Rejection of the Westernization Model of Eating Disorders

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Introduction

Current theory in clinical psychology holds that eating disorders (EDs) arise from the Western ideal of bodily thinness (Keith, 2011, p. 214). If this is true, the growing prevalence of EDs in non-Western countries likely follows from the expansion of Westernization and the Western thinness ideal. However, if incorrect, this theory might adversely influence the diagnosis and treatment of non-Western patients with EDs who seek treatment from Western doctors. If culture influences the perception or definition of "normal" eating patterns, Western physicians might overlook culture-specific symptoms of non-Western patients. Indeed, much of the cross-cultural research on this subject compares populations based on only a few diagnostic tests for ED symptoms, or studies Western populations from a Western viewpoint. The current literature evaluates past research on the validity of the Westernization model for EDs, as well as the influence of this framework on testing measures.

Literature Review

The purpose of this literature review is to evaluate and ultimately refute the cross-cultural validity of the Westernization model of EDs. While all past research performed within the confines of this model should not be dismissed, it is not an appropriate frame through which to conduct research on all populations. That is, not all cultures or populations have been as heavily influenced by Westernization as past research assumes. Rather, native culture also influences the

manifestation of EDs. This review describes ED etiology, explains the Westernization model of EDs, and demonstrates the limitations of the Westernization model in research and diagnosis.

Clinically speaking, the category of ED is wide and varied. Though much current research focuses on either anorexia nervosa or bulimia nervosa, other atypical eating disorders exist and are not as well researched (Fairburn & Harrison, 2003). This literature review will focus on research performed on all eating disorders.

Though EDs vary in terms of diagnostic criteria, they generally manifest similar symptoms. According to Professors Christopher G. Fairburn and Paul J. Harrison, people with EDs all exhibit "a definite disturbance of eating habits or weight-control behaviour… [resulting] in a clinical impairment of physical health or psychosocial functioning… The behavioural disturbance should not be secondary to any general medical disorder or to any other psychiatric condition" (2003). This description of EDs only numerates symptoms of the disorders, but does not analyze etiology. This is because the causes of EDs are so varied; few symptoms are universal. Studies suggest different cultural, biological, and environmental factors play a part in the development of these disorders (Fairburn & Harrison, 2003).

The Westernization model is a long accepted theory of cultural ED etiology. Essentially, it suggests that Western standards of beauty have been so widely disseminated among the non-Western world that they erase traditional standards of beauty. Since a major feature of Western beauty is thinness, non-Westerners develop EDs in an attempt to become thin (Keith, 2011, p. 214). This is the model through which past research examines EDs. Indeed, an epidemiological study performed by Nadaoka et al. proved that, as Japan industrialized, the incidence of EDs increased (1996). They contend that "slim bodies are admired and considered to be symbolic of beauty and intelligence, and this information is propagated by the mass media" (Nadaoka et al., 1996). As mass media spreads the Western thinness ideal, ED rates should rise. A study of

Fijian girls from an area with little prior exposure to media confirmed this hypothesis (Becker et al., 2001). Traditional Fijian culture accepts women with large body sizes, as the girls in the study showed prior to experimentation. They were then subjected to prolonged exposure to European and American television shows starring thin women. The girls scored higher on the Eating Attitudes Test, reported greater body dissatisfaction, and exhibited higher levels of self-induced vomiting with the goal of weight loss (Becker et al., 2001). Taken together, these studies support the Westernization model of EDs. As non-Western individuals grow better acquainted with the thinness ideal, they become more likely to lose weight though restricting or binging and purging (Nadaoka et al., 1996; Becker et al., 2001).

However, researchers also saw limitations to the Westernization model. For example, Nadaoka et al. noted, "Recent statistical studies on eating disorders in Japan revealed that the incidence of eating disorders had not increased compared to previous data" (1996). Conflicting results of similar studies show that there is a lot of variability in testing methods and the reliability of results. Similarly, the research on the Fijian girls is flawed in that the sample is from a culture that does not traditionally value thinness. Indeed, the researchers note, "There is a pronounced disparity between the narrow range of body shapes portrayed on television and those of ethnic Fijians in a setting in which traditional culture supports a keen attentiveness for appetite and weight change" (Becker et al., 2001). The study neglects the effect of Western influence on cultures that either value thin frames, or in which the individuals have naturally thin body types. Though these studies both support the Westernization model of EDs, they are not generalizable because of limited sample and study range.

As previously mentioned, there are certain limitations to the Westernization model. The literature refuting this model falls into two basic categories: unequal cross-cultural study and different psychological etiology between cultural groups.

The Westernization model is flawed in that it suggests that subjects of cross-cultural research wish to appear more Western. It ignores the idea that the studies themselves might be flawed because of Western bias. For example, the *DSM*, or *Diagnostic and Statistical Manual of Mental Disorders*, is the primary source of diagnoses and guidelines for treatment of psychological problems. However, it is issued by the American Psychological Association, or APA, and is used primarily by Western physicians treating Western patients. Nakai et al. wanted to see whether the *DSM-IV-TR*, the revised fourth edition of the handbook, was as accurate when applied to a Japanese population (2013). The *DSM-IV-TR* was very good at diagnosing patients with anorexia nervosa or bulimia nervosa, but failed to identify other, less common EDs for Japanese patients. However, researchers found that a different diagnostic tool, the Broad Categories for the Diagnosis of Eating Disorders (BCD-ED) scheme "dramatically decreased" the proportion of diagnoses that the *DSM-IV-TR* was unable to define. In other words, this study showed that even tested and respected diagnostic tools, like the *DSM-IV-TR*, do not necessarily account for cross-cultural differences.

Researchers often group cross-cultural research in terms of "Western" or "non-Western." These terms are misleading because they suggest that there are only two culturally different groups in the world. Cross-cultural research on EDs is certainly guilty of this error. Kayano et al. performed a large-scale study of eating disorder symptom manifestation on Indian, Omani, Euro-American, Filipino, and Japanese adolescents (2008). They used a standardized questionnaire to examine the drive for thinness and general attitudes toward eating. Results showed that Euro-American teenagers displayed the greatest drive for thinness out of the tested participants, and that abnormal eating attitudes were more apparent in participants from the other cultures. Additionally, "The relationship between body mass index and eating attitudes or fat phobia in Indian, Omani and Filipino subjects differed from that in subjects from Western

countries and Japan" (Kayano et al., 2008). This study refutes the Westernization model in two important ways: firstly, Western and non-Western cultures manifest EDs with different symptoms; and secondly, non-Western cultures display symptoms differently from each other.

Sometimes ED studies are flawed, and can erroneously support the Western model. For example, Rotem Kowner studied body esteem, generally assumed to play a large role in the development of EDs, to compare Japanese individuals with American, Chinese, and Israeli participants (2002). The results of the study showed that Japanese men and women scored significantly lower on the standardized measure of body esteem than all other participants. Though the study's questionnaire was supposedly standardized, meaning that it was translated correctly and should therefore be an equal measure of body esteem in any country, researchers failed to account for cultural norms. Past research has shown that Japanese culture stresses self-effacement and values the "humble presentation of self typical of collective societies" (Lincoln, 1989 as cited in Kowner, 2002). Since the standardized test required a self-descriptive measure, it is likely that a lot of the Japanese participants misreported their body image. Thus, the study was flawed because it failed to discount this alternative explanation of body esteem score.

Taken together, these studies show that current thought surrounding ED diagnosis is flawed. Cultural differences account for how ED symptoms are manifested (Kayano et al., 2008), as well as for how accurately diagnostic tools diagnose EDs based on these variable symptoms (Nakai et al., 2013). These studies refute the Westernization model in that they show how Western thought does not influence all non-Western cultures in similar ways, and that current diagnostic tools might overestimate this influence.

The Westernization model also assumes that Western influence is the reason for different etiologies, or causes, of EDs in non-Western cultures. However, there is a growing body of literature that refutes this on the grounds that culture-specific norms also greatly influence the

formation of EDs. This section of the literature review examines studies performed on Japanese and North American samples. The studies all underline the same theory of causation: Though it is possible that Westernization influences the development of EDs, traditional Japanese culture actually has more influence over ED formation among Japanese.

Pike and Mizushima used the Eating Disorders Inventory-2, a standardized measure, to analyze ED symptomology in Japan and North America (2005). Although the study found many differences between the two groups, one was extremely striking: Japanese participants with EDs reported greater fear of adulthood and the stresses that come with maturity. This measure was found weak among the North American participants, and suggests that the fear of maturity results from significant cultural differences (Pike & Mizushima, 2005). More importantly, "These findings provide further support to the argument that it is essential to… avoid ethnocentric attributions and misinterpretations and… understand the potentially diverse cultural contributions to the development and expression of eating disorders (Katzman & Lee, 1997; Steiger, 1995)" (Pike & Mizushima, 2005). In other words, because this study found symptomology for participants with similar EDs to be strikingly different between the two samples, culture plays a stronger role in ED etiology than the Westernization model suggests.

Mukai, Kambara, and Sasaki used the standardized Eating Disorder Inventory and the Eating Attitudes Test to compare samples of Japanese and American collegiate women for eating disturbances as well as body dissatisfaction (1998). Results showed that, in general, Japanese women perceived greater fatness than American women despite having lower BMIs. Though Japanese women reported greater body dissatisfaction, the levels of eating disturbances for the two groups were comparable. The need for social approval significantly predicted the levels of body dissatisfaction and eating disturbances among Japanese women, but not among American women. Similar to the results of Pikes and Mizushima's (2005) study, Mukai et al. (1998) found

different psychological symptoms that seem to be culture-specific. If Westernization causes EDs to form in non-Western nations, such as Japan, it follows that populations in Japan with EDs should exhibit the same symptoms as those populations in Western nations. It appears, however, that they do not. There must, then, be some culture-specific factors that cause the same disorders to manifest differently in these two regions.

As previously stated, ED symptoms differ in Japanese and North American samples. To compare this with the Westernization model, however, the symptoms must be placed in a cultural context. Do these symptoms stem from the desire to obtain the ideal Western body shape? Smith and Joiner performed a study on perceived Japanese and American body ideals (2008). Their results showed that, to some degree, Japanese women believe that the Western ideal of thinness is desirable. However, results also showed that Japanese women tend to believe that an even thinner body than that of the Western ideal was the optimum size for a woman. The researchers surmise, "It may be misleading to explain the rising rate of eating disorders in Japan simply as a result of 'Westernization"' (Smith & Joiner, 2008). Taken together, the three studies examined in this section suggest that differences in psychological symptoms cannot entirely be attributed to Western influence, but rather are a result of Westernization added to the influence of a society's native culture (Mukai et al., 1995; Pike & Mizushima, 2005; Smith & Joiner, 2008).

If modern researchers rely on the Western concept of beauty to guide their studies, they might make incorrect assumptions about the presence or manifestation of EDs in non-Western cultures. Modern diagnostic tools are constantly updated and modified based on new research findings. If current research makes incorrect assumptions about EDs in non-Western populations, diagnostic tools could be incorrectly modified and cause misdiagnoses. This is dangerous because non-Westerners seeking treatment from Western physicians might be misdiagnosed and given harmful or unnecessary treatments. Although few studies assess the

validity of Western ED diagnostic tools in non-Western cultures, the next example discusses a diagnostic tool tainted by Western bias.

Zandi et al. tested the validity of a diagnostic tool for psychotic and mood disorders known as the Comprehensive Assessment of Symptoms and History, or CASH (2007). This study was performed on a population from Morocco, a culture that traditionally does not automatically assume hallucinations and dissociation to be the product of mental illness. For example, in Moroccan culture, "sensations of floating above or outside of the body are not necessarily a medical condition, but a religious phenomenon or a culturally appropriate idiom of distress" (Zandi et al., 2007). After testing the supposedly standardized CASH measure, researchers found that this test improperly diagnosed Moroccan patients with schizophrenia after displaying such culturally appropriate symptoms. This poor validity stresses the importance of cultural-specific standardization of tests, a concept that has been largely neglected thus far in clinical research (Zandi et al., 2007).

Although this study does not necessarily apply to research on EDs, it does make a strong argument for examining cross-cultural test validity. The preliminary research performed for this literature review did not turn up any studies of the validity of Western ED testing measures, such as the Eating Disorders Inventory or the Eating Attitudes Test, in Japan. Rather, the studies identified in this review that involve these tests simply compared how Japanese subjects scored versus North American subjects (Nakai et al., 2013; Kayano et al., 2008; Kowner, 2002; Pike & Mizushima, 2005; Mukai et al., 1998).

This literature review covers current research on the Westernization model of EDs as well as research surrounding how Western bias affects diagnoses. It is not, however, impossible to create a mostly unbiased measure. Prince et al. attempted to create a diagnostic test for dementia that was cross-culturally valid for populations from Western Asia, Southeast Asia, and

Latin America (2003). They were able to correct for possible cultural and educational bias as well as for "methodological artefacts… by careful attention to translation and rigorous training procedures" (Prince et al., 2003). Thus, Western bias can be overcome if enough planning goes into the research process.

Conclusion

Past research on EDs grossly exaggerates the effect that Westernization has on the development of EDs in non-Western countries (Becker et al., 2001; Nakai et al., 2013). The Westernization model fails to account for how differently the disorder is manifested in Western and non-Western cultures (Pike & Mizushima, 2005; Kayano et al., 2008; Nakai et al., 2013). Since this flawed thought influences the creation of diagnostic tests, non-Western patients might be misdiagnosed. Although rare, misdiagnoses of psychological conditions because of the Western bias have occurred (Zandi et al., 2007). The current literature review is crucial because it highlights and reinforces the necessity of culture-specific testing methods.

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Sandra Wilson is a fourth-year Psychology major from La Habra, a small city in Orange County. She first became interested in psychology after completing a summer internship at a pediatric occupational therapy clinic during high school. As an undergraduate at UC Merced, Sandra has worked as a research assistant in a cognitive science lab, and studied abroad in order to take a wider variety of psychology courses. She is an active member of Psi Chi, the International Honors Society of Psychology, and is currently working with the group on a research study.

After completion of her Bachelor of Arts in Psychology, Sandra plans to enter into a Psy.D. or graduate program in Clinical Psychology. Her interest in clinical psychology, as well as her interest in studies abroad, prompted her review of literature surrounding eating disorders, and the dangers of limited cultural awareness influencing diagnoses.

In her free time, Sandra enjoys reading a good Stephen King or Agatha Christie novel, sipping a strong cup of coffee, and taking long walks with her German sxhepherd.