

Eating disorders among professional fashion models

Antonio Preti^{a,c,*}, Ambra Usai^a, Paola Miotto^b,
Donatella Rita Petretto^a, Carmelo Masala^a

^a Department of Psychology, University of Cagliari, Italy

^b Unit for Eating Disorders, Department of Psychiatry, ULSS 7, Conegliano, TV, Italy

^c Genneruxi Medical Center, Cagliari, Italy

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Abstract

Fashion models are thought to be at an elevated risk for eating disorders, but few methodologically rigorous studies have explored this assumption. We have investigated the prevalence of eating disorders in a group of 55 fashion models born in Sardinia, Italy, comparing them with a group of 110 girls of the same age and of comparable social and cultural backgrounds. The study was based on questionnaires and face-to-face interviews, to reduce the bias due to symptom under-reporting and to social desirability responding. When compared on three well-validated self-report questionnaires (the EAT, BITE, BAT), the models and controls did not differ significantly. However, in a detailed interview (the Eating Disorder Examination), models reported significantly more symptoms of eating disorders than controls, and a higher prevalence of partial syndromes of eating disorders was found in models than in controls. A body mass index below 18 was found for 34 models (54.5%) as compared with 14 controls (12.7%). Three models (5%) and no controls reported an earlier clinical diagnosis of anorexia nervosa. Further studies will be necessary to establish whether the slight excess of partial syndromes of eating disorders among fashion models was a consequence of the requirement in the profession to maintain a slim figure or if the fashion modeling profession is preferably chosen by girls already oriented towards symptoms of eating disorders, since the pressure to be thin imposed by this profession can be more easily accepted by people predisposed to eating disorders.

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1. Introduction

High-risk group studies are a promising area of investigation to discover the most likely factors that may affect the onset, the development and the outcome of mental disorders. In the field of eating disorders, high-risk group studies include investigations on twins, on people born after perinatal complications, and on individuals who suffered severe negative life events in childhood or early adolescence, such as sexual and physical abuse (Dansky et al., 1997; Cnattingius et al.,

* Corresponding author. Centro Medico Genneruxi, via Costantinopoli 42, I-09129 Cagliari, Italy.

E-mail address: apreti@tin.it (A. Preti).

URLs: <http://www.anoressianervosa.it> (A. Preti),

<http://www.anoressianervosa.it> (A. Usai),

<http://www.anoressianervosa.it> (P. Miotto),

<http://www.anoressianervosa.it> (D.R. Petretto),

<http://www.anoressianervosa.it> (C. Masala).

1999; Bulik et al., 2000). High-risk groups might also include people whose behavioural patterns feature as specific antecedents of the future development of an eating disorder, such as excessive dieting, professional pressure to be thin, and excessive exercise. On these grounds, ballet dancers and athletes were extensively investigated to identify the major correlates of the risk of eating disorders (Sundgot-Borgen, 1994; Abraham, 1996).

Professional fashion models are also considered a high-risk group for eating disorders that affect themselves, as a consequence of the professional pressure to be lean (Garner and Garfinkel, 1980; Brenner and Cunningham, 1992), and others, since the image of a model may stimulate unrealistic expectations in female adolescents, who might think that being thin will help them to achieve success and attract attention (Wiseman et al., 1992; Mondini et al., 1996). On the other hand, those individuals who are constitutionally able to maintain low weights, to diet effectively or to vomit easily might be attracted to this profession.

In Italy, young girls applying to modelling agencies to become fashion models are required to meet the standard image of a good-looking person, to be at least 1.70 m tall, and not to wear a size larger than S. Likely enough, the high competitiveness of the fashion world and the pressure to maintain a thin shape favour the development of specific methods for models to control weight, such as dieting, abstinence from food, excessive exercise, self-induced vomiting and/or use of drugs to decrease caloric intake.

Both restrictive dieting and the use of purges to reduce caloric intake have been consistently reported as precursors of eating disorders, and some authors think they are, in fact, the major determinants of the onset of an eating disorder (Garner, 1993). Garner and Garfinkel (1980) were the first to show that modelling students are at risk of eating disorders, though later studies did not replicate their initial findings (Van Hanswijck de Jonge and Van Furth, 1999). Nevertheless, a more recent study, which analyzed the self-report inventories of 63 professional fashion models of international origin, found a higher prevalence of partial-syndrome eating disorders than among 126 young Italian girls from Northeast Italy (Santonastaso et al., 2002). Although this study suggests that fashion models really bear a higher risk of eating disorders than their peers, its results suffer from two major limitations affecting their generalization: data were based on self-report inventories only, which may be biased by social desirability and propensity to hide socially stigmatised behaviours, and the control group was not matched to the index cases on

the basis of social and cultural backgrounds. Since both social and cultural factors are thought to contribute to the risk of developing an eating disorder in a significant way (Dolan, 1991; Crago et al., 1996), the control group composition plays a major role in influencing the reliability of the results of a study carried out to ascertain the prevalence of eating disorders in a high-risk group.

To overcome some of the major limitations of earlier studies on high-risk groups, we investigated the prevalence of eating disorders in a group of female professional fashion models born and living in Sardinia, whom we compared to a group of peers of the same social and cultural background. We selected female friends of the index case as controls, a group likely to include a higher proportion of individuals with shape and weight concerns, since people tend to become friends with people who are similar to them. However, our major aim was to determine whether being a fashion model, per se, is associated with a higher risk of eating disorders, other factors being equal. The study was based on both questionnaires and face-to-face interviews, so as to reduce the bias due to symptom under-reporting and to responding influenced by social desirability (Miotto et al., 2002). We predicted that fashion models would have a higher prevalence of eating disorder symptoms and syndromes than their well-matched peers.

2. Methods

2.1. Subjects and procedure

All three modelling agencies in Cagliari and Oristano (Sardinia, Italy) were involved in the study. All the female models working for these agencies were included, provided that they were professionally working in the fashion field: all those who were working on an occasional basis, or who had been in for less than a 6-month period, were excluded. The initial sample included 62 female models, all born in Sardinia and aged 16 to 34 years. Seven models (11.3% of the sample) did not agree to participate in the study, so the final sample included 55 female fashion models working in the field on a professional basis. We were unable to obtain information such as dates of birth, height, weight, and reason for non-participation from the seven models who did not agree to participate in the study, since informed consent was mandatory to undertake the study.

Upon recruitment, all participants were asked to take at least two female friends with them, provided their friends were neither involved in the fashion field nor

working as fashion models, in order to build a contrasting control group with the same social and cultural background. The control group was matched to the index cases and it was double the size of the models' group, so that its composition might mirror the fashion models' social and cultural background. None of the models' friends refused to participate in the study.

The control group consisted of 110 girls, all born in Sardinia and 15 to 34 years old, who were either unemployed or were employed in jobs that do not imply having to comply with a specific ideal of beauty. Most control girls were secretaries, students, shop assistants, hairdressers and nurses.

2.2. Assessment

Both models and their friends were informed that the study was about eating and attitudes towards the body among girls born in Sardinia. The models and their friends who agreed to participate in the study were asked to fill out a set of questionnaires and then to take part in a detailed interview, the Eating Disorder Examination, 12th edition. Confidentiality was guaranteed on the answers given on the questionnaires and obtained in the interview, and informed consent was obtained from each participating girl.

Before the interview, the participants received an envelope containing the set of questionnaires: the socio-demographic section, including a query on socio-economic status, followed by a group of self-report inventories selected to explore abnormal eating patterns and their related psychological symptoms, including the Eating Attitudes Test (EAT), the Bulimic Inventory Test of Edinburgh (BITE), and the Body Attitudes Test (BAT).

Participants were asked to put the questionnaires back into the envelope after filling them in, and to give the sealed envelope back to the examiner (AU) before starting the interview.

The study was carried out between April and October 2002; all meetings were confidential and most were organised at the girls' homes or in secluded rooms.

The Body Mass Index [BMI=weight (kg) divided by height (m) squared] was obtained from self-reported data on weight and height. The use of self-reported information could be criticized as a method of calculating BMI, since some studies found a discrepancy between self-reported data and actual height and weight (Giacchi et al., 1998). However, the magnitude of misreporting is small, and recent studies have shown that self-reported BMI is a rather reliable index of body size and an adequate method

to obtain such information in community studies (Pitilainen et al., 1999).

The EAT questionnaire (Garner and Garfinkel, 1979; Cuzzolaro and Petrilli, 1988; Garfinkel and Newman, 2001) aims at measuring abnormal eating attitudes and behaviours, in particular those of a restrictive type that characterize anorexia nervosa. We used the 26-item Italian version of the EAT, which proved able to discriminate between clinically diagnosed cases of eating disorders and healthy controls around the original cut-off. A cut-off of 20 is thought to screen out clinically relevant eating disorders, mainly in the anorexia spectrum. Previous community studies have shown that this scale offers good reliability and validity as well as reasonable sensitivity and specificity, but poor positive predictive value because of a very low base rate of eating disorders (Favaro and Santonastaso, 2000). The sensitivity and specificity of the 40-item EAT in the young Italian population were estimated, respectively, at 0.50 and 0.95 for a cut-off=30 (Favaro and Santonastaso, 2000). No study has yet estimated the sensitivity and specificity of the EAT-26 in the Italian population.

The BITE (Henderson and Freeman, 1987) is a measure of bulimic pathology consisting of 30 items that reflect the presence/absence of behaviours and attitudes associated with bulimic disorders (Symptoms scale), and three items that measure the severity of specific bulimic behaviours (Severity scale). A cut-off of 20 in the BITE Symptoms scale is thought to screen out clinically relevant eating disorders in the bulimic spectrum. We used a not yet validated Italian version of this scale, which in preliminary studies proved useful in discriminating bulimic patients from healthy controls (Monteleone et al., 2001).

The BAT (Probst et al., 1995) is a 20-item questionnaire aimed at measuring attitudes towards one's own body. This questionnaire is thought to measure mainly three areas of body experience: negative appreciation of body size, lack of familiarity with one's own body, and general bodily dissatisfaction. Patients suffering from eating disorders tend to score significantly higher at the BAT than normal healthy people (Probst et al., 1995, 1999). We used an Italian translation of the BAT (Santonastaso et al., 1995), which proved to possess good psychometric properties in terms of validity and reliability, and proved effective at detecting cases of bodily dissatisfaction even when the disturbance was not associated with an eating disorder. No study has yet evaluated the sensitivity and specificity of the BAT in the Italian population. However, by using the point-biserial correlation coefficient to estimate concordance between inventory scores and the dichotomous results of a clinical interview for the presence of a bodily dissatisfaction

disorder, the validity of the questionnaire was set at 0.67 (Favaro et al., 1997).

The EDE (Fairburn and Cooper, 1993) is a structured interview aimed at acquiring detailed descriptions of the symptomatology that is likely to occur when an individual suffers from an eating disorder. The interview focuses on core symptoms such as restraint on eating, food avoidance, fasting, bulimic episodes in the past month, self-induced vomiting in the past month, excessive physical exercise, importance of shape and weight, and fear of weight gain. Following Santonastaso et al. (2002), we applied DSM-IV criteria for the diagnosis of anorexia and bulimia nervosa as far as the full syndrome is concerned, and the following criteria for partial-syndrome diagnosis: partial-syndrome anorexia nervosa was diagnosed in case of underweight one of the following symptoms: amenorrhoea, influence of body shape and weight on self-evaluation, or fear of gaining weight; partial-syndrome bulimia nervosa was diagnosed in case of binge eating (at least 8 episodes per month in the previous 3 months) and self-esteem depending upon the influence of body shape and weight on self-evaluation, or repeated purging behaviour (at least 8 episodes per month in the previous 3 months, even without binge eating episodes). The EDE has proved a valid instrument in accurately identifying patients with full and partial eating disorder syndromes (Binford et al., 2005); however, we are unaware of any study that specifically tested this procedure in the Italian population.

2.3. Statistical analyses

All data were coded and analysed using the Statistical Package for the Social Sciences (SPSS). Scores were calculated according to the manuals on each questionnaire, and they are expressed as the mean plus the standard deviation. Scale reliability was measured by Cronbach's coefficient alpha, a measure of internal consistency (Cronbach, 1951).

Since the sample was large enough, we decided to rely on the analyses of group differences through robust and easily understandable parametric tests. Unpaired *t*-tests, after Levene correction for inequality of variance, were used to determine whether variables differed among groups of subjects in a significant manner. This test is robust enough to withstand violations of normal distribution, giving quite accurate results even when the distribution is skewed (Altman, 1991). Chi-square tests were used for categorical data. Pearson's correlation coefficients were used to examine associations between two continuous variables.

We used multiple outcome measures (self-report questionnaires and the answers in a face-to-face interview), and the likelihood of finding a statistically significant result by chance alone increases with the number of tests undertaken (the so-called Type I error). Modifying the *P* value to account for the multiple tests performed, the so-called Bonferroni adjustment, is a frequently used approach to reducing the chance of Type I error. With this method, the conservative alpha value set to reject the null hypothesis (0.05) takes into account the number (*k*) of comparisons done, according to the following formula: $P=(1-\alpha)^k \approx 1-k\alpha=\alpha/k$ (Bland and Altman, 1995). A priori, we planned a total of 22 comparisons so that, according to the Bonferroni adjustment, the null hypothesis (i.e., no difference between the index cases, the fashion models, and the contrast group, the controls) at the 0.05 level should only be rejected with *P* lower than $0.05/22=0.0022$.

However, there are good reasons to consider the Bonferroni adjustment as inappropriate and even unnecessary for pre-planned hypotheses tested with multiple comparisons. The Bonferroni adjustment is, indeed, a rather heroic, highly conservative remedy, inflating the likelihood of Type II error, so truly important differences are deemed to be non-significant (Perneger, 1998). The correction reveals nothing about exactly *which* statistically significant result was found by chance alone.

Moreover, its effects depend on the number of tests performed: adding by chance some more tests would modify the alpha level, which is absurd within the current scientific paradigm. The Bonferroni correction might be useful in repeated analysis or in sequential testing, but with pre-established hypotheses, and pre-planned testing, the better choice is thought to accurately describe the results, with inclusion of the effect size and/or confidence interval. Therefore, we reported all results of the performed tests, using as a measure of the effect size the Cohen's *d* (standardized mean difference, the difference in means divided by the within-group standard deviation) for continuous variables, and the BESD (Binomial Effect-Size Display, a point-biserial correlation *r*) for the categorical ones, coded as dummy 0/1 (with caseness, being a model or having the symptoms, labelled as 1) (Rosnow et al., 2000). Suggested levels of the effect size were: *d* around 0.20=small effect, *d* around 0.50=medium effect, and *d* around 0.80=large effect, for the standardized mean difference; BESD around 0.10=small effect, BESD around 0.30=medium effect, BESD around 0.50=large effect, for the Binomial Effect-Size Display.

3. Results

3.1. General characteristics of the sample

Table 1 summarizes the main characteristics of the sample. Models were more often employed than their peers, but fewer had obtained a university degree (Table 1). In addition, significantly more models reported a low BMI than their peers; significantly more models also reported a BMI below 18 than their peers, this value indicating under-nutrition: 34 (54.5%) as against 14 (12.7%) among controls (chi-square with Yates correction=32.74, $df=1$, $P=0.0001$, $BESD=0.46$).

3.2. Scores on the eating disorders inventories

Cronbach's alpha for the eating disorders inventories was good enough for both groups: $EAT=0.81$; $BITE=0.78$, $BAT=0.87$, among fashion models; $EAT=0.79$; $BITE=0.87$; $BAT=0.85$, among controls.

We found no statistically significant difference between models and controls, as far as the distribution of answers to the inventories was concerned, nor did we find any difference in the proportion of fashion models and controls who scored above the cut-off on the EAT, the BITE or the BAT (Table 2).

In both groups, however, the inventories were correlated with one another, indicating their ability to cover a spectrum of largely coinciding, though not overlapping symptoms (Table 3). We found no links between age, school or occupational status and eating disorder inventories; however, we found a statistically significant correlation between BMI and each eating

disorder scale in models and controls, though with opposite results: we found a negative relationship among models, and a positive relationship among controls. In the sample, four models (7.2%) and no controls reported a score above the cut-off on the EAT in the presence of a BMI below 18, a profile suggesting anorexia nervosa (chi-square=5.41, $df=1$, $P=0.02$, $BESD=0.22$).

3.3. Results of the interview

On the EDE, 10 models (18.1%) and 8 controls (7.2%) reported important restrictive eating in the previous 3 months (chi-square=3.43, $df=1$, $P=0.06$, $BESD=0.16$); 5 models (9.0%) and 9 controls (8.1%), reported important fear of gaining weight (chi-square=0.00, $df=1$, $P=1.00$).

Bulimic episodes were frequent in the sample: 33 models (60%) as against 38 controls (34%) reported bulimic episodes in the previous 3 months (chi-square=8.68, $df=1$, $P=0.003$, $BESD=0.24$).

Models were slightly more likely to report self-induced vomiting as a method to reduce calorie intake: 2 (3%) vs. 1 (1%) (chi-square=0.38, $df=1$, $P=0.53$). About 9% of models, and no controls, reported that they practiced some kind of structured physical activity to control weight (chi-square=7.45, $df=1$, $P=0.006$, $BESD=0.25$). Three models (5.4%) and four controls (3.6%) reported the use of laxatives and/or diuretics as a method to control weight (chi-square=0.02, $df=1$, $P=0.89$).

Two models (3%) and two controls (1%) reported that they felt a strong sense of guilt after eating (chi-square=0.03, $df=1$, $P=0.85$). One model out of five

Table 1
General features of the sample

Number	Models		Controls		df	T	P
	55		110				
	Mean	S.D.	Mean	S.D.			
Age	23.2	4.2	24.4	4.1	163	-1.66	0.09
BMI	17.9	0.7	20.3	2.6	142	-8.59	0.0001
	No.	%	No.	%	df	χ^2	P
School					3	7.05	0.07
Compulsory	18	32	17	15			
High school diploma	32	58	77	70			
University degree	5	9	15	13			
Occupational status					3	36.75	0.0001
Unemployed	0	0	42	38			
Employed for a long time	16	29	24	21			

Table 2

Distribution of scores on the EAT, BITE and BAT: comparisons with two-tailed Student *t*-test, after Levene correction for inequality of variance, for continuous measures, and chi-square, with Yates correction, for categorical ones (proportion of cases above the cut-off)

	Models (no. 55)		Controls (no. 110)		Cohen's <i>d</i>	<i>df</i>	<i>T</i>	<i>P</i>
	Mean	S.D.	Mean	S.D.				
EAT	6.9	8.4	5.6	8.1	0.15	163	0.95	0.34
BITE symptoms	6.1	4.1	5.2	4.7	0.20	163	1.32	0.20
BAT	27.9	9.9	29.4	12.2	0.13	163	−0.86	0.42
	<i>N</i>	%	<i>N</i>	%	BESD	<i>df</i>	<i>X</i> ²	<i>P</i>
EAT>20	5	9.0	8	7.2	0.02	1	0.00	0.95
BITE>20	1	1.8	3	2.7	−0.02	1	0.00	1.00
BAT>36	8	14.5	24	21.8	−0.08	1	0.82	0.36

(21%), as against 7% of controls, reported a heavy influence of body shape and weight on self-evaluation (chi-square=5.98, *df*=1, *P*=0.01, BESD=0.21). Finally, five models (9%), and three controls (2%) reported important menstrual difficulties (chi-square=1.98, *df*=1, *P*=0.16, BESD=0.14).

Using DSM-IV criteria for the diagnosis of full-syndrome anorexia and bulimia nervosa on the basis of EDE answers, we found an equal proportion of cases among models and controls: one (1.8%) among models and two (1.8%) for both anorexia and bulimia nervosa (in both comparisons, chi-square=0.00, *df*=1, *P*=1.00). However, more models than controls were found to meet the partial-syndrome criteria for anorexia nervosa: seven (12.7%) as against four (3.6%) among controls (chi-square with Yates correction: 3.72, *df*=1, *P*=0.05, BESD=0.17). No statistically significant difference was found for partial-syndrome bulimia nervosa: two (3.6%) among models as against two

(1.8%) among controls (chi-square=0.03, *df*=1, *P*=0.85).

Finally, three models (5.4%) and no controls reported they had received a formal diagnosis and treatment for anorexia nervosa in the past. No girls in the sample reported they had ever received a formal diagnosis of bulimia nervosa.

4. Discussion

To our knowledge, this study is the first to compare professional fashion models to a well-matched control group composed of girls of the same age, social and cultural background, using both self-compiled inventories and a detailed face-to-face interview. However, our sample did not include top models, who might form a separate subset of professional fashion models with a different risk of eating disorders than their colleagues. Indeed, agencies in large towns, such as Milan or London, are likely to be contacted by models of various nationalities, and tend to be more selective and more competitive.

On the whole, the professional fashion models in our sample do not seem to suffer, per se, from a higher risk of eating disorders than their peers, as far as full-syndrome anorexia or bulimia nervosa is concerned. However, they report a symptom profile indicative of a higher risk of a partial eating disorder syndrome in the anorexia nervosa spectrum. The fashion models in our sample admitted an earlier formal diagnosis of anorexia nervosa more often than their peers; moreover, they more often declared a BMI below 18, the cut-off for under-nutrition, and they more often, but without reaching a statistically significant level, reported menstrual difficulties, an oft-reported problem in eating disorders. On self-compiled inventories, fashion models did not differ from their peers significantly; however, in

Table 3

Pearson's correlational analysis between eating disorder inventories and BMI

	BMI	EAT	BITE
<i>Models, 55</i>			
EAT	−0.33*		
BITE	−0.30*	0.69**	
BAT	−0.26*	0.65**	0.68**
<i>Controls, 110</i>			
EAT	0.03		
BITE	0.30*	0.58**	
BAT	0.40**	0.57**	0.65**

* Pearson's *P*<0.005.

** Pearson's *P*<0.0001.

a face-to-face interview, they were more likely to admit symptoms in the spectrum of eating disorders.

It should be borne in mind that the method of selection of the control group in this study might have led to rather conservative results: since our major aim was to determine whether being a fashion model per se is associated with a higher risk of eating disorders, all other factors being equal, we decided to rely on a sample from the same social and cultural background of the index case as a contrast group. We therefore selected female friends of the index case as controls, a group likely to include a higher proportion of individuals with shape and weight concerns. People, indeed, tend to become friends with individuals who are similar to them.

However, our results are strictly comparable to another study that used a control group drawn from the general population: [Santonastaso et al. \(2002\)](#) found a mean BMI of 17.7 ± 0.9 among models and 20.3 ± 2.3 among controls, a prevalence of full-syndrome anorexia nervosa of 1.6% among models and 0.8% among controls, and of partial-syndrome anorexia nervosa of 12.7% among models and 2.4% among controls. In their study, full-syndrome bulimia nervosa reached 0% among models and 2.4% among controls, whereas partial-syndrome bulimia nervosa reached 7.9% among models and 1.6% among controls.

The higher prevalence of anorexia nervosa and of its partial syndrome as against bulimia is surprising, since bulimia nervosa is generally considered more common than anorexia ([Nielsen, 2001](#)); however, data are drawn from small samples, and both groups are likely to belong to a subpopulation in which individuals concerned with shape and weight are over-represented.

As in previous studies ([Santonastaso et al., 2002](#)), the most evident difference between fashion models and their peers is the higher percentage of underweight among models, namely with BMI below 18: 54% among models as against 12% among controls. Such a difference is based on statistical grounds, even considering the most conservative value for the alpha level (i.e. the $P=0.0022$ of the Bonferroni adjustment as a threshold to reject the null hypothesis at the 0.05 level).

It has been suggested that fashion models are chosen for this profession because they have an uncommon constitution that lies at one extreme of the normal distribution of body types, rather than resulting from purposely practiced dieting ([Brenner and Cunningham, 1992](#)). Therefore they would conform to the extremely restrictive shape and weight requirements of their profession without the risk of developing an eating disorder. However, like [Santonastaso et al. \(2002\)](#) in a

previously published study, we found that a subset of fashion models is really more likely to use unhealthy methods to control their weight than their peers.

Yet, despite a higher prevalence of the symptoms linked to eating disorders, fashion models are less likely to report bodily dissatisfaction, though the difference on the BAT did not reach statistical significance. Since body dissatisfaction is an important antecedent of eating disorders, the stronger satisfaction models reported about their physical aspect, as a reflection of their perceived smart appearance, has been proposed to work as a protective factor against the risk of eating disorders, and to account for the modest frequency of full syndromes among them ([Santonastaso et al., 2002](#)). On the other hand, we cannot exclude that those who declined to participate in the study could as well be more likely to suffer from full-syndrome eating disorders. It must be stressed, however, that the individuals affected by anorexia nervosa report lower body dissatisfaction when their body weight is low. Since the fashion models in our sample report a larger proportion of symptoms in the spectrum of anorexia nervosa than controls, lower body dissatisfaction could mirror the higher risk of anorexia nervosa in models.

In a cross-sectional study, only hypotheses can be put forward, and no definite conclusions can be drawn from the results. On a conservative basis we assume that the choice of fashion modelling as a profession might be influenced by a pre-existing propensity to maintain a lean body, with girls prone to eating disorders being more likely to conform to the shape and weight requirements of the modelling profession than girls without symptoms of eating disorder: this proneness to eating disorders would select a higher number of girls for this profession than would be expected on the basis of the prevalence of these disorders in the general population. In our sample, three models, and no control, reported they had received a formal diagnosis and treatment for anorexia nervosa in the past. This corresponds to a lifetime prevalence of 5.4%, higher than the 0.28% prevalence estimated in population studies ([Nielsen, 2001](#)).

Girls prone to eating disorders would be more likely to maintain the ideal body weight and shape required to become a model and to be successful in the highly competitive professional fashion world. Girls prone to eating disorders also tend to be more aggressive and assertive than their peers ([Miotto et al., 2003](#)), and this would be another factor helping them when facing competitive rivals. It might be that girls prone to eating disorders who choose to become fashion models preserve their symptoms because the pressure to be

thin becomes egosyntonic, since it is rewarded by professional success.

All these speculations, however, require appropriate testing, and we think that further studies will be necessary to establish whether the slight excess of partial syndromes of eating disorders among fashion models observed in this study is an effect of the requirement of the profession to maintain a slim figure, or the fashion model profession is preferentially chosen by girls already oriented towards eating disorder symptoms, since the pressure on thinness imposed by this profession can be more easily accepted by people predisposed to eating disorders.

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