

The variable presentation and early recognition of anorexia nervosa in Hong Kong

SK Leung, S Lee

One of the western diagnostic criteria for anorexia nervosa is a “morbid or intense fear of fatness”, which is absent in some Chinese anorexic patients in Hong Kong. As a result, patients often visit non-psychiatric doctors and have extensive investigations performed. By the time they are referred to psychiatrists, some may already have reached an advanced stage of illness. In this report of two patients with anorexia nervosa, we attempt to illustrate the variable presentation of anorexic patients in Hong Kong, and to alert health professionals to the early recognition and treatment of this potentially lethal disorder.

HKMJ 1997;3:433-5

Key words: Anorexia nervosa; Body image; Cultural characteristics

Introduction

Anorexia nervosa (AN) is associated with dangerous physical complications and suicide, and is a potentially life-threatening condition. Our clinical experience during the past 10 years suggests that AN is becoming a more common problem in Hong Kong.¹ The diagnostic criteria listed in the Classification of Diseases in the latest international (ICD-10) and American (DSM-IV) systems of psychiatric classification require that the individual has a “body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea”² and an “intense fear of gaining weight or becoming fat, even though underweight.”³ This ‘fat phobia,’ however, may not be present in all anorexic patients in Hong Kong, and also some other Asian countries such as India and Malaysia.^{1,4,5} Consequently, exclusive reliance on western diagnostic criteria may lead to the underrecognition of AN.

Case 1

A single female student aged 18, height 1.6 m, was referred to the Department of Psychiatry at the Prince of Wales Hospital (PWH) by the medical unit of the

Queen Elizabeth Hospital (QEH) in 1995. She complained of belching and epigastric bloating after meals for the past 3 years, following the sudden death of her father when she was in Form 4 at school. To avoid the discomfort, she took less and less food and ate a soft or fluid diet. She ate very slowly, and took 2 to 3 hours to finish a meal. Her weight decreased from 41.4 kg to 33.4 kg (weight loss of 19.3%) during this time. She developed secondary amenorrhoea 2 years after the onset of her eating problem. There was no binge-eating, laxative abuse, self-induced vomiting, or excessive exercise. She felt she was underweight and wanted to gain weight. Investigations performed at the QEH included an upper gastrointestinal endoscopy, colonoscopy, and ultrasound of the abdomen, and were found to be normal.

A mental status examination given on admission showed no depressive or psychotic features. She felt there was something wrong with her, but was not sure whether it was of somatic or psychological origin. She felt that her condition would improve if she gained weight. A physical examination revealed a blood pressure of 110/70 mm Hg and a pulse rate of 66 beats per minute. She was emaciated (body weight 33.4 kg, body mass index [BMI] = 13.05 kg/m²) and had generalised wasting of muscles. Secondary sexual characteristics were present and routine blood investigations were normal. Low levels of oestradiol, luteinising hormone (LH), and follicle-stimulating hormone (FSH) were shown on a luteinising hormone-releasing hormone (LHRH) stimulation test to be hypothalamic in

Department of Psychiatry, Prince of Wales Hospital, Shatin, Hong Kong

SK Leung, MB, BS, MRCPsych

Department of Psychiatry, The Chinese University of Hong Kong, Shatin, Hong Kong

S Lee, MB, BS, MRCPsych

Correspondence to: Dr SK Leung

origin. No motility disorder was demonstrated on Barium swallow.

The patient was the youngest of seven siblings. Her father was described as easy-going and quiet, while her mother was dominant, controlling, and demanding. Nonetheless, she had a closer relationship with her mother than her father. She enjoyed being the youngest child at home. Being sexually immature, she was uneasy about heterosexual relationships. She had completed Form 5, and wanted to go to university, but she was quite disappointed at her poor School Certificate examination results. She admitted that she preferred to stay in childhood forever, because adult life seemed to involve going to work in a tough outside world. Although her family tried to hide it from her, she was aware that her father had committed suicide.

Treatment included individual psychotherapeutic sessions with the aim of helping her to face the challenge of growing up and planning her future life as an effective adult, and a weight-gaining dietary programme. Her family was involved at a later stage, in an attempt to get her mother and siblings to relate to her as an adult. Attempts were made to resolve her grief towards her father but this was resisted by the family members, who probably also harboured unresolved grief. Her weight gain significantly improved after the grief towards her father was acknowledged. She was discharged with a body weight of 41.2 kg. At follow-up 2 months later, her body weight was 43.8 kg (BMI = 17.11 kg/m²) and transient menstruation had returned. She still complained of epigastric bloating, but managed to attend a computer course and felt more able to cope with the adult world.

Case 2

The second patient was a female single clerk aged 18, height 1.6 m, who was referred to the Department of Psychiatry at the PWH by its medical unit in 1996 because of significant weight loss and poor feeding for the past 2 years. The patient had a background of persistent low mood, which had been ascribed to her unsatisfactory academic performance despite her industry. She envied her two siblings who were more successful academically. She was unhappy with her body and was bothered by repeated taunts by her schoolmates who called her a "fat girl." She had dieted, induced vomiting, and abused laxatives for 2 years; her weight dropped from 55 kg to 35 kg (a weight loss of 36.4%) during this period. She became amenorrhoeic 1 year after the onset of her eating problem. Her mood was often low, and was associated with tiredness, lack of

interest, and a sense of worthlessness. She also became more irritable, and had heated rows with her father who reprimanded her for not eating. Nonetheless, she still coped with her job until 1 week before admission, when she felt too weak to continue working.

A mental status examination revealed a depressed mood and guilty feelings over not being an achiever like her younger siblings. She felt insecure about her future, but denied any suicidal contemplation. She only started to feel that she was 'too thin' in the 2 months before referral and considered a modest weight gain of 5 kg to be optimal. A physical examination showed that she was emaciated (body weight 35.8 kg, BMI = 13.98 kg/m²) and lanugo hair was present. Her blood pressure was 114/82 mm Hg and the pulse rate was 80 beats per minute. Routine blood investigations revealed hypokalaemia (potassium = 1.9 mmol/L; normal range, 3.5-5.0 mmol/L), which required potassium supplementation. An LHRH stimulation test showed the low levels of oestradiol, FSH, and LH to be hypothalamic in origin.

The patient was the eldest child. She was emotionally distant from her father, who was a dominant figure in the family but who spent little time at home. In contrast, she was able to share her feelings with her mother, who was an affable housewife. She felt dejected because she perceived that her siblings would rather attend to their studies than talk with her. She stopped studying after Form 4 because of unsatisfactory academic results and was upset about this failure. She had no dating or sexual experience. By playing a passive-aggressive role in the family, she could gain considerable attention and while at work, she also behaved in a childish fashion.

The patient was managed with a weight-restoring diet and individual psychotherapeutic sessions, which addressed her dysfunctional attitudes and ineffective social skills. Gradually, her weight increased and her mood improved. She was discharged with a body weight of 41.2 kg (BMI = 16.09 kg/m²).

Discussion

Both patients exhibited psychobehavioural features commonly seen in patients with AN. The first patient was an overprotected child. Her anorexia could be seen as a means of avoiding growing up. She used her stomach problem as an excuse to stay at home. Her unresolved grief towards her father could also have contributed to her illness, as could have the unwillingness of her family to discuss his suicide. On the other

hand, the second patient experienced long-standing sibling rivalry, which manifested as the avoidance of open communication. Her unsatisfactory academic achievement contrasted with her high expectations. As a result, she had low self-esteem, which was further diminished by repeated taunts of being fat. She responded to these stressors by dieting, the success of which led to transient feelings of improved self-worth and self-control. In both patients, immaturity and conflict-avoiding behaviour in the family were prominent features.

There is an obvious difference, however. For the second patient, peer pressure and the cultural desire for thinness were predisposing factors that prompted her weight-controlling behaviour. In contrast, this 'fat phobia' was absent in the first patient, who does not fulfill the ICD-10 or DSM-IV criteria for the diagnosis of AN. A study of 70 Chinese AN patients in Hong Kong found that 58.6% of patients did not exhibit any fear of fatness throughout their illness. Instead, these patients give epigastric bloating (31.4%), lack of appetite/hunger (15.7%), or simply eating less (12.9%) as their reasons for food refusal and emaciation. Compared with anorexics who have a fat phobia, they were significantly slimmer premorbidly and were less likely to exhibit bulimia. Dietary restriction was the sole or chief method of weight reduction.¹

The first patient illustrated many of the features seen in these anorexic patients. Possible explanations for the absence of fat phobia in anorexic patients in Hong Kong and other Asian countries have been discussed elsewhere,¹ but it has been argued that fat phobic AN may become more common as a result of modernisation—international fashions, dietary patterns, and the changing gender roles of young Chinese women have been suggested.¹ More culture-flexible criteria for diagnosing AN, which include “when others attempt

to make her/him increase food intake, the patient complains of abdominal bloating, or pain, loss of appetite, no hunger, distaste for food, fear of fatness and/or ‘I don't know’ in order to resist such attempts” rather than just the “morbid or intense fear of fatness,” have been proposed to reduce the underdiagnosis and undertreatment of AN patients in non-western cultures.^{6,7}

Anorexia nervosa patients often present with weight loss, amenorrhoea, or gastric bloating and are initially seen by non-psychiatric doctors (especially gynaecologists and gastroenterologists), and have multiple investigations performed before they are referred on to psychiatrists. A mean weight loss of about 33% occurs (BMI = 13.35 kg/m²).⁶ One possible reason for such late recognition could be the lack of fear of fatness in some AN patients, who are presumed to be suffering from some primary physical disease. An increased awareness of the variable presentation of AN will enhance the early recognition and treatment of this potentially lethal disorder, which it is predicted will affect more young Chinese women in the future.⁶

References

1. Lee S, Ho TP, Hsu LK. Fat phobic and non-fat phobic anorexia nervosa: a comparative study of 70 Chinese patients in Hong Kong. *Psychol Med* 1993;23:999-1017.
2. World Health Organization. The ICD-10 classification of mental and behavioural disorders – clinical descriptions and diagnostic guidelines. Geneva: WHO, 1992.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994.
4. Khandelwal SK, Saxena S. Anorexia nervosa in people of Asian extraction. *Br J Psychiatry* 1990;157:784.
5. Goh SE, Ong SB, Subramaniam M. Eating disorders in Hong Kong. *Br J Psychiatry* 1993;162:276-7.
6. Lee S. Clinical lessons from the cross-cultural study of anorexia nervosa. *Eating Disorders Review* 1996;7:1-4.
7. Weiss MG. Eating disorders and disordered eating in different cultures. *Psychiatr Clin North Am* 1995;18:537-53.