

THE THIN IDEAL, DEPRESSION AND EATING DISORDERS IN WOMEN

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Summary—It is proposed that a cultural ideal of thinness for women causes depression at a higher rate among women than among men. This model accounts for five currently unintegrated trends in the epidemiology of depression. It explains why: (1) twice as many women as men are likely to be depressed; (2) this sex difference emerges at puberty; (3) this sex difference is only found in western countries; (4) there is more depression today; (5) the average age of onset for depression is younger now than in the past. Four parallel trends in eating disorders can also be accounted for by the same factor.

This paper proposes that a cultural ideal of thinness for women, which is well below the average weight of women in that culture, directly causes body dissatisfaction at a higher rate among women than men. In turn, body dissatisfaction, coupled with the importance women attach to their weight (Rozin and Fallon, 1988), leads to depression among women. Since such a stringent cultural standard does not exist for men and since men do not attach such significance to being overweight (Rozin and Fallon, 1988), this model predicts a higher incidence of depression in women.

This hypothesis can, in part, account for five unintegrated trends in the epidemiology of depression: (1) depression is more prevalent in women than in men; the female to male ratio is typically reported as 2:1 (Nolen-Hoeksema, 1987); (2) this sex ratio first appears at puberty; before puberty depression is twice as common in boys, after puberty it is twice as common in girls (Rutter *et al.*, 1986); (3) this sex ratio is only reported in western societies; it is not reported in rural, non-modern societies (Nolen-Hoeksema, 1987); (4) the rate of depression has been increasing, especially among young females (Klerman, 1988); (5) the age of onset for depression is younger in the present generation than for older generations (Klerman, 1988).

Four of these trends are parallel to trends in eating disorders: (1) the majority (95%) of eating disorder patients are female (DSM III R, 1987); (2) eating disorders emerge at puberty (DSM III R, 1987); (3) eating disorders are present in western countries and absent in non-western countries (Garner and Garfinkel, 1980); (4) the incidence of eating disorders has risen over the past 20 yr (Silverstein *et al.*, 1986).

The similarity between the epidemiology of depression and that of eating disorders may not be a coincidence. One factor which may contribute strongly to both is women's pursuit of thinness. The model presented in this paper incorporates the view that eating pathology occurs as a result of, and as a strategy to deal with, depression and it therefore predicts the above trends.

THE MODEL: WHY WOMEN ARE MORE DEPRESSED THAN MEN AND WHY THE MAJORITY OF EATING DISORDER PATIENTS ARE FEMALE

Women, having a very finely tuned idea about what is an acceptable body, rapidly internalize the current standard of female beauty. In western cultures women, especially those in the higher socioeconomic classes, try to emulate the standard of beauty presented in the fashion media (Streigel-Moore *et al.*, 1986). This standard, which has become increasingly thin recently (Silverstein *et al.*, 1986) I will call the 'thin ideal'.

In a culture that idealizes a standard of thinness that is well below the weight of the average woman (Garner *et al.*, 1985) it is not surprising that women typically believe that they are heavier than the ideal and heavier than what is most attractive to the opposite sex (Fallon and Rozin, 1985). Middle-aged men and young and middle-aged women see discrepancies between their own weight and the ideal but only women deem this important (Rozin and Fallon, 1988). Since it has been

suggested that women's self-esteem is more closely tied to their appearance than is that of men (Davies and Furnham, 1986) and that being overweight has more negative consequences for women (Stake and Lauer, 1987), this is again not surprising.

Given these two conditions, (1) a cultural ideal of hard-to-achieve thinness for women and (2) a perceived discrepancy between women's actual weight and this ideal, it is hypothesized that women will be more dissatisfied with their bodies than men. When this is combined with the belief that this discrepancy is important, it is hypothesized that women will become depressed at a higher rate than men.

There are two possible ways by which depression may result. First, body dissatisfaction itself, coupled with the belief that it is important, may place women at risk for depression. It may be that a woman's constant disparaging view of her own attractiveness to the opposite sex creates negative thoughts about herself and her prospects, and lowers her self-esteem. For Beck (1973) depression stems from a negative view of the self, the future, and the world. This is the negative triad. A negative view of one's body, coupled with the view that a thin body is crucial to one's present and future is a recipe for depression.

The second way is via dieting. For many women in western cultures body dissatisfaction and a belief in the prize of thinness inevitably produces dieting. There are many more dieting articles written for women than for men and there are many more women than men dieting at any one time (Fallon and Rozin, 1985; Herman and Polivy, 1975; Nylander, 1971; Rodin *et al.*, 1984; Streigel-Moore *et al.*, 1986). Dieting, however, is not a good method of weight reduction for many people. Although some may initially lose weight when dieting, few maintain the lower weight (Brownell and Jeffery, 1987). One reason is that physiological regulatory mechanisms work against weight loss. Ironically, many dieters end up fatter because of the persistent after-effects of the bodily defenses which endeavour to keep weight stable (Brownell, 1988; Brownell, Greenwood, Stellar and Shrager 1986; Brownell, Nelson Steen and Wilmore, 1987; Streigel-Moore *et al.*, 1986). This suggests that there are a large number of women who are constantly failing to achieve an important goal.

In western culture we believe that weight is controllable (Polivy and Herman, 1983). It is not clear that this is wholly true. This model proposes that women who are dissatisfied with their bodies, who believe that they should be able to control this aspect of their life, experience a profound lack of control in an area that is important to them. Their self-esteem when they fail on their diets or regain lost weight. These women will be at risk for depression via helplessness.

According to the learned helplessness model of depression (Seligman, 1975), the experience of a lack of control and the expectation of future uncontrollability is sufficient for the onset of depression. The model presented here suggests that the uncontrollability associated with failed dieting produces these effects. Thus, the women who experience constant failure and uncontrollability in their dieting will be prone to depression. Empirical evidence supports this hypothesis. Generalized feelings of failure are significantly related to dieting and concern with weight (Kagan and Squires, 1983), and repeat dieters report lower self-esteem than do non-dieters (Dykens and Gerrard, 1986). Further, many depressed view their own bodies negatively (Rierdan, Koff and Stubbs, 1987, 1988) and often turn to food to assuage their depression (Polivy and Herman, 1983). This may create a cycle of body dissatisfaction, dieting, depression *ad infinitum*.

The model outlined above is represented in Fig. 1.

Having presented the model, three caveats, however, are in order. First, this model proposes that the thin ideal is one causal factor which may explain why women are more depressed than men. It is not presented as the only factor. It remains for future research to determine how much of the variance this factor accounts for. Second, most of the data presented in this paper to support the hypothesis is correlational. While I recognize that causality cannot be determined from such data, the model does predict these correlations. Longitudinal studies which would test the model are suggested later in the paper. Finally, this paper does not distinguish between studies that concern symptoms of depression and those that concern the syndrome of depression. It also does not enter into the debate as to whether or not clinical depression is discontinuous with the milder forms. The model simply argues that one factor contributes to women's proclivity to become depressed, that is, the wish to be thin.

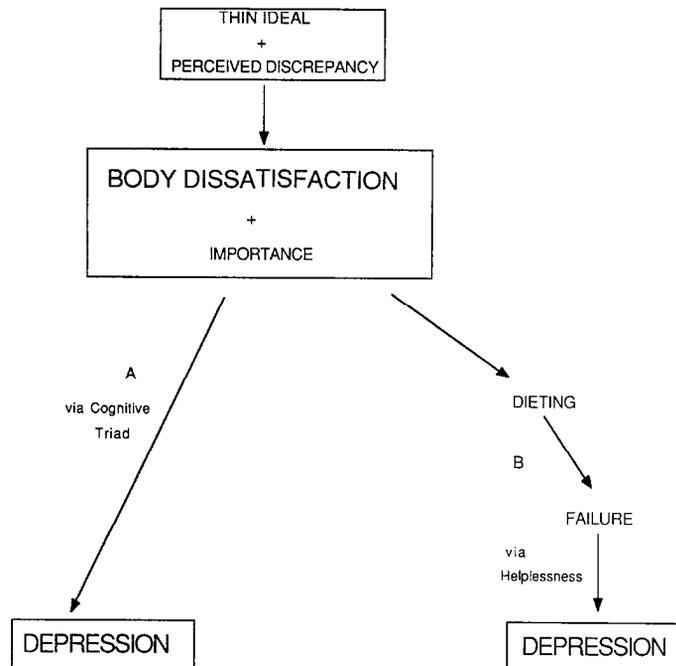


Fig. 1. The model.

EATING DISORDERS AND THE THIN IDEAL

Depression in women may set the scene for the onset of eating disorders. The unrealistically thin ideal may make it more likely that a small minority of depressed women will develop an eating disorder as a result of, and in an attempt to combat, their depression.

It has been argued that those adolescent girls who develop an eating disorder have internalized the thin ideal to a greater extent than other girls prior to the onset of the pathology (Scott, 1987; Streigel-Moore *et al.*, 1986). This may be a result of 2 factors: (1) their all-pervasive low self-esteem, lack of autonomy and feelings of ineffectiveness and inadequacy (Slade and Dewey, 1985; Streigel-Moore *et al.*, 1986); and (2) their high need for social approval (Squires and Kagan, 1985). This greater internalization of the thin ideal in the pre-anorexic suggests that she would have felt more dissatisfied about her body than most adolescent girls. While there are presently no studies of body dissatisfaction and importance of appearance prior to the onset of the eating pathology, studies of body satisfaction among anorexics and bulimics have reported that both eating disorder groups are more dissatisfied with their bodies and overestimate their body size more than controls (Collins, Beumont, Touyz, Krass, Thompson and Philips, 1987). It has also been reported that eating pathology is associated with a greater emphasis on the importance of appearance (Timko, Streigel-Moore, Silberstein and Rodin, 1987).

Given both a greater dissatisfaction with their bodies and an increase in the importance they attach to how they look, it is predicted that those girls who go on to develop an eating disorder would have been more depressed prior to the onset of the disorder than other girls. Again, while this hypothesis has not been directly tested there is ample evidence to suggest that there is a relationship between eating disorders and depression (e.g. Herzog, 1984; Walsh, Roose, Glassman and Sadik, 1985). Some studies have reported that episodes of depression precede the onset of the eating disorder and that the pathology is used to combat depression (Strober and Katz, 1987; Szmukler, 1987).

How would the development of an eating disorder combat depression? If we accept that a negative view of the self and low self esteem lead to depression then depression should be alleviated once the person feels better about herself. Anorexia does at least provide weight loss. Initially this may be sufficient to make the anorexic like her appearance more and to increase her self-esteem (Slade, 1982). If we accept the argument that failed dieting leads to depression through a failure to control something that should be controllable, finding a different way to succeed in exerting

control in that area should break up the helplessness and loss of control experienced. It also should thereby remove the depression.

One major theory of anorexia and bulimia can be interpreted along these lines and can be extended to incorporate the thin ideal as a causal factor (Slade, 1982). In brief, this theory argues that there are a number of risk factors for eating pathology. One risk factor is a "general dissatisfaction with life and the self" (Slade, 1982, p. 169). This factor resembles depression. I suggest that it may arise because the pre-anorexic has more strongly internalized the thin ideal and has therefore a greater dissatisfaction with her own body. She also may place greater importance on her appearance than other girls. According to the model presented earlier depression would likely occur either directly from her dissatisfaction with her body or from repeated dieting and constant failure to lose weight.

This first factor, dissatisfaction, combines with a tendency for perfectionism according to Slade (1982). This results in a need for complete control over some aspect of life. Control over the body by means of dieting follows (Slade, 1982). If the dieting is successful it will eventually spiral into full-blown anorexia and in some instances progress to bulimia (Slade, 1982). Slade does not address the issue of why this diet works when others have not. I suggest that when all of the above factors are operating, the diet is now entered into as a decision to stop eating altogether as opposed to merely cutting down on calories or eating less. It is a conscious decision to exert control and thereby lessen the initial depression.

In a review of the literature on the link between depression and eating pathology Szmuckler (1987) concludes that depression is one pathway to eating pathology. He suggests that both anorexia and bulimia serve to defend against depression. I suggest that initially both serve to reduce weight and establish control in at least one area of the girl's life. Even bulimics have more control while they have the disorder than they would have without it. Bulimics may not have control over their eating as the anorexics do, but they do have control over their weight through purging. They, like the anorexic, are able to maintain a body weight that is lower than their pre-bulimic weight (Garner, 1986).

WHY THE SEX DIFFERENCE IN DEPRESSION AND EATING DISORDERS EMERGES AT PUBERTY

This paper hypothesizes that the thin ideal may have its biggest impact during puberty when physical changes increase the discrepancy between the body image of the adolescent girl and the ideal, and when sexual attractiveness becomes important. It is therefore predicted that the sex difference in depression would emerge at puberty. It is also predicted that eating pathology would emerge during adolescence.

A number of studies of depression before and during adolescence report that there is a rise in the rate of depression for both girls and boys as they enter the adolescent years (Angold, 1988a,b; Harrington, Fidge, Rutter, Pickles and Hill, 1990; Rutter, 1980, 1982; Rutter, Angold, Harrington, Nicholls and Taylor, 1989; Rutter, Izard and Read, 1986. Depression is also more frequent in adolescent girls than in adolescent boys (Girgus, Nolen-Hoeksema and Seligman, 1989; Rutter, 1980, 1982; Rutter, Graham, Chadwick and Yule, 1976; Rutter *et al.*, 1986, 1990). One study reports that depression is twice as common in boys before puberty and twice as common in girls after puberty (Rutter *et al.*, 1986).

Not all reports have demonstrated this rise in the rate of depression and the change in the sex ratio across puberty (Rierdan *et al.*, 1987; Simmons and Blyth, 1987). As both Rierdan *et al.* (1988) and Harrington *et al.* (1990), point out, however, this is difficult to interpret due to lack of homogeneity in both the samples studied and the measures taken.

The model proposed here puts forward one explanation as to why girls may become more depressed around the time of puberty and significantly more depressed than boys. Specifically it is suggested that girls will start to become more dissatisfied with their bodies at just the time when they begin to develop more body fat (Rutter, 1980).

Bodily changes during puberty influence self perception and it is at this time that sex differences in children's body satisfaction appear (Polivy and Herman, 1983; Rierdan and Koff, 1985). These sex differences intensify throughout adolescence as girls become less and less satisfied with their bodies (Rierdan *et al.*, 1987). At every age they are less satisfied than boys (Girgus *et al.*, 1989).

Further, girls perceive larger and larger discrepancies between their actual shapes and their ideal shapes with age. Girls want to be increasingly thin. This is not the case for boys (Girgus *et al.*, 1989).

In a culture that idealizes thinness in women adolescence is a particularly difficult time for the young girl. Girls learn early on that appearances are important, and they become extremely sensitive to the cultural demands of femininity (Streigel-Moore *et al.*, 1986). When the feminine ideal is prepubescent, an emaciated woman with slender hips and breasts, the adolescent girl views her own body with extreme dissatisfaction. This becomes increasingly so as physiological changes take place during puberty, since at this time weight gain for girls is primarily in fat (Streigel-Moore *et al.*, 1986). Therefore it is not surprising that adolescent girls become more dissatisfied with their bodies than do boys. Puberty takes them further from the pre-pubescent cultural ideal while it takes boys closer, since weight gain for boys is primarily in muscle (Streigel-Moore *et al.*, 1986).

It is precisely because the discrepancy between ideal and actual body image emerges for girls as they go through puberty that they are more likely to be dissatisfied with their bodies at just the same time that they come to believe that the way they look is important. According to the model presented here, they are more likely than adolescent boys to become depressed either because they believe they are unattractive or because they are more likely than boys to diet (Garner and Garfinkel, 1980; Streigel-Moore *et al.*, 1986) and typically fail.

There is some evidence for this hypothesis. It has been demonstrated that a negative body image correlates with depression during adolescence in both girls and boys (Girgus *et al.*, 1989; Rierdan, 1985, 1987). Further, body image satisfaction accounts for a small but significant part of the variance in predicting those girls at risk for depression (Rierdan *et al.*, 1990). Body image satisfaction also predicts those girls who will become depressed after menarche when controlling for depression before menarche (Rierdan *et al.*, 1989). Finally, Girgus *et al.* (1989) report that girls who are dissatisfied with their bodies are more likely to become depressed when they are faced with negative life events than are girls who are satisfied with their bodies. This was not the case for boys, depression following negative life events was independent of body image satisfaction.

According to the model presented here adolescent girls are also therefore more likely to develop an eating disorder than boys.

THE PRESENCE OF A SEX RATIO IN DEPRESSION AND EATING DISORDERS EXCLUSIVELY IN WESTERN SOCIETY

Some evidence suggests that cultures that have the thin ideal also have more depression in women than in men. They also have eating disorders.

The presence or absence of a thin ideal across cultures has not been systematically examined to date. However, Sobal and Stunkard (1987) reviewed 137 studies in both developed and developing countries of the relationship between socioeconomic status and obesity in men, women and children. They report that in certain developed countries by and large there is more obesity in the lower classes. This was only clearly the case for women and there were no consistent findings for either men or children. In developing countries Sobal and Stunkard (1987) find that the relationship is as consistent but in the opposite direction. There is more obesity in the higher social classes in men, women and children. As Sobal and Stunkard (1987) point out, this fat ideal is the reverse of western attitudes both among women and towards feminine beauty.

The incidence of a significant sex ratio showing a higher rate of depression among women across cultures has been documented by Nolen-Hoeksema (1987). She reports that this sex ratio is found only in western industrialized countries. It is not found in rural, non-modern societies. In Table 1, I present the absence or presence of the thin ideal, as defined by thinness in the higher socioeconomic class, in a number of cultures. I also present the presence or absence of a higher rate of depression among women than among men. Where there is data on both variables (in six cases) there is no culture that has the thin ideal without also having significantly more depression in women. Further, all cultures that do not have more depression in women also do not have the thin ideal. This data supports the hypothesis that a thin standard for women predisposes a culture to a higher rate of depression among women than among men.

Table 1. The thin ideal for women across cultures and its relationship to the female/male sex ratio in depression. (Numbers correspond to references)

Culture	Thin ideal*	Sex difference†
American whites	X 1-24	X 1-13
New Zealand	X 28, 29	X 16
Sweden	X 39-41	X 21, 22
United Kingdom	X 30-37	X 14, 15
Nigeria	O 49	O 19, 20
India	O 42, 43	O 17, 18
Germany	X 38	
Holland	X 26, 27	
Czechoslovakia	X 25	
Australian Aborigines	O 44	
Colombia	O 45, 46	
De Cunha Islands	O 48	
Xhosa	O 47	
Australia		X 23-25
Canada		X 26
Denmark		X 27-29
Hong Kong		X 3
Iceland		X 32, 33
Iran (urban)		X 34
Israel		X 37, 38
Kenya		XO 39
Egypt		O 30
Iran (rural)		O 35
Iraq		O 36
Rhodesia		O 40
Uganda		O 41

X = Thinness associated with the higher class and more women depressed than men; O = Obesity associated with the higher class and no significant sex difference in depression. A blank entry denotes no available data.

*References taken from Sobal and Stunkard's (1987) review article (see Appendix A). †References taken from Nolen-Hoeksema (1987) (see Appendix B).

Table 2. The thin ideal for women across cultures and its relationship to eating disorders. (Numbers correspond to references)

Culture	Thin ideal*	Eating disorder†
American whites	X	X 1
Czechoslovakia	X	X 2
Germany	X	X 27
Holland	X	X 3
New Zealand	X	X 5
United Kingdom	X	X 6
India	O	O 4
Australia		X 18, 19
Belgium		X 28
Canada		X 20
China		X 5
Denmark		X 21
Finland (eastern)		X 22
Japan		X 17, 24, 25
Malaysia		X 8
Switzerland		X 23
South Africa (caucasian)		X 26
American blacks		O 7, 9-13
Arab cultures		O 14
Maoris		O 5
Muslims		O 5
New Guinea		O 15
West Africa		O 16
Sweden	X	
Aborigines	O	
Colombia	O	
De Cunha Islands	O	
Nigeria	O	
Xhosa	O	

X = Eating disorder reported and thinness associated with the higher social class; O = No eating disorder reported and obesity associated with the higher class. A blank entry denotes no available data.

*See Table 1. †See Appendix C.

Exactly parallel findings have been obtained for the thin ideal and eating disorders. It has been suggested that anorexia and bulimia are limited to western culture (Garner and Garfinkel, 1980). To date, however, this claim has not been sufficiently substantiated (Prince, 1985). An extensive search of the cross-cultural literature on eating disorders by the present author is summarized in Table 2. I have presented each culture that has a reported sample of anorexic or bulimic cases. I have also presented studies which have failed to find eating pathology in a specific culture. In general eating pathology exists in western cultures but not in non-western cultures.

When we compare the absence or presence of anorexia and bulimia with the absence or presence of the thin ideal in a culture, we find that of the seven cultures for which we have both eating disorder data and class preference data, all cultures that have eating disorders have the thin ideal. Further, no culture that does not have the thin ideal has eating disorders. This is strongly in line with the suggestion that the presence of the thin ideal predisposes a culture to eating disorders.

Studies of women who have changed cultures provide additional evidence of the effect of the thin ideal on the presence of eating pathology. Non-western women, when placed in a western culture, soon lose the ideal of feminine beauty held in their own culture and internalize the thin ideal held in the west. These women are then more likely to develop an eating disorder than are other women who remained in their own culture. It appears that exposure to middle-class values in the west, which include the idealization of thinness in women, increases the risk of eating disorders (Buchan and Gregory, 1984; Furnham and Alibhai, 1983; Hooper and Garner, 1986; Naser, 1986; Silber, 1986; Thomas and Szmukler, 1985).

In conclusion, the presence of the thin ideal in a culture is associated with both more depression among women than men in that culture and with the presence of eating disorders. Table 3 compares all three of these factors simultaneously by looking at: (1) the thin ideal; (2) eating disorders and (3) more depression in adult females across cultures. In the four cultures for which there is data for all three variables, that is, America, India, New Zealand, and the United Kingdom, there is no discrepancy. If one variable is present all three variables are present. If one variable is absent all three variables are absent.

Table 3. The thin ideal, the female/male sex ratio in depression and eating disorders

Culture	Ideal*	Sex difference†	Eating disorder‡
American whites	X	X	X
New Zealand	X	X	X
United Kingdom	X	X	X
India	O	O	O
Sweden	X	X	
Nigeria	O	O	
Czechoslovakia	X		X
Germany	X		X
Holland	X		X
Australia		X	X
Canada		X	X
Denmark		X	X

X = Thinness associated with the higher class, more depression in women than men, and eating disorder reported; O = Obesity associated with the higher class, absence of a significant sex difference, and no eating disorder reported. A blank entry denotes no available data.

*See Table 1. †See Table 1. ‡See Table 2.

These data support the hypothesis that the presence of the thin ideal in any culture predisposes the culture to a higher rate of depression among women than among men and to eating pathology in a small subset of women.

THE COHORT EFFECT: WHY IS THERE MORE DEPRESSION WITH EARLIER ONSET AND MORE EATING DISORDERS NOW?

The rate of depression has been increasing, especially among young adults and adolescents as has the incidence of eating disorders. One factor that may contribute to this trend, at least in part, may be the rise of the thin ideal in this century. This factor may also be partly responsible for the earlier onset of depression we see today.

Today's cultural standard for thinness has not always been accepted. The thin ideal has become increasingly emaciated over the past 20 yr (Garner and Garfinkel, 1980). In an attempt to document the shift in this cultural preference Playboy centrefolds from 1959 to 1979 were selected. These were compared to the nationwide female average weight matched for age and height. In 1959 the centrefolds on average weighed 91% of the average woman. By 1979 they weighed 84% (Garner and Garfinkel, 1980). These results were substantiated when the Miss America Pageant Contestants were viewed over the same time period. There was a 0.13 kg decline in weight per year for the contestants and a 0.17 kg decline for the winners (Garner and Garfinkel, 1980).

These results were particularly striking when we consider that the average woman under 30 has become heavier while the ideal has become thinner (Garner and Garfinkel, 1980). Given the greater discrepancy between the ideal presented and the actual weight of the average woman, it is hardly surprising that there is also a dramatic increase in the number of dieting articles in popular womens' magazines (Garner and Garfinkel, 1980).

The greater discrepancy between the thin ideal and the weight of the average woman across time may produce more body dissatisfaction in women in this generation than in the last. As a result more women may be depressed today and there may be more eating pathology. The earlier onset of depression may also be predicted since pubescent girls exposed to the thin ideal at just the time that they begin to develop more body fat will be more likely to be dissatisfied with their bodies at an earlier age than those girls who went through puberty in earlier times when the ideal was not operating.

In conclusion, the increasingly thin ideal for female beauty over the past few decades may explain, at least in part, the present rise in the rate of depression among women and the increasingly early onset of depression. It may also explain the same cohort effect that has occurred with eating disorders. The incidence of anorexia and bulimia has risen as the ideal body has become thinner. Additional factors may be operating to produce these effects, but this model at least points to one factor.

SUMMARY

This paper has proposed a model which states that the thin ideal of western societies may be a causal factor in the higher rate of depression seen among women in western cultures at the present time. It may also cause eating pathology in a subset of those depressed women. This model explains and integrates, at least in part, a number of puzzling trends in the epidemiology of both depression and eating pathology.

So far, however, as indicated earlier, all the data I have presented to support my hypotheses have been correlational in nature and rely on already existing datasets. Although the correlations are predicted by the model I have presented, they do not provide specific evidence for a *causal* model. The basic tenets need to be tested more directly. A more decisive test would be a longitudinal, cross-cultural puberty study. The model would predict that in a culture that held the thin ideal we would see a much larger increase in depression in girls than in boys beginning at puberty and continuing through adolescence. Individual differences in depression would be preceded by individual differences in body dissatisfaction and the importance attached to it. In a culture that does not hold the thin ideal there would be no difference in the rates between girls and boys across the same time period.

Finally, the model implies that if the thin ideal of western cultures were replaced by a more realistic (i.e. fatter) ideal, there would be less depression and less eating pathology among women in those cultures. Although it could be argued that women want to be thin because, in general, men are sexually attracted to thin women and simply making the ideal heavier will not change this preference nor ultimately the amount of female depression. Mens' attraction to very thin women, however, may be exaggerated by women. In the Fallon and Rozin (1985) study men tended to choose a heavier figure as their ideal feminine body than women believed men found attractive. Womens' preoccupation with thinness may not reflect an accurate perception of mens' preferences. Instead it more probably reflects the aspiration to look like the women in fashion and beauty advertisements.

How can a culture change its body ideal? One way which we may currently be seeing is through the use of heavier models in popular womens' magazines. If the models that women aspire to look like become heavier, women will perhaps feel happier with a few pounds more than they do today. Even the use of heavier models does not, however, rid us of the fact that models tend to come in the currently fashionable size and shape while women do not. For as long as women try to look like a current ideal they will persevere in their attempts to change themselves. It is, at any rate, time to encourage an ideal that will better serve the physical and psychological health of women.

Of course another 'treatment' is to de-emphasize the importance of weight. Although middle-aged men in the Rozin and Fallon (1988) study reported a disparity between their ideal and their actual body image, it seems to have few negative effects on them. It may be because they did not think the disparity was very important. This alternative, however, may be difficult to achieve in a society dedicated to the pursuit of thinness.

Finally, my argument against dieting and thinness is not the same thing as an argument against fitness. If women considered beauty to come from good health, rather than emaciation, depression and eating disorders would take less of a toll.

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REFERENCES

- American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd rev. edn). Washington, D.C.: APA.
- Angold, A. (1988a). Childhood and adolescent depression: I. Epidemiological and aetiological aspects. *British Journal of Psychiatry*, **152**, 601–617.
- Angold, A. (1988b). Childhood and adolescent depression: II. Epidemiological and aetiological aspects. *British Journal of Psychiatry*, **153**, 476–492.
- Beck, A. T. (1973). *The diagnosis and management of depression*. Philadelphia: University of Pennsylvania Press.
- Buchan, T. and Gregory, L. D. (1984). Anorexia nervosa in a black Zimbabwean. *British Journal of Psychiatry*, **145**, 326–330.
- Brownell, K. (1988). Danger to dieters: The yo-yo trap. *American Health*, March, 78–84.

- Brownell, K. and Jeffery, R. W. (1987). Improving long-term weight loss: Pushing the limits of treatment. *Behavior Therapy*, **18**, 353-374.
- Brownell, K., Nelson Steen, S. and Wilmore, J. H. (1987). Weight regulation practices in athletes: analysis of metabolic and health effects. *Medicine and Science in Sports and Exercise*, **19**, 546-556.
- Brownell, K., Greenwood, M. R. C., Stellar, E. and Shrager, E. E. (1986). The effects of repeated cycles of weight loss and regain in rats. *Physiology & Behavior*, **38**, 459-464.
- Collins, J. K., Beumont, P. J. V., Touyz, S. W., Krass, J., Thompson, P. and Philips, T. (1987). Variability in body shape perception in anorexic, bulimic, obese and control subjects. *International Journal of Eating Disorders*, **6**, 633-638.
- Davies, E. and Furnham, A. (1986). Body satisfaction in adolescent girls. *British Journal of Medical Psychology*, **59**, 279-287.
- Dykens, E. M. and Gerrard, M. (1986). Psychological profiles of purging bulimics, repeat dieters, and controls. *Journal of Consulting and Clinical Psychology*, **54**, 283-288.
- Fallon, A. E. and Rozin, P. (1985). Sex differences in perceptions of desirable body shape. *Journal of Abnormal Psychology*, **94**, 102-105.
- Furnham, A. and Alibhai, N. (1983). Cross-cultural differences in the perception of female body shapes. *Psychological Medicine*, **13**, 829-837.
- Garner, D. M. (1986). Cognitive therapy for bulimia nervosa. *Annals of the American Society of Adolescent Psychiatry*, **13**, 358-390.
- Garner, D. M. and Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine*, **10**, 647-657.
- Garner, D. M., Rockert, W., Olmsted, M. P., Johnson, C. and Coscina, D. V. (1985). Psychoeducational principles in the treatment of bulimia and anorexia nervosa. In Garner, D. M. and Garfinkel, P. E. (Eds), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 513-572). Guildford Press: New York.
- Girgus, J. S., Nolen-Hoeksema, S. and Seligman, M. E. P. (1989). Why do sex differences in depression emerge during adolescence. Paper presented at the American Psychological Association, New Orleans, August 1989.
- Harrington, R., Fudge, H., Rutter, M., Pickles, A. and Hill, J. (1990) Adult outcomes of childhood and adolescent depression: I. Psychiatric status. Manuscript submitted for publication. Institute of Psychiatry, London.
- Herman, C. P. and Polivy, J. (1975) Anxiety, restraint and eating behavior. *Journal of Abnormal Psychology*, **84**, 666-672.
- Herzog, D. B. (1984). Are anorexic and bulimic patients depressed? *American Journal of Psychiatry*, **141**, 1594-1597.
- Hooper, M. S. H. and Garner, D. M. (1986). Application of the eating disorders inventory to a sample of black, white and mixed raced schoolgirls in Zimbabwe. *International Journal of Eating Disorders*, **5**, 161-168.
- Kagan, D. M. and Squires, R. L. (1983). Dieting, compulsive eating, and feelings of failure among adolescents. *International Journal of Eating Disorders*, **3**, 15-26.
- Klerman, G. L. (1988). The current age of youthful melancholia. Evidence for increase in depression among adolescents and young adults. *British Journal of Psychiatry*, **152**, 4-14.
- Nasser, M. (1986). Comparative study of the prevalence of abnormal eating attitudes among Arab female students of both London and Cairo University. *Psychological Medicine*, **16**, 621-625.
- Nolen-Hoeksema, S. (1978). Sex differences in unipolar depression: Evidence and theory. *Psychological Bulletin*, **101**, 259-282.
- Nylander, J. (1971). The feeling of being fat and dieting in a school population: Epidemiologic interview investigation. *Acta Sociomedica Scandinavica*, **3**, 17-26.
- Polivy, J. and Herman, C. P. (1983) *Breaking the Diet Habit. The Natural Weight Alternative*. New York: Basic Books.
- Prince, R. (1985). The concept of culture-bound syndromes: Anorexia nervosa and brain-fag. *Social Science and Medicine*, **21**, 197-203.
- Rierdan, J. and Koff, E. (1985). Depression in adolescent girls. Poster presented at the meeting of the Society for Research in Child Development, Toronto, Canada.
- Rierdan, J., Koff, E. and Stubbs, M. L. (1987). Depressive symptomatology and body image in adolescent girls. *Journal of Early Adolescence*, **7**, 205-216.
- Rierdan, J., Koff, E., and Stubbs, M. L. (1988). Gender, depression and body image in early adolescents. *Journal of Early Adolescence*, **8**, 109-117.
- Rierdan, J., Koff, E. and Stubbs, M. L. (1989). Identifying girls vulnerable to disruption following menarche: A prospective study. Poster presented at the International Congress of Psychosomatic Obstetrics and Gynecology, Amsterdam.
- Rierdan, J., Koff, E. and Stubbs, M. L. (1990). A longitudinal analysis of body image as a predictor of the onset and persistence of adolescent girls' depression. *Journal of Early Adolescence*. In press.
- Rodin, J., Silberstein, L. and Striegel-Moore, R. (1984). Women and weight: A normative discontent. *Nebraska Symposium on Motivation*.
- Rozin, P. and Fallon, A. (1988). Body image, attitudes to weight and misperceptions of figure preferences of the opposite sex: A comparison of men and women in two generations. *Journal of Abnormal Psychology*, **97**, 342-345.
- Rutter, M. (1980) *Changing Youth in a changing society: Patterns of adolescent development and disorder*. Cambridge, Mass.: Harvard University Press.
- Rutter, M. (1982). The developmental psychopathology of depression: Issues and perspectives. *Conference on depression and depressive disorders: Developmental perspectives*. Philadelphia.
- Rutter, M., Izard, C. E. and Read, P. B. (1986). *Depression in Young People. Developmental and Clinical Perspectives*. New York: Guildford Press.
- Rutter, M., Graham, P., Chadwick, O. F. D., and Yule, W. (1976). 'Adolescent turmoil: fact or fiction?' *Journal of Child Psychology and Psychiatry*, **17**, 35-36.
- Rutter, M., Angold, A., Harrington, R., Nicholls, J. and Taylor, E. (1990). Age trends in patterns of psychopathology in child psychiatric clinic attenders. Unpublished manuscript.
- Scott, D. W. (1987). The involvement of psychosexual factors in the causation of eating disorders: Time for a reappraisal. *International Journal of Eating Disorders*, **366**, 199-213.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development and death*. San Francisco: Freeman.
- Silber, T. J. (1986). Anorexia nervosa in blacks and Hispanics. *International Journal of Eating Disorders*, **5**, 121-128.
- Silverstein, B., Peterson, B. and Perdue, L. (1986). Some correlates of the thin standard of bodily attractiveness for women. *International Journal of Eating Disorders*, **5**, 895-905.

- Simmons, R. G. and Blyth, D. A. (1987). *Moving into Adolescence. The impact of pubertal change and school context*. New York: Aldine De Gruyter.
- Slade, P. (1982). Towards a functional analysis of anorexia and bulimia nervosa. *British Journal of Clinical Psychology*, **21**, 167–179.
- Slade, P. and Dewey, M. E. (1986). Development and preliminary validation of S.C.A.N.S.: A screening instrument for identifying individuals at risk of developing anorexia and bulimia nervosa. *International Journal of Eating Disorders*, **5**, 517–538.
- Sobal, J. and Stunkard, A. J. (1989). Socioeconomic status and obesity: A review of the literature. *Psychological Bulletin*, **105**, 260–275.
- Squires, R. L. and Kagan, D. M. (1985). Sex-role and eating behaviours among college women. *International Journal of Eating Disorders*, **4**, 539–548.
- Stake, J. and Lauer, M. L. (1987). The consequences of being overweight: A controlled study of gender differences. *Sex Roles*, **17**, 31–47.
- Streigel-Moore, R. H., Silberstein, L. R. and Rodin, R. (1986). Towards an understanding of risk factors for bulimia. *American Psychologist*, **41**, 246–263.
- Strober, M. and Katz, J. L. (1987). Do eating disorders and affective disorders share a common etiology? A dissenting opinion. *International Journal of Eating Disorders*, **6**, 171–180.
- Szmukler, G. (1986). The epidemiology of anorexia nervosa and bulimia. In Szmukler, G., Slade, P. D., Harris, P., Benton, D. and Russell, G. F. M. (Eds), *Anorexia nervosa and bulimic disorders* (pp. 143–154). Oxford: Pergamon Press.
- Szmukler, G. (1987). Some comments on the link between anorexia nervosa and affective disorder. *International Journal of Eating Disorders*, **6**, 181–189.
- Thomas, J. P. and Szmukler, G. I. (1985). Anorexia nervosa in patients of Afro-Caribbean extraction. *British Journal of Psychiatry*, **146**, 653–656.
- Timko, C., Streigel-Moore, R. H., Silberstein, L. R. and Rodin, J. (1987). Femininity/masculinity and disordered eating in women: How are they related? *International Journal of Eating Disorders*, **6**, 701–712.
- Walsh, B. T., Rosse, S. P., Glassman, M. and Sadik, C. (1985). Bulimia and depression. *Psychosomatic Medicine*, **47**, 123–130.

APPENDIX A

References: Thin Ideal

- | | |
|---|--|
| 1. Diehl (1933a, b) | 25. Dancova and Hejda (1975) |
| 2. Hathaway and Foard (1960) | 26. Baeke <i>et al.</i> (1983) |
| 3. Moore <i>et al.</i> (1962) | 27. Beidell <i>et al.</i> (1986) |
| 4. Comstock and Livesay (1963) | 28. Birbeck (1981) |
| 5. Goldblatt <i>et al.</i> (1965) | 29. Benson-Cooper <i>et al.</i> (1975) |
| 6. Burnight and Marden (1967) | 30a. Silverstone (1968) |
| 7. Kannel <i>et al.</i> (1969, 1975) | b. Silverstone <i>et al.</i> (1969) |
| 8. Zechow (1969) | 31. Silverstone (1970) |
| 9. Reivich <i>et al.</i> (1973) | 32a. Baird <i>et al.</i> (1974) |
| 10. Herman (1973) | b. Baird (1974) |
| 11a. Rimm and Rimm (1974) | 33. Ashwell and Etchell (1974) |
| b. Oken <i>et al.</i> (1977) | 34. Ashwell and North (1977) |
| 12. Garn <i>et al.</i> (1975, 1976, 1977) | 35. Rona and Morris (1982) |
| 13. Benbrook (1976) | 36. Braddon <i>et al.</i> (1986) |
| 14. Roe and Eichwort (1976) | 37. Power and Moynihan (1987) |
| 15. Charney (1976) | 38. Pfanz (1963) |
| 16. Garn <i>et al.</i> (1977, 1980, 1981) | 39. Noppa and Hallstrom (1981) |
| 17a. Lowenstein (1977, 1978) | 40. Hallstrom and Noppa (1981) |
| b. Lowenstein and Abraham (1979) | 41. Abramhanson (1956) |
| c. National Center for Health Statistics (1981) | 42. Clarke (1966) |
| d. Garn <i>et al.</i> (1981) | 43. Driver and Driver (1983) |
| 18. Kohrs <i>et al.</i> (1979) | 44. Brown and Barrett (1973) |
| 19. Stewart <i>et al.</i> (1980) | 45. Mueller and Reid (1979) |
| 20. Saltzer and Golden (1985) | 46. Mueller (1979) |
| 21. Ross and Mirowsky (1983) | 47. Sever <i>et al.</i> (1980) |
| 22. Jeffery <i>et al.</i> (1984) | 48. Marshall <i>et al.</i> (1971) |
| 23. Stern <i>et al.</i> (1984) | 49. Okeke <i>et al.</i> (1983) |
| 24. Forman <i>et al.</i> (1986) | |

APPENDIX B

References: Sex Differences

- | | |
|----------------------------------|----------------------------------|
| 1. Williams and Spitzer (1983) | 8. Eaton and Kessler (1981) |
| 2. Faden (1977) | 9. Frerichs <i>et al.</i> (1981) |
| 3. Rosen <i>et al.</i> (1964) | 10. Radloff (1975) |
| 4. Pederson <i>et al.</i> (1972) | 11. Amenson and Lewinsohn (1981) |
| 5. Weissman <i>et al.</i> (1977) | 12. Weissman and Meyers (1978) |
| 6. Stangler and Printz (1980) | 13. Blumenthal (1975) |
| 7. Myers <i>et al.</i> (1984) | 14. Baldwin (1971) |

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|--|---|
| 15. Dean <i>et al.</i> (1981) | 29. T. Fremming (1961, in Helgason, 1961) |
| 16. Christie (1968) | 30. El-Islam (1969) |
| 17. Rao (1970) | 31. Yap (1965) |
| 18. Mohan (1972) | 32. Helgason (1977) |
| 19. Ezeilo and Onyeama (1980) | 33. Helgason (1961) |
| 20. Leighton <i>et al.</i> (1963) | 34. Bash and Bash-Leichti (1974) |
| 21. Essen-Moeller (1956) | 35. Bash and Bash-Leichti (1969) |
| 22. Essen-Moeller and Hagnell (1961) | 36. Bazzoui (1970) |
| 23. Berah (1983) | 37. Halevi <i>et al.</i> (1969) |
| 24. Krupinski and Stoller (1962) | 38. Gershon and Liebowitz (1975) |
| 25. Byrne (1980) | 39. Vadher and Ndetei (1980) |
| 26. Canadian Bureau of Statistics (1970) | 40. Buchan (1969) |
| 27. Weeke <i>et al.</i> (1975) | 41. Orley and Wing (1979) |
| 28. Sorenson and Stromgren (1961) | |

APPENDIX C

References: Eating Disorder

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|-----------------------------------|-------------------------------------|
| 1. Strober <i>et al.</i> (1986) | 15. Burton-Bradley (1982) |
| 2. Faltus (1986) | 16. Prince (1985) |
| 3. Hoek and Brook (1986) | 17. Mizushima and Ishii (1983) |
| 4. Sharma (1982) | 18. Touyz and Beumont (1985) |
| 5. Dare (1986) | 19. Huon and Brown (1986) |
| 6. Crisp (1980) | 20. Leichner <i>et al.</i> (1986) |
| 7. Robinson and Anderson (1986) | 21. Nielsen (1986) |
| 8. Buhrich (1981) | 22. Jalkanen <i>et al.</i> (1986) |
| 9. Jones <i>et al.</i> (1980) | 23. Willi and Grossman (1983) |
| 10. Hamilton <i>et al.</i> (1985) | 24. Miyai <i>et al.</i> (1975) |
| 11. Thomas and Szmukler (1985) | 25. Yoshikatsu <i>et al.</i> (1978) |
| 12. Gray <i>et al.</i> (1987) | 26. Buchan and Gregory (1984) |
| 13. Hsu (1987) | 27. Steinhausen (1986) |
| 14. Nasser (1986) | 28. Vandereycken (1986) |