Objective: A key feature of the stereotype that exists of those groups and individuals most likely to develop an eating disorder relates to socioeconomic status. The prevailing wisdom about this relationship is that there is an increased prevalence of eating disorders in high socioeconomic groups. The aim of this paper is to assess the validity of this view and to examine the ways in which this stereotype was created. Method: Articles written between the early 1970s and the early 1990s, which include assessment of socioeconomic status, are reviewed and the evidence for and against the stereotype is examined. Results: It was found that existing research fails to support this stereotype for eating disorders as a whole, that the relationship between anorexia nervosa and high socioeconomic status remains to be proved, and that there is increasing evidence to suggest that the opposite relationship may apply to bulimia nervosa. Discussion: The powerful influence of clinical impression, sources of bias in referral procedures, methodological problems in existing research, and the failure to adequately separate anorexia nervosa from bulimia nervosa when referring to common predisposing factors, are discussed in relation to why the stereotype exists. © 1996 by John Wiley & Sons, Inc.

It has become something of a cliché to quote an observation made by Fenwick (1880) over 100 years ago, that anorexia nervosa was more commonly found in the wealthier classes of society than amongst those who have to procure their bread by daily labour. Yet it is this observation that provided the basis for one of the key stereotypical features currently attributed to those groups and individuals most likely to develop an eating disorder, and which frequently figures as a feature meriting etiological status in eating disorder theory. To this day the prevailing wisdom concerning the relationship between eating disorders and socioeconomic status in both the professional and the lay person’s mind, is that there is an increased prevalence of eating disorders in high socioeconomic status groups.
The aim of this paper is to review the evidence from existing research for and against this stereotype, to discuss how and why the stereotype exists, how valid it is in the face of the evidence, and to address the implications the stereotype has for theories of etiology. It is argued that evidence from research does not support the relationship between eating disorders and high socioeconomic status but that despite the lack of empirical evidence, the stereotype remains firmly entrenched. A number of factors are suggested that could account for this anomaly including the powerful influence of clinical impression, sources of bias in referral patterns, problems in the methodology of existing research, and the failure to adequately separate bulimia nervosa from anorexia nervosa when discussing common predisposing factors.

REVIEW

Few studies have specifically addressed the relationship between socioeconomic status and eating disorders, although a number of studies have included socioeconomic status as one of the demographic variables assessed. Papers published before 1970 are not included in the present review because poor methodology makes comparisons with later studies difficult to interpret. Studies showing an excess prevalence of anorexia nervosa in high socioeconomic groups were reported during the 1970s and early 1980s six times in Britain (Kendell, Hall, Hailey, & Babigan, 1973; Morgan & Russell, 1975; Crisp, Palmer, & Kalucy, 1976; Kalucy, Crisp, & Harding, 1977; Crisp, Hsu, Harding, & Hartshom, 1980; Margo, 1985) and once in both the United States (Garfinkel & Garner, 1982) and New Zealand (Hall 1978). Following the “discovery” of the disorder, the first papers describing bulimia nervosa reported that the same relationship applied (Johnson, Stuckey, & Lewis, 1982; Fairburn & Cooper, 1984). However, from the mid 1980s to the present, an increasing number of studies have examined the relationship between socioeconomic status and eating disorders. Since 1983, 13 studies have failed to find a relationship between high socioeconomic status and eating disorders and of these, 5 studies have found the opposite to be true.

Early Studies

The following studies illustrate some of the methodological problems present in the early studies which demonstrate an increased prevalence of eating disorders in high socioeconomic groups. In 1973 Kendell et al. summarized demographic data on anorexia nervosa from retrospective reviews of the psychiatric case registers of three different areas: North-East Scotland, Camberwell in London, and Monroe County, New York State. The authors concluded that the findings of their review provided substantial evidence for a high socioeconomic status bias in anorexia nervosa. However, the number of cases identified in each area was small, and the one register reporting a significant relationship between high socioeconomic status and anorexia nervosa was based on only 8 patients with anorexia nervosa. The validity of the authors’ conclusion was made more questionable by their assumption that “nearly all anorexics living in a register catchment area are sooner or later seen by a psychiatrist and reported to the register.” No attempt was made to justify this assumption at the time, and more recent studies indicate that it is ill founded (Goldberg & Huxley, 1980; Hoek, 1993).

In 1976, Crisp et al. published the findings of their study of the prevalence of anorexia nervosa in nine populations of schoolgirls between 1972 and 1974. The authors concluded
that severe anorexia nervosa in girls aged over 16 was found five and a half times more frequently in private schools compared to state schools and that this discrepancy almost certainly reflected a socioeconomic status factor for the disorder.

However, the methodological problems of this study render the seminal conclusions of its authors highly questionable: Firstly, the authors report that they surveyed the schoolgirls whereas in fact no survey took place. Instead, all cases were “case-spotted” through the authors collaboration with teachers at the schools. One way in which bias could be introduced into this method of case detection is apparent from the authors’ own observation that “it was immediately clear that all the independent schools were very familiar with the problem.” It is possible that given the greater awareness of anorexia nervosa on the part of staff at private schools, that staff at these schools might attribute a psychological origin to thinness in a pupil whilst thinness in state schools might be attributed to deprivation by their less informed state school colleagues. The fact that four of the private schools included in the study were selected because there had been one or more referrals to the authors’ clinic from those schools, whilst no referrals had come from either of the participating state schools, appears to confirm this suspected bias. Finally, seven of the nine participating schools were privately run whilst only two were state run. Thus, the number of pupils “surveyed” in the private schools was four and a half times greater than those “surveyed” in the state schools.

Two case series reports by Morgan and Russell (1975) and by Crisp et al. (1980) are frequently referred to as providing substantial proof of a high socioeconomic status bias in anorexia nervosa. Yet in both these series, only the most severe cases are included, shedding doubt on the validity of their findings. Subjects were all patients with long histories of illness, resistant to treatment, and at the time of assessment many were tertiary referrals. In the first series, Morgan and Russell found that 66% of their anorexic patients came from socioeconomic groups I and II whilst only 18% of the general population came from these groups. It is ironic, given how seminal this report became, that even at the time the authors questioned the validity of their results, comparing their results to those derived through epidemiological study and stating that: “it is uncertain, therefore, whether higher social class is associated with increased causal factors, or merely reflects differences in attitude to feeding disorders and a willingness to seek psychiatric help.”

In 1982, Garfinkle and Garner stated that until the late 1970s no adequate investigations of the prevalence of anorexia nervosa existed. Given this lack of any real population data and the methodological problems of most of the earlier studies, it is somewhat surprising that the relationship between high socioeconomic status and eating disorders was considered confirmed. It is interesting to note how a clinical myth builds up evidence to support the myth. For example, one early anorexic case series which is frequently referenced as supporting an increased prevalence of eating disorders in high socioeconomic groups, actually contains no assessment of socioeconomic status at all (Halmi, 1974; Dolan, Evans, & Lacey, 1989; Hall, 1978). Another example is the demographic review by Kendell et al. (1973), which the authors claimed provided substantial support for high socioeconomic bias in anorexia. Yet, as previously mentioned, this widely referenced conclusion was based on only one of the three registers analyzed, and unlike the slightly larger registers which demonstrated no socioeconomic bias, this register contained only eight cases (Crisp, et al., 1980; Morgan & Russell, 1975; Szmukler, McCance, McCrone, & Hunter, 1986). However, the myth became a clinical fact, so much so that in 1985 in his theoretical paper on the epidemiology of eating disorders, Szmukler (1985), having assessed existing prevalence studies, merely stated that “the relationships with sex, age and social class are well known.”
Recent Studies

In the United States, two epidemiological studies conducted in the mid-1980s, examining the prevalence of bulimia nervosa and bulimic symptoms in high school students, found no significant socioeconomic status differences between bulimic and nonbulimic students (Crowther, Post, & Zaynor, 1985; Johnson, Lewis, Love, Lewis, & Stuckey, 1984). In the introduction of the second of these studies the authors, referring to normal-weight bulimics, state that "these individuals are predominantly single Caucasian females in their early 20's who are well educated. . . ." Given these assumptions, the authors' conclusion that "analysis of the demographic data did not yield any differences between the two groups" comes as somewhat of a surprise.

In Britain, two epidemiological studies have been conducted using London schoolgirls. In both studies, no relationship between socioeconomic status and eating disorders was found (Mann et al., 1983; Johnson-Sabine, Wood, Patton, Mann, & Wakeling, 1988). In the summary of the latter study, the authors point out that the results of their study fail to substantiate many of the generally accepted associations between putative risk factors for eating disorders, particularly socioeconomic status, and abnormal eating attitudes in schoolgirls. Instead, they found that many of these "accepted risk factors for eating disorders" were associated with general psychiatric morbidity and were not specific to eating disorders.

Two other British studies found no relationship between eating disorders and socioeconomic status: In the first, the demographic profiles of two different psychiatric groups were compared in a retrospective case note study (Eagles, Wilson, Hunter, & Callender, 1990). All young females diagnosed as anorexic between 1972 and 1979 were compared with all those receiving a diagnosis for affective psychosis in the same period. The authors found that although anorexics and young females with affective psychosis constituted two quite distinct patient groups, there was no significant difference between the two groups for socioeconomic status. Commenting on the latter finding, the authors suggest that further doubt is cast upon the traditional belief of an upper social class preponderance in anorexic girls. Leighton and Millar (1985) conducted a case note review of all females diagnosed as anorexic between 1979 and 1983 in Glasgow. In contrast to earlier British case series reports, the socioeconomic status distribution of anorexic patients in Glasgow during this period was no different than that of the local general population. One reason the authors suggest to account for the discrepancy between their findings and the findings of the Maudsley study (Morgan & Russell, 1975) was that the Maudsley group were a selected, more seriously ill sample.

Dolan et al. (1989) state that "reports of the basic family characteristics of anorexia nervosa have suggested that social class, . . . may be associated with anorexia nervosa and may have etiological importance, possibly mediated by effects upon values, attitudes, and patterns of child rearing." However, in two studies specifically examining the relationship between family background and eating disorders, the traditional association between eating disorders and high socioeconomic status was not found (Dolan et al., 1989; Rastam & Gillberg, 1991). In a methodologically rigorous study, Dolan et al. (1989) compared the family composition and socioeconomic status of 50 bulimic patients with 40 control subjects drawn from the same clinical catchment area. This strategy of comparing the clinical population with a sample selected from the same defined area was adopted to minimize the effects of referral bias. The only difference found in the family composition was that the bulimic patients had older parents than controls. No differences were found in family size, birth position, or sibling sex ratio and no differences were found in socioeconomic
status. A total of 86% of subjects were classified for socioeconomic status with 60% being accounted for by socioeconomic groups III, IV, and V. Similarly, the authors of the second study found that there was no support for the notion of a typical anorexia nervosa family. The design and size of this study were similar to the first, except that the patients were anorexic not bulimic. No significant relationship was found between anorexic families and socioeconomic status, but a slight tendency for anorexics to belong to the lowest socioeconomic groups was found.

Since the mid 1980s, five studies have found an excess prevalence of eating disorders in low socioeconomic groups. In the United States, a well-designed epidemiological study using a nonstudent population was conducted, which specifically addressed the relationship between eating disorders and socioeconomic status. Socioeconomic status was classified solely on the basis of income and subjects were drawn from nine communities with different incomes in East Massachusetts. The final study population was evenly matched for lower and upper income subjects. Bulimia nervosa was found to be significantly more common in lower income women than in upper income women. The same trend was observed for anorexia nervosa, but did not reach statistical significance (Pope, Champoux, & Hudson, 1987).

In 1984, Lacey reported that of a sample of female bulimic patients from his clinic, the majority came from socioeconomic group III. Socioeconomic groups IV, II, and I, respectively, were the next most represented groups. In another study focusing on bulimia nervosa, Rand and Kuldau (1990) assessed rates of bulimic symptoms in students and nonstudents. They found that of three bulimic behaviors with differing prevalence rates in groups of subjects of different socioeconomic status, all occurred more frequently in the group with the lower socioeconomic status. In a clinical profile of anorexic patients in a non-Western culture, Lee (1991) described 16 restricting anorexics from Hong Kong. Interestingly, of the 16 patients, only 1 came from a middle socioeconomic status family, while all the rest came from families of low socioeconomic status.

Finally, the traditional relationship between socioeconomic status and eating disorders was turned upside down in a prevalence study conducted by the present authors looking at eating disorders in a young homeless population (Freeman & Gard, 1994). Of the 83 young homeless subjects interviewed, a total of 19.1% of these were found to have an eating disorder, including 2.4% anorexia nervosa; 8.3% bulimia nervosa. Even when the small sample size was allowed for, confidence limits around the rates detected showed a clear excess of eating disorders in the homeless compared to the general population. All homeless subjects came from socioeconomic groups IV and V.

To summarize, between 1973 and 1985, eight studies found an increased prevalence of anorexia nervosa in high socioeconomic groups, but the methodological problems of these studies make their findings hard to interpret and difficult to generalize (see Table 1). From the early 1980s to the present, eight studies have failed to find the same relationship between anorexia nervosa and socioeconomic status, and the results of four of these tentatively suggest the opposite could be true (see Table 2). Two of the earliest reports on bulimia nervosa found an excess of cases in high socioeconomic groups (see Table 1), but nine subsequent reports failed to confirm this relationship, and of these four found the opposite relationship (see Table 2).

To conclude, the evidence supporting a preponderance of eating disorders in high socioeconomic groups appears to be based almost entirely on small, uncontrolled anorexic case series from clinical samples which include large numbers of tertiary referrals (see Table 1). Interpretation of these data in some of the studies reviewed here has clearly been subject to type I error. In contrast, those studies that either found no significant
Table 1. Studies that reported an excess of eating disorders in high socioeconomic groups (SES)

<table>
<thead>
<tr>
<th>Study</th>
<th>Source, Type, Number of Subjects, and Method</th>
<th>SES Distribution</th>
<th>Relationship Found Between SES and Eating Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kendell et al. (1973)</td>
<td>Case register AN patients 1960–1969 (n = 24)</td>
<td>I &amp; II: 40%; III: 54%; IV &amp; V: 17%</td>
<td>No significant excess</td>
</tr>
<tr>
<td></td>
<td>Case register AN patients 1963–1971 (n = 47)</td>
<td>I &amp; II: 34%; III: 49%; IV &amp; V: 18%</td>
<td>No significant excess</td>
</tr>
<tr>
<td></td>
<td>Case register AN patients 1965–1971 (n = 8)</td>
<td>I &amp; II: 85%; III: 14%; IV &amp; V: 0%</td>
<td>Excess in high SES groups</td>
</tr>
<tr>
<td>Morgan &amp; Russell (1975)</td>
<td>Case series AN inpatients 1959–1966 (n = 41)</td>
<td>IV &amp; V: 2.4%</td>
<td>Excess in high SES groups</td>
</tr>
<tr>
<td></td>
<td>Concurrent series of AN patients and families (n = 56)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisp et al. (1980)</td>
<td>Case register follow-up consecutive series AN patients 1968–1972 (n = 102)</td>
<td>I &amp; II: 71.6%; III: 18.6%</td>
<td>Excess in high SES groups</td>
</tr>
<tr>
<td>Garfinkel &amp; Garner (1982)</td>
<td>Case series AN patients before 1975 (n = 51)</td>
<td>I &amp; II: 52%; III–VII: 29.4%</td>
<td>Excess in high SES groups</td>
</tr>
<tr>
<td></td>
<td>Case series AN patients after 1976 (n = 198)</td>
<td>I &amp; II: 52%; III–VII: 48%</td>
<td>No significant excess</td>
</tr>
<tr>
<td>Johnson et al. (1982)</td>
<td>Self-selected BN postal survey volunteers (n = 316)</td>
<td>1: 29.4%; II: 12.9%; III: 25.8%</td>
<td>Clustering of subjects in SES groups I, III, &amp; IV</td>
</tr>
<tr>
<td>Margo (1985)</td>
<td>Case register AN patients 1967–1979 (n = 40)</td>
<td>1 &amp; II: 77.1%; III: 17.1%; IV &amp; V: 5.7%</td>
<td>Excess in high SES groups</td>
</tr>
</tbody>
</table>

Note: AN = anorexia nervosa; BN = bulimia nervosa.

* Monroe County.
* NE Scotland.
* Camberwell.
Table 2. Studies that reported either no significant relationship between eating disorders and socioeconomic status (SES) or an excess of eating disorders in low socioeconomic groups

<table>
<thead>
<tr>
<th>Study</th>
<th>Source, Type, Number of Subjects, and Method</th>
<th>SES Distribution</th>
<th>Relationship Found Between SES and Eating Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann et al. (1983)</td>
<td>Screening for abnormal eating attitudes 15-year-old state school girls (n = 254)</td>
<td>Total population: I &amp; II: 8%; III: 56%; IV &amp; V: 10%</td>
<td>No SES difference between cases and normal subjects</td>
</tr>
<tr>
<td>Johnson et al. (1984)</td>
<td>Screening for BN and bulimic behavior High school students (n = 1,268)</td>
<td>SES not formally assessed</td>
<td>No difference in parental education and employment status between bulimic and normal subjects</td>
</tr>
<tr>
<td>Lacey (1984)</td>
<td>Case series BN patients (n = 50)</td>
<td>SES not formally assessed</td>
<td>Excess in middle and low SES groups</td>
</tr>
<tr>
<td>Crowther et al. (1965)</td>
<td>Screening for BN and binge eating High school students (n = 363)</td>
<td>Total population: I &amp; II: 26.3%; III: 31.2%; IV &amp; V: 42.4%</td>
<td>No SES difference between bulimic and normal subjects</td>
</tr>
<tr>
<td>Pope et al. (1987)</td>
<td>Screening for eating disorders in the community lower vs. upper income communities (n = 394)</td>
<td>SES defined solely by income</td>
<td>BN significantly more common in lower income subjects; Similar but non significant trend for AN</td>
</tr>
<tr>
<td>Johnson-Sabine et al. (1988)</td>
<td>Screening for abnormal eating attitudes State schoolgirls (n = 1,010)</td>
<td>Total population: I &amp; II: 22%; III: 40%; IV &amp; V: 20%</td>
<td>No association between abnormal eating attitudes and SES</td>
</tr>
<tr>
<td>Dolan et al. (1989)</td>
<td>Case series BN patients (n = 50)</td>
<td>I &amp; II: 26%; III: 46%; IV &amp; V: 14%</td>
<td>SES distribution same as local clinical catchment area</td>
</tr>
<tr>
<td>Eagles et al. (1990)</td>
<td>Case register AN patients (n = 73)</td>
<td>I &amp; II: 48%; III: 39%; IV &amp; V: 13%</td>
<td>No SES difference between AN patients and patients with affective psychosis</td>
</tr>
<tr>
<td>Rand &amp; Kulda (1990)</td>
<td>Screening for BN and bulimic behaviors in adult general population (n = 2,115)</td>
<td>I &amp; II (low): 23.5%; III: 23.3%; IV &amp; V (high): 54.2%</td>
<td>Bulimic behaviours with different prevalence rates in SES groups all occurred more frequently in low SES subjects</td>
</tr>
<tr>
<td>Lee (1991)</td>
<td>Case series AN patients (n = 16)</td>
<td>SES not formally assessed</td>
<td>All but one patient from low SES groups</td>
</tr>
<tr>
<td>Rastam &amp; Gillberg (1991)</td>
<td>Case series AN patients (n = 51)</td>
<td>Three-point SES classification</td>
<td>No SES difference between AN patients and age, sex, matched controls. Slight tendency for AN patients to belong to low SES groups</td>
</tr>
<tr>
<td>Freeman &amp; Gard (1994)</td>
<td>Prevalence of eating disorders in young homeless population (n = 84)</td>
<td>All subjects from SES groups IV &amp; V</td>
<td>All cases from low SES groups</td>
</tr>
</tbody>
</table>

Note: AN = anorexia nervosa; BN = bulimia nervosa.
relationship between eating disorders and socioeconomic status or found the opposite relationship are both more various in the methods used, and though far from impeccable appear to be more methodologically sound. Evidence from this group of studies comes from epidemiological surveys of abnormal eating attitudes as well as of the two main eating disorders, and from case series (see Table 2), and conclusions drawn appear to be more in keeping with the results found.

**DISCUSSION**

Considering the lack of empirical validation for a preponderance of eating disorders in high socioeconomic groups, the existence of this stereotype would be mysterious were it not for the influence that clinical impression exerts in the formulation of diseases. Clinicians working in a particular field would not be human if their view of a disorder was not affected by the individuals they saw with that disorder. Indeed, clinical impression is not only valid, it is an invaluable tool in the conceptualization and understanding of diseases. However, the disadvantage of reliance on clinical impression is that these impressions are necessarily limited to cases seen, and thus upon those who receive treatment within the relevant health care system, which is in turn subject to the many biases inherent in the referral procedure. Conclusions drawn by clinicians are necessarily limited by these points and therefore cannot validly be applied to whole populations.

The first clear account of anorexia nervosa dates back to the 17th century (Morton, 1689), whereas bulimia nervosa was first described by Russell in 1979 (Russell, 1979). Until the early 1980s, all the studies which included an assessment of socioeconomic status focused exclusively on anorexia nervosa. Although bulimia nervosa has attracted a great deal of research, stereotypical attributes of the bulimic individual are as yet ill defined. It appears that the stereotype of those individuals most likely to develop an eating disorder is still based almost exclusively upon cases of anorexia nervosa. This is in spite of the fact that bulimia nervosa is now recognized as being a far more common disorder than anorexia nervosa (Fairburn & Beglin, 1990), and that clinical descriptions of bulimic patients paint a picture of a far more heterogeneous group than their anorexic counterparts.

Some methodological problems of the earlier studies demonstrating a preponderance of eating disorders in high socioeconomic groups have already been mentioned. In addition, a pervasive problem which has frequently been noted is that of comparing cases identified in different studies using different diagnostic schemes (Szmukler, 1985); a number of comprehensive critiques of existing epidemiological research have been written (Szmukler, 1985; Hoek, 1993) and the lack of controls in clinical case series has also been noted (Dolan et al., 1989). Therefore, for the purposes of this discussion only a few points will be discussed.

Methods of socioeconomic status classification are different in many of the studies reviewed raising the question of whether systems used to classify social class in Britain and other European countries should be seen as comparable to those used in the United States to classify socioeconomic status. American classification systems tend to stratify according to income alone whilst in Britain stratification based on occupation attempts more overtly to represent both income and education. However, the way in which most studies tend to group the two highest groups and the lower groups together for the purpose of analysis probably makes any discrepancies in classification less important.
The use of the Eating Attitudes Test (EAT) (Garner & Garfinkel, 1979) in epidemiological studies has been criticized on a number of grounds (Williams, Hand, & Tarnopolsky, 1982). However, two points are particularly relevant to this review. First, the EAT was designed to detect cases of anorexia nervosa and is therefore far more efficient at detecting cases of anorexia nervosa than bulimia nervosa. Since evidence from this review suggests that socioeconomic status distribution may be different for the two disorders, the results of studies using the EAT as a screening instrument should be interpreted with caution (e.g., Mann et al., 1983). It has also been suggested that response to the EAT may be affected by socioeconomic status (Eisler & Szmukler, 1985). When mean scores on the EAT from private and state schools were compared, the authors found that although mean scores on the EAT were significantly higher in the state schools, the number of cases of anorexia nervosa identified was higher in the private schools.

The validity of generalizing the findings of epidemiological studies conducted on highly selected, captive populations to the general population has been questioned (Patton & King, 1991). Many studies fail to meet any of the criteria for a good epidemiological study, and yet are labeled as such (Fairburn & Beglin, 1990). Similar problems apply when the captive population being studied is a clinical one (Theander, 1985). In such studies, the nature of the subjects will depend on a number of factors such as the geographical location of the clinic, the demographic distribution of the local population, the availability of other facilities in the area, and whether or not the clinic specializes in eating disorders.

In his excellent review of epidemiological studies and eating disorders, Hoek (1993) uses Goldberg and Huxleys' (1980) model of the pathway to psychiatric care in eating disorders. The model has five levels of morbidity (community, total in primary care, conspicuous in primary care, total psychiatric patients, psychiatric inpatients only) divided by four filters (illness behavior, detection of disorder, referral to psychiatrist, admission to psychiatric beds). Hoek calculates that only 70% of women with an eating disorder in the community will visit their general practitioner for some sort of medical or psychological problem during the course of 1 year. From the model, Hoek concludes that of women with eating disorders who do visit their general practitioner, approximately 50% of anorexia nervosa cases, but only a minority of cases with bulimia nervosa, are detected by their general practitioner. Of the cases detected, most cases of anorexia nervosa, but only half the cases of bulimia nervosa, will be referred to mental health care. Given these figures, the author's suggestion that social class bias might be associated with the structures, norms and thresholds of the health care system seems justified (Hoek, 1993). To summarize, referral procedures necessarily depend on the above points and will also be subject to numerous other sources of bias, the most salient of which are discussed below.

One explanation that has been suggested to account for the under use of health care resources by certain groups in society is that different groups may interpret disease symptoms in different ways. It has been suggested that the low referral rate of black and Asian women suffering from bulimia nervosa to eating disorder services in Britain may be partially attributable to the way in which these women interpret the bulimic symptoms. They are less likely to interpret various symptoms as worthy of medical attention and therefore less likely to present to their general practitioner complaining of an eating disorder (Dolan, Lacey, & Evans, 1990). It is possible that a similar explanation might be applied to the cases of eating disorders found by the present authors in a homeless population, none of whom were receiving treatment, and their disadvantaged status forced them to interpret their symptoms within a hierarchical framework of priorities based on necessity (Freeman & Gard, 1994).
Hoek (1991, 1993) argues that the true incidence rate of bulimia nervosa seems still as much a secret as the syndrome itself is for many patients. He points out that although normal-weight bulimia nervosa is the most common condition in mental health care, incidence rates for bulimia nervosa fail to reflect this. Hoek attributes this discrepancy to the smaller perceptability of bulimia nervosa compared to anorexia nervosa, and states that the condition is frequently missed by general practitioners.

Dolan (1990) suggests that health care professionals may fail to recognize eating disorder symptoms in groups in which they do not expect to find them such as nonwhite women. The homeless are a good example of a population in which eating disorders are not expected, are not looked for, and are not treated. A study conducted by Kutcher, Whitehouse, and Freeman (1985) indicated that it is not just in disadvantaged groups such as the homeless that eating disorders may go undetected and untreated. They found an eating disorder prevalence of 13.8% in a large group of psychiatric inpatients. As was the case with the homeless, very few of these individuals had ever received treatment for their eating disorder. It has been suggested that the idea that professionals may be blind to hidden eating disorders in groups and individuals where they are not expected, might also account for the underdetection of eating disorders in men (Sterling & Segal, 1985), ethnic minorities (Dolan et al., 1990), and in cases younger than the age group most usually associated with eating disorders (Hodes, 1993).

As previously noted, most of the evidence for an increased preponderance of eating disorders in high socioeconomic groups comes from uncontrolled case series on small numbers of anorexic patients, whereas the sources of evidence against this relationship are more diverse. Although some of the evidence against comes from case series of anorexic or bulimic patients and uncontrolled prevalence data, a substantial amount of the evidence comes from epidemiological studies of abnormal or eating disordered attitudes. One interpretation of the evidence for and against the relationship between eating disorders and high socioeconomic status might be that whilst abnormal eating attitudes may be more prevalent in low socioeconomic groups, there is still an excess of clinical cases in high socioeconomic groups. If this is the case, two possible explanations should be considered. First, this is a real phenomenon, in which case research should now focus on what features inherent to high socioeconomic backgrounds cause abnormal attitudes to convert to clinical disorders, and conversely what features inherent to low socioeconomic backgrounds act to protect individuals with abnormal attitudes from developing clinical disorders. Second, the alternative is that this is not a real phenomenon, but an artefact attributable to biases in data collection and interpretation, most notably to bias inherent to small studies using clinical samples.

It is the contention of the present authors that the many arguments discussed above should incline one towards the second explanation: That those individuals who do receive treatment for their eating disorder should not be considered representative of the eating disorder population as a whole. Further, that clinical impressions and research conclusions based on this subgroup can only validly be applied to the group itself and cannot validly be extended to all individuals suffering from an eating disorder.

To conclude, first, the evidence from the majority of existing research fails to support the traditional view of a preponderance of eating disorder cases in high socioeconomic groups. Second, this review suggests that the relationship between anorexia nervosa and high socioeconomic status is not proven. Further, there is increasing evidence to suggest that if there is a skewed relationship between bulimia nervosa and socioeconomic status, that it is of a preponderance of cases in low socioeconomic groups. Thus, the present review indicates that the traditional association between eating disorders and high socioeconomic
status, has at best, yet to be demonstrated and at worst, represents an artefact created and perpetuated by clinical and empirical processes. If the latter is true, theories of etiology reliant on this stereotype must also be questioned. It is important to do so, not only because theories of etiology will continue to guide and inform research, but because these theories are frequently translated into theories of treatment.

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