The Hidden Layers:

Acknowledging the Political Dimension of Eating Disorders

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“Oh, she don’t see, the light that’s shining deeper than the eyes can find it. Maybe we have made her blind”

- **Alessia Cara**

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Abstract

This dissertation argues that a comprehensive understanding of eating disorders requires the acknowledgement of their political dimension, in addition to their social and medical facets. The study challenges the limited perspective that predominantly discusses the medical aspects of eating disorders by emphasising their stigmatisation and the importance of considering their social and political dimensions. The study comprises three chapters examining different dimensions of eating disorders. The first chapter explores their medical factors, including various disorder types and associated stigmatisation. The second chapter investigates the social dimension by analysing societal pressures and gender inequality, revealing a connection between eating disorders and female experiences in contemporary society. The third chapter explores the political dimension, refuting the strict separation between the social and the political. Drawing on the theories of de Beauvoir, Foucault, and Butler, it demonstrates how societal pressures, norms, and power dynamics contribute to eating disorders. The dissertation argues that socially constructed beauty standards are not merely cultural obsessions but unconscious political mechanisms that oppress women. The dissertation asserts that a holistic understanding of eating disorders necessitates the recognition of their social and political dimensions in conjunction with their medical facets. It emphasises the need for systemic changes to foster a healthy relationship with food and promote self-acceptance. By creating a culture that celebrates body diversity, rejects unrealistic expectations, and embraces acceptance, society can effectively address the complexity of eating disorders and cultivate a more compassionate environment.

Keywords: eating disorders, political dimension, oppression

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Unveiling the Dimensions of Eating Disorders

The pressure people endure today to appear according to unattainable standards is enormous. While it applies to all age categories, girls as young as seven encounter intense and unobtainable pressures to be perfect, according to the Girls' Attitudes Survey 2022 (Girlguiding, 2022). At the same age, a quarter of American children engaged in dieting (Howard, 2018). In the United Kingdom, only 59 per cent of the 3015 interviewed seven to 21-year-old girls are happy with their bodies, with the percentage decreasing the older they got with similar trends observed throughout Western society[1]. Another British study from the Mental Health Foundation found that one in five adults felt ashamed or disgusted by their body image in the last year (2019). These feelings and beliefs deeply impact their daily lives, from feeling; judged more for their looks than abilities, that they need to be perfect, and that their appearance holds them back (Mental Health Foundation, 2022).

Body image concerns can be a risk factor for mental health problems. They are associated with poorer quality of life, psychological distress, and the risk of unhealthy eating and movement behaviours (Mental Health Foundation, 2022).

Eating disorders affect up to 5 per cent of the population, with a higher percentage in adolescence and young adulthood in women (Guarda, 2023). There is an increase in mental health problems and eating disorders that can be observed in modern society. This prevalence and severity are documented in various studies (Smink et al., 2012). It is a common phenomenon

[1] While this paper mainly discusses Western society, this does not discredit that the trends are not present in other societies. However, as I use Western philosophers to discuss the topic at hand, their theories apply better to this society as they might not directly translate to other regions.

that the general public and sufferers refer to eating disorders by personified nicknames such as Ana for anorexia or Mia for bulimia (Siddiqi, 2014). These nicknames show how common eating disorders are while also diminishing their severity. The fact that these concerns are so widespread says something about our dominant societal beliefs. They are not individual problems but rather societal structures that are constantly reinforced. Of course, these disorders have a myriad of causes. Still, it is becoming increasingly evident that society plays a significant role in shaping the perception and treatment of individuals' bodies and plays a role in developing eating disorders (Burns & Malson, 2009).

The official definition of an eating disorder is “any of various psychological disorders characterised by abnormal or disturbed eating habits, esp. anorexia nervosa or bulimia” (Oxford English Dictionary, 2008). The Cambridge Dictionary defines the term as: “a mental illness in which people eat far too little or far too much food and are unhappy with their bodies” (2023). The Oxford Languages dictionary states that eating disorders are “any range of mental conditions in which there is a persistent disturbance of eating behaviour and impairment of physical or mental health” (n.d.). The American Psychiatric Association sees them as “behavioural conditions characterised by severe and persistent disturbance in eating behaviours and associated distressing thoughts and emotions” (Guarda, 2023). These definitions depict eating disorders as behavioural, medical, and individual conditions solely concerned with food intake and outward appearance. This is a dominant view in society and one that I want to challenge.

In this dissertation, I defend the following statement; acknowledging the political dimension of eating disorders in conjunction with their social and medical facets is vital to fully comprehend their societal prevalence and connection to oppression.

I present three dimensions of eating disorders; the medical, the social, and the political. In three chapters, these dimensions build on top of each other to increasingly create a holistic and comprehensive understanding of eating disorders. The first chapter explains existing eating disorders and their consequences, together with the current medical views of these illnesses. The medical dimension is the most represented in literature and presents the dominant view of eating disorders. The second and third chapters aim to attenuate this dominance by adding two additional dimensions. The chapter on the social dimension contains two sections; societal pressures and gender inequality. These sections work through cultural norms and gender roles connected to food to show society's influence on eating behaviour. Literature begins to acknowledge the social cause of eating disorders, but the underlying political dimension is overlooked when merely framing them as a societal consequence. By adding the political dimension, eating disorders can be seen as an active tool to achieve sustained oppression of women. To make this final claim, the third section first goes into the debate between the social and political. Hannah Arendt separated these spheres, but feminist literature often sees them as vitally connected. Connecting these two spheres bridges the social dimension with the political and makes space to see eating disorders as a political manifestation of power structures. Using the theories of Simone de Beauvoir, Michel Foucault, and Judith Butler, I show that the social and the political are inherently related and that social issues influence the political. Their theories on power and the oppression of women further demonstrate this connection while providing additional background for the final section. The last section of this dissertation outlines why eating disorders are part of female oppression through the beauty myth and the meaning of fat. A conclusion comprehensively summarises the main ideas presented in the dissertation.

The Medical Dimension of Eating Disorders

In the first chapter, I look at eating disorders from their medical perspective. I first introduce eating disorders by delving into various types, symptoms and possible treatment options. Thereafter, I highlight the current dominant beliefs on their background and prevalence to complete the view that the rest of the paper tries to attenuate. The medical dimension of eating disorders is deeply ingrained in society and often leads to a skewed view of the illness.

Types, Consequences, and Treatment

"Eating disorders are a mental illness in which people eat far too little or far too much food and are unhappy with their bodies" (Cambridge Dictionary, 2023). This definition is a perfect example of the narrow understanding of eating disorders. The currently accepted definition focuses on how eating disorders are medical illnesses that revolve around unhealthy eating behaviours and body dissatisfaction. If the definition mentions examples, these are almost exclusively anorexia nervosa and bulimia nervosa.

However, there are ten acknowledged types of eating disorders. These disorders are anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding and eating disorders (OSFED), pica, rumination disorder, avoidant restrictive food intake disorder (AFRID), unspecified feeding or an eating disorder, muscle dysmorphia, and orthorexia nervosa. These disorders are included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013). The DSM-5 is the official framework for classifying disorders and clarifying their criteria (Thornton & Argoff, 2009). The list in the fifth edition is more extensive than in the fourth edition, showing a growing

recognition of the diversity and seriousness of eating disorders. I will provide a quick overview of some types to show their diversity and perception. I took their descriptions mostly from the DSM-5, as this manual is used by clinicians as a diagnostic tool and it includes the most widely-accepted medical view of these diseases.

Anorexia nervosa is characterised by restriction of calorie intake and dangerous weight loss (APA, 2013). Anorexia nervosa is the eating disorder with the highest mortality rate of any psychiatric diagnosis other than opioid use disorder (Guarda, 2023). The mortality rate is an estimated ten per cent within ten years of the onset (Rikani et al., 2013). The occurring dieting and exercising behaviour are driven by the intense fear of weight gain. Literature states that anorexia includes avoiding food, severely restricting food intake and using weight loss methods such as over-exercising and using laxatives, weighing the body, and having a distorted body image (National Institute of Mental Health, n.d.).

Bulimia nervosa includes recurrent episodes of binge eating and inappropriate compensatory behaviours to prevent weight gain, including self-induced vomiting, using laxatives or other medications, fasting, or excessive exercise. Binge-eating is defined as consuming an amount of food larger than most people would eat in a prior defined period. Furthermore, there is a perceived lack of control over eating during these episodes. Often self-evaluation is influenced by body shape and weight. The diagnosis of bulimia is not weight dependent as patients can have any weight ranging from underweight to obese (APA, 2013). Individuals often alternate between dieting and restricting and binge eating, followed by feelings of shame or embarrassment (Guarda, 2023). The hidden nature of this disease makes it harder to

identify as an outsider, as the eating behaviours may not be as visible as those of other eating disorders.

Binge Eating Disorder has a similar definition as bulimia but does not include inappropriate compensatory behaviour. A binge-eating episode is associated with three or more of the following signs; eating much more rapidly than usual, eating until uncomfortably full, eating large amounts of food when not psychically hungry, eating alone, and feeling disgusted with oneself, depressed, or guilty afterwards (APA, 2013). Binge eating disorder is the most common eating disorder in the United States (National Institute of Mental Health, n.d.).

Pica and rumination disorder are two disorders that are different from what one would assume to be an eating disorder. They are not associated with control or weight obsession and are, therefore, often forgotten as eating disorders. Pica includes the persistent eating of nonnutritive, nonfood substances and other eating behaviour that is not part of a culturally supported or socially normative practice (APA, 2013). Rumination disorder is the repeated regurgitation of food that is re-chewed, re-swallowed, or spit out that does not belong to other medical conditions such as gastroesophageal reflux (APA, 2013).

Orthorexia Nervosa is another category that has grown in prevalence and is described as an obsessive focus on ‘healthy’ eating concerning emotional distress around food (APA, 2013). 'Healthy' is defined by a dietary theory of which the specifics vary. Weight loss is not the primary goal, but ultimately to promote optimum health. This results in feelings of distress, impurity and anxiety when breaking self-imposed rules. The eating disorder becomes clinically impairing from malnutrition, impairing social, academic or vocational functioning, or body image dependent on eating behaviour (APA, 2013).

These types of disorders are still not encapsulating all different experiences. Therefore, the category OSFED exists. This diagnostic category includes all other eating disorders and disturbed eating behaviours (APA, 2013). People can fall into this category when for example, the frequency of the behaviour or the weight does not meet the diagnostic criteria. A substantial proportion of patients in treatment fail to meet the criteria for anorexia and bulimia as they are completely based on the Body Mass Index (BMI) or frequency of compensatory behaviour (Zimmerman, 2008). Conditions that do not meet these criteria are often called atypical (Ekern, 2016), and the DSM-5 does not include them separately. An example of one of these OSFED illnesses is atypical bulimia nervosa. This category may include individuals who do not have binge episodes but engage in purging behaviours or those who do not engage in these behaviours often enough to be classified as having bulimia (Fairburn & Walse, 2002).

To highlight how severe an eating disorder can be, I state some symptoms that may develop related to starvation or purging behaviours[2]. These generally divide into emotional and physical symptoms. Emotional signs can include; preoccupation with weight, food, calories and dieting, food restriction, food rituals, skipping meals, and mood swings (NEDA, n.d.). The physical manifestation can include the ceasing of the menstrual cycle, dizziness, brittle hair, cold intolerance, muscle weakness, heartburn and reflux, severe constipation, bloating, stress fractures, depression, anxiety, poor concentration, weight loss or gain, sleep problems, dental problems, and impaired immune functioning (NEDA, n.d.; Guarda, 2023).

[2] These symptoms are not a checklist and should not be regarded as such. Someone with eating disorders will not have all these signs and do not fit within a neat box. It is rather a general overview of behavioural and physical signs that may indicate the presence of an eating disorder.

Treating eating disorders involves multiple forms, including psychotherapy, medications, and nutrition counselling (NEDA, n.d.). These treatments contain levels of intensity. In addition to various forms of therapy, treatments can be categorised as either inpatient or outpatient. Outpatient treatment is the least restrictive level of care, allowing life to continue while seeing, for example, a nutritionist, therapist, and other professionals in a real-life setting (NEDA, n.d.). A variation of outpatient treatment is the Intensive Outpatient Program (IOP). IOP exists for those requiring more guidance, including family support groups and topic-focus groups and includes more frequent contact with professionals (NEDA, n.d.) The next intensity is residential treatment, where a patient lives in a 24-hour care facility with constant monitoring. This differs from inpatient or hospitalised treatment, where the main focus is medical stability and interruption of weight loss instead of physical and psychological healing (NEDA, n.d.).

Medical Stigmatisation

Eating disorders are grave and often fatal illnesses. Yet they are plagued by misconceptions and stigmatisation in society. It is a commonly held misbelief that these disorders are merely lifestyle choices about vanity and are undertaken voluntarily, disregarding the severity of the conditions (National Institute of Mental Health, n.d.). Such misconceptions create a climate of secrecy and shame, where individuals struggling with disordered eating feel isolated and misunderstood (Toledo Center for Eating Disorders, n.d.).

Stigma within the medical community presents itself in two types. There is social stigma involving prejudiced attitudes others have towards the illness, and there is self-perceived stigma involving internalised feelings used against the self (Toldo Center for Eating Disorders, n.d.).

These stigmas influence the disease by worsening mental health symptoms, creating isolation, fostering feelings of self-doubt, and delaying treatment. Because of stigma, people with an eating disorder often avoid seeking help (Toldo Center for Eating Disorders, n.d.). Overcoming the stigma surrounding eating disorders is crucial as it significantly impacts mental health symptoms, treatment-seeking behaviour, and overall well-being.

The medical community plays a crucial role in identifying, diagnosing, and treating eating disorders. However, the misunderstandings around weight stereotypes create potential barriers to treatment approaches. The prevailing belief has often associated eating disorders exclusively with underweight individuals or those exhibiting rapid weight loss (Toledo Center for Eating Disorders, n.d.). This focus on weight as a diagnostic tool has perpetuated the misconception that only individuals who are visibly thin or experiencing weight loss are suffering from an eating disorder. Consequently, individuals with eating disorders who do not fit the stereotypical appearance may face challenges in obtaining an accurate diagnosis or receiving appropriate treatment (Barbone-Cone et al., 2010). Since there are multiple treatment options, implementing the right treatment plan and tackling the root of the problem instead of only regaining medical stability is crucial.

While there is a growing inclusion of multiple factors contributing to the development of eating disorders, the evidence for biological and psychological factors remains inconclusive (Rikani et al., 2013). A body of research carefully examined possible risk factors associated with eating disorders. Yet, research has not uncovered the exact aetiology or the correlation between these factors (Rikani et al., 2013). Although generally agreed that biological factors play a role in

developing an eating disorder (Raphael & Lacey, 1994), the environment can hinder or accentuate these risk factors.

Through this research, I aim to demonstrate the critical significance of this often-overlooked environment. I do not discredit the influence of genetics and personality. Instead, I argue that eating disorders are predominantly caused by the society in which we currently live. It is inadequate to explain eating disorders solely based on personal or hereditary factors and consider them a private issue, considering the prevalence of eating disorders has significantly increased over the past five decades (Tenore, 2001; Galmiche et al., 2019). In the following sections, I highlight the social nature of eating disorders and the underlying political dimension that contribute to their emergence. By examining the framing of eating disorders as a social problem, I demonstrate how it intertwines with political motives and illustrate the inherent politicism within social dynamics.

The Social Dimension of Eating Disorders

In the second chapter, I aim to highlight the social dimension. This section is divided into two smaller parts. I first go into the existing pressures of society using the example of beauty ideals to show that these are a factor in the development of eating disorders. The second part shows the influence of gender norms and inequality, using the meaning of food as a descriptor for unequal status.

Societal Pressures

We are subjected to the norms of society daily. This subjection inevitably affects us. In this section, I argue that social pressures lead to the development of eating disorders through adherence to social norms. There are multiple reasons that social norms can create stress. Specific social standards guide behaviour within social coordination and relationships (Bicchieri & Muldoon, 2011). These norms encompass influences like cultural values, traditions, media, institutions, and peer groups. Regular interaction with these norms leads to the formation of norms and societal pressure, which manifests in different ways. This pressure contains elements of socialisation, media influence, and institutional and peer pressures. These pressures create the feeling of conformity, compelling people to adhere to societal expectations to gain acceptance and avoid social rejection. It becomes a moral duty to adhere to expectations (Widdows, 2018, p. 2). Orbach describes that in 1995, an American television channel started broadcasting in Fiji, portraying several sitcoms (2011, p. 388). Three years later, the prevalence of bulimia had increased from near zero to 11.9 per cent (Orbach, 2011, p388). The idea of having to change one's body became internalised. Consequently, this moral duty perpetuates a cycle where social norms create pressure, leading to conformity and reinforcing these social norms.

Influential social norms can be seen in the context of ideals. It is often overlooked that ideals do not exist out of nowhere but serve a purpose (Widdows, 2018, p. 1-16). The portrayed images of proper womanhood are powerful as they are presented as the only possible reality (Orbach, 1998, p. 24) and are becoming more rather than less dominant (Widdows, 2018, p. 3). Yet, beauty is not universal, although Western societies often pretend that all ideals of female

beauty stem from one archetype (Wolf, 2002, p. 12). Across the world, groups admired vastly different standards; the Maori fat vulva and the Padun hanging breast (Wolf, 2002, p. 12). When the standards are ignored, one risks becoming an outcast, as not conforming is not an option (Widdows, 2018, p. 4). However, these images of beauty standards constantly change, meaning there is no stable milieu for women as visual culture reshapes the body continuously. The only constant is that women must be a form of thin (Widdows, 2018, p. 4). For example, from the 1990s to the 2000s the ideal changed drastically from heroin chic— extremely thin and walf-like— to curvacious yet skinny (Howard, 2018; Widows, 2018). The portrayal of these ideals influences women's perceptions of their bodies.

In the 1920s and 1980s, there was a noticeable shift in societal admiration towards a more slim physique. These decades represent the thinnest ideals in American history (Harrison & Cantor, 2006). This shift in beauty ideals coincided with a subsequent epidemic of eating disorders, with women feeling compelled to conform to the new standard (Howard, 2018). The notion persisted that to belong and be fashionable, one had to alter their body (Howard, 2018). Similarly, in the 1960s and 1970s, there was a significant increase in the prevalence of anorexia nervosa patients that required hospitalisation (Howard, 2018). This increase coincided with a shift to slender models and thinner bodies after a decade favouring a higher bust-to-waist ratio (Howard, 2018). These examples highlight how changes in societal beauty standards can profoundly affect individuals' body perceptions and contribute to the development of eating disorders.

However, being presented with these ideals persistently creates an environment where thinness and perfection are equated to attractiveness, success, and acceptance. These pressures

breed body dissatisfaction and actively push women, and increasingly men, to change their bodies. People resort to extreme measures to possibly achieve the current beauty ideal in shape or weight. These measures can be in the form of plastic surgery, lifestyle changes, or eating disorders: including restricting eating, excessive exercise, and purging or binge eating.

The social dimension becomes evident when we recognise that women do not starve themselves for private relationships but rather work to alter their appearance within a public and social order with a vested interest in their eating habits (Wolf, 2002, p. 189). Hunger and thinness are not private aesthetics but are imposed upon individuals by the community. These societal pressures are perpetuated by various industries that profit from maintaining these unrealistic beauty standards (Widdows, 2018, p. 2). For instance, the beauty, fashion, and diet industries thrive on promoting products targeted at ‘fixing’ the latest perceived flaws that stand in the way of the perfect body. They capitalise on the insecurities and body dissatisfaction fueled by societal pressures. Moreover, political institutions and policies directly affect eating disorder development by failing to provide adequate support systems. The lack of accessible mental health services, insufficient funding for treatment and limited education on body positivity and self-acceptance further exacerbate the problem. This situation highlights the need for systematic changes that challenge the status quo and prioritise the well-being of individuals over profit-driven industries.

In conclusion, the social nature of eating disorders becomes visible through their entanglement with societal norms, pressures and ideals. Here we can see that, under beauty ideals, the body is never only a body (Widdows, 2018, p. 3). There is no such thing as a body unmarked or unshaped by culture (Orbach, 2011, p. 390). The impact of social pressure is

undeniable, with individuals feeling compelled to conform to unrealistic beauty standards to gain acceptance and avoid social rejection. This cycle of pressure and conformity, combined with the interests of industries, perpetuates the social norms that fuel the development of eating disorders.

Gender Inequality

Eating disorders have the highest mortality rate of any psychiatric illness, yet they are underrepresented in the scientific literature or public discourse (Butterfly Foundation, 2020). They have historically been portrayed as primarily affecting frail young adolescent females, perpetuating the misconception that they are gender-specific (Sangha et al., 2019). While 90 to 95 per cent of individuals diagnosed with anorexia or bulimia are women, research suggests that up to one in four people with an eating disorder is male (Sangha et al., 2019). Male sufferers are often teased and disbelieved for suffering from a ‘female disease’. These stereotypes and expectations surrounding gender roles contribute to the reluctance of men to seek diagnosis or participate in research studies on eating disorders (Sangha et al., 2019).

The dismissal of female eating disorders and male experiences can be attributed to the deeply ingrained societal attitudes and systems of misogyny. Misogyny, the belief in the inherent inferiority of women, is deeply rooted in social, economic, and political systems (United Nations, 2022). Its consequences range from gender-based violence to sexualisation and marginalisation (United Nations, 2022). Moreover, misogyny perpetuates gender stereotypes of roles and traits.

Traditionally, men are associated with confidence, strength, and independence, while women are linked to nurturing, empathy, and emotional sensitivity (Planned Parenthood, n.d.).

The masculine traits are deemed desirable, powerful and authoritative, while femininity and women are devalued and considered inferior (Becker, 1999). An example of misogyny connected to eating disorders can be seen in gendered eating behaviours.

While eating disorders are ultimately mental disorders with physical manifestations, they revolve around food. Therefore, it is crucial to clarify the connection between food norms, gender inequality, and the development of eating disorders. Food represents love, language, connection, and memories within a family and other intimate settings (Wolf, 2002, p. 189). Meals are social events that symbolise social worth and inclusion (Young et al., 2009).

Within a public setting, food adds status and honour (Wolf, 2002, p. 189). Therefore, sharing food in public is a determination of power relations and possibly creating social equality. Companion, a word for friend, comes from the Latin with and bread, those who break bread together (Wolf, 2002, p. 189). The moment men engage in food rituals such as toast or offerings, they become allies and equals. However, societal norms have set different standards for women, perpetuating a sense of inferiority. Women eat less in public, take smaller portions, or choose lighter and healthier options, compared to men, reflecting feelings of inadequacy (Wolf, 2002, p. 189). Numerous studies indicate that women change their eating habits or consume up to 130 calories less when in the company of men (Young et al., 2009; Otterbring, 2017). Women feel judged on their attractiveness, femininity and desirability based on their food choices (Young et al., 2009).

These gendered eating behaviours are not limited to public settings but also occur within families. Traditionally, women are in charge of the household feeding pattern: doing the choosing, buying, and cooking of the food (Orbach, 1998, p. 162). Yet, in many traditional

households, it remains the norm for the man, the head of the house, to be served first (Junnarkar, 2016). A study in Indian households even found that in a quarter of them, women are expected to have their meals after the men have finished (Hathi et al., 2021). These dynamics perpetuate unequal treatment and reinforce traditional gender roles. That women can give birth to and breastfeed infants is one of the only genetic differences between men and women (Orbach, 1998, p. 23). Yet it is used to create an unequal division of labour, power, roles, and expectations which has become institutionalised (Orback, 1998, p. 23).

Modern female dieting and eating behaviour descend from a long history of unequal eating. Women have always eaten less and worse than men. For example, in mediaeval France, women received a third less grain (Wolf, 2002, p. 190). Today where hunger goes, women are still the first to notice (Elks, 2020). Hunger is ingrained in the upbringing of women starting from birth. In a sample of babies, girls were fed twice as short and only got breastfed 66 per cent of the time, as opposed to 99 per cent of boys (Orbach, 1998, p. 31). A study in the United States found that parents urge their sons to eat regardless of their weight, while they only do so with their daughters if they are relatively thin (Wolf, 2002, p. 191).

If women cannot eat the same food and portions as men and have never been able to, they cannot experience the same social status and honour as men. This gender inequality around food and eating contributes to the development of eating disorders, as individuals, especially women, internalise and embody these behaviours. The norm to eat less or alter behaviour can lead to restrictive eating patterns, excessive exercise, or even purging behaviours. Therefore, understanding the meaning of food within the context of gender inequality and its direct impact on behaviour is crucial to recognise the social nature of eating disorders. They arise from

unequal power dynamics that shape the relationship with food, body image, and self-worth. If eating disorders are feminine and exist to change something about the female body, then this same female body is seen as wrong and less than a mens (Wolf, 2002, p. 196). Women are made to hate their bodies, and with that also hate their femaleness (Wolf, 2002, p. 197). It can not be a coincidence that society dismisses a female illness, and sufferers feel guilt.

The Political Dimension of Eating Disorders

In the previous sections, I have demonstrated the medical and social dimensions of eating disorders. In the medical dimension, I defined various eating disorder types beyond the commonly mentioned anorexia nervosa and bulimia nervosa, highlighting the misconceptions and stigma surrounding these illnesses. The social dimension depicted societal pressures, including social norms and beauty ideals, and gender inequality as contributing factors to the development of eating disorders. I discussed how stereotyping and unequal treatment and expectations contribute to the marginalisation of female experiences and the increasing prevalence of eating disorders.

In the final chapter, I create the argument that eating disorders contain a crucial political dimension. To build up this argument, I connect society to politics by discussing Hannah Arendt's division between the social and the political. Arendt's theory of the social and the political argues that these two realms are distinct. While her works continue to impact the world, feminist literature widely critiques them. I argue for the inherent relations between the social and the political. This is relevant for the overall argument as it connects the social dimension to the political dimension. By connecting the social and the political, I can show how they flow into

each other and claim that social issues, including those discussed, are present in the political dimension, influencing its inner workings. I use arguments and critiques made by Judith Butler, Simone de Beauvoir and Michel Foucault to show that, according to feminist and critical thinkers, the social and the political deeply connect. After having constructed this argument, I use this knowledge to connect this society to the oppression of women. I argue that eating disorders are a political tool to oppress the female population by looking at the beauty myth and the meaning of female fat. These examples support the important political dimension of eating disorders that need to be seen in conjunction with the social and medical dimensions to understand their prevalence.

Hannah Arendt

Hannah Arendt was a prominent German political theorist and philosopher exploring themes including power, freedom, and the nature of political action during Nazi Germany and Soviet communism (Passerin, 2006). One of her notable works is *The Human Condition*, which describes that the social and the political are fundamentally distinct and separate spheres of human activity (Arendt, 1958, p. 28).

The political realm is the more fundamental realm, as Arendt saw political action as an expression of human freedom and the highest form of activity. Humans transcend their interests and work towards common goals of universal significance through public and collective action and power in this political realm (Arendt, 1958, pp. 30-31). The political realm, or the public sphere, works as a space for action and negotiation so individuals can engage in meaningful dialogue and build coalitions. It preserves human freedom and autonomy.

The social realm, or the private sphere, is characterised by activities and relationships that revolve around the necessities of life and the human conditions of labour, work, and sociability (Arendt, 1958, pp. 30). The social is about satisfying human desires, including the need for food, shelter, and companionship, both biological and material (Passerin, 2006).

The social realm is a counterbalance to the political, providing individuals with a space of individuality essential to developing an identity. Because of this counterbalance, Arendt is convinced that the social and the political operate according to different principles and, therefore, must be distinct. The social realm serves necessity, and the political realm uses the principle of freedom (Arendt, 1958, pp. 28-31). The social domain is insufficient for human flourishing, as solely in the political realm do individuals achieve their true potential. The private sphere represents intimacy, individuality, and personal interests and identities. Therefore, this is inherently not public and political as it has nothing to do with shared goals.

To Arendt, the modern world is one of mass society, and the rise of the social threatens the distinction between the social and political realms (Passerin, 2006). The rise of the social resulted from the emergence of new forms of social organisation based on economic expansion in the 18th century and administrative criteria instead of classically emphasising human agency and individual responsibility (Arendt, 1958, pp. 38-50). While social labour, the production and reproduction of goods and services needed for life maintenance is crucial, it should also stay separate from political action. Through economic growth, social labour became more time-consuming, leaving less energy to engage in the political sphere. Arendt argues that social labour can interfere with the development of the public sphere through a preoccupation with material concerns and individual interests (Arendt, 1958, pp. 38-50).

Bringing the social into the political makes individuals more concerned with their material well-being than the common good of the public sphere. She actively believed that making the personal political could reduce individual freedom and autonomy as personal choices and preferences are subordinated to political goals and objectives (Arendt, 1958, pp. 73-74). When the personal becomes political, people are no longer free to base their choices on their values but rather according to conformity and political ideology. When the personal is political, it leads to the erosion of individuality. Blurring the boundaries can lead to politicising issues that exclusively belong to the individual, such as personal relationships and family dynamics (Arendt, 1958, p. 41). Eating disorders fall into this category. Seen as a private issue, they should not penetrate the political realm. To Arendt, a bodily illness should be part of the social realm and could not be caused or related to political issues.

While Arendts' ideas continue to shape political philosophy, they have come under much criticism. Some scholars argue that her separation is too rigid and fails to account for the intertwinings of the two spheres where social actions, for example, are necessary for political activity (Pitkin, 2008). Some argue that especially relationships and family dynamics, and other social topics have important political implications and can not, in any way, be neatly separated from the political (Mouffe, 1992).

The Social is Political

In this second part of the chapter, I present some counter-arguments to Arendt. Her theory received critique over the years, and many relevant philosophers have published their stances in reaction. I start with Simone de Beauvoir as she argued that gender, a social topic, is political. I

add Michel Foucault and Judith Butler. I take these thinkers to make my point, as they have contributed valuable works on relevant topics that are still influential in debate. De Beauvoir and Foucault lived in this same period as Arendt, contrasting her ideas in the same context, and Butler adds a more modern view. This creates a connection between people and their politicisation and place in society. I combine their critique of Arendt with theories on power, oppression and ideals to provide more support to make the claim of eating disorders as political in the final section. While theories could have been added throughout the dissertation, I present them in this section to keep the overview comprehensible and their ideas organised.

Simone de Beauvoir

Simone de Beauvoir, a renowned French philosopher and feminist theorist of the 20th century, is known for her contributions to existentialism and feminist theory. She wrote the groundbreaking work *The Second Sex* in 1949, challenging traditional notions of gender and power dynamics. De Beauvoir argues that gender is a social construct and that it is used to justify the subordination of women. In this work, she also saw gender as a political issue. Challenging it was vital to achieving gender equality.

De Beauvoir sees gender as political while it is socially constructed. She challenges the belief that women are inherently subordinate to men, asserting that their subordination results from socialisation practices defining femininity as passive, emotional, and dependent (Simons, 1949). According to Beauvoir, gender inequality and the perception of women in relation to men are rooted in deep-seated social norms and institutional mechanisms reinforcing the patriarchal structure of society (de Beauvoir, 1949). Within this, she recognises that gender roles are not

simply individual preferences but are embedded in society. Therefore, it is not only related to the self and society but also to the political. It also leads to significant political implications, as changing the gender norms would require political actions to go against practices and institutions. Therefore, feminists must go beyond individuals and must address systematic factors. De Beauvoir's argument demonstrates a connectedness between the social and the political, stating that social norms are not neutral but shaped by power relations and politics (1949).

Within her work, de Beauvoir examines the oppression of women extensively. Some key themes that she presents are social construction, the roles of socialisation, and the impact of the patriarchy. As she argues that womanhood is constructed she touches upon the myth of woman, which refers to challenging the notion of essential femininity (de Beauvoir, 1949, p. 34). The myth of women argues against the idea that women possess inherent characteristics or qualities, and it moves into her other concept of the otherness of women. De Beauvoir asserts that women have been relegated to a position of otherness, defined in opposition to men, which resulted in their marginalisation and subjugation (de Beauvoir, 1949, p. 26). Women have been seen as others based on their socially constructed qualities. They are defined in terms of their differences from the constructed male form. Through their othering, women are restricted in their agency and self-determination (de Beauvoir, 1949, p. 78). The position of the Other denies women full autonomy and limits their ability to define themselves independently of societal expectations and masculine norms. Women's reproductive roles and how they have been controlled and regulated by society are an example of these limits. There are often multiple means, such as religious

injunctions, legal restrictions, and social pressures, intending to maintain patriarchal power structures.

She argues that the impact of patriarchal systems and power structures maintains women's subordination (de Beauvoir, 1949). She states that the patriarchy is a social organisation placing men in positions of power and authority and women in subordinate positions, creating a hierarchical structure in political, economic, and social areas, leading to the marginalisation of women (de Beauvoir, 1949).

Michel Foucault

In his essay "What is Critique?" Foucault goes against Arendts' distinction as he believes it problematic since it obscures how power operates within social relations (Foucault, 1996). Foucault, a French historian and philosopher, states that power is not simply present in the political sphere but also within the social realm (Foucault, 1996). He worked extensively on power, knowledge, sexuality, and punishment and how these shape individuals, institutions and societies (Gutting & Oksala, 2003).

His concept of power/knowledge suggests that power is not, per definition, repressing individuals but can also work to create new forms of subjectivity, productivity and social relations. The work *The Birth of Biopolitics* (Foucault, 1979) contains an example of governmentality. Governmentality refers to power operating through techniques that shape the behaviour of individuals and populations (Foucault, 2010, p. 16). Modern states use surveillance, discipline and regulation to control their citizens and ensure obedience. Governmentality does only include political power, but also the regulation of social and economic relations.

Neoliberalism, the dominant form of governmentality in contemporary societies, transforms them into political issues. In this process, the line between the social and the political becomes blurred. This blurring, Foucault states, also happens in the production and regulation of knowledge. Knowledge is not neutral but shaped by power relations and interests. As a result, the production and dissemination of knowledge is a form of governance and shapes how the population and individual people understand and act within the world. Through all these examples, Foucault shows that power is not solely present in politics but also used throughout social relations, including practices and everyday discourses (Foucault, 1996).

While Foucault did not place a central focus on eating disorders in his work, he touched upon related topics indirectly. His framework of power relations, subjectivity, and societal norms can provide insights into the broader context of body, health, and social practices relevant to understanding eating disorders as a political issue. He argues that the body is not simply a biological entity but rather a site of power (Foucault, 2010). He disregards the idea that the body is neutral, emphasising its shaping through historical, cultural, and social forces.

A key concept he brings up regarding the body is biopower (Foucault, 2003, p. 243). The term refers to how power operates in the collective life of populations, focusing on managing and controlling life processes, such as birth, death, health, and reproduction (Foucault, 2003, p. 243). He states that modern society develops new forms of power that regulate and govern populations through techniques; such as surveillance, medicalisation, and normalisation. These mechanisms extend power beyond the individual body and into the realm of societies.

Foucault also discusses the concept of docile bodies, which is the idea that bodies are subjected to disciplinary practices to make them obedient, productive, and efficient (Foucault,

1979, p. 135). These practices often arise in institutions, including schools, hospitals, and prisons, where individual bodies are trained, regulated, and made docile to serve specific purposes. In *Discipline and Punish: The Birth of the Prison* (1979), Foucault mentions some examples. The first example is disciplinary practices in schools. Within this institution, students' bodies are subject to strict regulations and surveillance (Foucault, 1979, p. 136). The techniques to achieve this are, for example, hierarchical structures and examinations. Foucault states that schools are powerful mechanisms of control and create a system with constant monitoring and assessment based on performance. Examinations are not only a measurement tool but also create discipline and conformity. The students are expected to adhere to specific standards, follow prescribed curricula, and achieve desired results to succeed within the educational system. The hierarchy of authority creates a pervasive atmosphere of visibility and scrutiny, and the constant presence of teachers instils a sense of control.

Foucault explores how power operates through various strategies to control and disciple bodies, including those related to bodily practices and beauty norms. Beauty norms can be seen as mechanisms of control reinforcing societal expectations and perpetuating oppressive dynamics. His analysis of regulation and surveillance techniques relates to beauty norms and the oppression of women. Beauty norms can be seen as a manifestation of biopower, as they influence and regulate the bodies of individuals within the society. Beauty standards can be used to shape and control collective notions of attractiveness and contribute to the production of particular subjectivities. These norms are one aspect of the inscription of power on the body. The body becomes a target of power, subject to social expectations and pressure to conform to specific ideals.

While Foucault did not focus primarily on the oppression of women, his theories can be applied to understanding certain aspects and offer insights into broader power dynamics and societal structures that contribute to oppression. This analysis can provide a theoretical lens to consider how social and political forces impact body image, self-perception, and the development of disordered eating habits, which can be expanded upon with specific examples from the works of other philosophers.

Judith Butler

Butler argues that Arendt fails to recognise how social and individual experiences connect to overarching political structures and processes (Butler, 1997). Judith Butler is an influential American philosopher, gender and critical theorist most known for their work on gender and queer theory (Duignan & Meinwald, 2023). They described critiques of how the separation does not give an adequate understanding of power in the private realm in the book *The Psychic Life of Power* (Butler, 1997). Butler argues that power is not only present in the public sphere, but also seeps into personal life through social norms, expectations, and cultural practices. In their book *Gender Trouble: Feminism and the Subversion of Identity*, they argue that gender holds power in both the private and the public spheres (Butler, 1990). According to Butler, gender is not a fixed identity but is reiterated through actions and behaviours. They claim that social norms and expectations shape gender and that the power dynamics present in society shape these norms. They state that, for example, what it means to be either “man” or “woman” is shaped by our cultural norms enforced through various forms of power, such as institutional policies, social pressures, and media representation (Butler, 1990, pp. 118-119). When constantly

presented with these norms and views, they slowly seep into the private sphere and form how we think about ourselves and our relationships with others. For example, how we understand and adhere to gender norms possibly affects romantic relationships, our interactions with friends and family, and even our sense of self and self-worth.

In short, Butler argues that the public is present in the private. The power of the public sphere shapes how we understand and interact with ourselves and others. Personal values are not only transferred from person to person. They are profoundly shaped by larger social and political environments. Therefore, their critique of Arendt is that one can not separate the private and the political as power relations press through both simultaneously.

Butler also critiques Arendts' argument of individual freedom and autonomy and seeing the person as subordinate to the political. Arendt states that individuals are increasingly subjected to conformity and standardisation, which limits their freedom of action. This conformity limited their effectiveness in political action as this is best done when individuals can think and act freely (Passerin, 2006). However, Butler argues that this stance overlooks the crucial social action that promotes political change (1997). They state that social action against the political system is vital to challenge the norms and practices that shape current society and personal experiences and relationships within it. Political action is never simply the result of individual agency but is always shaped by social forces (Butler, 2005, p. 4). This statement comes together with her argument that individuals are not solely autonomous agents but also subjected to overarching social structures.

Butler discussed eating disorders concerning her broader analysis of identity, gender, and body image. The cultural ideas of beauty, which emphasise thinness, create a normative

framework of conformity (Butler, 2004). This framework can lead to body dissatisfaction and internalised inadequacy (Butler, 2004). The drive to attain a specific shape ties into societal expectations and gender norms. They suggest that eating disorders are performative acts shaped by power dynamics in the social context (Butler, 2004). Butler explores the contribution of the patriarchy and societal pressures to body image issues and disorders of eating patterns. While they do not specifically link eating disorders to female oppression, the broader themes are addressed in their works. Butler speaks of gender performativity, which refers to the idea that gender is not a fixed identity but performed and constructed through everyday actions, language, and behaviours (Butler, 1990, p. 179). Individuals continually practise gender by conforming to societal norms and expectations. Butler highlights how these norms can serve as control mechanisms, shaping how individuals express their gender identities (Butler, 1990, p. 159). The same could be said for beauty norms and ideals. Their control extends beyond individual experiences and contributes to the systematic oppression of women. By adhering to and reinforcing societal gender norms, individuals unknowingly participate in perpetuating gender-based inequalities and power dynamics.

Through the knowledge theories of Butler, de Beauvoir, and Foucault, I have shown that the theory of Hannah Arendt, in which she claims that the social and the political are two completely separate realms, does not hold up. Feminist scholars and critical thinkers agree on their innate connection showing that multiple social issues are political, and politics seeps into the social. These thinkers use examples from gender to knowledge production. This scope shows even more in how far the social is political. De Beauvoir underscores the social construction of gender and the impact of patriarchal systems. Foucault emphasises the intricate working of

power dynamics and their place within social relations, discipline and regulation of behaviour and bodies. Butler highlights the significance of social norms and institutions. These perspectives collectively emphasise that eating disorders cannot be reduced to solely medical or sometimes social problems, but are deeply embedded in political contexts. I will expand on this argument in the final section, arguing exactly how eating disorders are used to oppress women and that they are, in part, a consequence of the politicisation of individuals.

The Oppression of Women

According to Iris Marion Young, a political theorist and feminist philosopher with work on social justice and critical, democratic, and feminist theory, oppression is a structural phenomenon (Allen, 2008). Oppression refers to the vast and deep injustices various groups suffer as a consequence of everyday practices of a well-intentioned society (Young, 1990, p. 41).

In this final section, I argue that the structures of oppression uphold a system that continuously undermines female power and that the political dimension of eating disorders could be viewed as a solution to achieve this. I first work through examples of oppression to depict the depths of female oppression. Next, I explain the political function of the beauty myth. I use the work of Naomi Wolf to work through this concept. While some of her ideas may be slightly outdated, I agree with the overarching argument she makes. Lastly, I speak of the symbolic meaning of female fat, emphasising what eating disorders try to oppress.

The oppression of women has been deeply rooted in legal and economic systems, structures of violence, and cultural norms, leading to systematic disadvantages and unequal treatment (Young, 1990, p. 39-65). These multiple faces, while only some examples, provide an

insight into female struggles. Women have often been subject to legal and political restrictions limiting their rights and autonomy (United Nations Human Rights, 2014). Women's rights to own property, participate in politics, education, and bodily autonomy are still limited in the form of legal barriers (Center for Reproductive Rights, 2022). Economically, women are paid less than male colleagues and are sometimes excluded from professional fields (Fransen et al., 2010). Domestic abuse, sexual assault, and harassment are widespread: leading to oppression through violence and abuse (Cudd, 2006). These structures create a culture of silence and the oppression of women. Social and cultural oppression is entrenched in societal norms and practices that limit freedom, agency, and self-expression through objectification, societal pressures, and beauty standards.

In her book, *The Beauty Myth* (1990), Noami Wolf details how socially constructed beauty becomes an oppressing norm through institutions such as the media, advertising, and the beauty industry. I use this book to show how eating disorders can be regarded as political. I present her work to support my claim and underline my argument.

Wolf speaks of the beauty myth, referring to the idea that the pursuit of physical attractiveness and adherence to conventional beauty standards are used as a means of social control that targets women (Wolf, 1990). These standards often portray youth, flawless skin, and specific proportions so that women's self-worth depends on their appearance. Wolf (1990, p. 186) and Widdows (2018, pp. 118-119) discuss the one-stone solution, which drops the ideal weight one stone, or about 6 kg, below most women's natural weight. Following this ‘solution’ creates a wave of self-hatred in Western society, making space for the beauty and cosmetic industry to exploit. As the ideal is below the average weight, it ensures that women are constantly obsessed

with maintaining a shape that is not *natural* to them. This obsession can be the precursor of a pattern of unhealthy eating habits (Shisslak et al., 1995).

According to Wolf (2002), the beauty myth serves a political purpose. She states that the more powerful women have become politically, the heavier these ideals weigh down on them. These pressures cause them to focus their energy solely on their appearance and distract from progress and important personal aspects such as education, career, and personal fulfilment. She argues that the myth is created out of political fear as women gain power and freedom that threatens the status quo (Wolf, 2002, p. 16). The possibilities for women have grown exponentially and, therefore, threaten to destabilise the institutions of male-dominated culture (Wolf, 2002). The beauty myth is not about women but, at its heart, connects to male institutions and institutional power (Wolf, 2002, p. 13). There is no biological justification for the beauty myth and self-starvation; it is the realisation of current power structures, economy, and culture to create a counteroffensive against women (Wolf, 2002, p. 13). Wolf (2002) argues that it is not about appearance but about prescribing behaviour and power relations.

The described oppression of women means that their bodies are subject to society. I argue that eating disorders correlate to this oppression as the rise of eating disorders has, on multiple accounts, coincided with political change for women. Wolf (2002, p. 184) states that the obsession with thinness began to occupy the female mind when Western women received voting rights between 1918 and 1925. Simultaneously, one of the thinnest beauty ideals was present (Harrison & Cantor, 2006). Wolf indicates another parallel in the 1960s when women entered male dominated spheres. In the two decades after the beginning of second-wave feminism, the

prevalence of anorexia nervosa experienced a drastic increase just as the beauty ideals dropped in weight (Wolf, 2002, pp. 184-185).

To discuss eating disorders, often resulting in weight loss, means to discuss the inherent symbol of female fat. Society sees having fat as a lack of self-control or willpower (Orbach, 1998, p. 22). Being fat has been reduced to personal failure rather than looking at the current social conditions or other contextual reasons (Orbach, 1998, p. 22). In *Fat is a Feminist Issue*, Susie Orbach states that being fat is a way to express the anger women are denied and raised to suppress (1998, p. 49). According to her, fat means protection, sex, nurturance, strength, boundaries, mothering, assertion, and rage (Orbach, 1998, pp. 22-23). It can be a direct response to gender inequality and the oppressive manifestation of a sexist culture. It is a way of rejecting powerlessness and demands of female appearance (Orbach, 1998, p. 33).

According to Wolf, female fat subconsciously relates to fertile sexuality (2002, p. 184). Researchers from the University of Hawaii School of Medicine found that women with more fat tend to have more sex than thinner women (Kaneshiro et al., 2008). Nobel prize-winning geneticist James Watson explained that extra fat boosts endorphins and sexual desire-linked hormones (McVeigh, 2000). Fatty tissue stores sexual hormones, and low-fat reserves are connected to low levels of oestrogen and other sex hormones and inactive ovaries (Wolf, 2002, p. 192). Therefore, fat is not simply a bodily tissue but can regulate female sexuality (Wolf, 2002, p. 192). Thus, she states, to ask a woman to become unnaturally thin, with a fat-to-lean ratio below 22 per cent, is to ask her to give up her sexuality (Wolf, 2002, p. 192).

Dominant culture articulates the morality of female fat with words as good or bad and feeling guilty for not being thin enough. We express shame when we feel we did something

wrong, which results in punishment (Wolf, 2002, p. 186). However, the sufferers of eating disorders are not the ones that should experience guilt. The dominant feeling of guilt shows that the cultural obsession with thinness does not relate to female beauty but to obedience. If the conversation revolved around health, the debate would not discuss females to this extent. Too much fat is far more dangerous for men than women, and there is little to no evidence to conclude that a degree of fatness causes poor health among women (Wolf, 2002, p. 186). Men are more likely to develop health conditions related to weight (Rudnicki et al., 2022). A study in 1990 looking for a link between obesity and heart disease in women shows that weight only mattered a fraction of what it did in male subjects (Wolf, 2002, p. 187). The film *The Famine Within* highlighted a study in sixteen countries that failed to recognise the correlation between fatness and ill health (Wolf, 2002, p. 187). Female fat is not necessarily unhealthy. The magazine Radiance stated that research has shown that women may have a longer and healthier life if they way up to 15 per cent above the life insurance figures and refrain from dieting (Wolf, 2002, p. 187).

The patriarchal structure oppresses outspoken en assertive women with boundaries, trying to curb them from existing. Prolonged and periodic caloric restriction, i.e. eating disorders, result in distinctive personality traits such as passivity, anxiety, and emotionality (Herman & Polivy, 1975). Wolf suggests that those are precisely the traits the dominant culture seeks to incite in women's private sense of self (2002, p. 187), making dieting the most important sedative in women's history.

In conclusion, the female beauty ideal, leading to self-starvation or other coping mechanisms, is not a cultural aesthetic but an unconsciously used political solution to oppress

women. Eating disorders are a logical response to this oppression, trying to regain control of a situation. By observing eating disorders through this lens, we can understand them as a form of self-defence against the political agenda working to undermine women. Women are subjected to societal pressures that demand conformity to an image devoid of fat and power, forcing them to sacrifice an essential part of themselves in pursuit of acceptance. The link between the political dimension of eating disorders and the oppression of women sheds light on their societal prevalence. By acknowledging this underlying dynamic, we gain a deeper understanding of the motivations behind these disorders and the urgent need for broader societal change as our communal attitude shapes the context in which we harm or empower individuals.

Conclusion

In this dissertation, I defended the statement that acknowledging the political dimension of eating disorders in conjunction with their social and medical facets is vital to comprehend their societal prevalence and relation to oppression. By highlighting their medical and stereotypical view, I critique the narrow understanding of eating disorders and highlight their medical stigmatisation. I emphasise the need to consider their social and political aspects. The subsequent two chapters show what these aspects entail. The second chapter explored the significance of the social dimension of eating disorders. I focussed on the pressures and expectations through social norms and the gender inequality in gender roles and eating behaviours. The pressure to conform to societal expectations for acceptance becomes a moral duty, and the portrayal of beauty perpetuates these cycles of pressure. The dismissal of female eating disorders and male experiences can be attributed to deep-rooted misogyny, internalising gender stereotypes and devaluing femininity. That eating disorders overwhelmingly are a feminine problem suggests a relation to the experience of being a female in current society. Therefore, in the final chapter, I explored the connection between the social and political. I showed that these realms are connected and influence each other by disproving Hannah Arendts' separation, using the theories of de Beauvoir, Foucault, and Butler. These thinkers provided insightful views on power, gender, and the oppression of women, which I used to strengthen my argument. They demonstrate that societal pressures, cultural norms, and power relations play a critical role in developing disordered eating behaviours. The last section of the third chapter highlights the final element of the dissertation statement as it connects eating disorders to oppression and their political motivation. Women's oppression is a structural phenomenon rooted

in legal, economic, and cultural systems, leading to systemic disadvantages and unequal treatment. The socially constructed beauty standards promoting self-starvation are not cultural obsessions but an unconscious political means to oppress the female population, denying them their agency. This final argument adds an overlooked dimension to the recognition of eating disorders and further attempts to reduce the medical stigmatisation and dominance of eating disorders in society.

By recognising the social and political dimensions of eating disorders, we can move beyond the stigmatisation of individuals and instead focus on addressing the systemic factors that contribute to the increasing prevalence of these harmful conditions. Eating disorders are political phenomena that call for a collective effort to dismantle harmful norms and challenge oppressive systems. If not, we continue to live in a society continuously telling women that they; are not enough; cannot be accepted as they are born; have to fight for recognition; can only be seen through the eyes of others. We need to make sure that we create a culture that celebrates body diversity, rejects unrealistic beauty standards and radiates acceptance. This requires a systematic change and the implementation of inclusive practices and policies, fostering a healthy relationship with food and the self. Only through a multifaceted approach can we truly address the complexities of eating disorders and work towards a more inclusive and compassionate society.

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