

On the Horizon: Considering the Implications of Non-Western Cases of Anorexia Nervosa on Description and Diagnosis

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Abstract

Eating disorders have often been characterized as byproducts of a flawed Western societal structure that places inordinate pressure on women to conform to media and peer standards of beauty and thinness. Although the DSM-5 can be said to reflect a Western description of eating disorders and their subtypes, its model lacks explanatory power for cases that deviate from its narrow diagnostic criteria and fails to attribute blame to specific components of said culture. The source of eating disorders in both specific cases and historical cases are still unclear due to variation. I outline these flaws, review the historical data, and assess recent changes in the incidence and course of eating disorders to illustrate the urgency of revising common conceptions of eating disorders. Devising more accurate diagnoses of eating disorders and more effective long-term treatments requires examining alternative hypotheses and rejecting an exclusively Western model of description.

Keywords: eating disorders, incidence and diagnosis, anorexia nervosa, cross-cultural models, DSM-5

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In the Western world, the discrepancy between the size of an average woman and the size of an average model is increasing. Rates of eating disorders are increasing in Europe, Australia, and the United States. Media content about dieting has also increased, and women have reported more dieting behavior and increased dissatisfaction with their size (Miller & Pumariega, 2001, p. 94). In the United States alone, roughly 11 million people are affected by eating disorders, and the mortality rate for anorexia can be as high as 20% (Miller & Pumariega, 2001, p. 101; Eating Disorders Coalition, n.d.). All of these concerns seemingly implicate modern Western media, culture, and values for the relatively high incidence of eating disorders in the Western world. However, this explanation is inconsistent with research showing that eating disorders have existed throughout history, and are becoming prevalent in non-Western populations. I contend that eating disorders are not just manifestations of Western values, but disorders with much historical precedent and with a large cultural component to their expression. This distinction is critical because the way that we conceptualize eating disorders has broad implications for the efficacy of treatment and the applicability of diagnostic criteria. In this paper, I explain and challenge the traditional description of eating disorders before providing a historical overview of anorexia nervosa. I conclude by considering hypotheses regarding the prevalence of eating disorders in non-Western cultures that could allow clinicians to reexamine the etiology of these disorders and to diagnose and better treat cases that do not fit the traditional Western model.

Traditional Concepts of Eating Disorders

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) states the criteria necessary to determine a diagnosis of anorexia nervosa. First, the individual his or her consumption severely enough to cause “significantly low body weight[, ... which] is defined as a weight that is less than minimally normal” (American Psychiatric Association & American Psychiatric Association Task Force on DSM-5, 2013). People with anorexia also exhibit extreme fear of gaining weight and a distorted perception of their body shape and size¹ (American Psychiatric Association & American Psychiatric Association Task Force on DSM-5, 2013). Although the DSM definition does not implicate specific groups of people as being at higher risk, society usually considers eating disorders to be diseases primarily or exclusively affecting Westernized females.

Anorexia and other eating disorders are often considered derivatives of a society with misplaced cultural values and expectations for women. Media coverage bolsters the typical image of people with anorexia being white, upper class females by featuring young, white female models, which places pressure on this demographic to conform to perceived norms and might explain the lower prevalence of eating disorders in men (Miller & Pumariega, 2001, p. 96). This conceptualization of eating disorders reflects a belief in cultural determinism, which posits that ideas about beauty are culturally determined (Furnham & Baguma, 1994, p. 81). Accordingly, an

¹Note that the DSM-5 has made a few changes compared to the DSM-IV, the most notable being the changes to the second criterion and the changes to the amenorrhea feature. The second diagnostic criterion for a diagnosis of anorexia nervosa is “Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight” (American Psychiatric Association & American Psychiatric Association Task Force on DSM-5, 2013). Previously, it was limited to the fear of gaining weight or becoming fat. The DSM-5 has also deemphasized the fact that females who are anorexic and who have reached pubescent maturity are usually amenorrheic, moving it into a discussion of potential additional features rather than listing it in the criteria.

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important variable affecting the prevalence of eating disorders in minorities may be their acculturation into white Western society (Silber, 1986, as cited in Miller & Pumariega, 2001, p. 98). The traditional hypothesis thus implicates Western culture, with its competing pressures to conform and to succeed, as both a necessary and sufficient cause for the maladaptive cognitive mechanisms underlying anorexia and other eating disorders.

Problems with an Exclusively Western Framework

I argue that culture is merely a factor to the development of psychological disorders. Western culture in particular contributes to the development of eating disorders, including the specific form or diagnosis of a disorder, the expression of distress, and a sufferer's concept of abnormality, but is not a necessary cause. Therefore, reliance on a narrow, modern, Western concept of anorexia nervosa is misleading for diagnosis and treatment.

Problem 1: Research Findings

Western culture cannot be the sole determinant of eating disorders because there have been several non-Western cases, particularly in Asia (Miller & Pumariega, 2001, p. 101). Miller and Pumariega (2001) attribute the increased international prevalence of eating disorders to familial and cultural conflicts that produce dissonance within individuals during a crucial period of their development. However, these conflicts surely vary given the specific cultural and societal elements to which individuals are exposed. For example, a study by Hill and Bhatti (1995) that examined the eating behaviors of British girls found that, while both Asians and Caucasian nine-year-olds were highly cognizant of body shape and thinness, the Asian girls showed much more "dietary restraint" than the Caucasian girls (Miller & Pumariega, 2001, p. 100). Furthermore, dietary restraint was positively correlated with the adoption of traditional cultural values, indicating that cultural values influenced Asian girls' eating behavior, not just exposure to mainstream ideas and pressures. In the United States, a study by Snow and Harris (1989) found "a substantial incidence" (p. 334) of disordered eating in Southwestern Hispanics and Pueblo Indians. Snow and Harris report that 11% of participants met DSM criteria for bulimia, and over half reported some disordered eating behavior. The participants were minorities of low socioeconomic status and living in rural communities, making them markedly different from the stereotypical white, upper class, Westernized female with anorexia.

Another conflict between the existing research and the Western model of anorexia appears when one examines cross-cultural views of body image. A study by Furnham and Baguma (1994) measured Ugandan and British subjects' evaluations of body shapes ranging from extremely underweight to obese (p. 83). If the traditional Western model is correct, one would expect that British participants would evaluate the relatively underweight body shapes as more attractive than would Ugandan participants because Britain is more Westernized. However, the authors report that the main differences were in the groups' evaluations of the healthiness of each figure, not the attractiveness. Specifically, the Ugandan participants rated the four heaviest body shapes as relatively healthy, whereas the British participants considered those shapes to be relatively unhealthy. This challenges the common assumption that Western societies pressure adolescent women to conform through stringent definitions of *attractiveness* and therefore predispose that population to eating disorders. If Western culture is to be implicated at all, then, it must have another specific mechanism for predisposing its population to eating disorders.

Problem 2: Lack of Specificity

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There are two ways in which the Western conceptualization of anorexia is too vague: it fails to specify which aspects of Western culture predispose adolescents to eating disorders,² and it fails to explain how eating disorders can develop in non-Western cultures. Regarding the former, some scholars believe that Western culture is responsible for the emergence of fat phobia, which is consistent with the remarkable absence of this phobia in most Asian countries (Miller & Pumariega, 2001, p. 101). Although the DSM-5 has made significant improvements over the DSM-IV in allowing flexibility in diagnosing cases that do not feature fat phobia, neither the Western model nor the DSM-5 allow for cases that are not aesthetically motivated, such as Katzman and Lee's (1997) example of a wife who starved herself to avoid having children (p. 388). The Western conceptualization of anorexia also omits an explanation of why eating disorders develop in non-Western cultures. Emphasizing Western aspects of anorexia leads one to fixate on fat phobia, when this symptom may be more broadly, and likely more accurately, described as a phobia of losing control (Katzman & Lee, 1997, p. 390). In this view, the societal balance of power, rather than gender or the media per se, may be the critical factor. Thus, this paper argues that the 'fat phobia' component of the second criterion should be exchanged for the 'fear of losing control' that is listed as a common sub-feature, because the latter is more applicable across cultures. This explanation could apply to Western cases that are atypical (i.e., focused on control rather than appearance), as well as to non-Western cases, and even to cases in cultures who believe that beauty is not culturally determined at all. Although the Western model fails to explain these concerns, the DSM diagnostic criteria nevertheless reflect Western values.

The Historical Expression of Anorexia Nervosa

I now turn from a general overview of problems with the Western model of eating disorders to a historical example of anorexia nervosa, which highlights many of the aforementioned problems with the model. This case study will demonstrate the contribution of culture to the expression of symptoms – however, it seems that specific cultural experience affects symptoms more than Western culture in particular. This distinction broadens the Western model to be consistent with both historical and contemporary evidence regarding the prevalence of and variation in eating disorders.

Historically, anorexia nervosa was typically motivated by religious beliefs rather than body image or societal concepts of attractiveness. The first recorded death from self-starvation occurred in the fourth century A.D. in Rome, driven in part by the teachings of Saint Jerome that emphasized personal discipline (Bemporad, 1997, p. 404). There were also recorded cases in the fifth and eighth centuries in which girls believed that they were demonically possessed and had to refuse food to return to a state of purity or goodness. Additional cases of anorexia followed with the introduction of Eastern asceticism, which held that bodily needs are evil and must be resisted to achieve purity (Bemporad, 1996, p. 220). This cultural influence dominated over the previously esteemed Greek concept of "a sound mind in a sound body," providing an early example of the power of acculturation in affecting the prevalence of eating disorders (Bemporad, 1997, p. 404). Some well-known figures, such as Vardhamana (the founder of Jainism), Buddha, and the goddess Uma, engaged in self-starvation for religious motivations (Bemporad, 1996, p. 218). This notion of 'holy anorexia' became especially popular during the Renaissance, a period of relative affluence, and was often rewarded with sainthood (Bemporad, 1997, p. 407).

²Put another way, why don't all Western adolescents develop eating disorders? What features of Western culture are especially risky, and to which adolescents in particular?

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Another prevalent motivation for anorexia was a profound feeling of helplessness or a lack of control. For example, one explanation for the cases of anorexia that were reported in ancient Greece is that citizens were losing political control of a weakening city-state, prompting them to turn inward as a means of gaining control (Bemporad, 1997, p. 404). Another example involved Saint Wilgefortis, who wanted to be a nun and refused food to become less attractive and dissolve the plans for her arranged marriage. This example is antithetical to the Western model, as Saint Wilgefortis believed that becoming thinner would make her unattractive; furthermore, she only sought this aesthetic change as a means to an end – namely, gaining control over her future. As Bemporad (1997) remarks, “this behavior can be seen as a remedy for the physiological burdens associated with being female or as an assertion against the obedience expected of women” (p. 406). Furthermore, the phenomenon that eating disorders have historically been quite rare in poverty-stricken areas suggests that, when food is scarce, rejecting it does not provide an adequate feeling of control (Bemporad, 1996, p. 220). This fear of losing control is relevant to modern descriptions of anorexia, as it may apply to a larger proportion of current cases than the largely Western concept of fat phobia.

While there has been historical variation in individuals’ motivations underlying anorexia, there has also been a great deal of change in its definition. Originally considered a variant of hysteria, anorexia was not recognized as a psychological disorder until the mid-1800s (Bemporad, 1996, p. 225; Miller & Pumariega, 2001, p. 95). Some intellectuals in the 1700s were convinced that anorexia incorporated sitophobia, a dread of food stemming from either a fear of poisoning or from a divine command to abstain. A diagnosis of chlorosis was also common from the 1600s to the 1800s, which had very similar physical symptoms to modern-day anorexia, but was thought to be caused by a buildup of toxins in menstrual fluid (Bemporad, 1996, p. 226). In the 1800s, secular motivations for eating disorders emerged, and the church began to interrogate people showing symptoms of anorexia, rather than rewarding them for adopting a lifestyle free of wants. Self-starvation was also seen as a novelty act. For instance, people paid money to see anorexic adolescents or professional hunger artists (men who resisted food as a show of strength) at circuses (Bemporad, 1996, p. 228; Bemporad, 1997, p. 409). A conflict developed between religion and medicine in explaining the ability of people with anorexia to subsist without food: religion proclaimed a divine role in the survival of individuals with anorexia, whereas doctors sought to explain it in biological terms for the first time (Bemporad, 1997, p. 409).

The first biological descriptions of anorexia emerged in the mid-1800s, with multiple modifications in the twentieth century. An early theory, designed during the era of hunger artists, suggested that the organs of people with anorexia created fuel by fermentation and eliminated the need for food; although patently false, the theory was an important step in the conception of anorexia as a disorder with biological rather than religious undertones (Bemporad, 1996, p. 224). In 1873, the first full medical description of anorexia nervosa was created, notably without the modern-day specification of fat phobia (Bemporad, 1997, p. 411; Miller & Pumariega, 2001, p. 95). This definition predated a clear change in body image in the Victorian period: well-fed women were no longer a symbol of wealth, and thinness was emphasized as an indicator of femininity (Bemporad, 1997, p. 410). Thus, the DSM’s emphasis on body weight and shape actually reflects relatively recent changes in anorexia nervosa. Weight phobia only became a criterion in 1970, and eating disorders were not subdivided into anorexic and bulimic types until 1979 (Russell, 1985, pp. 103-4). These changes in the description of anorexia nervosa reflect aspects of Western culture and society, but may not be universally applicable.

Recent Changes in the Expression and Description of Eating Disorders

By examining historical variations in the expression and prevalence of anorexia, I have challenged the assertion that anorexia is a modern phenomenon of Western societies. Similarly, although the DSM-5 implicitly reflects a Westernized concept of anorexia, studying recent changes in eating disorders reveals how recently Western society has emerged as a contributory factor.

Incidence of Eating Disorders

In the twentieth century, and especially in the latter half, there has been a much higher incidence of eating disorders. This phenomenon is not exclusive to the United States: for example, Sweden experienced a fivefold increase in eating disorders between 1930 and 1950, which Russell (1985) attributes to increased societal pressures about body image (p. 102). Similarly, Hall, Cousins, and Power (1991) found that Mexican American daughters' ideal body shape was significantly thinner than that of their mothers, reflecting changes occurring even across one generation (as cited in Miller & Pumariega, 2001, p. 98).

An increasingly globalized, interconnected world exposes more people to the societal pressures common to many industrial countries, which partially explains the increased prevalence of eating disorders. Foreign exchange programs and immigration can also expose people to these pressures, especially adolescents and young adults, who are in a pivotal stage of development and often pursue these cross-cultural opportunities (Miller & Pumariega, 2001, p. 99). These experiences can then predispose an individual to an eating disorder that contains features of his or her native culture blended with this pressure to conform. For example, in the Middle East, vomiting rather than restriction tended to be a symptom of anorexia, likely reflecting cultural values or traditions that make the act of vomiting more feasible than restriction (Miller & Pumariega, 2001, p. 102). Furthermore, as irregular eating behavior becomes more prevalent, media or personal discussions of this behavior can contribute to its spread. Bruch posits that the increasingly high incidence of eating disorders can be attributed to copycat behavior, whereas as recently as the early twentieth century, people with anorexia had to come up with the idea of food refusal independently (as cited in Bemporad, 1997, p. 413). Russell (1985) claims that these copycat cases are examples of "vulnerable individuals who, in earlier times, would have developed different forms of neurotic illness – possibly hysterical or anxiety states" (p. 106), which further implicates cultural pressures in determining the specific course of one's illness.

Weight Phobia in Anorexia Nervosa

Weight phobia as a necessary factor for diagnosis is a recent addition to the criteria for anorexia nervosa. This development may severely limit the diagnosis, detection, and treatment of non-Western or otherwise atypical cases. Weight phobia is common among Western people with anorexia, and it has scientific support: Russell (1985) demonstrates that people with anorexia tend to overestimate their own body width, reflecting the cognitive dysfunctions that spur weight loss even when they are severely underweight (p. 103). However, making weight phobia a necessary criterion for an anorexia nervosa diagnosis, as the DSM-IV did, ignores the role of culture in determining how one experiences distress and what is abnormal (Dolan, 1991, p. 76). As previously demonstrated, while weight phobia is common in Western cultures, this phenomenon may demonstrate as a fear of losing control in cultures with different body image ideals. This criterion predisposes healthcare professionals to adopt a Western model of the disease, which hampers their ability to recognize variations in symptoms across other populations. Given that the variability should increase as more cases emerge, this problem is

even more important. Even though the DSM-5 has built in some flexibility surrounding this criterion, it is still not inclusive enough to diagnose the full range of variability properly because the criteria are still oriented toward appearance rather than power and control.

Recent developments in the description of eating disorders reflect the higher incidence of (and variation in) eating disorders in Western society, but do not fully account for corresponding increases in other societies. The DSM-5 has taken steps toward correcting some of these diagnostic issues; however, the criterion of weight phobia, as well as the overall emphasis on appearance, may still mask even greater increases in non-Western populations than are currently recognized. Accuracy is crucial for the prospects of treatment of and prevention in atypical cases, and for understanding the etiology and symptoms of specific eating disorders.

Alternate Cultural Hypotheses for the Description and Diagnosis of Eating Disorders

In consideration of the historical development and evolution of anorexia nervosa, I now introduce two hypotheses regarding how culture contributes to the onset of eating disorders. I thus address one of the aforementioned problems with the Western model: it declines to assert what facets of Western culture are at fault. Is the problem the pressure to conform to certain body image standards, either from the media or from peer groups? Or is it certain expectations for female behavior more generally that make women feel out of control? This ambiguity precludes the Western model from being a truly useful hypothesis for description, diagnosis, or treatment. In contrast, the following hypotheses use the previous discussion of description and diagnosis to motivate and support their specific etiological claims.

Hypothesis 1: Clash of Cultures

The clash of cultures hypothesis has the potential to add a more global dimension to the Western model, and it also suggests why a large percentage of Westernized females fail to develop eating disorders. Industrialization is one way that cultures rapidly evolve, but it can induce dissonance among individuals reluctant to experience such change (Miller & Pumariega, 2001, p. 99). Individuals who change communities often experience identity confusion and isolation, and, if coupled with oppression in the new community, these women may be especially likely to adopt disordered eating as a coping mechanism (Katzman & Lee, 1997, p. 391). As Hare (1981) notes, “diseases, like species, represent the balance of a process by which living organisms struggle to adjust to a continually changing environment” (as cited in Russell, 1985, p. 101). Historical evidence for this hypothesis includes the aforementioned effect of East Asian asceticism on Greek concepts of the body, as well as Greek feelings of helplessness in politics. Based on this hypothesis, lack of exposure to Western ideas may be a preventive factor for eating disorders, but it does not preclude their development; furthermore, Western culture itself may not be especially dangerous if it does not produce cognitive conflict.

Hypothesis 2: Feminist Theories of Eating Disorders

Like the clash of cultures hypothesis, feminist theories are advantageous in their specificity and applicability to non-Western cultures. Feminist theories posit that restricting food intake (or absorption, via purging behaviors) is a method of self-definition, control, and/or anxiety expression for women in cultures with expressed or implied body image norms (Miller & Pumariega, 2001, p. 104). Furthermore, the potential for control is amplified when women’s freedoms increase, which is when eating disorders are most common. Historical examples show that wealthy societies do not increase risk for an eating disorder unless they also have relatively broad women’s rights. Bemporad (1997) cites examples from certain ancient Greek and modern Muslim societies in which there exist affluent communities with severely restricted freedoms for women, and virtually no eating disorders have been reported in such communities (p. 414). Thus,

the specific mechanism implicated in feminist theories is the presence of body image norms, when coupled with broad women's rights and relative affluence.

Reconciling the Alternative Hypotheses

Both sets of alternative hypotheses suggest specific cultural factors that are implicated in eating disorders; in this sense, they are more powerful than the common Western hypothesis. They are also consistent with previously reviewed literature on the description and diagnosis of eating disorders. Both hypotheses support the conclusion that a social cause of eating disorders stems from women's roles within a larger cultural framework, which suggests more variability in eating disorders than if culture itself was the primary determinant. Both hypotheses also explain why only certain people in a culture develop eating disorders. To be most effective, prevention and treatment initiatives should consider specific individual variables stressed in one or both theories and, as Katzman and Lee (1997) suggest, look comprehensively at patients as individuals rather than focusing solely on symptoms of anorexia (p. 391). It is also crucial to recognize that these new hypotheses may more accurately indicate risk for certain subtypes of eating disorders than for others. This would be particularly likely if the DSM-5 were revised in line with the changes I suggested earlier, motivated both by historical analysis and contemporary research.

Conclusions

In short, anorexia nervosa has strong historical and cultural components of its expression and conceptualization; it is not a recent outgrowth of a Western culture emphasizing female body image and thinness. A theory advocating Western society as a necessary cause of eating disorders cannot be reconciled with historical or modern evidence, and it is not particularly powerful without more specific risk factors for susceptibility to eating disorders. However, this theory is common among laypeople and has influenced the DSM's ill-advised use of weight phobia as a criterion for anorexia nervosa and bulimia nervosa. The conceptualization of anorexia nervosa and other disorders is crucial for proper diagnosis and treatment. Furthermore, it may be essential to properly define and categorize such disorders in order to produce accurate assessments of etiology. Future research should assess international rates of anorexia nervosa, especially in countries where little to no data is currently available, and reexamine the justifications for weight phobia and for the subdivisions of eating disorders.

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