), Hepp et al (2005) did, however, find a correlation between higher levels of masculinity and lower levels of ED symptoms.

There is no consensus but most studies have found that either low levels of masculinity or high levels of femininity, and sometimes both, are related to eating disorders. A meta-analysis of twenty-two studies published between 1981 and 1990 showed that 'eating-disordered women reported higher levels of femininity' (Murnen and Smolak, 1997: 237) and that 'Those diagnosed with AN were likely to score higher on the gender role endorsement measures compared to control groups' (Murnen & Smolak, 1997: 238). Also, 'Nineteen of these studies indicated...eating disordered people had lower masculinity scores than did controls' (Murnen & Smolak, 1997: 238). The authors, however, note that there was significant heterogeneity between studies and that conceptual tools in the studies they analysed were far from consistent. The relationship tends to be more pronounced when the studies differentiate between AN and BN (e.g. Murnen & Smolak, 1997) as often BN is presented as having some relation to masculinity or androgyny. Paxton and Sculthorpe (1991) used the Personal Description Questionnaire (PDQ), which differentiates between 'positive' and 'negative' gendered characteristics and they found a relationship between high levels of eating disordered behaviour and femininity, particularly 'negative' femininity. They therefore concluded that 'women with disordered eating may oversubscribe to negative rather than positive feminine sex role characteristics' (Paxton & Sculthorpe, 1991: 589).

Similarly, Martz, Handley & Eisler (1995) proposed that BSRI and similar scales were inappropriate in their lack of differentiation between positive and negative gendered characteristics so used the Feminine Gender Role Stress Scale (FGRS scale). The FGRS, initially developed by Gillespie and Eisler (1992), measures the:

cognitive tendency among women to appraise specific situations as highly stressful because of commitments, beliefs, and values that are a result of rigid adherence to the traditional feminine gender role (Martz et al., 1995: 495).

Martz et al found a correlation between ‘feminine gender role stress’ and EDs so proposed that:

a rigid commitment to fulfilling imperatives of the feminine gender role, such as the focus on one’s physical attractiveness and a need for approval by others, creates significant stress and explains why more women than men manifest eating disorders (Martz et al., 1995: 494).

Although there has been much debate and disagreement regarding the relation between femininity and AN many psychiatrists have clung to the notion that there is some relation between the two.

For the purposes of this paper the veracity of the results is less interesting than the repeated attempts to discover a relationship and the enframing of gender as a quantifiable and manipulable substance that exists within individuals and can potentially increase susceptibility towards, or protection from, the development of eating disorders, particularly AN. I argue that attempts to quantify gender in such a manner are indicative of a broader issue; that gender has increasingly come to be seen as something that can exist to a greater or lesser extent within an individual. Approaches to gender identity seen above have little sense of the dynamic, processual, social character of gender and gender relations. It has become increasingly possible, therefore to speak of women or men being more feminine and that this is potentially dangerous for their mental health.

I argue that gender identity scales are a particularly seductive method of analysing gender that, despite Bem’s and other’s efforts, maintains an individualised focus. Gender, a dynamic, processual, social phenomenon is rendered static, and individual. Although the androgyny scales allow for an individual to be perceived as possessing traits of either gender, the traits themselves are still gendered. The scales render gender calculable and comparable and allow disparate individuals to be compared and ranked. Such scales reveal gender as a cumulative force that can be increased or decreased within an individual. As Nikolas Rose asserted:

One of the major contributions of the psychological sciences to our modernity has been the invention of techniques that make individual differences and capacities visible through devising means whereby they can become inscribed or noted in legible forms. The routine inscription of personal capacities into documentation enables the individual to become simultaneously calculable [...] and practicable (Rose, 1999: 19).

Gender scales have not unearthed the true form of gender as it exists in individuals but have reformulated how gender has been understood and produced means by which it can be manipulated. Femininity and masculinity can, therefore, be perceived within an individual and accumulated within a population which can be governed in relation to gender.

The developments charted above, with the move from psychoanalytic understandings, to Bruch’s psychodynamics, moved gender into a more central role in how AN was understood. The innovations of Bem and others in developing gender scales reproduced gender as a manipulable quantity within individuals, calculable differences in femininity and masculinity thereby became visible within individuals, it thus became feasible to propose that gender could be a causative, or protective, factor in the development of AN. Some psychiatrists have, therefore suggested that the anorexic woman ‘had failed to incorporate those traditionally

“masculine” traits...that are now particularly essential for optimal functioning by a woman in Western society’ (Sitnick & Katz 1984: 82). Following this logic the authors suggested treatment would be ‘related to facilitating the development of such “masculine” traits...[as]...assertiveness, perseverance, self-confidence, and independence’ (Sitnick & Katz 1984: 86). As gender came to be perceived as a quantity that an individual can possess in varying quantities it became increasingly convincing to speak of femininity as to some extent causing AN and of masculinity as protecting against it.

Masculinity as protection against AN

The much lower incidence of AN in men and boys has strengthened the proposition that there is something fundamental about femininity that produces AN. The relation between femininity and AN has been so strong that some psychiatrists have denied that it can occur in males because of the insistence on amenorrhea for diagnosis (Cobb, 1943; Kidd & Wood, 1966; Nemiah, 1950), its atypical psychopathology (Selvini 1964) or claims that anorexia in males is always a result of schizophrenia (Korkina et al cited in Svec, 1987). The debate over the existence of primary MAN seems to have disappeared, however, around the same time that amenorrhea was dropped as an essential diagnostic criterion from AN. The dissenters were largely silenced with Feighner’s et al’s (1972) definition that shifted amenorrhea to a secondary criteria as a manifestation of an endocrinological disorder that can be manifest in men as a lack of sex drive.

Despite the acceptance of the existence of MAN it is still considered to be somehow synonymous with femininity; something out of the ordinary has to occur to a man to make him anorexic, often it is claimed that the pathology is more severe (Bramon-Bosch, Troop & Treasure, 2000; Fichter, Daser & Postpischil, 1985; Hebebrand et al., 2003; Nicolle, 1938). Just as male hysteria was initially ‘discovered’ in men who had been exposed to the traumas of industrial accidents or ‘shell shock’ (Link-Heer, 1990), men must become feminized in order to become anorexic. Probably the most persistently cited link is between MAN and homosexuality the emergence of which is seen as the significant and traumatic event that is required as the catalyst for men to develop AN. Just as femininity is presented as being consistent with AN so various forms of “abnormal” sexuality are seen to be consistent with MAN.

MAN patients are often characterised as having little to no libido and, perhaps more importantly, that this is met with indifference or relief (Crisp & Burns, 1983; Lindblad, Lindberg & Hjern, 2006; Muise, Stein, & Arbess, 2003; Ronch, 1985). Male sexuality is often defined by action as opposed to passive femininity in the sex act itself but also, as Martin (1990: 75-76) demonstrated, physiology text books, through their descriptive language, represent the everyday process of menstruation as failed production and male reproductive physiology as remarkable. The norm of female reproduction is failure, so reproductive failure for a man is, to some extent, feminine, the emphasis placed on successful male sexual performance for defining masculinity Martin suggests, is inspired by that very capitalistic fear of lack of production (Martin, 1990: 75).

Sexual passivity has historically been characterised as feminine. Freud claimed that the female's juvenile libido is 'due, in part, to females' sexual passivity; they tend to channel their libidinal energies towards enticing men at the expense of their own full sexual expression' (Gremillion, 1992: 61). As sexual passivity is seen as feminine and due to attempts to attract men it is conceptually fitting that this is linked with homosexuality. Many writers report homosexuality in MAN patients (Bramon-Bosch et al., 2000; Carlat, Camargo, Herzog, & Herzog, 1997; Fichter et al., 1985; Hepp, Milos, & Braun-Scharm, 2004; Muise et al., 2003), although others do not (Hall, Delahunt, & Ellis, 1985). Some report asexuality which is usually perceived as being the result of conflicts or guilt over sexual orientation (Crisp & Burns, 1983; Muise et al., 2003). Homosexuality is presented as an important part of the male pathology but is almost entirely absent from the female; this disjunction does not seem to harm the increasing claims for a common pathology across the sexes, if anything it strengthens such claims. This would seem to be because it is not the lack of sexual activity in females and males or the homosexuality per se that is seen as constructive of the pathology, but the feminisation of people of both sexes.

As femininity is seen as productive of AN, masculinity has been associated with protection against it. Elements of culture deemed to be masculine, such as team sports, have been proposed as a protection against the development of body image disturbance leading to eating disorders:

The socialization of a team activity reinforces an outside source of acceptance of one's body. This may create a psychological prophylaxis against the distorted body image of anorexia nervosa. Female sports traditionally were solo athletic activities with little physical contact and an emphasis on one's appearance or grace. The women involved in team sports may have a body image like those found in men (Halperin, 1996: 165). Similarly, a focus group study has seemingly demonstrated that media influence, often seen as a prime suspect in the production of body image problems in women, has less of an impact on boys:

Boys use media images to gain information about current fashions, but said that they do not compare their body with muscular celebrities and models. Thus, based on growing evidence from both qualitative and quantitative research (Jones et al., 2004; Ricciardelli & McCabe, 2001, 2003), the mass media appears less influential in the development of body image for boys than girls[...]Unlike girls, who grow farther away from their thin ideal during adolescence, boys experience their pubertal changes in appearance as favourable, perhaps helping buffer them against body dissatisfaction (Hargreaves & Tiggemann, 2006: 573).

Masculine roles are again presented as a kind of prophylactic against the development of body image concerns. Boys are presented as being resistant to mass media influence, from their own reports; this of course does not mean that they necessarily are but rather that they consider themselves to be. They are likely to present themselves in this way as may be aware that to be influenced by the media is generally associated with femininity. The above study is complemented by others that suggest gay men are, like women, self-objectifying thus resulting in higher levels of body dissatisfaction (Martins, Tiggemann & Kirkbride, 2007).

Many have claimed that AN is spreading through populations as an epidemic (Gordon, 2000) as dangerous aspects of cultural femininity were increasingly transmitted through TV (Becker et al., 2002), magazines (for a review and critique see Bray, 1996), and female dominated spaces such as ballet schools and girls' schools (Brumberg, 1997). The notion that feminine culture is somehow productive of AN and can spread in an epidemic fashion is significantly different to the early psychoanalytic notion that merely proposed that AN was simply less common in men. AN is, then, presented as occurring in an individual who is too open to external influence, particularly from feminine culture, because they have not developed the requisite individual autonomy. These notions seem to reproduce the masculinist approach to psychiatry that has long been criticised for devaluing the interpassivity seen to be characteristic of feminine relationships in favour of the individuality and autonomy long associated with masculinity. The gender identity scales described above are a powerful tool for identifying the supposedly psychologically dangerous feminine traits in individuals but obscure the relational character of gender and eating disorders.

Conclusion

Gender was initially of significance to nineteenth physicians who had an interest in AN, such as Gull, largely because it occurred more in women. The revolution in interpretation that occurred with the expansion of psychoanalytic techniques into the mainstream of the psy sciences fundamentally reformulated the object of analysis but also made it more complex and opaque. In order to regain some clarity in the clinical picture Bruch situated AN in the relations between individuals and their society and concentrated on observable symptoms that denoted a perceptual disorder. Bruch's intervention facilitated feminist critiques which inverted her individualising theory to place the emphasis on the damaging effects of social and cultural forces. The feminist critique was potentially destabilising to the psy sciences as it demonstrated the cultural production of anorexic behaviour. The psychiatrists were able to combat the critique and regain their authority to define AN through the use of gender identity scales. These scales rendered the amorphous notion of gender as an observable, quantifiable, "thing" that can be intervened upon by the expert psychiatrist to improve psychological functioning. Moreover, gender identity is revealed to the individual and enables them to take it as an object as seen through the normalising lens of psychiatry. Femininity, thus, came to be positioned as a risk factor in the development of AN with masculinity as a protection.

Gender Identity scales came to form part of a seemingly more solid base for the diagnosis of AN by providing gender quotients in different forms which could be attached to particular individuals. The development of AN by a particular individual could then be attributed to the possession of a certain quotient of gender identity thereby sidestepping the earlier feminist critiques which proposed some psychiatric approaches were individualising and victim blaming. It would, therefore, no longer be proposed that AN was the result of the deficiencies of a particular individual, rather they would be considered to be too feminine. By breaking femininity down into what are perceived to be its constituent parts the extent to which femininity is aligned with pathology is obscured yet this aspect of the psychiatric approach is retained.

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