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Literature Review: Anorexia in Mainland China and Hong Kong
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I. Introduction

The current cultural perspective in the West (and, by subsequent measures, other regions in the world where western medicine and psychiatry is present) of anorexia and other eating disorders is that they are caused by the increasing presence in the media of western standards of female beauty—in short, thinness and youthfulness.

In his book *Crazy Like Us* (2010), Ethan Watters recounts the rapid rise of anorexia in China during the 1990s. The common perception of such a meteoric rise, as previously stated, is the belief that western images of women pervaded into Chinese culture (especially Hong Kong) and drove women to starve themselves to achieve an ideal body weight. Watters, however, points to different contributing factors that are often overlooked by the literature on eating disorders.

Before anorexia became more common among the female Chinese population, a few cases of "atypical" anorexia presented themselves to clinicians—"atypical" in the sense that the women afflicted with the disorder did not starve themselves to become thin. They had no sense of body dysmorphia and understood that they were underweight. Instead, they presented with predominantly anxious and/or depressive symptoms and reported a physical inability to eat. Anorexia only started to rise dramatically in Hong Kong after the highly publicized death of an anorexic teenage girl who collapsed and died in public in 1993. Once the disorder became known to the public and throughout popular

discourse did the prevalence of the disorder start to rise.

As cultural psychologists have recently argued, the application of western psychology onto non-western cultures may, at best, have no effect on treatment, and at worst, may be detrimental to the outcomes of individuals afflicted with eating disorders and other mental illnesses. For this reason, I conduct the following literature review (comprised of existing psychological literature on the topic of anorexia in mainland China and Hong Kong) with the following questions in mind:

1. Is anorexia diagnosed and viewed through the lens of a uniquely western perspective (aligning closely with the DSM-5 diagnosis/symptoms)? In the selected papers, are cultural variants (e.g., anorexia stemming from somatic complaints) considered as mediating factors and given appropriate discussion?

2. Is the origin of anorexia attributed solely to the presence of western media, or are other cultural considerations taken into account (e.g., anorexia stemming from trauma, loss, socioeconomic status)?

The purpose of this review is not to establish whether increased westernization in Asian countries has caused a rise in eating disorders, but whether the studies themselves are westernized. Are cultural factors accounted for when studying eating-disordered populations in China/Hong Kong, or does the psychological research itself approach these issues from a western perspective? The implications behind an answer to this

question may have profound impacts on the treatment of anorexia in Asia.

II. Western Definitions and Perspectives on Anorexia

The DSM-5 (2013) provides the following criteria for diagnosis of anorexia: "… persistent energy intake restriction [Criterion A]; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain [Criterion B]; and a disturbance in self-perceived weight or shape [Criterion C]."

In order for diagnosis, an individual must be clinically underweight (with a Body Mass Index (BMI) less than 17kg/m^2). The DSM also highlights thought processes often accompanying the disorder: weight-loss is seen as an accomplishment and demonstration of self-control, whereas weight gain is seen as a failure of restraint and willpower.

Under the "Culture-Related Diagnostic Issues" section of the disorder, the authors briefly acquiesce that in Asia there is sometimes an absence of "fat phobia" (e.g., intense fear of weight gain), where "the rationale for dietary restriction is commonly related to a more culturally sanctioned complaint such as gastrointestinal discomfort." Although admitting to such a cultural discrepancy, the authors of this section do not extrapolate further on the possible consequences of western diagnosis on this specific population. No other advice for culturally sensitive diagnosis is given.

Regarding cultural catalysts of anorexia, psychologists unanimously agree that the emphasis on female beauty in western media (specifically the United States and Canada) is closely related to the rise of eating disorders in Asian countries (Spettigue & Henderson, 2004). Beauty, rather than achievement or character, are emphasized as the

most important attributes a woman must possess in order to be happy, successful, and respected by others. Furthermore, the multi-billion dollar beauty and diet industries that played a role in the creation of these ideals are dependent on them; therefore, there is not only cultural but economic motivation that drives proliferation of thinness in the media.

III. Literature Review: Studying Anorexia and other Eating Disorders in China and Hong Kong

Ngai, Lee, & Lee (2000) conducted a qualitative review of four Chinese patients in Hong Kong. The authors contend that 'fat phobia' (e.g., intense fear of being fat or gaining weight) should not be an essential feature for diagnosis of anorexia nervosa (AN) in Asia—as such, the different presentations of AN (in regard to fat phobia) are outlined in this paper. The authors argue that 'atypical' (an absence of fat phobia) presentations of AN are actually valid variants of the disorder and deserve recognition in diagnostic literature and by clinicians working within China.

Ngai et al. present case studies of four patients with different subtypes of AN. Fat phobia type I is congruent with the current DSM-5 definition and the authors believe that currently, this is the most common type of AN present in Hong Kong. Fat phobic type II presents with fat phobia at the beginning of disease onset, but gradually diminishes as the individual progresses through the disease to the point where they are severely underweight. The patient presenting with FP-II in this study initially restricted food intake because she thought fatness was "a symbol of ugliness and inefficiency," but as she became underweight she experienced feelings of guilt (for her family blaming

themselves for her illness) and recognized the physical consequences of her disease.

Throughout the course of non-fat phobic type I, a patient expresses no desire to lose weight or be thin. The patient in this case who was diagnosed with Non-PH I was sexually abused by her father and manifested her loss of bodily autonomy by refusing to eat, an act she associated with her father (who was a "voracious eater"). In this sense, anorexia may be viewed as a manifestation of trauma rather than the outcome of sociocultural pressures to be thin. Finally, as seen in non-fat phobic type II, anorexics initially exhibit no desire to be thin, but may become fat phobic during treatment of disease when weight is gained back.

This study presents a refreshing view of anorexia nervosa, providing subtypes of the disorder that may be culturally bound or more relevant in Asian societies. The DSM and other western literature on anorexia rarely differentiate between fat-phobic and non-fat phobic subtypes of anorexia—according to western definitions, in order for AN to be diagnosed, one *must* present as consistently fat-phobic during the course of illness. In this sense, the Ngai article successfully introduces challenges to the rigid guidelines of anorexic diagnosis (and by extension, treatment). Although the sample in this instance was small (only four patients described), the paper also introduces other causal factors of AN, for example the experience of sexual trauma and association of food with the perpetrator. In this case, onset of illness was caused primarily by pervasive bodily trauma. Widening the window for exploration of trauma as cause for eating disorders may bring a more nuanced definition into psychological research focused on eating disorders.

One study that traces the history of AN in China is that by Lee et al. (2009), who studied patients with eating disorders (EDs) at a clinic in Hong Kong from 1987 to 2007 in two cohorts (cohort 1 dates from 1987-1997 (N=67), cohort 2 dates from 1998-2007 (N=128)). The authors of this study also raise the point that fear of fatness did not always present in patients with EDs, but this is not the main focus of their paper. Rather, it is that cohort 2 was almost double the size of cohort 1. The authors attribute the rise of urbanization and increasingly westernized media throughout the timespan of cohort two as the main catalyst in the rise of EDs in a clinical setting. Patients were diagnosed via the Chinese version of the Eating Attitudes Test-26 (EAT-26), as well as criteria from the DSM-III (1987) or DSM-IV-TR (2000). Clinicians specified after diagnosis as to whether the patient was fat phobic or non-fat phobic. Results indicate that 66% of patients with AN were fat phobic and 39% were not. Most of the fat phobic patients were from cohort 2, another indication that westernization may increase the desire to be thin as well as a preoccupation with fatness.

While this study successfully traces the rapid rise of EDs in Hong Kong during a period of critical economic development and urbanization (within a single clinical setting), it is important to note that the researchers in this study used western measures to diagnose said EDs. The authors mention that they used a Chinese version of EAT-26, but do not clarify whether this is merely a translated version of the original American assessment, or if it had been modified to appropriately reflect Chinese cultural variances. Furthermore, patients were diagnosed with the DSM, which (as previously mentioned) requires that an individual who is anorexic as fat-phobic. The authors decline to clarify

how they used the DSM to diagnose these patients while also classifying them into fat phobic and non-fat phobic subgroups. No cultural mediators are mentioned (e.g. AN as a response to trauma, loss, affect, mood disorder etc.). The rise of anorexia nervosa is solely attributed to westernization.

Lai et al. (2013) provide the nutrition transition model (which contends that as societies industrialize, urbanize, and grow in GDP, dietary habits undergo a societal shift) as a possible link between economic development and rise of eating disorders in China. The authors of this study administered a number of assessments to students in Hong Kong ($N=909$, $M_{age}=14.7$) to measure eating habits and sociocultural attitudes towards appearances and eating. Measures administered were Stunkard's Figure Rating Scale (FRS), the Motivation for Eating Scale (MFES), the Revised Restraint Scale (RRS), the EAT-26, and the Sociocultural Attitudes Towards Appearance Scale (SATAQ). The authors report that 70.4% of females expressed a desire to be thinner, and, in tandem with other studies, concluded that such desires to be thin were influenced by the sociocultural messages disseminated by increasingly westernized media in a time of economic change.

There was no discussion or measurement of fat phobia in this study. Additionally, although the measures included here are reliable and valid, the authors do not specify whether they are so when tested in non-western samples. No other potential causes for eating disorders are proposed or discussed. EDs are contributed solely to westernization —other potential causes, mentioned earlier in this review, are not mentioned.

Jackson & Chen (2007), like the researchers of the Lai et al. study, also attribute the rise in eating disorders in China to urbanization and westernization. They approach

EDs via a dual pathway model: People experience pressures from the media, family, and friends—and thus experience body dissatisfaction and changes in eating habits because such pressures are repeated and reinforced upon individuals on a daily basis. They recognize other possible causes of EDs, such as social comparison to peers and negative affect (e.g., people may engage in disordered eating to relieve anxiety and obtain a form of emotional release). There is also recognition that fat phobia is not always the cause of restricted food intake (an alternate explanation would be that a patient may feel physically unable to eat).

The authors of this study also mention concerns about facial attractiveness, which may be particularly unique to Chinese populations (compared to the West), and stand as a risk factor for the development of EDs. However, prior to this study, such a possible link has not been explored in psychological literature. The authors thus conclude that before any definitive assumptions can be made the concept should be tested further.

The authors assessed a sample of 1,297 females and 754 males (M_{age}=15.81) from ten cities in Mainland China. Measures administrated were the Eating Disorder Diagnostic Scale (EDDS), the Perception of Teasing Scale (POTS), the Physical Appearance Comparison Scale (PACS), the Positive and Negative Affect Scale (PANAS), and the Negative Physical Self-Scale (NPS). The NPS is important to note because it was specifically developed for use in adolescent and young adult Chinese populations. It is the only measure I have discovered in my research for this review that is culturally specific to the population it is measuring. All other measures used by the authors of this study were developed in the United States. Their cross-cultural validity and reliability is

unknown. Interestingly, the PANAS has a special version, the I-PANAS-SF, which was developed specifically for international use (Karim, Weisz, & Rehman, 2011), but was not implemented in this study. The authors make no mention of their purposes for using PANAS over I-PANAS-SF.

Jackson & Chen report that those who had higher rates of pathologized eating tended to compare themselves to others at higher rates. Additionally, "preoccupations with facial appearance emerged as one of the strongest individual factors discriminating between symptomatic and less symptomatic groups." This finding is unique in this literature review thus far because it presents a promising culturally specific catalyst of the development of anorexia and other eating disorders, despite the rise in westernization (and in many ways, homogenization) of popular culture and media in China.

Finally, Tong et al. (2014) measured the prevalence of EDs among female university students in city of Wuhan (N=8,444). Measurements administered were the Eating Disorders Inventory-1 (EDI-1) and the Eating Disorders Examination (EDE). Unlike the previously discussed articles, the authors here specifically mention that both measures have shown strong validity and reliability in non-western contexts, despite the fact that they were originally administered by and for western populations.

Like all the other studies in this review, they attribute the presence of EDs to rising westernization and urbanization. While it is not pertinent to discuss the results in this study (because they are essentially similar to previously discussed studies), it is important to include because of a large sample and usage of robust measures. Also similarly to some of the other articles reviewed here, there is no mention of fat phobic

and non-fat phobic subtypes of AN, nor are other possible causes of EDs discussed (to reiterate: the contention that EDs could possibly be caused by trauma, loss, or Axis I disorders).

III. Discussion and Conclusion

To succinctly summarize the studies included in this literature review is difficult in the sense that they are not uniform in their methods, hypotheses, and findings. This was something I was not anticipating. I expected the widespread usage of western terminology and measurement to research and discuss the prevalence of anorexia and other eating disorders in China and Hong Kong. In some respects, I was wrong.

For one, the ideas of culturally-specific causes of anorexia were broached, such as concern with facial attractiveness, the presence of fat phobia, and nuanced causal factors of AN (such as trauma). However, I believe that they were not given significant attention within the selected literature. That is, conceptions that anorexia may not be solely the product of westernization (and that it presents only as it does in the west) were afterthoughts or included in 'future directions' sections. Future studies should be devoted solely to causes of anorexia other than increasing urbanization.

Building upon this argument, I turn to the measures used in the discussed studies. Most (if not all) were developed in the United States for western populations. While they may be nevertheless reliable and valid enough to be tested in non-western studies, efforts should be taken to develop more measures dedicated to Asian or Chinese populations. There may be data waiting to be found that otherwise would not be effectively assessed

by the current conventions of measurement.

Finally, while I do have experience in analysis of psychological research and some knowledge of cultural differences between cultures, I myself am not Chinese. I am completely unfamiliar with the experiences of Chinese culture, and therefore should in no way be considered an authoritative voice on the topic of anorexia in Chinese culture. Someone with better knowledge and experience of cross-cultural research and psychology would probably pick up on nuances that I am blind to because of my own western cultural experiences. Therefore, this literature review, while comprehensive, should be viewed as a preliminary venture into the influence of westernized psychology on understanding eating disorders in China.

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