There has been a growing interest in eating disorders among Singaporean medical professionals since the 1990s, and the Singaporean public is also starting to become aware of the risks of these conditions. This ethnographic research on eating disorders in Singapore, conducted in 2001, however, found that the majority of the informants with these conditions have struggled with a lack of understanding from others. This thesis aims to increase understanding by bringing these under-represented sufferers' voices to the forefront.

This thesis focuses on the immense fear and guilt about gaining weight that are shared by these individuals. Unlike medical science, which usually considers such fear and guilt to be pathological, this thesis looks at these emotions as cultural by using the anthropological theory of feelings as well as the theory of the body politic. By illustrating how thinness has become an ideal image for Singaporean women in the past twenty years, cultural components of these feelings become readable to those without eating disorders.

This thesis recommends two ways to increase understanding of the informants' inner struggles. First, medical science should consider culture a possible cause of eating disorders, since the exclusion of culture from the etiology legitimizes a lack of understanding on the part of those without eating disorders. Secondly, instead of asserting that appearance is unimportant, those without eating disorders should acknowledge that appearance plays an important role in human lives across every culture. Furthermore, they need to understand that while society superficially encourages people to accept themselves as they are, it stigmatizes fatness more forcefully. Lastly, they need to consider that the dieting industry often exploits medical science to justify its image of the ideal female body.
Thinness in Asia:
Eating Disorders in Singapore as Seen Through Anthropological Eyes

by
Maho Isono

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Maho Isono, Author
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Introduction

On the first day of September 2001, I was sitting with a 19-year-old junior college student in a small consultation room at the Institute of Mental Health (IMH) in Singapore. The air-conditioned room was cool enough for me to escape from the heat and humidity outside; fall is not a word for Singaporeans, who live just above the equator. On my first day in Singapore, I was incapacitated in this tropical weather by an incomprehensible stomachache and headache, and I still was struggling with this climate weeks later. I had been there for two months already to research eating disorders in Asian cultures.

This student’s name was Ming; she was a Chinese-Singaporean who had suffered from eating disorders for four years and was my 15th informant who had an eating disorder. Her diagnosis was bulimia nervosa accompanying depression with a previous history of anorexia nervosa. Her weight of 46.1 kg [101.4 lbs.] with a height of 157 cm [5’2’’] was rated as low normal, which was slightly higher than her borderline underweight, 45.6 kg [100.3 lbs.]. In my eyes, her body looked fragile but did not look emaciated. Ming-Min was a talkative and insightful woman who loved literature; most people could not tell she had an eating disorder by looking at her outer appearance. She had a grand dream she wanted to attain with this fragile body – going to the US after graduation to study psychology in order to help people who struggle with eating disorders. During my second interview with her, she gave a lot of valuable information that helped me to understand eating disorders in Singapore, much as she had done the first time we had spoken.

Just before I finished interviewing Ming, she started talking about her boyfriend, and a comment that she made stuck in my mind. She mentioned that, although her boyfriend knew about her disease, he did not understand the “underneath” problem behind her bulimia—I asked if she could tell me about this underlying problem. She answered, “I am always influenced by others. What is my idea? Where am I?” Since I was always impressed with her thoughtful
opinions, I asked her, “Do you think so? But it seems like you have your own ideas. I talked with many people, and you are one of them who have very insightful ideas about many things.” “Really?” she answered with a good smile. Before I left Singapore, we saw each other once again and parted with the promise to reunite in the US.

This thesis will aim at illuminating eating disorders from patients’ perspectives based on the voices of 16 Singaporean individuals, aged 15 to 26 years, who have been diagnosed as having an eating disorder. Patients’ voices are my focus in this research because they have not been emphasized or acknowledged in most current studies of eating disorders. Presenting their points of view is important, since, although eating disorders are frequently presented in public, the central focus often is how much or little those with eating disorders eat, and how “abnormally” they are obsessed with their appearances. This focus may be a way of describing eating disorders; however, such descriptions do not show individuals’ inner struggles that exist behind such behaviors, such as Ming’s “underneath problem” about her existence.

Although I will attempt to illustrate patients’ points of view, this thesis is different from autobiographies written by individuals who actually suffer from eating disorders, since I will consider these 16 individuals’ perspectives as a form of cumulative knowledge, rather than as separate, subjective opinions. In order to do so, this thesis will focus on two themes shared by these informants—their immense fear and guilt towards gaining weight and their magnified inner pain caused by a lack of understanding from others—and will analyze those themes from an anthropological perspective. Medical science usually considers such fear and guilt pathological; however, this thesis will look at these emotions as cultural by situating them in an anthropological theory of feelings and will attempt to erase this lack of understanding by making cultural components of these feelings readable to those without eating disorders. By doing so, patients’ points of view will become knowledge through which we can learn a function of Singaporean culture and society.
This thesis assumes three types of readers. The first readers are those without eating disorders. I would like for them to see a different face of eating disorders, which they would never have known only by reading the diagnostic criteria of eating disorders, and to know that those with eating disorders are not as "abnormal" as they are represented to be in public. The second readers are medical professionals. In current medical science, culture is not considered a cause of eating disorders; however, I will claim that this exclusion originates from medical science simplifying the concept of culture. In Chapter Three, I will clarify the concept of culture, which has remained ambiguous in the study of eating disorders, and I will demonstrate how insiders' perspectives of eating disorders connect to culture. I would like for medical professionals to reconsider whether the exclusion of culture from the etiology of eating disorders is truly appropriate. The third readers are those with eating disorders. I would like for them to understand the cultural implications of their conditions. I believe that knowing about such implications will empower them just as medical science empowers them by showing the medical implications of their conditions.
Literature Review

This chapter will illustrate eating disorders from three perspectives - diagnosis, history, and epidemiology\(^1\) - and will move on to introduce three explanatory models of eating disorders - psychology and family, society and culture, and biology. After the introduction of these three models, I will introduce the biopsychosocial model, the integration of all the three models, which is largely accepted as the best model to explain the development of eating disorders, and I will illustrate eating disorders in Asia with the special focus on these conditions in Japan, Hong-Kong, and Singapore. This chapter will conclude by pointing out that the current literature on eating disorders lacks the patients' perspectives of these disorders.

Eating Disorders' Three Facets: What are eating disorders?

The Diagnostic Facet

In the Fourth Edition of Diagnostic and Statistical Manual of Mental Disorders (the DSM-IV), a worldwide text for mental disorders used by medical professionals, eating disorders currently are divided into three branches: anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (EDNOS) (The American Psychiatric Association [APA] 1994). This section will show the diagnostic characteristics of each of these disorders and introduce binge eating disorders and night eating syndromes, new types of eating disorders that may be recognized as independent clinical entities in near future.

\(^1\) Epidemiology roughly means the study of the distribution of a disorder (Thomas 1997).
Anorexia Nervosa

Anorexia nervosa is characterized by the intense fear of fatness, an excessive drive for thinness even though underweight, and the absence of menstruation (amenorrhea). The DSM-IV defines anorexia nervosa as:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height. (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

B. Intense fear of gaining weight or becoming fat, even though underweight

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) (APA 1994)

The persons who show all four criteria are further categorized into two sub-types: binge-eating/purging type and restricting type. These are defined as:

**Restricting Type**: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas.)

**Binge-Eating/Purging Type**: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting, or the misuse of laxatives, diuretics, or enemas (APA 1994).

The DSM-IV's criteria are largely accepted by practitioners; however, Singaporean doctors often use a Body Mass Index (BMI) below 17.5 as an alternative criterion to define medically
underweight persons, instead of using the DSM-IV’s criterion of “weigh[ing] less than 85% of that expected.” The BMI is defined as weight (kg)/[height (m)]², originally selected by the Food and Agricultural Organization of the United Nations (FAO) in order to monitor nutritionally at-risk populations, is a current common tool to define if a person is underweight, normal, or overweight (Shetty & James 1994). There are two different classifications for Asians and Caucasians, because of their biological differences. For Caucasians, a BMI score under 20 is considered underweight, from 20 to 25.9 is normal, and more than 26 is overweight. For Asians, a BMI score under 18.5 is defined as underweight, from 18.5 to 23.9 (22.9) is normal, and more than 23.9 (22.9) is overweight (The World Health Organization Western Pacific Region 2000).

The BMI 17.5, as an alternative criterion to diagnose anorexia nervosa, is indicated in another reliable diagnostic manual, the ICD-10 Classification of Mental and Behavioral Disorders, published by the World Health Organization in 1992. My supervisor, Dr. Lee, explained that an Asian’s weight will be less likely to drop to less than 85% of expected body weight. Thus, a BMI score below 17.5 is a more sensitive criterion for Asians than the DSM-IV criterion to help prevent clinicians from underdiagnosing anorexic individuals.

Persons who binge and purge are sometimes misconceived as suffering from bulimia nervosa; however, this is wrong because persons who are of normal medical weight cannot be diagnosed as bulimic (Beumont 2002). Even though an individual overeats and throws the food up, her/his diagnosis will not be changed to bulimia nervosa, but remains as anorexia nervosa while her/his subtype will be changed to binge-eating/purging subtype. Not the presence of binge eating and purging but rather being medically underweight and having amenorrhea differentiates anorexia nervosa from bulimia nervosa.
Bulimia Nervosa

Bulimic persons are not as emaciated as anorexic individuals but usually have medically normal or slightly higher weight while struggling with the same issues of weight and body shape from which anorexic patients suffer. The DSM-IV defines bulimia nervosa with two subtypes in the following manner:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following
   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during the episodes of Anorexia Nervosa

Specify Type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
Nonpursging type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (APA 1994)

Compensatory behaviors refer to actions of trying to compensate for what has been binged so as to avoid further weight gain. Bulimic individuals conduct compensatory behaviors
after binging on food; however, if they just binge and do not purge, their diagnosis will be “eating disorders not otherwise specified.”

**Eating Disorders Not Otherwise Specified (EDNOS) & New Eating Disorders**

Doctors diagnose persons as having EDNOS when the patients’ symptoms do not fulfill the full criteria of either anorexia nervosa or bulimia nervosa (Fairburn & Walsh 2002). For example, persons whose bulimic symptoms last less than three months are diagnosed as having EDNOS. Persons who show all criteria of anorexia nervosa but still menstruate fall into EDNOS (APA 1994).

Some clinicians attempt to differentiate three “new” eating disorders from anorexia nervosa, bulimia nervosa and EDNOS so as to make them distinct clinical entities. The first is “binge eating disorder” (BED) which currently is categorized as a part of EDNOS (Grilo 2002) and is defined as “recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa” (APA 1994:550). The second is night eating syndrome. Individuals who suffer from night eating syndrome rapidly increase their food intake from evening to midnight and suffer from the symptoms of insomnia and depressed mood at night (Stunkard 2002). The third is muscle dysmorphia where patients are obsessed with their muscles and their body sizes despite their large and muscular bodies in reality (Phillips 2002). Muscle dysmorphia is sometimes called “reverse anorexia” (Phillips 2002).

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2 Body dysmorphic disorder is a variation of eating disorders. It is defined as “a preoccupation with an imagined defect in appearance; if a slight physical anomaly is present, the person’s concern is markedly excessive. The preoccupation causes clinically significant distress or impairment, and it cannot be better accounted for by another mental disorder” (Phillips 2002:113).
2002:116), since the symptoms are contrary to anorexic individuals who are concerned with their body sizes being too large despite them being underweight.

**The Historical Facet of Eating Disorders**

The movement to increase the types of eating disorders has, in fact, kept occurring since the 1970s when doctors started to recognize anorexia nervosa as one common mental disorder among adolescent girls. At that time, bulimia nervosa was considered a part of the symptoms of either anorexia nervosa or obesity. This section will trace the history of self-starvation and binge eating and purging throughout history and will review how the current diagnostic system was established.

**History of Self-Starvation & the Establishment of the Diagnostic Criteria of Anorexia Nervosa**

Historical facts of anorexic behaviors show that self-starvation has existed since ancient times and has been interpreted depending on the historical context. Initially self-starvation was not considered mental disorders. The history of self-starvation goes back to the thirteenth century, when fasting was a central spiritual practice among (mostly female) Christian saints (Vandereycken & van Deth 1994; Brumberg 2000). In the medieval era (from the thirteenth to the sixteenth centuries), survival without food was considered a “female miracle” that symbolized the sustenance of life through the body and blood of Christ (Brumberg 2000:42). One fourteenth century fasting saint, Catherine of Siena ate only a handful of herbs and pushed twigs into her throat to throw food up when forced to eat; however, such behaviors were not

---

3 Religious starvation may be traced back to before the thirteenth century. For example, Beumont et al. (1988) discovered documentation of a girl who lived in the fourth century and died of self-starvation. This record implies that her starvation was religiously motivated.
conceived as a sign of illness but were seen as her success in placing her spirit over her body through the grace of Christ (Brumberg 2000). Medical professionals of the time called this spiritually motivated fasting “anorexia mirabilis” (miraculously inspired loss of appetite) or “inedia prodigiosa” (great starvation) (Brumerberg 2000:44); both are now called “holy anorexia” by the current medical community (Nasser 1997).

However, the rise of science in the late seventeenth century changed the climate surrounding holy anorexia. Instead of pastors and priests, doctors started having the authority to explain long abstinence from eating, edged out the religious explanation of what food avoidance was, and claimed that prolonged fasting was a partial symptom of disorders such as hysteria, mania, melancholy and chlorosis (Brumerberg 2000; Vandereycken 2002a). Although some people preferred the traditional explanation of fasting, the mainstream explanation gradually became scientific. And in 1694 such starvation was finally claimed as an independent clinical entity, rather than a partial symptom of other disorders, by Richard Morton, a British physician (Vandereycken 2002a). He understood it as “nervous consumption” (consumption is defined as causing loss of strength or size; emaciating), that is, patients’ severe weight loss was based on neurotic pathology, not the result of other types of consumption such as tuberculosis, cold, or fever (Vandereycken 2002a). His report is now largely recognized as the first medical report of anorexia nervosa, because he connected weight loss to neurosis and treated it as a syndrome rather than a symptom (Beumont et al. 1988; Vandereycken 2002a).

Morton’s report did not invite much attention from other doctors when it was published; however, 200 years later, such starvation was brought to light again by Ernest-Charles Lasègue, a Parisian neurologist, and William Gull, a London physician. In 1873, Lasègue and Gull simultaneously proposed prolonged self-starvation as an independent clinical entity;
Lasègue named it “anorexie hystèrique,” and Gull initially called it “anorexic hysterique” and renamed it “anorexia nervosa” in 1874. Their descriptions address issues that Morton does not point out but that are often seen in current anorexic patients, such as young women being the most vulnerable group to the syndrome, hyperactivity, and amenorrhea (Gordon 2000; Vandereycken 2002a). While Lasègue and Gull’s descriptions of anorexia are still applicable to today’s anorexic patients, there were two characteristics that they did not point out but which are very common in the current anorexic patients: the body image problem and the drive for thinness (Vandereycken 2002a). A half century later in the 1960s, Hilde Bruch, an American psychiatrist, added these features to the traditional description of anorexia nervosa, and a basis for the current diagnostic criteria of these conditions was established.

**History of Overeating and Purging**

Bulimia nervosa emerged in the Western psychiatric scheme more dramatically than did anorexia nervosa. Unlike the term anorexia nervosa coined in 1884, the term bulimia nervosa was recently proposed in 1979 (Stein & Laakso 1988). During the 1970’s doctors increased their attention to bulimic symptoms, since they recognized a group of patients who showed similar symptoms to anorexia nervosa but had features clearly distinguishable from “pure” anorexic patients. They were different from anorexic patients in that their weights were medically healthy but they suffered greatly from body image issues and regularly binged on food but maintained their weight with compensatory behaviors. Doctors initially regarded these symptoms as variants of anorexia nervosa or sometimes symptoms of obesity (Vandereycken 1994; Gordon 2000; Vandereycken 2002a).
However, in the 1970s, the numbers of patients who showed this condition rapidly increased and became separable from both anorexic and obese patients (Vandereycken 1994; Gordon 2000; Vandereycken 2002a). Bulimia began to shift from a symptom to a syndrome, and several names were proposed for this new syndrome, such as “thin fat syndrome,” “binge eating syndrome,” and “dietary chaos syndrome,” but finally “bulimia nervosa” was chosen as the most appropriate name for this syndrome (Vandereycken 1994). The bestower of this name was Gerald Russell, a British psychiatrist. He systematically analyzed his 30 patients who were closer to anorexic patients but not completely identical with them and published “Bulimia nervosa: an omniscient variant of anorexia nervosa” in 1979 (in Vandereycken 1994). Russell’s designation, along with a clear description of the syndrome, was adopted to the revised versioned DSM-III in 1989 (Vandereycken 1994; Gordon 2000; Vandereycken 2002a).

The proliferation of bulimia nervosa, having an elusive cause, guided researchers to pose the same question given to anorexia nervosa: is bulimia nervosa a “new” disorder? After tracing the historical evidence of bulimic behaviors, they found that the word “bulimia” is derived from a Greek word boulimous, which literally means ox (bous)- hunger (limios) (Vandereycken 2002a), and the term “nervosa” is rooted in a Latin word, nervus, and means “for nervous reasons” (Thomas 1997).

The use of the word “bulimia” can be traced back to the second and third centuries AD and has continuously appeared in medical documents with many variations, such as bulimus, boilsmus, and boilsme, or described by the related words kynorexia and fames canina which means “overeating followed by self-induced vomiting” (Vandereycken 2002a; Stein & Laakso 1988). Parry-Jones and Parry-Jones (1991) reviewed 12 cases of bulimic behaviors from the fifteenth to the eighteenth centuries, and showed that the term bulimia included a wide range of
behaviors. For example, one case note reported a man in 1800 who ate "174 cats, dead and alive, and he also ate dogs and rats and, on the occasion, the shot-off leg of a comrade in arms" (132). Another four cases were related to the sufferers having worms, and two of these bulimic behaviors were cured by the expulsion of the worms. However, according to the authors, no cases talked about mental abnormality except one in which a male committed suicide.

In the nineteenth century, two European doctors made very detailed classifications of bulimic behaviors. Cullen (1818) distinguished three types of bulimia: bulimia hellunum ("excessive hunger"), bulimia syncopalis ("fainting from hunger"), and bulimia ematia ("overeating with vomiting") (in Parry-Jones and Parry-Jones 1991:136). Hooper (1820) identified nine types of bulimia, such as bulimia with convulsion, bulimia with heartburn, and bulimia from the presence of worms (in Parry-Jones & Parry-Jones 1991). However, these historical facts do not prove that bulimia "nervosa" has existed since the second century since doctors at that time considered these bulimic conditions as gastric dysfunction, not mental disorders (Stain & Laakso 1988; Parry-Jones & Parry-Jones 1991; Vandereycken 2002a).

Bulimia nervosa had begun to be connected with mental disorders in the eighteenth century although it was not the mainstream diagnosis. For example, Blancard, a Dutch physician, in 1702 mentioned that his bulimic patients had "a defection of the spirits," probably indicating their depression (Stain & Laakso 1988). In 1767, Guiapom, a French physician, made the connection between bulimia and hysteria and observed depressive modes in his bulimic patients (Parry-Jones & Parry-Jones 1991). In the late nineteenth century, bulimia was commonly connected to mental disorders, especially as a symptom of hysteria, although core features of bulimia nervosa, such as fear of fatness and body image problems, which are mentioned in the DSM-IV, had not been addressed at that time (Vandereycken 2002a). As I have shown, while
bulimic conditions were noted throughout history, such behaviors only recently have been connected to mental disorders.

**Epidemiological Facts of Eating Disorders**

Eating disorders are also known as having an interesting epidemiology. This section will illustrate the brief epidemiology of both anorexia and bulimia nervosa and present geographic factors of eating disorders that make these conditions very unique when compared to other Western psychiatric disorders.

**Epidemiology of Anorexia Nervosa and Bulimia Nervosa**

Anorexia nervosa showed a rapid rise in cases in the 1960s. Bruch (1978), an authority on anorexia nervosa in the mid twentieth century, states that before the 1960s, anorexia nervosa was a disorder which most doctors had heard of at medical school but had never encountered in clinical settings; however, after that decade anorexia nervosa started showing a rapid rise, and it became a common mental disorder among adolescent girls by the late 1970s.

Anorexia nervosa also had a peculiar epidemiology. Bruch (1978) explains:

New diseases are rare, and a disease that selectively befalls the young, rich, and beautiful is practically unheard of. But such a disease is affecting the daughters of well-to-do, educated, and successful families, not only in the United States but in many other affluent countries. (vii)
In the Western practice of child psychiatry where more boys than girls are diagnosed as having mental disorders, anorexia nervosa reverses this tendency⁴ (Di Nicola 1990b)—boys who are diagnosed as anorexic represented only one out of ten cases (Bruch 1978).

The current DSM-IV estimates that the prevalence of anorexia nervosa is 0.5%-1% among late adolescents and early adults in the affluent Western affluent countries. The onset of the disorder often occurs between the ages of 13 to 18, the average age being 17 (APA 1994). While Bruch (1978) stressed that girls from the upper middle class are particularly vulnerable to anorexia nervosa, the latest epidemiology often cuts off this class factor, because the disorders are now prevalent in various classes (Hoek 2002).

Bulimia nervosa also has a similar epidemiology to anorexia nervosa. According to the DSM-IV, the onset of bulimia nervosa usually occurs among young adolescents and young adults, which is a little later than that of anorexia nervosa. Its prevalence of 1%-3% among young adolescents and young adult females is higher than that of anorexia nervosa, but like anorexia nervosa, nine out of ten bulimic patients are females (APA 1994). Eating disorders show a unique characteristic in terms of gender, and they also have unique epidemiology in terms of geography.

**Geography and Eating Disorders: From Western Specific Disorders to Globalized Disorders**

Geographic facts of eating disorders are roughly dividable into two stages: the first stage is eating disorders before the 1990s, when eating disorders were believed to be Western-specific

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⁴ Although there are other psychiatric syndromes which also have reversed inclinations, such as overdoses and shop-lifting (Littlewood & Lipsedge 1987 in Di Nicola 1990b), these are not clinical entities (Di Nicola 1990b).
mental disorders with exceptions, such as Japan (Gordon 2001). The second stage starts after the 1990s when the disorders were recognized as globalized.

The sharp increase in the number of anorexic patients after the 1960s and bulimic patients after the 1970s in Western affluent societies called for a growing interest in eating disorders from both Western doctors and lay people. For example, in 1981, The International Journal of Eating Disorders was founded to encourage research on eating disorders and related behaviors (Brumberg 2000). At the National Library of Medicine in the USA, the numbers of articles indexed about eating disorders skyrocketed during this decade: About 500 articles on anorexia nervosa were indexed from 1966-1977, and the numbers doubled in the 1980s. The increase of articles on bulimia nervosa was more dramatic—from fewer than 10 articles in the decade of 1966-1972 to more than 150 articles in the 1980s (West 1987).

The Western public also became knowledgeable about eating disorders by the 1980s. Popular magazines such as People, Mademoiselle, and Seventeen began featuring articles about anorexia nervosa in the middle 1970s. Karen Carpenter's shocking death from complications of anorexia nervosa in 1983 definitely made the disorder well-known and showed to the American public that anorexia nervosa was fatal. In the 1980s, information about the disorders, including films, autobiographies, and educational books became easily available. "You look anorexic" became a common remark about thin people, and jokes even were made out of it, such as the "anorexic cookbook" (Brumberg 2000).

While there was rapidly growing interest in eating disorders in the West during the 1980s, researchers found eating disorders to be remarkably rare in societies and/or populations that had not adapted to Western affluent cultural values (Azevedo & Ferreira 1993; Di Nicola 1990b). For example, in Malaysia in 1981, there were only 30 anorexic patients among 60,000
new psychiatric referrals (Buhrich 1981 in Di Nicola 1990b). In South Africa, no African patients were reported in the 1980s, while Caucasian women had been diagnosed as having eating disorders since the 1970s (Gordon 2001). In India in the early 1980s', there were no reports of anorexia nervosa (Gordon 2001). Furthermore, Azevedo and Ferreira (1993) found that eating disorders also were very rare in the Western developing community of a Portuguese territory in the Azores archipelago. In 1989, they surveyed the prevalence of the disorders among 1234 school students (age 12-20) in this region by using the DSM-III diagnostic criteria, and only 0.48% and 0.16% of the subjects showed partial symptoms of anorexia nervosa and bulimia nervosa, respectively. These studies strongly suggest that eating disorders specifically occur in Western affluent societies, and based on these facts, Prince Raymond, an MD, proposed that eating disorders be designated as “culture bound syndromes” (CBSs) (Di Nicola 1991b), that in general refer to conditions which are unique to a particular society but are absent in other societies (Nasser 1997).

However, after the 1990s, the disorders’ cultural boundary was “unbounded,” since non-Western countries started reporting the existence of eating disorders within their populations (Gordon 2001:1; Nasser 1997). For example, in 1995 South Africa made the first report of two black anorexic patients and one individual who showed a partial symptom of bulimia nervosa (Szabo & Grange 2001). In 1998 T.N. Srinivasan and T.R. Suresh, Indian doctors, stated that although both anorexia and bulimia nervosa seemed not to manifest in India, their partial symptoms had started emerging. Furthermore, Nobakht and Dezhkam (1999) surveyed the prevalence of eating disorders among young females from the ages of 15-18 in Teheran, the capital city of Iran, and estimated a lifetime prevalence of 0.9% for anorexia nervosa and 3.2% for bulimia nervosa, percentages which are comparable to those in Western countries (0.5-1% for
anorexia nervosa, 1-3% for bulimia nervosa). In addition to these countries, multiple non-Western countries, such as Argentina, South Korea, Mexico, and Turkey, made their first reports of eating disorders after the 1990s (Gordon 2001). All these cases show, eating disorders appear to have disseminated into non-Western countries after the 1990s with the wave of globalization all over the world. Since this dissemination has not seen in other Western psychiatric disorders, some researchers suspected the possibility that culture might be a cause of eating disorders (Gordon 2001).

The Etiology of Eating Disorders: Why do eating disorders occur?

The definitive causes of eating disorders are unknown; however, Western psychiatry understands that eating disorders develop through the interaction of multiple factors: biological, psychological, familial, societal, and cultural. This integration of multiple factors is called the biopsychosocial model of eating disorders and is largely accepted by Western psychiatry. This section will illustrate the psychofamilial, sociocultural, and biological models and will show how these models are integrated under the banner of biopsychosocial model in explaining the etiology of eating disorders.

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5 It is likely that “the first report” means the first one written in English although Gordon (2001), the author of this review, does not mention it.
6 Etiology: 1. the study of the causes of disease; 2. the cause of disease (Thomas.1997: 679)
The Psychofamilial Model

Anorexia Nervosa

From the 1940s to the 1960s\(^7\), Freudian psychoanalysis composed the explanatory model of anorexia nervosa. Psychoanalysis considered that eating was an expression of libido and sexual desire and addressed anorexia nervosa as a result of insufficiently developed female sexuality\(^8\). The treatment, then, followed this model although failed to show efficacy (Brumberg, 2000; Gordon, 2001; Beumont et al. 1988). When this psychoanalytic model faced difficulties in practice in the 1960s, Bruch made a major theoretical breakthrough in the theory of anorexia nervosa by expanding the perspective from her anorexic patients’ sexual factors to their family dynamics (Gordon 2001). Her description is called “anorexogenic family environment” and was thought to be crucial for the development of anorexia nervosa during the 1960s and 1970s (Schmidt 2002).

Bruch (1987) stressed that excessively over-controlling parents and never-give-any-trouble children are the common pre-familial characteristics seen in the family of anorexic children. She states that children with such parents lack a sense of autonomy and strive to answer others’ expectations while failing to develop an ability to make their own judgements. Bruch explains that when such children fail to answer other’s expectations or are incapable of handling new demands, they attempt to change their bodies so as to either solve their problems or stay in childhood (1987). In The Golden Cage, she often highlights the characteristics of mothers of anorexic patients: they are very devoted to rearing their children while at the same time being

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\(^7\) It was probably Lasègue, a proponent of “anorexie hystérique” in the late eighteenth century, who first established an elaborated psychofamilial model of the disorder by linking it to familial conflicts (Brumberg, 2000). However, explaining all his model would go far beyond my thesis.

\(^8\) Anorexic patients were often seen as “defending themselves against fantasies of oral impregnation, or against promiscuous impulses.” (Gordon 2001:117)
successful career women, and they feel that they sacrificed their aspirations for their family's well-being before their children were born. Further, they are success-oriented in everything, and they tend to be preoccupied with physical appearances and behaviors.

Bruch radically altered the initial psychoanalytic model. However, after her proposal, mothers were harshly accused that their daughters developed anorexia nervosa for two reasons. First, anorexic girls reject becoming mature women because their mothers cannot embrace their femininity. Secondly, anorexic girls starve themselves to have a sense of autonomy; since their mothers control their lives, the body becomes the only domain that they can control. Furthermore, psychoanalysis supports these ideas by claiming that mothers are entirely responsible for their children's healthy mental status (Bruch 1978; Gordon 2001).

However, this mother-blaming was negated by two criticisms in the late 1980s. First, this does not consider societal conditions that may have given contradictory messages about femininity to mothers, as will be described in the next section. Secondly, this excludes the fathers' roles in childrearing while imposing its whole responsibility on mothers. The psychofamilial model of anorexia nervosa eventually became more holistic rather than focusing on one family member (Vandereycken, 2002b). Currently, clinicians often describe the family of anorexic patients as "avoiding open discussion of disagreement between parents and children and [as having] less clear interpersonal boundaries" (Vandereycken 2002b:216). In terms of personality traits, this model includes as risk factors: perfectionism, negative self-evaluations (Fairburn et al. 1999), the tendency to avoid harm to themselves (The Academy of Eating Disorders 2002), obsessive-compulsive characteristics (Wonderlich 2002), and extreme compliance (Schmidt 2002).
Bulimia Nervosa

Although less focused than anorexia nervosa, bulimia nervosa also was interpreted as one of the many problems of orality in the context of psychoanalysis (Vandereycken 1994). After the psychoanalytic interpretation was edged out, researchers became interested in the link between childhood trauma and the disorder’s development. Although it was discovered later that while childhood trauma is a contributing factor, there seems to be no specific link between the two (Shimidt 2002). Currently, the family of bulimic patients are often described as “conflicted, badly organized, uncohesive, and lacking in nurturance or caring” (Vandereycken 2002b: 216). Gordon (2001), a psychologist, also observed that parents of bulimic patients often fail to give their children emotional support because of their own problems, such as divorce, mental illness, or a preoccupation with their career, and, thus, bulimic patients often try to fulfill their loneliness and void by bingeing on food. Impulsiveness, interpersonal sensitivity, narcissism and low self-esteem are usually listed as personality traits of bulimic patients (Wonderlich 2002). Parental obesity, childhood obesity, and early menarche are familial-physical characteristics often seen among them and their families (Fairburn et al. 1999; Schmid 2002). Individuals with these traits may become appearance-conscious more overtly than others, because these characteristics are likely to heighten their sensitivity to criticism and/or may increase the possibility of being teased about their bodies.

9. “The oral stage of psychosexual development, which involves sucking or chewing on objects other than food” (Thomas et al., 1997: 1352).
10. Narcissistic personality is defined as “inflated self-importance and a need for attention and admiration” (Wonderlich 2002: 207). Thus, narcissistic persons are hypersensitive to stressful interpersonal relationships, from which they may not receive positive attention and admiration, and tend to criticize themselves (Wonderlich 2002).
The psychofamilial model points out the individual and/or familial characteristics that should be considered in treatment. However, this model alone cannot answer questions such as why women are more vulnerable to eating disorders, or why eating disordered patients seem to have increased since the 1960s (Brumberg 2000).

The Sociocultural Model

In conjunction with the psychofamilial model, the sociocultural model came to the forefront of the study of eating disorders, especially in the 1990s. This section will focus on three types of sociocultural models that analyze women’s status in society, the role of mass media, and Westernization.

Saving Mothers

The initial sociocultural model stems from the early psychofamilial model that claims the mother’s entire responsibility for their daughters developing anorexia nervosa and analyzes eating disorders by looking at mother-daughter relationships as socially constructed, rather than pathological. Feminists, in particular, analyze the societal conditions that affected mothers since the 1940s and claim that society after the 1940s was constructed in such a way that mothers were unable to accept their femininity and individuate their daughters from themselves.

Susie Orbach, a feminist psychologist, claims that mothers of anorexic daughters have lived in the midst of uncertainty in the mid-twentieth century. In the 1940s working women were respected for compensating for the lack of laborers resulting from men going to war. However, after men came back from war in the late 1940s, motherhood was elevated to being “almost saintly,” because female labor was not needed as much as before (1986:37). Women were thus encouraged to stay home and were taught that they were entirely responsible for their children’s
and husbands' well-beings. After women's liberation occurred in the 1960s, there was a feeling of freedom and more possibilities opened for women. However, this liberation had a pseudo aspect: childrearing still meant mothering, and the glass ceiling continued to exist in the workplace (Orbach 1986).

Since motherhood was presented as that which should be the center of a woman's identity, mothers felt that there was nothing to hold on to if their daughters were independent. On the other hand, they hoped that their daughters would achieve what they could not accomplish, even though they wanted to. In such a social context, women were confused with what it meant to be a woman and gave contradictory messages to their daughters: “be like me” and “do not be like me”; consequently, these girls also were confused with their femininity and rejected being mature women. Orbach, in sum, argues that patriarchy causes this confusion in women by disallowing them to use their talents freely outside home in order to maintain male authority. This theory put a stop to the “mother-blaming” by illustrating women's societal positions since the 1940s; however, it remained in the traditional theory that anorexia nervosa develops because of unhealthy mother-daughter relationships, rather than going beyond this relationship.

Ultra femininity

Going beyond mother-blaming, the contemporary sociocultural model focuses on the effect of mass media images on women. Rita Freedman, a psychologist, calls anorexia nervosa “a dramatic attempt to achieve ultra femininity,” and denies the traditional idea that anorexic patients reject womanhood (1984:36). This model concentrates on the idea of slimness surrounding the female body and claims that anorexic patients try to become “super” women.
who can compensate for any contradictory societal messages by having a slim body and looking attractive, vulnerable, and dependent as a woman while maintaining a sense of self control through their anorexia. Their emaciated bodies appear far away from femininity, but this is the tragic consequence of a tremendous effort to embody the slim women in mass media (Turner 1984).

In fact, after the 1960s, Western fashion models became slimmer and slimmer. They weighed an average of 140 lbs in 1894, 125 lbs in 1947, and 118 lbs in 1975 while their heights became taller: 5’ 4” in 1894 and then 5’ 8” in 1975 (Fallon 1994). In the early 1990s, there were some female models who were 5’ 10” and 110 lbs, who weighed 30 lbs less than the average woman and met one of the DSM-IV criteria for anorexia nervosa, based on low body weight (Heinberg 1996).

While advanced technology disguises illusion as reality, women on screen, even though manipulated by technology, emerge as true beautiful women and tell young women: “It is attainable” (Fallon 1990; Rodin 1992; Freedman 1986), and “Real persons become only flawed imitations of the perfect image” (Callaghan, 1994:xii), and the young women are physically and psychologically damaged by this image. Murphy calls this phenomenon “symbolic violence” (1994:74), and this symbolic violence is a central argument of the current sociocultural model.

**Westernization and Eating disorders**

The proliferation of eating disorders in non-Western countries seem to parallel the progress of Westernization; thus, scholars have suspected that Westernization largely is

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11 Hesse-Biber points out that female body images in educational materials also have become thinner since the 1990s, while those of boys have remained unchanged (1996:98).
responsible for the occurrence of eating disorders in non-Western countries. For example, Fiji is a
country where plumpness is celebrated traditionally and where the illness of *macake* is identified
as a problem of undereating; however, since Western TV programs were first introduced in this
country in 1995, the ideal body image there has been in transition. A study shows that in 1998 74
percent of the Fijian girls, aged 17 on average, answered that they feel “too big or fat” at least
sometimes; three percent of young girls reported that they purged to control weight in 1995, but
in 1998, the percentage was raised to 15 percent (Gillyatt & Reynolds 1999). Likewise,
Gunewardene et al. (2001) investigated the relationship between exposure to Western culture and
dieting among 100 Australian, 60 Chinese Australian, and 100 Chinese. The authors measured
the degree of Westernization by the language spoken at home and found significant correlation
between dieting and Westernization.

Similarly, Nasser Marvet (1997) and Vincenzo Di Nicola (1991b), Egyptian and
Canadian psychiatrists, respectively, theorize eating disorders in sociocultural contexts and state
that the sociocultural model better includes all the cultural changes that have been caused by
Westernization/industrialization rather than only looking at the transformation of the ideal female
body image from plumpness to thinness. For example, Nasser (1997, 2001) names eating
disorders “culture chaos syndromes” and states that eating disorders are expressions of culture in
countries undergoing modernization/industrialization; under the modernization, traditional values
and new values are always in conflict with each other, and individuals feel chaotic and have
difficulty building stable identities. Likewise, Di Nicola (1991b) names eating disorders
“cultural change syndromes,” which emerge in the societies where traditional cultural values
become unstable because of the intrusion of new and different cultural values.
Several reports support their insights. For example, A.H. Crisp, a British psychiatrist comments that non-white adolescent females often develop anorexia nervosa with relation to cultural conflicts between their traditional culture and the mainstream British culture (Soomro et al. 1995). In the same vein, a study reports that Hong-Kong born females who hold more traditional values are less satisfied with their bodies and show more disturbed eating attitudes than Westernized-Hong-Kong born females; this result probably implies that the first group struggles more with cultural conflict between the traditional and the new than the latter group (Lake et al. 2000) Another study shows that second generation Mexican American women had the greatest eating disturbance compared to other generations. This result implies that the second generation struggles with the greatest cultural conflicts between their first generation parents and the outside Western culture among other generations, and this conflict may contribute to their eating disturbances (Chamorro & Flores-Oriz 1998). The terms cultural chaos syndrome and culture change syndrome both were created in the context where eating disorders started to be seen outside of Western countries.

**Anthropology and Eating Disorders**

While culture has received significant attention in the study of eating disorders, only a few anthropologists have conducted research on eating disorders (Fabrega and Millar 1995). Among few, Brown and Konner (1998) give us an interesting lens through which we can analyze eating disorders. They cross-culturally compare female ideal body images in terms of the degree of industrialization as well as the risk of famine and claim that industrialization can reverse the ideal body type from plumpness to thinness. They state that under industrialization, individuals started having sedentary lives and began eating more fat and sugar while consuming less fiber.
Furthermore, since food scarcities were no longer the main concern of their lives (although some people are still hungry), being fat is not an accomplishment. They conclude that plumpness becomes a symbol of beauty and high-status in societies where it is difficult to become fat, while thinness is valued in a setting where even the poor can be fat. Not only the image conveyed by Western mass media but also life style changes influence the creation of ideal body images.

To my knowledge, Richard O’Conner (unpublished manuscript) is the only anthropologist who analyzes anorexia nervosa through the eyes of anthropology. He criticizes the current sociocultural model as not written from anorexic individuals’ perspectives but from the perspectives of those who are healthy, and he claims that only accusing patriarchy, mass media, and modernization (Westernization) can not fully connect society to anorexic individuals. He claims that researchers should focus on the societal contexts where upper-middle-class adolescent anorexic girls live. He calls these societal contexts “niche-specific conditions” and employs three niches as a means to fill the gap between society and anorexic persons: The first niche is the “upper-middle-class niche” that “equates self-worth with self-control.” The second one is “a female niche” that “stresses bodily control and sympathy with society.” The last one is “the adolescent niche” that “imposes crises of self-worth and self-control.” By theorizing these three niches, he proposes that the sociocultural model of anorexia nervosa should include “moral sentiment,” which means that anorexic girls try to be good people rather than supermodels. He also mentions that class factors cannot be measured by only income level, since upper-middle class values are diffused across various classes through educational systems and mass media. His argument is interesting; however, it is uncertain whether it truly is written from “anorexic perspectives,” since his paper is highly theoretical and does not employ any actual voices of anorexic individuals when analyzing anorexia nervosa.
These sociocultural models are strong in explaining why young women are the most vulnerable to eating disorders and why eating disorders have proliferated in the last part of the twentieth century all over the world. However, this model alone cannot explain why a certain group of people in a society develops eating disorders while other groups do not.

**Biological Models**

From 1910 to around the 1940s, anorexia nervosa was believed to have purely biological causes because of Simmonds's disease, which was proposed by a German physician named Moris Simmonds in 1914 (Vanderycken 2002a). This disease refers to a condition in which "complete atrophy (a wasting; a decrease in size of an organ or tissues) of the pituitary gland causes loss of function of the thyroid, adrenals, and gonads, premature senility, psychic symptoms, and cachexia" (Thomas 1997:1761). Simmonds discovered atrophy of the pituitary gland in some emaciated patients, and clinicians believed that anorexia nervosa was a symptom of Simmonds' disease (Vanderyckena 2002). It took a few decades for this theory to be negated, as severe weight loss was rare in Simmonds' disease patients, and atrophy of the pituitary gland is a secondary phenomenon of anorexia nervosa (Beumont et al. 1988).

After this theory was disproved, biological models have not been used in mainstream explanatory models of eating disorders, and, instead, psychological and sociocultural factors of eating disorders have received special attention from scholars. However, interest in biological causes of the disorders have started reviving since the late 1990s. For example, some researchers argue that subtle brain damage may cause anorexia nervosa or bulimia nervosa (Schmidt 2002; Parry-Jones and Parry-Jones 1991). In The International Journal of Eating Disorders in 2002, there is a series of articles published which discuss the relationship between the temperature of
pregnant conception and the occurrence of anorexia nervosa (Willoughby et al.). Among several biological arguments, I will focus on the genetic theory of eating disorders that seems most accepted in the contemporary medical community.

*Genetic Influences on the Development of Eating Disorders*

Researchers have been interested in the relation between genes and the development of eating disorders since the late 1990s, since a number of family studies have found that eating disorders commonly run in families. Families and relatives of individuals with eating disorders are several times more likely to have eating disorders or partial syndromes than families and relatives whose members do not have eating disorders (Strober & Bulik 2002; Bulik 2001). Also, eating disorders seem to cross-transmit through family members—if a family member has bulimia nervosa, the rate of anorexia nervosa in the family is elevated, and vice versa (Bulik 2001). These results suggest that eating disorders may have genetically transmittable factors, and that anorexia nervosa and bulimia nervosa have shared factors in their etiologies. However, family studies cannot determine whether these transmittable factors are genetic or environmental, and this is where twin studies come in (Strober & Bulik 2002; Bulik 2001).

Twin studies employ two genetically identical twins (monozygotic) and non-identical ones (dizygotic) to research how much “addictive genetic effects,” “common environmental effects,” and “unique environmental effects” contribute to the development of eating disorders. The term “addictive genetic effects” refers to the “cumulative impact of many individual genes each of small effect” that influence the development of psychiatric disorders, individual traits, or behaviors (Bulik 2001: 67); “common environmental effects” are the factors by which both twins are equally influenced, such as social class and culture; “unique environmental effects”
refer to factors to which both twins are differently exposed, such as types of peer groups and different parental attitudes towards each twin (Bulik 2001).

Multiple twin studies have been conducted and show that both anorexia nervosa and bulimia nervosa usually exhibit substantial to moderate genetic heritability. Cynthia Bulik (2001), a psychologist at the Virginia Institute for Psychiatric and Behavioral Genetics, re-analyzes four studies that employed clinically diagnosed anorexic twins and estimates that the development of anorexia is 88% accounted by additive genetic effects, 0% by common environmental effects, and 12% by unique environmental effects. Population based twin studies of anorexia nervosa also show 58% genetic heritability of anorexia nervosa (Wade 2000). These studies estimate a substantial genetic heritability of anorexia nervosa; however, Bulik (2001) argues that, researchers need to obtain larger sample sizes with sufficient statistical strategies, so as to draw a strong conclusion for this discussion.

Twin studies of bulimia nervosa are also re-analyzed (Bulik et al. 2000), and, based on this reanalysis, Bulik (2001) concludes:

[B]ulimia nervosa is familial and that there appears to be a moderate to substantial contribution made by genetic factors and a moderate contribution of unique environment to liability to the disorder. The contribution of shared environment is smaller and perhaps zero (76).

Explaining the reasoning of her conclusion completely goes beyond the purpose of this review, since it would include substantial knowledge of statistics; thus, I will briefly summarize the logic in her claim.

There have been three studies of clinically bulimic twins; however, Bulik (2001) concludes that the results of these studies are “imprecise” (76) because of small sample sizes and
the wide confidence intervals. Bulik et al. (2000) reanalyze three population based twin studies of bulimia nervosa and estimate that its genetic heritability is variable, ranging from 31 to 54%; shared environmental effects are almost zero; unique environmental effects are substantial ranging from 46% to 68%. However, these population based studies have methodological problems such as having difficulties in detecting both additive genetic effects and common environmental effects, while shared environmental effects are likely to be increased when measurement errors occur (Bulik et al. 2000).

Thus, Bulik et al. (2000) focus on research that used methodologies, such as “interview[ing] an individual on more than one occasion about their life time history of bulimia nervosa” (Bulik 2001:76), to overcome the problems above so as to better detect additive genetic and common environmental effects. There are three studies that take such methodologies. Two of them, Bulik et al. (1998) and Wade (1999), estimate substantial contributions (59 and 83%) of additive genetic effects in liability to bulimia nervosa, with narrower confidence intervals than the previous twin studies, and they both estimate common environmental effects as zero with small confidence intervals (in Bulik et al. 2000). On the contrary, the other research, Kendler et al. (1995), estimates lower genetic heritability of 28% to the liability of bulimia nervosa and higher common environmental effects of 37% (in Bulik et al. 2000). However, by focusing on

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12 A confidence interval (CI) is a specified probability in which a “particular interval contains the parameter being estimated” (Ramsey & Schafer 1997). Even though this is not exactly what CI indicates, “there is little harm in using this casual interpretation in practice” (Ramsey & Schafer 1997: 39). Thus, a narrow CI with a certain probability is more accurate in answering the question being asked than a wide CI with the same probability (Ramsey & Schafer 1997). The twin studies in this section all use a 95% CI. This roughly means, for example, that Wade et al. (1999 in Bulik et al. 2000) estimate that the genetic heritability of bulimia nervosa is 59% with the 95% CI ranging from 36 to 68%. This CI suggests that, in this study, the genetic heritability of bulimia nervosa is assumed to be in the range between 36% and 68% with a 95% probability.
the results of the first two studies and also those of the previous twin studies, Bulik (2001) concludes that bulimia nervosa is familial.

Some researchers even suggest that the factors that have been interpreted as environmental may be under genetic control (Bulik 2001). For example, they assume teasing experiences—experiences of individuals who are teased about their body sizes—may be familial in the way that some individuals are genetically more sensitive to these experiences and are more likely to go on a diet afterwards (Storber & Bulik 2002).

A genetic etiology of eating disorders is largely accepted by psychiatrists, and research which attempts to detect genes that play a role in the etiology of anorexia nervosa and bulimia nervosa has already been undertaken (Bulik 2001). However, like the previous two models, the biological model alone cannot wholly explain the development of eating disorders, as we consider the questions such as why adolescent girls are the most vulnerable to suffering from eating disorders, and why these conditions have become common places in industrialized societies in the late 20th century.

The Biopsychosocial Model

Since one model alone cannot elucidate the whole nature of eating disorders, the medical community has integrated the primary three models and called it the biopsychosocial model. According to this model, eating disorders are caused by an interaction of multiple factors, such as biology, family, psychology, and culture (The Academy of Eating Disorders 2002). I will introduce four proposals rooted in the biopsychosocial model so as to represent how this model integrates multiple factors in order to explain the development of the disorders. The
biopsychosocial model is characterized by excluding culture from the ultimate cause of the disorders and seeing culture as shaping or triggering the disorders.

**Culture-Bound Syndromes/ Culture Chaos Syndromes**

As I mentioned, eating disorders were proposed as culture-bound syndromes (CBSs) by Prince in 1985. However, it is important to know that despite the term “culture,” CBSs do not include culture as a causal force of a CBS. The basic agreement of CBSs in biomedicine is that culture does not cause a disorder but does shape its presentation and explanations (Nasser 1997). In Western biomedical understanding, a CBS is like a container specifically designed by each culture; the design of the container may change for each culture anchored in a specific historical period, but the content (etiology) is universal. The “true” cause of the CBS must be found “inside” the neurobiology after stripping the “outside” cultural wrappings away. To understand this idea more clearly, let us look at another CBS called susto.

*Susto*, translated as “soul loss,” is a CBS seen in the Latin-American and the Mexican-American community residing in the USA (Rubel et al. 1985). Patients who suffer from *susto* show symptoms such as restlessness while asleep, listlessness, loss of appetite, and depression. The local people do not associate *susto* with any mental disorder in Western psychiatry but understand it as caused by a person’s soul separating from his/her body (Rubel 1998, Rubel et al. 1985). Doctors oriented in Western psychiatry explain that *susto* may be depression, anxiety, or even schizophrenia, but are unable to wholly classify it in their diagnostic system (Rebel et al. 1985). They, thus, call *susto* a CBS, but disagree that *susto* is caused by soul loss. They assume that this explanation of *susto* is culturally molded and does not explain its ‘true’ cause.

Nasser (1997; 2001), a proponent of culture chaos syndromes, shares the same
theoretical position with the concept of CBSs. Pointing out that the decline of hysteria coincided with the rise of anorexia nervosa, she argues that both disorders may share a similar neurotic base, but they are expressed differently because of different cultural contexts and historical periods. The symptoms of hysteria may indicate repressed female sexuality in a bourgeois society, and anorexia nervosa probably reflects societal demands for women to be thin.

**Gene × Environment Interaction/ Culture Change Syndromes**

"Gene × environment interaction" and "culture change syndromes" suggest that culture triggers individual predispositions to eating disorders in the development of eating disorders. The proponents of "gene × environment interaction" argue that the environment acts as a "releaser" (Bulik 2001:72) for a genetic predisposition. For example, Western cultures that impose the ideal of thin beauty on women can release individual genetic vulnerability to eating disorders. This theory assumes that the 'true' cause of eating disorders is a set of genes, and that culture switches on the genetic predisposition. Gene × environment interaction, therefore, rejects "genetic determinism," (meaning that if an individual has specific genes, he/she will certainly develop an eating disorder) (Gorwood 2001:92). Genes contributing to the development of eating disorders have a significant impact when specific triggering conditions, such as familial, personal, or affective environments are present (Gorwood 2001). Di Nicola's proposal of anorexia nervosa as a culture change syndrome is very similar to the theory of gene × environment interaction. He proposes that, in the cases of anorexic patients in non-Western cultures and among immigrants to the West, the "outside" cultural change triggers the "inside" individual predisposition to anorexia nervosa. As I have shown, in the biopsychosocial model on the whole, culture is excluded from the "true" causes of eating disorders but is considered as
playing a role in shaping the presentations or explanations of eating disorders or triggering individual predisposition to the disorders.

Eating Disorders in Asia

Among Asian industrialized societies, eating disorders are commonly known as mental disorders. Among several nations, I chose to present here a discussion of eating disorders in Japan, Hong-Kong, and Singapore. We should recognize that doctors in these countries are educated in Western medicine; thus, eating disorders are considered mental disorders and are not understood in the context of Eastern medical knowledge. In the section on Singapore, I will include the comments of my interviewees who are medical professionals, including three Singaporean psychiatrists, a Singaporean psychologist, and an Australian psychiatrist who visited Singapore as a temporary guest at the Institute of Mental Health, a mental hospital in that country.

Japan

Japan is known as the only non-Western country where eating disorders were reported as early as in the West (Gordon 2001). In fact, anorexia nervosa had been first reported in the 1940s by two Japanese doctors (in Suzuki 1997 in Japanese), while Ishikawa (in Gordon 2001) seems to be the first Japanese doctor who suggested the increase of Japanese anorexic patients to Western doctors in 1965.

Japan also has a long history of self-starvation that goes back to around the ninth century when Japan had only opened itself to China and Korea (Suzuki 1997). One twelfth century writing that collected stories and legends from the eighth to ninth centuries reports that there was a monk who was heartbroken and did not eat for three years (Suzuki 1997; Shinmura 1998).
Another ancient text written in the late 1200s introduces a man who stopped eating because he was distressed with his defeat in *utakai*, which was the competition of Japanese traditional short poetry popular among samurai and monks (Suzuki 1997; Shinmura 1998). These symptoms were called *husyokusou*, which is translated literally to “non-eating disorder” in the *Edo* era (1600-1845). One doctor in this period wrote that he saw more than 30 *husyokusou* patients; he reports that they were mostly women and threw food up when forced to eat. By contrast, there seem to be no documents of bulimic behaviors existing in Japanese ancient writings (Suzuki 1997).

Japanese doctors had already paid attention to eating disorders by the middle twentieth century although they only saw a few hospitalized anorexic patients. These patients were often “beautiful upper-class girls” whose fathers had high social status such as CEOs and doctors (Suzuki 1997:55, translated by author); however, with Japanese economic development, eating disorders were transformed from disorders for upper-class young women to ones for ordinary people (Suzuki 1997). In the 1980s, eating disorders already had become topics that often were featured by Japanese magazines (Asano 1997, written in Japanese). In 1989 a non-profit organization called the Nippon Anorexia Bulimia Association was established. By the middle 1990s, eating disorders were well known in Japan. In my research through the Internet in 2000, there were 18 recognized non-profit self-support groups for people with eating disorders all over the country, including one for males.

Increased numbers of patients with eating disorders have been reported since 1965 (Ishikawa in Gordon 2001). In 1985 Suematu researched hospitals all over Japan and declared that the numbers of anorexic patients (N=1312) in 1985 had doubled when compared to 1976 (in Nasser 1997). In 1997, the Kagoshima University Hospital located in Kagoshima, a South Japan
local prefecture, reported an acute increase in the number of patients with eating disorders since 1992. The number of new patients (N=42) in 1997 was 6 times greater than in 1992; the numbers of revisits (N=24) and hospitalizations (N=25) in 1997 were 5.5 greater than in 1992 (Nozoe et al. 1997).

While various Japanese suffer from eating disorders, Suzuki (1997), a Japanese doctor, argued that patients with eating disorders have certain characteristics in common, such as having good school transcripts and coming from cities. In 1989, he classified patients with eating disorders coming from the big city of Urawa in Saitama prefecture adjacent to Tokyo, by the ranks of high schools to which they belonged. He found that 30 times as many patients attended A+ ranked schools as those who attended C and D ranked schools. In 1991 he also reported that 93% of patients with eating disorders in this prefecture came from cities, 7% from towns, and 1% from villages.

While the increase of patients with eating disorders has been reported for a long time, the prevalence of eating disorders in Japan is somewhat uncertain. In 1996, Kuboki et al. (in Gordon, 2001) estimated that the prevalence of anorexia nervosa in Japan was from 0.25 to 0.307%, which is much lower than in the West. However, this result may lack accuracy since the authors only targeted large hospitals that have more than 200 beds and based the result on a low response rate (64.3%) from these hospitals (Nakamura et al., 1999). Nakamura et al.(1999) also surveyed the prevalence rate of eating disorders in Niigata, a Western Japan local prefecture, and estimated that anorexia and bulimia nervosa had a 0.17 % and 0.0579 % prevalence, respectively, among 15-29 years old females by targeting hospitals and clinics (N=1456) in this prefecture. These prevalence rates were also much lower than in the West; however, it is questionable if this estimation can represent the prevalence rate all over Japan, since this is a prevalence rate taken...
over only five days in a geographically limited area, which means that 17.0 and 5.79 young females per 100,000 are estimated to suffer from anorexia nervosa and bulimia nervosa respectively from the five days' research period (10/20/24/97) in Niigata.

Regarding the etiology of eating disorders, Japanese doctors seem not to consider the preference for thinness as a cause of eating disorders. In Japan, mother-blaming is still strong although this had already faded in the West by the early 1990s. Asano (1996), a sociologist, understands mother-blaming as a backlash against the 1980s feminist movement in Japan. In fact, there is a male Japanese psychiatrist who connects the increase of anorexic patients to women's independence in the 1980s and questions whether women can be truly liberated by rejecting their femininity—house chores and raising children—and attaining equal careers with men (Asano 1996). Simosaka (1989) and Saito (1994), authorities of the study of eating disorders in Japan, also claim that the changes of the Japanese women's socially expected roles were largely responsible for the increase of the numbers of eating disordered patients. For example, Shimosaka (1989) states:

Before the war, women probably did not complain about staying home and being housewives, since they accepted patriarchy, male superiority, poverty, and Confucian ethics as normal everyday experiences. However, after the war, women needed more to satisfy themselves, such as love relationships with their partners, school lives, careers, and hobbies (595, translated by author).

He also mentions that mothers of eating disordered patients often try to have an equal power to their husbands, to create a “[husband-wife] coalition party,” and thereby make their families dysfunctional (1989:595). He claims eating disorders as an identity problem of women and
concludes that it will be difficult for women to satisfactorily build their identities as long as patriarchy—"no matter if it is good or bad"—exists (1989:595). In like manner, Saitou (1994) comments that anorexia nervosa is a female rejection of femininity and asked mothers who attended in his lecture, "Have you ever showed your daughter that you are joyful to be born as women?" (1994:4). Suzuki (1997) also argues that the preference for thinness in Japan is not a cause of eating disorders, since patients with these disorders do not diet to attract men but rather to reject their femininity. Although these patients do not articulate their desire for staying immature, this is assumed to be their underlying thought.

Kasahara (1996), another Japanese doctor, does not blame mothers for patients' eating disorders; however, like Suzuki, he argues that the development of eating disorders is not the result of the preference for thinness in Japan but rather related to individual personal weakness and parental problems in raising children. For example, people binge on food to relieve stress and develop bulimia nervosa, or they lose their appetite from stress and develop anorexia nervosa. In either case, their parents tend to control them excessively. In other cases, people develop eating disorders because of their abnormal personality traits, such as obsessive-compulsiveness and immaturity, and their parents who tend to spoil them.

While eating disorders are continuously looked at as the patients' rejection of their femininity and mother-blaming is still strong, some scholars have started taking different views. For example, Nishizono-Maher (1995) criticizes the thought that forced feeding helps women accept their femininity by recovering female passiveness. Asano (1996) conducted qualitative research on seven Japanese women with eating disorders and analyzed the results from a gender perspective. She shows that her interviewees are confused with the fact that being good humans are incompatible with being good women since being good humans often implies being
masculine. She also demonstrates that her interviewees are struggling with the double standard that while appearance is an important factor in being accepted as a good woman by Japanese society, there is an ideal that those who are concerned with their appearance are superficial. She also warns that Japanese doctors tend to seek for the reasons for the development of eating disorders in individual weakness and abnormality, while neglecting societal pressures to be thin that is imposed on women. Her book is written in Japanese, but I believe that it is the first book about eating disorders in Asia based on qualitative research.

In addition to the Western influence on the Japanese medical community, I assume that the strong mother-blaming stems from Confucian ethics in Japan which claim that mothers have the entire responsibility in raising children as well as a Japanese governmental policy after World War II that emphasized the gender based division of labor—women staying home to do household chores and raise children and men going outside to work—to rapidly grow the Japanese economy.

Hong Kong

In Hong Kong, patients with eating disorders (predominantly anorexic) have shown an increase since the 1990s. For example, Lee and Katzman (2002) report that the growth in the number of patients has increased from two per year at the beginning of the 1990s to at least one per week in the year 2000 at an outpatient psychiatric clinic where Lee works. Furthermore, the Hong Kong Eating Disorders Center received over 200 phone calls from Chinese women who were concerned about their bulimic behaviors in three consecutive months after its establishment in 2000. A community study found that three to ten percent of young females in Hong Kong are
estimated to suffer from disordered eating, a less severe form of eating disorders⁴¹ (Lee & Katzman 2002).

However, these issues are not the reason scholars pay special attention to eating disorders in Hong Kong; the reason, rather, is the existence of “non-fat phobic anorexia nervosa” (Lee 1993). Non-fat phobic anorexic patients do not show “the fear of fatness” by rejecting food, but express their reason for food avoidance differently. In 1993 Lee and Hsu, in fact, surveyed 70 Chinese anorexic patients and 58.6% (N=41) of the subjects were identified as suffering from this type of anorexia nervosa. This group expressed that they avoid eating because they have epigastric bloating (31.4%), express loss of appetite and hunger (15.7%), and explain they eat less (12.9%).

Since non-fat phobic anorexia nervosa is seen in other countries such as India and Malaysia (Lee 1994), Lee (2001) argues that the current criteria of anorexia nervosa is a Western ethnocentric one, which “does not objectively ‘describe’ anorexia nervosa but constructs it in the specifically [Western] fat phobic fashion” (49). He claims that various types of anorexia nervosa, such as the non-fat-phobic one, will continue to be underdiagnosed unless “the fear of fatness” is dropped from the current diagnostic criteria of anorexia nervosa (Lee 1993, 1994, 2001:49). For example, the prevalence of anorexia nervosa in Hong Kong was estimated as 0.03 % by Chen et al. in 1993 (in Lee 1994), which is much lower than in the West. However, Lee (1994) doubts the accuracy of this result, since this research employed the DSM-III criteria in its methodology, and, therefore, non-fat-phobic subjects would likely be uncounted. He also mentions that the Eating

¹³ Disordered eating involves “the situations wherein an individual develops some ritualistic or structured way of dealing with food or eating and exhibits some unhealthy behavior related to food and body weight. Although disordered eating may be seen as less severe than eating disorders, it can still lead to complications and consequences for the individual” (Robert-
Attitude Test (EAT), a questionnaire that is used to identify possibly anorexic individuals, fails to count non-fat-phobic anorexic individuals, since the EAT has fear of fatness as a central item to identify anorexic people (Lee 1994).

His proposal caused a controversial discussion among medical experts, and some scholars disagree with his proposal. For example, Habermas (1996) argues that anorexic patients typically deny their fear of fatness even though they have it. Rieger et al. (2001) claims that the exclusion of fear of fatness may overdiagnose patients who show a loss of appetite resulting from other symptoms, such as depressive moods, and states that when practitioners focus on the "egosyntonic" aspect of anorexia nervosa—the "sense of pleasure, accomplishment, and moral virtue [anorexic patients] derived from their pursuit of thinness," weight concerns such as the fear of fatness must be listed as a core symptom of anorexia nervosa (209). Nevertheless, no matter whether doctors agree with Lee's proposal or not, they largely accept the importance of a cross-cultural variety in eating disorders. By continuously presenting non-fat-phobic anorexia nervosa, Lee calls the universality of the Western diagnostic system into question. The weakness of his proposal is that other doctors in Asian countries, such as Japan and Singapore, seem to not follow his claims. In Japan, this type of anorexia nervosa is rarely focused on, and as I will present in the next section, Singaporean doctors do not commonly find such anorexic patients in their country.

**Singapore**

The prevalent rate of eating disorders among Singaporeans is unknown because of the lack of national statistics; however, in a collection of available data, eating disorders seem to
have shown a rise in cases in the early 1990s and had started being discussed more actively in public by the year 2000. In the 1980s, in fact, eating disorders only seemed to be minor mental disorders among Singaporeans. In 1982 Ong and Tsoi (in Ung et al. 1997) published the first report of eating disorders in *The Singapore Medical Journal*. This study concerns seven cases of anorexia nervosa and is the only medical report of eating disorders in Singapore in this decade. In 1985, Wing Foo Tosoi, a doctor, reviewed his 103 neurotic patients and, among them, only two individuals were diagnosed as anorexic. Moreover, Choo and Peng (1999) listed common psychological disorders—such as adjustment disorders and conduct disorders—among adolescents aged from 12-18 at the Child Psychiatric Clinic in 1975 and 1985, but eating disorders did not appear in their lists.

In the early 1990s, cases of eating disorders seemed to increase. For instance, in 1993, the Child Psychiatric Clinic had 444 outpatients aged from 12-18 and 4.1% of the total were diagnosed as having eating disorders. In a survey of the adolescent admissions at the Inpatient Unit of the Woodbridge Hospital, 2.7% of the patients were afflicted with eating disorders (Choo & Peng, 1999). Ung *et al.* (1997) report that numbers of admissions of patients with eating disorders to National University Hospital (NUH) in Singapore gradually had increased since 1993: 1.0% in 1993, 1.3% in 1994, 1.4% in 1995 and 2.0% in 1996.

Their research accord with Dr. Lee’s perception that cases of eating disorders at the IMH had increased after 1995 when eating disorders seemed to be reported more commonly among doctors and the support system also began shaping up. In 1995, the Eating Disorders

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14 Adjustment disorders are disorders or illnesses that are precipitated by stress or adverse circumstances. Conduct disorders refer to persistent disturbances in conduct such as stealing and fighting, which occur in both children and adolescents (Aw & Kok 1999).
Clinic was established at the IMH. In 1997, Ung et al. three studied fifty patients diagnosed with anorexia nervosa or bulimia nervosa from 1991-1996 at the NUH, and found that representations of eating disorders in Singapore were strikingly similar to those of the West. In February 2001, the Public Forum on Eating Disorders was held in Singapore, and Support for Eating Disorders, Singapore (SEDC) was launched during that conference. In May of the same year, The Sunday Times featured articles about the weight concern among women, with relation to eating disorders (Tan; Mulchand; 05/27/2001).

Current eating disorders in Singapore may show how eating disorders begin occurring in one country where they formerly were not present, according to Dr. Thompson, an Australian psychiatrist who was a temporary guest at the IMH. Dr. Thompson said that eating disorders in Singapore seem to be following patterns of eating disorders 30 years ago in Australia—patients are well-educated, middle class, young women. The other four Singaporean medical professionals also state that although they see a variety of patients with eating disorders in terms of ages, genders, and classes, the majority of the patients are young women who are often hard working and highly ambitious; and, non-fat-phobic anorexia nervosa is rare (Transcriptions). These characteristics also resemble Bruch’s description of anorexic patients in the 1970s when anorexia nervosa was becoming a common mental disorder among adolescent girls in the West.

The treatment of eating disorders often employs both medications such as anti-depressants and psychotherapy as seen in the West. These four Singaporean medical therapists mention that their treatment method does not have significant cultural differences from that of the West, although there seem to be some differences in treatments that reflect Asian values. Dr. Shu, a psychiatrist, points out that family values might be more sensitive issues than they are in
the West. For instance, if a family holds strong Confucius values that emphasize the parental authority over children, therapists need to respect their religious values while carefully encouraging children's individuation from parents when necessary. Foo, a psychologist, addresses cognitive behavior therapy as very effective in the treatment of bulimia nervosa. She assumes that this therapy focuses on behavior rather than patients’ feelings, and it might help Asian patients who often hesitate to show their inner weaknesses. Dr. Li mentions that when patients know their brains might be harmed by the complications of anorexia nervosa, some of them are motivated towards recovery because of the strong meritocracy existing in Singapore; thus, they need to have a nimble mind in order to get ahead and be successful.

Clinicians are concerned that the preference for thinness is going towards an extreme in Singapore, and they assume that Westernization is highly responsible for it. In fact, there is research that shows this correlation. Wang et al. (1999) surveyed the preference for thinness in Singapore among 200 Singaporeans (N =137 males, 143 females) aged from 17-22, and found out that the preference of thinness is prevalent among young females: 52% of females think about losing weight “many times,” “usually,” and “always,” while only 28 % of males answered in such terms. Even 31% of females whose BMIs are under 18.7 (the borderline normal/underweight) hope to be thinner. This research also found that speaking English at home is associated with body dissatisfaction. This may indicate that Westernization increases the preference for thinness in Singapore, since the youth speaking English at home are more likely to internalize a Western value of thinness through Western TV shows, music, and magazines than their Chinese-speaking counterparts.

While agreeing that Westernization is responsible for the proliferation of the disorders, all three psychiatrists avoided stating that Western culture can cause eating disorders, since they
agree with the biopsychosocial model that claims that culture triggers individual predisposition to eating disorders, but not their cause. They assume that anorexia nervosa is a biological disorder that has a genetic reason, and holy anorexia and anorexia nervosa are the same clinical entity that share the same etiology. Dr. Li also comments that she has seen one case where anorexia nervosa ran in three generations, daughter, mother, and grandmother. On the other hand, these psychiatrists reserve the possibility that bulimia nervosa might be a new disease originating in the twentieth century, although Dr. Shu states that in ancient times, there might not have been any social factors that would have triggered individual vulnerability to bulimia nervosa, since food was scarce and it was impossible for people to binge on food.

In Japan, Hong Kong, and Singapore, there are some differences in terms of doctors’ focal points on eating disorders: mother-daughter relationships in Japan, non-fat-phobic anorexia nervosa in Hong Kong, and Westernization in Singapore. However, since Western psychiatry is a basis of their practice, there are no significant differences in the ways of understanding and treating eating disorders in these countries: diagnosing patients by employing the DSM-IV criterion, prescribing medicine, and conducting psychological therapy are the preferred treatment methods. In the framework of Western psychiatry, Doctors modify their treatments in a culturally specific way when needed, such as doctors in Hong-Kong recognizing that anorexic patients do not always show the fear of fatness and Singaporean doctors being cautious of not destroying parental authority and harmony in the family. Nasser (1997) states that researchers should focus on globalization—the world is becoming homogenized—when conducting cross-cultural studies of these disorders. I also agree with her statement and would like readers to keep in mind that this thesis is written in the context of globalization, rather than in searching for Singaporean “exotic” norms that are unaffected by the wave of globalization.
The Lack of Patients' Perspectives

Eating disorders have been analyzed from numerous perspectives in the past forty years, and these conditions in Asia also have been presented actively in scholarly writings, especially after the 1990s. The prevalence of eating disorders in Asia and the presence of non-fat-phobic anorexia nervosa are the issues largely highlighted. One glaring oversight in these analyses is the under-representation of sufferers' voices. As far as I know, Asano (1996) is the only one who has written about Japanese eating disorders from the patients' perspectives, and her book is almost unknown outside of Japan since it is written in Japanese. This thesis, therefore, will endeavor to illustrate eating disorders in Singapore based on patients' points of view. Before introducing the patients' perspectives of eating disorders in Singapore, however, the next chapter will establish the new theoretical framework used in this thesis.
Defining the Framework—the Insiders’ Model of Eating Disorders

The theoretical backbone of the biopsychosocial model is the existence of “universal” causes of eating disorders, as introduced in Chapter Two. This universality, however, becomes problematic in delineating patients’ perspectives of eating disorders, since it reduces the credibility of their perspectives in the eyes of researchers in the following manner. First of all, researchers are able to disregard the patients’ points of view as unreal in terms of the true “universal” causes unless patients explain their eating disorders in “universal terms,” such as neurobiologically or genetically. Furthermore, patients’ perspectives are likely to be seen as pathological—generated by the universal causes. This also invalidates patients’ points of view, since researchers are likely to see patients’ perspectives as “abnormal,” and curable to a “normal” manner. Based on these reasons, this chapter will establish a new theoretical paradigm of eating disorders—“the insiders’ model of eating disorders.” Unlike the biopsychosocial model, the insiders’ model of eating disorders do not invalidate patients’ perspectives as unreal.

From Universality to Ambiguity: The Establishment of the Insiders’ Model of Eating Disorders

I will set two key arguments at the center of the insiders’ model of eating disorders to establish with researchers the validity of patients’ perspectives. I first argue that eating disorders do not emerge from universal causes to prevent researchers from discounting patients’ perspectives as unreal. The second argument is that patients’ perspectives are not pathological; thus, their points of view can not be rendered “abnormal” anymore. I will justify the establishment of these key points by focusing on the “ambiguity” of eating disorders, which refers to two facts. The first is that medical science has not yet discovered any universal causes
of eating disorders, as seen in Chapter Two. The second is that medical science has not succeeded in establishing the clear border between those with eating disorders from those without, which is seen in the recurrent modifications of diagnostic criteria of eating disorders occurring over 14 years from 1980 to 1994.

For example, the DSM-III published in 1980 listed 25% more weight loss than average as a criterion of anorexia nervosa; however, this was significantly modified to 15% weight loss seven years later as seen in DSM-III-R (Di Nicola 1990a). Likewise, the phrase “body image disturbance” which refers to overestimation of the body size, appeared in the DSM-III but was erased from the DSM-IV’s criteria of anorexia nervosa published in 1994. Studies found that many anorexic patients do not overestimate their body sizes (Garfinkel 2002). Moreover, while the DSM-III did not include body shape and weight concerns as criteria of bulimia nervosa, these concerns are included in the DSM-IV (Garfinkel 2002).

The current diagnostic criteria may still not correctly distinguish those with eating disorders from those without. For example, it is still uncertain if 15% weight loss is an appropriate diagnostic criterion of anorexia nervosa, and amenorrhea also may be an unnecessary criterion, since significant numbers of women menstruate while meeting all the other criteria of anorexia nervosa. Researchers are unsure if “binge eating and purgative behaviors at least twice a week for three months” is a reliable criterion to diagnose bulimia nervosa (Garfinkel 2002). These uncertainties are likely to bring about further modifications of the diagnostic criteria in the near future, as some have already argued to increase the number of categories for eating disorders. These modifications imply that individuals diagnosed as either anorexic or bulimic in the 1980s may not be diagnosed as such in the 1990s and vice versa. This fluctuation indicates that the border between those with and those without are mingled rather than clearly separated.
While psychiatrists such as Nasser (1999) and Beumont (2002) have already addressed that there is no clear border between those with eating disorders and those without, no one has focused on the contradiction existing between this blurred border and the biopsychosocial model. That is, if such causes exist, those with eating disorders and those without should be differentiated clearly in terms of whether these causes are present in them or not. I focus on this contradiction and justify both seeing eating disorders as not emerging from the universal causes and viewing patients’ perspectives as non-pathological.

When researchers study eating disorders in terms of this “ambiguity,” what should be questioned is the role of culture in the development of eating disorders. In the biopsychosocial model, culture is excluded from the “true” causes of eating disorders, as seen in the equation between holy anorexia and anorexia nervosa. Accordingly, both anorexias share the same universal causes; however, anorexic patients in the modern era explain their behaviors differently from fasting saints in the medieval era because each group comes from a different historical period and cultural context. These historical and cultural factors are not the “true” causes of eating disorders but play roles in triggering the universal causes of anorexia and producing the different accounts for self-starvation (Habermas 1996).

On the other hand, in the insiders’ model of eating disorders, such exclusion of culture from the etiology of anorexia nervosa is called into question. Since this model does not consider eating disorders resulting from “universal” factors, researchers will lose the foundation that allows them to exclude culture from their etiology. So, how does culture play a role in the insiders’ model of eating disorders?
Reconsidering the Role of Culture in the Etiology of Eating Disorders

The term "culture" is a word that frequently appears in articles written on eating disorders. However, as Nasser (1997) states, what these articles mean by "culture" is unclear, since there seem to be no articles that define culture before starting the discussion of eating disorders. As far as I can infer from these articles, those who are oriented in Western psychiatry usually use the word "culture" as molding the expression of eating disorders but not causing the disorders, as I have presented. In addition, these scholars often use the term "culture" and the word "society" interchangeably, as "culture" bound syndrome, "culture" change syndrome, and "culture" chaos syndrome are all established in the biopsychosocial model.

In the research of eating disorders done by social scientists, culture seems to be given a more active role in the etiology of eating disorders, but, again, no one seems to define what culture is. Moreover, the amount of power given culture in the development of these conditions depends on the scholars. For example, Orbach (1986), a feminist, claims that patriarchal culture causes both anorexia nervosa and bulimia nervosa. On the contrary, Bruneberg (2000), a historian, takes an approach that is close to the biopsychosocial model, saying that culture activates individual vulnerability towards eating disorders. In both articles, it is unclear if these two authors use the word "culture" in the same manner or not.

As Nasser (1997) states, the untheorized concept of "culture" may in part have allowed Western psychiatry, which in general considers all mental disorders as resulting from neurobiological factors, to exclude culture from the etiology of the disorders when it integrated all the models of eating disorders under the heading of the "biopsychosocial" model. Thus, before considering the role of culture in the insiders' model of eating disorders, I clarify the definition of culture based on anthropology.


Culture in Anthropology

The anthropological concept of culture is broadly described as the learned patterns of thoughts and behaviors shared by a group of people (Brown 1998; Heider 2001) that teach individuals how to relate with the rest of the world so that they can function as members of their society (Keesing 1981). Anthropologists claim that while culture plays a crucial role in shaping individuals’ lives, people are rarely conscious of the immense power of culture over their behaviors and thoughts unless they question their actions and the knowledge that they normally take for granted (Keesing 1981). Human beings subconsciously choose appropriate behaviors depending on a given situation and time, and this is what culture enables us to do.

While significantly affecting our lives, culture is difficult to define exactly, since a definition of something must address how to find it through pointing out its essence, as the definition of a table states, “a piece of furniture with a flat top that you put things on or sit at” (Sinclair 1997). “The learned patterns of thoughts and behaviors shared by a group of people” is a useful description to understand culture (Brown 1998); however, it covers too many areas to be an exact definition of culture—just listing a few, there are language, art, music, kinship systems, and religion. Furthermore, this definition does not tell exactly how and where anthropologists can discover culture, since these patterns of thoughts and behaviors are determined by the interaction of multiple factors, such as environment, gender, and economy. Culture appears everywhere in individuals’ lives in a variety of ways; therefore, anthropologists are cautious about defining culture, despite multiple proposals, since that clarification will determine where and how anthropologists search for a culture.

Instead of claiming which definition of culture is the best of all, anthropologists have established several theories suggesting how to discover culture by focusing on different aspects of it. For example, materialistic anthropologists argue that the essence of culture is to fulfill
human material needs, such as food and shelter; culture, thus, should be discovered through mainly observing how a set of behaviors shared by a social group adapts them to the surrounding environmental system and offers them survival tools (McGee & Warms 2000). Another theory, called structuralism, suggests that the essence of culture resides in the universal patterns of human thoughts underlying all different cultural patterns. Thus, in structuralism, you need to peel away layers of culture until you reach the cultural essence shared by all. Claude Levi-Strauss proposes that one human universal thought is the binary system that classifies the world into two oppositions, such as culture and nature, men and women, and good and evil (McGee & Warms 2000).

As I have shown, a culture shows different faces depending on which theory is used. However, this does not mean that the definition of culture is ambiguous, as several psychiatrists have criticized, but rather that culture has significant impact on our behaviors and thoughts in numerous ways; therefore, it can be defined from various perspectives. Medicine defines the diagnostic criteria of eating disorders in terms of what medicine considers significant in understanding the disorders without discovering the essence of them. Likewise, it is possible to define culture when researching eating disorders by focusing on a cultural aspect one considers the most important. Thus, I will define culture based on what the biopsychosocial model lacks in terms of accounting for sufferer's experiences.

**Culture as a Collection of Meanings**

In the insiders' model of eating disorders, culture is defined as the collection of meanings existing by transcending individuals' minds which they use to interpret their experiences and guide their actions (Geertz 1957 in Keesing 1981). This definition originates
from interpretive anthropology that sees the essence of culture in the insiders' perspectives, namely, how people who live in a culture understand their reality. This theory is adapted to my thesis, since it highlights the issues that the biopsychosocial model neglects.

The first of these issues is that "human beings act towards things on the basis of the meanings that things have for them" (Blumer 1969:2 as quoted in Spradley 1979: 6). "Meanings" does not refer to "referential" meanings attached to things—including sounds and actions—but symbolic ones. For example, the word "red" refers to a color, which is the "referential" meaning of red; however, when this color is used as a traffic light, it starts having a symbolic meaning of "stop" (Spradley 1979). At an intersection, what we act on is not the referential meaning of "red," but a symbolic meaning of "red" arising from its relation to this given situation. Symbolic meanings can also differ from culture to culture. In cultures that attaches the meaning of "wink" to an eye twitch, this can be recognized as a voluntarily eye twitch that sends a signal or hint to someone; however, in cultures that do not attach this meaning to such an action, it is nothing more than an involuntarily eye twitch (McGee & Warms 2000).

Human beings firmly anchor themselves in culture through acting out a collection of meanings, and the biopsychosocial model seems to sacrifice this significant influence of culture on human behaviors for the sake of searching for universal causes of eating disorders. Therefore, when researchers consider the role of culture in the etiology of eating disorders, they should explore whether any symbolic meanings play a role in the behaviors of those who have eating disorders while bearing in mind that insiders' accounts for their behaviors, such as "I stop because the red means stop," are as meaningful and convincing as neurobiological accounts for human behaviors.
Cultural Transcendence beyond Individuals' Minds

When scholars—usually social scientists—claim a cultural causation of eating disorders, other researchers—usually oriented in Western psychiatry—criticize this perspective often by stating that if culture is a “true” cause of eating disorders, it cannot explain why only a small number of people develop eating disorders while others who share the same culture do not (Ward et al. 2000; Bulk 2001). However, this statement is a theoretical inaccuracy caused by a complete simplification of the concept of culture, and this is the second issue that interpretive anthropology illuminates.

Cultural transcendence beyond individual's minds is another important concept in interpretive anthropology, which means that culture does not have complete control over individuals' behaviors and thoughts but there remains space for individuals to be diverse (Keesing 1981). Language, which is a collection of cultural meanings attached to a mere collection of sounds, is the best illustration to show this cultural transcendence. Even though Americans share the same language, English, it does not mean that they speak English in a homogenized manner; rather, their uses of English are diverse as seen in accents, colloquialisms, and writing styles. Nevertheless, we can recognize in general that American share the same language, since English exists by transcending individuals' mind.

Where, then, does this diversity come from? It may come from individuals' genetic traits; the ways their parents, friends, or teachers speak English; the influences of the books they have read; or a mixture of these factors. While it is a formidable task to determine what factor precedes the others in the creation of individual differences, there is one thing that is clear: the fact that Americans do not speak English in the same manner does not prove that culture is not a "true" cause of them speaking English.
Thus, even though all individuals who share the same culture do not develop eating disorders, it does not justify the exclusion of culture in the etiology of eating disorders. In testing the validity of the inclusion of culture in the etiology of eating disorders, what researchers should investigate is not whether all individuals sharing the same culture develop clinical eating disorders or not, but on what meanings those with eating disorders act and if these meanings are shared with those without eating disorders.

Ethnography, which anthropologists largely use in studying culture, is a powerful tool in exploring the meanings shared by a group of people. However, before explaining the concept of ethnography, I will address the third issue that interpretive anthropology elucidates, that is, the interlocked relationship between the human body and culture.

Body, Culture, and Society: Meaningful Body and the Body Politic

“The body is the first and most natural tool of man” (Mauss 1979, as quoted in Scheper-Hughes & Lock 1996). This quote illuminates not only the significance of the physical aspect of the human body but also the cultural aspect of the body, which is full of meanings. For example, corseting was a favorable body modification among American and British middle- and upper class women during the nineteenth century (Heider 2001). Corseting symbolized beauty, morality, and upper class on which these Victorian women valued (Lowe 1994). Similarly, among the Yanomanos, a tribe living in the Amazon, the adult male’s heads are often “criss-crossed by battle scars into which red dyes are rubbed [, and] the men’s mutilated crowns are kept clean and shaved for display.” Like corseting, this body decoration is meaningful. It symbolizes “the rivers of blood on the moon where the Creator-Spirit of the Yanomamo lives” (Scheper-Hughes & Lock 1996:217). These meaningful bodies have intrinsic relationships
to their society, as Mary Douglas, an anthropologist, states, “What is being carved in human flesh is an image of society” (1966, as quoted in MacGee & Warms 2000).

What we need here, before discussing the social aspects of the body, is a definition of society. The term “culture” and the word “society” should not be used interchangeably, as often is seen in the current study of eating disorders, since these are two different abstractions that are closely interlocked. In this thesis, society is defined as “all the communities that are connected politically and economically” (Keesing 1981:74). Considering the inseparable relationship between culture and society, the term “sociocultural” is also defined as the interaction of society and culture, as explained by Victor Turner, an anthropologist (in Keesing 1981). He employs the analogy of culture and society being score and orchestra, respectively, in explaining the interaction of these two concepts: all performers (societal members) in an orchestra (a society) share the same score (a culture) while each performer takes a different role depending on their capacities and roles given to them. Since score and orchestra are interlocked, when the score (culture) is changed, the performers in the orchestra (a society) act differently, and vice versa.

In a similar vein, the meaningful body interacts with society and “the body politic” illuminates this interaction. The body politic refers to:

The regulation, surveillance, and control of bodies (individuals and collective) in reproduction and sexuality, in work, and in leisure, in sickness and other forms of deviance and human differences (Schepet-Hughes & Lock 1998:209).

According to this theory, society has some power to control its members’ bodies in order to sustain itself, and the body that is regulated by its society is usually considered “correct” among the members of a society, and the “correct” body often is associated with cultural meanings, such as beauty, strength, and healthiness (Schepet-Hughes & Lock 1998:218).
Thus, by looking at the ideal body decoration and/or type shared among a group of people, we can assume with what kinds of social conditions this group lives. For example, a “correct” body shared by the Yanomano men is their criss-crossed heads. This illuminates a condition of their society, which is always exposed to the danger of encroachment on their land. That aggressiveness becomes an important male characteristic for the sake of protecting the community, and this is embedded in such male head decoration (Scheper-Hughes and Lock 1998). Similarly, what is carved out in corseting is an image of patriarchy that existed during the nineteenth century in Europe and America. First of all, corseting was an economical male control over women, since it restrained women from manual labor and forced their financial dependency on men (Turner 1984). Furthermore, this is an ideological justification of patriarchy, which reflects the male manipulation of the Biblical codes: women’s sexuality has been seen as the source of sin since The Fall of Men occurred from Eve’s temptation to Adam; women, thus, would draw men into deep sin again without males’ surveillance over them (Lowe 1994). Corset restrained women’s bodies in terms of sexual repression, and this symbolized the male authority over women (Lowe 1994).

The Victorian women did not choose the corseted body as an ideal in order to sustain patriarchy but chose it due to the meanings attached to it—beauty, morals, and upper class. While these cultural meanings attached to the ideal body images are a driving force that makes individuals choose a particular body type, the body politic reveals the system of society hidden in these meanings. Human beings link their bodies to society through acting on the meanings attached to their ideal body image.
The Weaknesses of the Sociocultural Model

The sociocultural model of eating disorders has focused on the link between thinness and the mass media, industrialization, the Western culture, or women’s position in the society, and each link can be theorized in either interpretive anthropology or the body politic or both. However, the current sociocultural model fails to show a clear tie between the evidence of sociocultural aspects of eating disorders and theories beyond the discipline of social science. Furthermore, the current sociocultural model does not bridge the gap between theories and sufferers’ lived experiences. This is a crucial deficit of the sociocultural model often claimed by social scientists who do not have enough experiences encountering patients with eating disorders.

This theoretically undefined model as well as the gap between theory and patients seem to result in medical professionals criticizing the sociocultural model. For example, Robert Palmer (2001), a psychiatrist, responds to the article written by Richard Gordon (2001), a psychologist who discusses the sociocultural influences on the rise of eating disorders in non-Western countries. Criticizing Gordon’s argument as “interesting guesses” that lack enough evidence to be validated, Palmer states:

What is most evident may not be most important and what is most important may not be most evident...Chatting about what we think we know is part of the joy of the exercise (18-19).

Unless researchers clearly tie the sociocultural model to theories and show how these theories connect to the patients’ real experiences, this model will fail to show its significance in the study of eating disorders. Below, I will summarize the theoretical framework of eating disorders and will move on to explain the methodology used throughout the fieldwork.
The Summary of the Insiders Model of Eating Disorders

The insiders' model of eating disorders does not fit into the theoretical paradigm of the biopsychosocial model, which is largely accepted by Western psychiatry. However, my aim is not to refute this model, but to construct another explanatory model by focusing on the "ambiguity," that has been neglected in the biopsychosocial model, although some psychiatrists have pointed out (Nasser, 1997; Beumont, 2002). I endeavor to establish such a model, since I believe that a variety of models to explain eating disorders should be prepared so as to answer the diverse needs of patients, as long as medical science takes a humanistic approach.

The insiders' model of eating disorders is established for the sake of increasing the credibility of the patients' perspectives in the eyes of researchers. This framework originates from the "ambiguity" of eating disorders, which refers to two facts: One is that medical science has not yet found the definitive cause of eating disorders, and the other is the blurred border between those with eating disorders and those without. Based on these facts, it becomes theoretically possible for researchers to see eating disorders as not emerging from the universal causes and to view patients' perspectives as non-pathological.

The insiders' model of eating disorders adopts interpretive anthropology and the body politic as strategies to clarify the concepts of culture and society as well as the social and cultural aspects of the human body. Culture is defined as the collection of meanings which transcend individuals' minds and which human beings use to interpret their experiences and guide their actions. Society refers to "all the communities that are connected politically and economically" (Keesing 1981:74). And the human body is theorized in the eyes of interpretive anthropology, from which the definition of culture arises, as well as the body politic, which accounts for the power of society to regulate the body. Within this theoretical framework, I will attempt to bring light to the patients' perspectives of eating disorders. By searching for the meeting points...
between the patients lived experiences and theory, I also will explore the spaces where the sociocultural model can reclaim its significance in the study of eating disorders without being described as intellectual "interesting guesses" (Palmer 2001).
Methodology

In May 2002, I was accepted as an intern at the Association of Women Action and Research (AWARE). In the beginning of June 2002, I flew to Singapore and stayed there until the middle of September while I researched eating disorders in that country. This research was conducted with two institutional approvals from the Ethics and Research Committee under the Institution of Mental Health (IMH) in Singapore, where I was accepted as a researcher, and the Institute of Research Board at Oregon State University. Dr. Lee Ee Lian, a psychiatrist, who has been in charge of the eating disorders clinic at the IMH for five years, became my supervisor as well as a mentor and gave me significant help throughout the research. During my field work, I endeavored to understand the patients' perspectives of eating disorders, and I chose ethnography as the best method to accomplish this goal.

Ethnography

Ethnography is the work of describing a culture, aiming at understanding another way of life from the insiders' point of view (Spradley 1979: 3). I looked at the patients' perspectives as a type of culture and the patients as insiders and then I employed ethnography. Ethnography begins with researchers' "conscious attitude of almost complete ignorance" (Spradley 1979: 4), despite their knowledge about their research topic. This ignorance means that ethnography is not a quantitative study that employs a rigid questionnaire with many samples but is based on in-depth research with a small number of samples.

The rigid questionnaires are good at increasing the sample numbers; however, in this type of study, researchers must know what questions should be asked to their samples in order to
discover the answer of their research topic, before they distribute such questionnaires to their samples. Anthropologists consider that such quantitative study is inappropriate to research culture. Since culture is often subsided at insiders' subconscious level and hardly articulated, such already-made-questionnaires questions are likely to be constructed by researchers' pre-conceived biases against a culture, and thus the result would also be twisted by their biases, rather than reflecting the insiders' perspectives. (Spradley 1979, Elvin 2000:4 & Atkinson et al. 2001).

To reduce their pre-conceived biases as much as possible, anthropologists stay in the field of their research throughout their research period through being involved in multiple events, such as talking with insiders, participating in their gatherings, and eating and drinking with them. By doing so, they learn things that they would never have known unless they live with insiders, and, from these experiences, they discover questions that should be asked to understand insiders' points of view (Elvin 2000; Agar 1996). Ethnography is about "learning people" rather than "studying people" (Spradley 1979:3).

This ethnographic learning process was important in this research, since I had neither been to Singapore nor met many people with eating disorders. Based on ethnography, I spent the first few weeks getting a general sense of what eating disorders in Singapore and Singaporean society are like by using a variety of methods: listening to Dr. Lee's perception of eating disorders on a daily basis, meeting with people at the SDES, participating the meetings regarding eating disorders at the IMH, hanging around with my new Singaporean friends, sightseeing in the city, and attending parties held by Singaporeans. These first hand experiences brought me many insights, which will be introduced elsewhere in the rest of this thesis.
Informants, Ethnographic Interviews & the Interview Procedure

Insiders who are closely contacted and asked various questions by anthropologists are called “informants;” they are a source of information and become teachers of anthropologists. Ethnographic interviews are a strategy that anthropologists use to “[get informants] to talk about what they know” (Spradley 1979:9). This is not a structured interview but an open-ended one that aims at extracting insiders’ unarticulated cultural knowledge by asking questions that expand on information from informants’ previous answers (Spradley 1979). Among several ways to conduct ethnographic interviews, I especially used “descriptive questions” developed by James Spradley (1979), an anthropologist, in interviewing informants with eating disorders, since “descriptive questions” help researchers find appropriate questions in order to discover insiders’ point of views. When asking descriptive questions, researchers choose a setting where informants’ cultural knowledge would likely appear and then ask them to describe the setting, and, from their descriptions, researchers create questions (Spradley 1979). I first will describe the demography of my informants and then will explain how I use descriptive questions in my research.

I had 37 informants: 20 patients with eating disorders; 5 Singaporean medical professionals including 3 psychiatrists, 1 psychologist, and 1 dietician; 8 women without eating disorders and 3 mothers; 2 media professionals; 1 French woman who tends to binge on food, 1 Australian psychiatrist, and 1 Canadian sociologist. All these informants were collected with the support of Dr. Lee, members at the AWARE, members of the Eating Disorders Support Group (EDSG), and my host family. Collecting informed consent (Appendix D) from all of the informants was required before I started interviewing. To protect the informants’ identities, there was no tape recording throughout the interview, and a pseudonym was arbitrarily assigned by me.
English was spoken throughout the interviews. Although several informants used English as their second language, all the informants spoke English very fluently since English is the most widely used language in Singapore. During each interview, I took detailed notes and transcribed them in a computer on the day of the interview.

Informants with Eating Disorders

All the informants with eating disorders were collected from Dr. Lee’s referrals and EDSG’s support. I did not initially target to interview a particular group, such as young anorexic women, because I conducted ethnography, avoiding doing research based on pre-assumptions. Thus, I just asked Dr. Lee to introduce her patients who felt comfortable talking with me; I contacted EDSG’s members through the introduction of Dr. Lee and asked them for permission to interview them.

When I interviewed these informants, I borrowed an empty consultation room at the IMH or Singapore General Hospital (SG). Dr. Lee orally introduced me to them and asked if they felt comfortable talking with me. Only after they orally consented I did guide them to the room where the interviews occurred and explain the informed consent, except in the case of one 15-year-old Indian woman who was a minor (under 17 years old). I gained consent to interview this informant from her father. The length of the interviews varied between 30 and 90 minutes.

I had 20 informants with eating disorders, 18 females and two males. In terms of age make-up, 80% (N=16) of the informants are 15 to 26 years old. The oldest informant is a 53-year-old Chinese woman, and a 15-year-old Indian woman is the youngest. Regarding the ethnic make-up, 85% (N=17) are Chinese; 10% (N=2) are Indians; 5% (N=1) are Malay. Eleven
informants were diagnosed as having bulimia nervosa (55%); 7 informants were diagnosed with anorexia nervosa (35%); 1 informant was diagnosed as having EDNOS (5%).

Although unintended, I ended up mostly interviewing informants who belong to the highest risk group of eating disorders in Singapore—young women—although this reflects Dr. Lee's consideration, too. When choosing people as my possible informants, Dr. Lee seemed to consider her patients' ages, occupations, personalities, and psychological conditions for the sake of protecting her patients' safety. This would be another reason why the majority of my informants were closer to my own age, 25 years old. While I interviewed individuals who belong to the highest risk group that suffers from eating disorders, I do not have any hospitalized informants whose medical complications were very serious and for whom medical interventions became necessary. I assume that if I had interviewed hospitalized patients, I would have had anorexic informants more than bulimic ones, since the former tend to have more serious medical complications than the latter (Beumont 2002).

The Rationale for the Creation of the Target Informants

"Eating disorders" is not the only item that defines the informants' world views, because there are also other multiple factors that influence their perspectives, such as educational levels and occupations. I decided to focus on generations, rather than other factors, because eating disorders have been linked to cultural changes, and there have been dramatic social changes in Singapore in the past 40 years. Thus, I determined that generational differences would have a more significant impact on the informants' world views, than other differences. I also focused on generations because 80% of informants with eating disorders are under 30 years old. Accordingly,
16 informants from the age of 15 to 26 are classified as the target group, while 3 informants over 30 are excluded from the analysis. I also glossed over ethnicities, genders, and nationalities, because Singapore is demographically 81% Chinese, so my population of 85% Chinese mimics this nicely. Ninety percent of these informants are women; thus, even though I do not focus on genders, the majority of the target group will automatically be women. I also included two female Chinese Malays in the target group, since one has been working in Singapore for a few years, and the other also visits Singapore almost every weekend and her educational level is very close to the others in the target group. Having divided the group by generations, I constructed the control group to correspond in terms of ages, as I will explain later in this section.

The Target Group

The target group consists of 16 eating disordered patients aged from 15-26 years. There are 14 Chinese, including one male, and two Indian females. Their mean age is 20: three are teenagers (15-19), and thirteen are in their 20s (20-26). Their education level is high. Eight of them have a college degree or are attending a college. One quit college to treat her bulimia nervosa. Three informants belong to secondary or junior high school (schools before college). Two are serving in Before Military Training (BMT), and one of them will go to medical school after finishing his service. Two of them had completed O-levels, which are secondary school examinations that take place at the age of 15 to 16 years old (Davidson 1999). Regarding diagnosis, 81% (N=13) suffer or suffered from bulimia nervosa (two of them have recovered); 12% (N=2) are diagnosed as having anorexia nervosa; 7% (N=1) were diagnosed as having EDNOS. Among the 13 bulimic patients, 4 of them had crossed-over from clinically diagnosed anorexia nervosa; 6 of
them experienced a weight loss from 5 kg (10 lbs.) to 20 kg (44 lbs.) before they went to hospitals and were diagnosed as bulimic. I succeeded in conducting follow-up interviews with 8 out of 16 target informants at least once and three times at the most. In follow-up interviews, I showed transcribed interviews to them so that they could correct my mistakes and so I could ask extra questions that I needed to ask. When it was impossible to meet them again, I sent transcribed interviews via e-mail and asked them to make corrections.

**Questions Asked**

I used the first eight interviewees to discover appropriate questions that would guide me to understand the patients' points of view. Thus, after I asked their general background including age, gender, ethnicity, occupation, religion, and diagnosis, I always asked them, “Could you describe how you have developed eating disorders?” This was the descriptive question that I considered would raise issues, which reflect the patients' points of view. After they had answered this question, I created further questions from what they said. For example, an informant mentioned that she decided to go on an extreme diet after her boyfriend and family members commented that her body was getting bigger. After she finished answering this descriptive question, I asked her what it was like when someone made comments about her body. She answered that it was “very upsetting and embarrassing.” From this response I asked her if there are any situations that made her feel the same way.

By continuing this process, I started seeing themes shared by these informants and made questions that were used to test whether these themes really are shared or not. For example, I realized that the informants perceived their ideal body weight between 45 [99 lbs] and 50kg [110
I, thus, decided to ask their perceived ideal weight at each interview and to make this question a follow-up for the informants to whom I did not ask it during our first interview. I usually asked the informants about the following issues: mass media influences on their body types, their perceived ideal body images, shopping for clothing, people’s comments on their bodies and their reactions to those comments, their relationship with doctors, feelings when they eat. However, even after I started building questions covering these issues, I analyzed each interview and kept revising the questions. Appendix A shows the possible questions used during the research. This questionnaire is the final version that I used to interview informants although I did not exclusively follow it.

Informants without Eating Disorders

After I confirmed that the majority of patients with eating disorders consisted of young women, I started interviewing young women without eating disorders and classified them as the control group. I first asked the staff at AWARE, my host family, and SEDS’s members to introduce their friends aged around 15-25 years old to me and then I increased these subjects in the snowball style. I gained informed consents from all of them or from their mothers when informants were minors. The places where the interviews occurred were chosen according to my informants’ convenience: coffee shops, fast food shops and their offices were used. There are eight young women whose ages are from 17 to 23, including five Chinese, a Caucasian-Chinese, an Indian, and a Japanese. This Japanese informant is not a Singaporean but has lived in Singapore more than five years. Six of them have college degrees, and the other two plan to go to college.

The interviews with these informants are comparative rather than ethnographic. I made questions based on the themes shared by the target group (Appendix B). By using these questions,
I tested if these themes are shared by the control group or not. For example, I found that shopping for clothing often negatively affects the target informants' body image; thus, I asked the control informants how they feel when they shop for clothing. I also had a chance to talk with three mothers. Two of them are my minor informants' mothers: one is Chinese and the other is Japanese. The other is a friend of this Japanese mother who also has a teenage daughter. I asked them how they perceive their daughters' weight consciousness.

Informants who are Singaporean Medical Professionals

I interviewed five Singaporean medical professionals including three psychiatrists and a psychologist who all specialize in treating eating disorders and a dietitian who consults people who are overweight or obese. I interviewed the dietician too, since obesity is often considered the other side of the coin of eating disorders in the literature; therefore, the interview with the dietitian concentrated on obesity and its control in Singapore. All interviews occurred at their offices after I gained their consent. When interviewing the other Singaporean medical practitioners, I attempted to understand their perceptions of eating disorders in terms of epidemiology, etiology, and treatment. When constructing questions for these medical professionals, I often used Dr. Lee's perceptions about eating disorders, since she was the one who always gave me her medical knowledge of eating disorders as well as talked with me about her experiences being a Singaporean. Appendix C includes questions I often used during the interviews with these medical professionals.
Informants who are editors of a Singaporean magazine

I also interviewed two editors of women's magazines due to the large number of articles that have been published about the relationship between the mass media portrayal of women and the rise of eating disorders. Both editors worked at the second biggest women's magazine in Singapore. One was a Chinese woman who was in charge of the features section, and the other, an Indian woman, was the editor of the health and beauty section. This magazine targets post-25 year-old women as its readers and features a variety of issues such as health, fashion, food, and traveling. The interviews occurred at their company. I asked them what kinds of fashion models are preferable in the current Singaporean society and who they choose as the models for their magazine, since the literature often claims that adolescent girls' body images are influenced by fashion models that the mass media promotes.

Caucasian Informants

There are three Caucasian informants. One is a 22 year-old French woman who has been staying in Singapore for 11 months and who regularly binges on food while being highly weight conscious. I met her through the introduction of the SEDS and interviewed her at a fast food shop. I used the same questionnaire employed for the informants with eating disorders, except for questions regarding her perceptions as a foreigner about Singapore society, weight and appearance issues in Singapore. At the IMH, I interviewed one 64-year-old Australian psychiatrist who has specialized in anorexia nervosa for more than 20 years. I also interviewed a 46 year-old Canadian sociologist who was the director of a non-profit organization for those with eating disorders in Canada; her interview occurred at a restaurant. Both were visiting the IMH as guests and stayed
in Singapore for a few weeks. I employed a similar questionnaire to the one used for Singaporean medical professionals specializing in eating disorders, but I also asked the Australian psychiatrist about his impressions about eating disorders in Singapore, as well as Singapore society in general, and his general perception about eating disorders, which I compared with the Singaporean medical professionals' perceptions. Likewise, I asked the sociologist about her general perception of eating disorders as a director of a self-support group and her impressions of Singapore society.

The Data Analysis

I began the data analysis by rereading my complete field notes and transcriptions several times. I picked up words and phrases that repeatedly appeared, investigated what context they were used in by the target informants, and analyzed symbolic meanings attached to these words and phrases. As I have explained in Chapter Three, symbolic meanings refer to the culturally defined connections between two or more things; for example, “red” means “stop.” In this research, symbolic meanings are more complex than “red means stop.” For example, “unable to find clothing that the target informants can fit into” connects to “feeling frustrated, embarrassed, and feeling fat.” In like manner, I search for how a concept connects to a different concept. These findings will be introduced in Chapters Five and Six. Since I did not use a rigid questionnaire and the informants expressed the same concept in various ways, I will show how many target informants share the same symbolic meanings and what kinds of words I categorized as the same. After I found shared meanings, I investigated whether these meanings were shared by the control group. If both groups share the same symbolic meanings, it means that these are culturally defined rather than generated by eating disorders. This analysis will be introduced in Chapters Five and Six.
Next I explored why informants create such symbolic meanings by employing the literature introduced in Chapter Two as well as by examining their points of view through the lens of the body politic, which will be shown in Chapter Six and Seven.

As the final stage of the analysis, I searched for the origin of the meanings that are only shared by those with eating disorders. I extensively analyzed five personal stories about the development of eating disorders by bringing together all of the knowledge I had previously discovered. I chose these stories because of the amount of time that I spent with their tellers. I interviewed all of them three times at least or had an interview that lasted more than ninety-minutes. After writing up the interviews, I asked all of them to look over the transcriptions and asked them to correct my mistakes. Based on these reasons, I concluded that these five case notes are accurate enough to be presented as examples of individuals' lived experiences of eating disorders.
The Lack of Understanding & Fear and Guilt towards Gaining Weight

There are two themes that emerge from the 16 target informants: One is a magnified inner pain caused by the lack of understanding from others. The other is an immense fear and guilt towards gaining weight. If pain is caused by such a lack of understanding, an increased understanding from others can be part of a healing process for them. Thus, the rest of this thesis will endeavor to increase other's understanding by deconstructing the fear and guilt towards gaining weight in a manner that will allow others to comprehend the layers of meaning embedded in these feelings.

This chapter will show how the target informants struggle with the lack of understanding from others; it will move on to deconstruct the informants' feelings of fear and guilt towards gaining weight by conceptualizing them within the anthropological theory of feelings; it will investigate the events that heighten the target informants' weight consciousness and their interpretations of these events. This chapter will conclude by stating that the target informants act on the culturally defined symbolic meaning attached to fatness and will segue into the next chapter by presuming that their fear arises from these meanings and their guilt is provoked by a cross-cultural norm of "appearance is unimportant."

The Lack of Understanding from Others

All the target informants struggle with the lack of understanding from others, except one. Only Sung, a 19-year-old Chinese boy who recovered from his bulimia and was satisfied with the comprehension he received from his family, did not. Other than his case, the target informants have hard time in gaining understanding from others. For example, Melinda, a 21-year-old Chinese who is bulimic, says that the lack of understanding from others is the hardest thing for her
to deal with: Her boyfriend did not believe eating disorders were diseases and her family said that these diseases were “ridiculous.” Jennifer, a 21-year-old Chinese who recovered from anorexia nervosa after crossing over from bulimia nervosa, also says that her father thought of her anorexia as “stupid.” Likewise, Beth, a 21-year-old Chinese treating her bulimia, claims:

Nobody understands eating disorders... My friends say, ‘eat regularly and eat normal food.’ But if I can do that, I would not have an eating disorder [bulimia nervosa]!

Ming, a 19-year-old Chinese treating her bulimia, also says that her boyfriend thinks of eating disorders as “vain,” (as in self-absorbed) diseases. Since others do not comprehend their struggles, they often stop sharing their problems with others as Yin-Ping, a 23 year-old Chinese who is treated for her bulimia, says:

[My family and friends] say everything depends on your decision and will. My friends told me, ‘How come you have such a problem?’ I did not talk about my illness with them any more.

Therefore, their therapists’ emotional supports play an important role in treating their eating disorders. When they were asked how their therapists—doctors and psychologists—have helped them, nine of the target informants listed emotional supports, such as understanding, acceptance, and encouragement, as the most helpful assistance from their therapist. This ties with the other six
informants' answer that their doctor's professional knowledge of eating disorders, including prescribing medicines, was a most helpful support.

Fear and Guilt towards Gaining Weight

As a means to increase others' understanding, I will focus on the emotions of fear and guilt towards eating, which are shared by the majority of the target informants. I asked my informants how they feel when they eat: Thirteen out of sixteen informants (81%) described their feelings towards eating as either “fearful” or “guilt-provoking”: three of the thirteen feel both fear and guilt; three of them feel fear; five of them describe their feeling as “guilt”; another says that she does not want to eat “frightening” food; the last says that she wants to avoid eating “sinful” food. Other feelings expressed by the rest of the three are “ashamed,” “numb,” “angry,” and “sad.” However, such fear and guilt are absent in the control group. For example, Mei, a 23-year-old Chinese, says, “I like to eat. I rather enjoy myself and feel happy [eating rather than restricting food].” Xin, a 23-year-old Chinese, also mentions, “There is no point to torture yourself [by eating less and exercising.]” Two control informants were dieting when I interviewed them, but they do not express the fear and guilt towards eating, like the rest of the control informants.

The target informants were asked why eating provokes fear and guilt, and they consistently answered that they feel so because eating may increase their weight. The reason for their fear and guilt is not eating per se, but the possibility of gaining weight caused by eating.

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1 These data did not include the answer of Ling. I interviewed her in her first visit at the IMH, and I talked with her before she saw her doctor. She, however, said that she hoped that her doctor would understand her.
However, there is a gap between “gaining weight” and “the fear and guilt,” since the target informants do not articulate why they have such emotions towards gaining weight. The biopsychosocial model would fill this gap by stating the fear and guilt towards gaining weight is induced by the individual pathology of eating disorders, since such feelings, especially fear, is considered a symptom of both anorexia nervosa and bulimia nervosa (APA, 1994). However, as I have stated, I will not apply this model to bridge this gap. This is not because I deny the usefulness of the biopsychosocial model, but I doubt if this model can truly increase others’ comprehension of the sufferers. Since, by assuming that fear and guilt are pathological, an application of this model would make others feel “sorry” for individuals who were born with these universal causes of eating disorders; however, increasing pity does not necessarily indicate an increase of understanding from others.

Anthropology, a discipline concerned with “understanding the ‘other,’” takes a different approach from the biopsychosocial model, when it comes to explaining others’ behaviors and thoughts (McGee & Warms 2000:1). In anthropology, the best way of understanding “the other” is to see others’ realities from their points’ of view, rather than from our own (Elvin 2000). Based on this theory, I will attempt to show why gaining weight provokes immense fear and guilt by bringing to light the target informants’ perspectives and analyzing them in the context of the insiders’ model of eating disorders. Although I mentioned that I employed ethnography as my research method by looking at the patients’ perspectives as cultural, I will clarify the concept of feelings used in this thesis by using the anthropological theory of feelings, a branch of interpretive anthropology.
The Anthropological Theory of Feelings

"[W]ithout culture, we simply would not know how to feel" (Schepers-Hughes & Lock, 1998: 219). Although a little exaggerated, this statement designates the premise of the anthropological theory of feelings that culture is embedded in humans' emotions. Anthropologists emphasize the significance of culture in emotions because anthropologists think that culture, thoughts, and feelings are interconnected—how people feel depends on how they understand the situation; how people understand the situation depends largely on how cultures organize humans' cognitive maps (Rosaldo 1984; Lutz & White, 1986; Heider, 2001).

Furthermore, anthropologists believe that true cultural knowledge is “tacit” (Spradley 1979:188; Rosaldo 1984); it appears in people’s taken-for-granted actions and is hardly expressed. Thus, in anthropology, feelings are seen as a reservoir of unarticulated cultural knowledge; in other words, these are the sense that “I am involved” (Rosaldo 1984:143). For instance, if you lose your wallet, you would get far more upset than anyone else; you “feel” the situation because you are “involved.” Since you are intensely involved, your feelings have knowledge to explain the situation more than any other person’s account, although the meanings of your feelings are not

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2 In psychology, emotion is defined as “a complex condition that arises in response to certain affectively toned experiences. Emotion has six components: 1. the subjective experience of the emotion. 2. Internal bodily responses, particularly those involving the autonomic nervous system 3. Cognitions about emotion and associated situation 4. Facial expression 5. Reactions to the emotion 6. Action tendencies” (Atkinson et al. 2000: 389) Psychology explains that these six components reciprocate each other and create one emotion; it also shows that there is an emotion which arises without cognition (Atkinson et al. 2000). Thus, although I use the terms of “emotion” and “feelings” interchangeably, these terms do not include the biological components of emotions such as components 1,2, and 4. My focus is on the cognitive aspects of emotion.

3 Emotion had been considered a human’s innate nature until recently. For example, Darwin saw emotion as “having functional and adaptive value” for humans’ survival. Ekman found that a facial expression to each emotion has cross-cultural similarity (Pervin 1996:306; Atkinson et al. 2000) This tendency caused less focus on the relation between culture and emotion; culture was just added on to the universal emotional aspects (Lutz & White 1986: 418). Anthropologists criticize this tendency and assert that culture actively participates in creating emotion (Rosaldo 1984; Lutz 1984).
articulated. Expanding the context from losing your wallet to a people feeling the culture, anthropologists believe that its members' feelings show how the culture is "in a very vivid way" (Levy 1984:220). Their job is, then, to try to make these feelings readable so outsiders can understand the meanings of the culture that the anthropologists study. I will combine this theory with the insiders' model of eating disorders, consider the target informants' fear and guilt full of "tacit" cultural knowledge, and endeavor to deconstruct their fear and guilt so others can read the meanings of their feeling.

Events that Heighten Weight Consciousness among Singaporean Youth and their Interpretations of these Events

This section will search for events through which the target informants have learned to be conscious of their weight, investigate how they interpret these events, and explore whether these situations potentially plant the seeds of fear and guilt in their minds. It also will examine whether the control informants have encountered the same events as the target informants have done and share similar interpretations with them. If both the target and control informants have experienced the same events and interpret them similarly, it will suggest that part of the target group's weight consciousness is culturally defined, rather than solely rooted in dysfunctional biology and/or psychology that is disassociated with their culture.

*Causal Conversation on Someone's Body*

"Have you put on weight?" is a common beginning sentence of conversation in Singapore. Casual conversation about someone's body shape is culturally acceptable among Singaporeans and more frequently seen than in Western countries.
Comments made about the target informants' bodies, in fact, sound very malicious. For example, Wei-Chen's grandmother mentioned to her, “Your buttocks are getting bigger”; Beth's friends teased her by saying “she has so much fat on her stomach!” in front of others; Ming’s friend told her, “You look like a hamburger.” Sarah, a 26-year-old Chinese who is treated for her bulimia, remembers that her family members as well as her friends teased her about her body by singing, “Bon, bon, fatty girl.”

Singaporeans who are used to this custom start feeling comfortable with their bodies when they go to Western countries because their Asian bodies are smaller than their Western counterparts; this comfort can be seen in two control informants' comments. Liou, a 20-year-old Chinese, studies politics in London and feels that the British do not care about their own body sizes or hers. Lani, a 22-year-old Indian, gained a BA degree in Australia. She has been hurt by people’s comments about her body shape in Singapore, by referring to her experience in Australia, concludes, “[Commenting on someone’s body] is one of the rude things done in Asia!”

On the contrary, Westerners have a hard time living in Singapore. Elizabeth, the 22-year-old French Caucasian informant, suffered from “insensitive” comments about her body size that she was not used to in France. After coming to Singapore in 1999, she put on 10 kg [22lbs] from the stress of living in a different country and her work and is deeply hurt by Singaporeans' direct comments on her body. She says:

Fat was less acceptable here... They are always talking about the way you look like, make-up, and clothes. They are more appearance conscious than people in France. The very first thing my [Chinese] friend who I have not seen for a while told me was about my weight. They were very direct. They said, “You have put on weight. You need to eat less.
Elizabeth also has a hard time with her 50-year-old Chinese landlady who always criticizes her body size. Elizabeth says, “She always makes comments about my body. Do you know what? She told me, ‘I think you have put on weight. You are really fat now. Isn’t it scary?’” Whenever she encounters people like that, she becomes very upset and depressed. However, she cannot defend herself. She says, “I am shy, so I cannot speak up.”

As Elizabeth states, casually commenting on someone’s body is unacceptable and taken as criticism in the West. However, this is not the case in Singapore. For example, comments such as “You put on weight” and “You look chubby” are seen as observable objective facts, not as criticism or teasing. Jennifer in the target group, explains that her diet was prompted by her family members’ comments about her body, like “How come you have put on weight?” and “Have you been exercising lately?” She interprets these statements as, “It is not quite teasing, but people made comments about my body.” This interpretation is often seen among the target informants. When they were asked if they were ever teased about their bodies, nine out of them (56%) corrected my question to say that they were not teased, but people made comment on their bodies while seven of them (44%) answered, “Yes.”

This perspective is seen among the control group. For instance, Tracy, a 23-year-old Chinese, mentions that her relatives often told her, “You are getting rounder” and “You are getting bigger now,” in their occasional family gatherings. She dislikes these comments and shows her frustration to me by saying, “They think they can say anything! The only thing they comment on is physical appearance.” As she states, however, she does not think of this as criticism or teasing but comments.
Both the target and control informants are hurt and embarrassed when others comments on their bodies; however, no one defends her/himself since each thinks of casual conversation about the body as acceptable or considers these comments accurate. For example, Beth in the target group explains that she was just patient when she heard these comments because it is “normal” for people to talk about someone’s body and these comments are mere jokes. Sarah, in the target group, told me, “I thought that it was my fault for being teased. Something was wrong with me.” Lani, in the control group, says, “My cousin teased me about my body in a very funny way. I had no choice, except laughing, even though I was upset.” Liou, in the control group, said that she did not show her uncomfortable feelings to her friend when he teased her about her body by saying “fat girl” since she thought of “fat girl” as true.

Casual conversation about body shape is also seen in Japan. For example, Nancy Rosenberger, an anthropologist who conducted ethnographic research in Japan, noticed this tendency. She explains:

When I went to Japan, I first gained weight. They said, ‘You got fat’ Of course, I did not like it. But interestingly, I did not feel it was a criticism. I had the impression that this was the observation of me that people there talked about.

I also realized this difference; I kept hearing people commenting on my body in Japan, but it rarely happens in the United States. Therefore, I felt that I was back in Asia, when an Indian lady told me, “You look chubby... No, no, no! I don’t mean you are fat. You are athletic and look healthy. So it is all right.”
Even though accepted, this custom can cause serious psychological damage to people. I will end this section by introducing the case note of Melinda and an e-mail I received from a British English teacher in Singapore during my research period to show how this custom has hurt people.

**Case Note 1: Melinda**

Melinda, a 21-year-old Chinese, does not remember her exact weight during childhood, but she vaguely guesses that she weighed around 60kg [132lbs] and recalls her body as being “plump.” Her current diagnosis is bulimia nervosa with a previous history of anorexia nervosa. Melinda has a frightful memory in childhood because of her “plump” body size and said this memory is definitely linked to her eating disorders.

One day at a public swimming pool, Melinda a primary school student, was measuring her weight at the side of the pool with a relative, and she heard a painful comment from behind her: “Your weight is so heavy! You need to slim down!” The speaker was a Chinese stranger who was standing in the line just behind Melinda. This man was peeking at her weight and ridiculed her. For Melinda, it was very embarrassing.

Her female school teacher and even her relatives teased her about her body size. Her teacher laughed at Melinda’s body in the classroom, drew a very round face on the blackboard, and pointed out that this was Melinda. From looking at this picture, Melinda thought of her face as stupid, clumsy, and fat. Likewise, her uncle and auntie used to call Melinda “Ah Pui,” a Chinese dialect, which she translated as “stupid fat girl.” Melinda was upset and felt angry with the teasing; yet she did not defend herself and kept everything inside her. Melinda concludes, “I met so many people who teased me about my body. I hate my childhood because of it.”
After she graduated from school, teasing about her body still continued. When she started working at the age of 19, she weighed 68 kg [149.6 lbs] with the height of 164 cm [5'4"] and was given a nickname of "the biggest girl" by her colleagues. This nickname revived her childhood experience and made her increasingly self-conscious about her body. Also, overwhelmed with job stress, she firmly decided to lose weight. Her mother’s kind comment, “You are natural,” did not change her resolution at all. Melinda strictly restricted food and became obsessed with exercise. Her weight dramatically dropped from 68 kg [149.6 lbs] down to 42 kg [92.4 lbs.] in a few months; her hair stopped growing and her menstruation also stopped. Melinda was diagnosed as anorexic.

Case Note 2: an E-mail from a British teacher in Singapore

I heard about your research through AWARE and was prompted to write to you. Even though I’m British, I did teach in a local neighborhood school in Singapore for three years before I moved to my current job. I just wanted to tell you about something that happened while I was teaching there.

The incident was not witnessed by me but by my colleague – the only other expert teacher in the school—and I think it says a lot about people’s attitude towards obesity in this part of the world. His form class—a group of Secondary 3 students/13-14 year olds—were scheduled for a health check on afternoon. He accompanied them to the designated room where the girls were told to queue to one side and the boys to the other. The girls were summoned first. My friend remained outside to supervise the boys. Although he was outside he was clearly able to see and hear what was going on inside the room, as were all the boys in the line.

The girls were weighed and their height measured, and this was then entered into their medical records. The nurse turned to one particular girl who was plump, but by no means overweight, and really turned on her. She told her she was "so fat and lazy" and said that she was doing nothing to help herself. The girl, by now close to tears, pleaded that she ran to school everyday, but the nurse just wouldn’t believe her; she just kept on. She told her that she would have to go and see a doctor, who would give
her pills to make her lose weight. My friend, likewise the boys in the class, heard every word.

In the year following this incident, this girl lost so much weight she was barely recognizable. Just before we left the school we both felt that she looked anorexic. She probably was. Obviously this whole story was relayed to me and sounds quite anecdotal, but I guess I’m writing to you because I have always felt terrible about what happened to this girl—as did my friend…The research that you’re conducting is long overdue and much needed.

Shopping for the Clothing

Singaporean clothing sizes in general are smaller than Western, and bigger sizes are less available, “ugly,” “old fashioned,” and “expensive,” to borrow the target and control informants’ comments. This gives both the target and control informants, except the only male informant, Sung, the feeling of insecurity and frustration when they shop for clothing in Singapore.

Indian and Caucasian women particularly have a difficult time finding clothing there because their bodies tend to be bigger than Chinese who are the majority. For example, Komala, a 19 year-old Indian girl treated for her bulimia, showed her anger with clothing in Singapore by saying, “S,S,S, all T-shirts are S!” Lani, an Indian woman in the control group, needs to wear XL in Singapore while she was able to wear sizes 8 to 10 in Australia. She claims, “[Clothing sizes in Singapore] are demoralizing!” Elizabeth also used to wear M sizes in France but needs to wear XL here, and she rarely finds clothes that she can fit into. She says:

I am embarrassed at shops. I feel that sales clerks are laughing at me because they know that there are no clothes that I can wear…I feel inferior to others because I am not the standard. If I were in the USA, I would be less conscious…Culture pressures me all the time!
These women struggle with clothing sizes in part because of their ethnicities. However, Chinese also have a hard time finding clothes. Liou, in the control group, weighs 57 kg [125.4 lbs] and is 159 cm [5'3"] tall. With this body size, she already has difficulty finding clothes in Singapore; she prefers to buy them in London where she currently studies. Melinda, in the target group, wishes to wear S size for tops and M for bottoms; in reality, she needs to wear L or M sizes; she says, “I feel more secure when I wear European sizes because I can wear an S size.” Xia, in the control group, says:

Sometimes I am too embarrassed to go to some shops [to buy clothes], because I cannot find the clothes that fit me. I feel the sales people look at me and laugh at me.

In addition to the already small clothing sizes in Singapore, several informants find that the clothes have become increasingly smaller lately. Two of the control informants, Xia and Tracy, realize that they cannot wear the sizes that they used to wear a few years ago. Tracy says,

I feel that clothes have been getting smaller in these last two or three years. I used to wear an M size. Although I don’t think my body has grown very much bigger, I sometimes have to get L size instead of M size now.

This phenomenon seems to have happened only to female clothes. Dr. Li realized that her husband’s clothing sizes are the same in England and Singapore, but not her size. She explains:

Men’s size are easier. Shirts go by neck with cm, and pants go by waist—also with cm. However, women’s size, S, M, and L, are not objective. The Singaporean S size is different from the S size in Europe and also shop to shop. Maybe they decide female sizes subjectively after they have made them.
Several informants remark that clothing in Hong-Kong and Japan is even smaller than in Singapore. Wei-Chen asks me, “Why are Japanese clothes so small? Even my mother cannot wear Japanese S size.” Hui, a 21-year-old Chinese anorexic woman, told me that Singaporean jeans are too big for her, so she needs to get them in Hong Kong or Japan. Although I do not know about clothes in Hong Kong, I as a Japanese agree with their perceptions. I weigh around 57 Kg [129 lbs] with the height of 155 cm [5’1”]. Even though it was difficult, I could at least find clothes in Singapore, but I had a much harder time buying them in Japan.

Singaporean women, or more probably Asians, learn to be conscious of their weight through clothing sizes. Despite no standardization of clothing size there, wearing L size—which stands for “large”—or the realization that there are no clothes that they can fit into may become an objective certification of the label “fat woman” or a validation of others’ comments like, “Have you put on weight?” Finding clothes is not only a practical issue but also a psychological matter for Singaporean women.

The Trim and Fit Program (The TAF)

The Trim and Fit Program (The TAF) is part of the ten-year national campaign to reduce obesity among Singaporeans. This program specifically targets school children whose ages range from 6 years old to 18 years old, and the participants are required to join weight reduction exercises after or before school. Although it is probably too early to assume that the TAF is successful, Chung, a Chinese dietician, concludes that the TAF has made some contributions to bringing the obesity rate down, since the obesity rates among children have decreased from 15 percent to 10 percent during this campaign (Transcriptions). (I will illustrate the details of the
TAF and obesity issues in Singapore in Chapter Seven.) However, my research shows some negative aspects of the program that need to be considered.

I have six informants who participated in the TAF program, four from the target group and two from the control group. I also talked with two mothers whose daughters participated in the TAF (these daughters do not suffer from eating disorders). Here are some excerpts from the target informants regarding their participation in the TAF program.

Sung, a 19 year-old Chinese boy, says:

It was okay [to participate in the TAF] but my friends were watching us while we ran during recess and they could play football instead. It was very embarrassing. Students did not want to be involved in this program because of it...Instructors did not blame us for our weight but they were strict and scary. The TAF affected my bulimia since it made me highly bodily conscious.

Likewise, Ying-Ping, a 21-year-old Chinese, says, “[It was] humiliating since this program singled out obese students. I was told, ‘You would look better if you cut that weight’ by my instructor.” Melinda says that she actually enjoyed playing games in the TAF program in her elementary school; however, she was hurt and upset when she needed to stand up in front of others to go to the program. Manisha, a 15-year-old Indian girl, wanted to drop out of the program, started an excessive diet, and lost 11 Kg [24 lbs] in a few months. She is not required to participate in the TAF program anymore, but she has, instead, developed anorexia nervosa. She did not talk a lot in front of me but says “[being in the TAF program] hurt me.”

The control informants who participated in the TAF also expressed the feeling of embarrassment during their participation. For example, Xia participated in the TAF when she
was in secondary school. She recalls her participation by saying, "I hated it. It was extra time and reminded me how fat I am. Were there any changes after my participation in the program? Nothing. I got more tired. I just hated it." Lisa is a 17-year-old junior college student who participated in the TAF for five years. She says, "The TAF took my whole school year. It was a waste of time and nothing changed. It was really upsetting." Lisa was told by her instructors, "If you lose all that weight, you will be very pretty," and "If you don’t lose weight, you cannot wear any kinds of clothes."

Two mothers whose daughters participated in this program also told me about their daughters’ psychological damage from the TAF. A Chinese mother who had a 16-year-old daughter who had participated in the TAF program once, says:

My daughter said that [girls] are made to feel in a way that it’s a sin to be fat. ‘Fat girls’ are rounded up to run and do sit ups and so on in the morning before school starts and also at recess after school... She is dieting and skips meals to try to stay out of the TAF program.

A Japanese mother living in Singapore told me that her daughter, Saki, participated in the TAF when she was in the fifth grade; Saki was honored on the stage in front of everyone because she succeeded in losing weight. She told her mother, "Mom, it was very embarrassing."

My informants agree with the intention of the TAF program—bringing down the obesity rate among school students—but disagree with the way the program is constructed, since the TAF program does not look at how active students are but only considers how much they weigh. A schoolteacher mentions:
It was very painful for me to see [the students in the program]. Kids would cry...They don't look at how active a student is. [Kids] might be born with a bigger figure than others.

By recalling the memory of looking at the students in the TAF, Liou also feels:

I think it is good for overweight students. But some students were good athletes and could run much faster than me. They were rounder but [the participation in the TAF] was not necessary.

I personally had the impression that the weight and height chart that decides if a student is overweight was a little strict. By referring to this chart, I, who weighed around 57kg [129 lbs] and 155cm [5' 1"] at the age of 16, probably would have been categorized as overweight and would have needed to participate in the TAF. Since I did not have any problems with physical activities, I imagine that I would have become very upset if I had been told to join in the TAF.

The other problem with the TAF is its lack of consideration for the possible psychological damage of the participants by being labeled "overweight." Lisa states:

Issues about the body never go away. I did not feel good at all. The TAF automatically makes you think that you are fat, slow, stupid and lazy... The TAF is very selective, only limited to fat people. People get the idea that the TAF is bad because it involves only overweight people who are stigmatized in this society.

Actual numbers of the TAF participants who will develop eating disorders may be very few. However, singling out overweight students and making them more visible in front of others probably contributes to creating negative perceptions towards overweight people not
only among participants but also students who look at them. The TAF aims at helping students’ physical health but can damage their psychology. Students learn it is bad to gain weight through the school program.

The Meanings of Gaining Weight

Similarities, rather than differences, stand out when comparing the interpretations of the three events—casual conversations on someone’s body, shopping for clothing, and the TAF program—between the target and control groups. Since the both groups interpreted these three events based on the meanings attached to fatness, such as stupidity, laziness, and ugliness, we can conclude that the interpretations of these three events experienced by the target informants are culturally defined rather than shaped by their “abnormal” psychology. Both the groups react to the three events with the feelings of hurt, embarrassment, and frustration, not because they feel like being unhealthy, but because they act on the meanings attached to fatness.

However, the origin of these meanings is uncertain, since the meanings attached to fatness are rarely articulated in situations that heighten the target and control informants’ weight consciousness. For example, a clothing label of XL does not state this as for ugly persons. Likewise, Singaporeans casually comment on someone’s body; however, they rarely say to him/her, “You have put on weight, you’re stupid and lazy,” excluding few exceptions like “Stupid fat girl” as Melinda was told. In like manner, Sung says that the TAF teachers were scary, but they did not criticize his personality because he was overweight. The target and control informants seem to have learned the meanings attached to fatness somewhere else and automatically conjure these meanings by themselves when they are present in such events.
Since this analysis does not show where these meanings come from, the next chapter will explore from where the stigma attached to fatness originates. However, before starting this exploration, we also need to examine whether the three events—casual conversations on someone's body, shopping for clothing, and the TAF program—plant the seed of fear and guilt towards gaining weight in the target informants' minds. Although this chapter alone does not elucidate why only the target informants feel fear and guilt towards gaining weight, we can understand the fear caused by these events by defining the meaning attached to fatness—stupidity, ugliness, and laziness—as stigma.

A stigma dehumanizes individuals based on an individual physical and/or psychological characteristics that makes her/him "not normal" or different from others who do not have these features (Brown 1996: 310). In Western psychology, fear is described as emerging when one faces "an immediate, concrete, and overwhelming physical danger" (Izard 1993:851 in Pervin 1996:331). Accordingly, we can assume that gaining weight is physical danger for the target informants because they feel that they are dehumanized by the stigma attached to fatness by gaining weight.

On the other hand, the seed of guilt is not seen in the three events since guilt is a feeling that "you ought to be blamed for something" and arises when "one has transgressed a moral imperative" (Lazarus 1991:122 in Pervin 1996:319). According to this definition, the target informants feel that they should be blamed for the issues regarding gaining weight because they have transgressed a moral imperative. To account for their guilt, we should look at gaining weight from a different angle—the unimportance of appearance that has also emerged from the research.
Appearance is Unimportant

"Appearance is unimportant. This is superficial," and, "You should accept yourself," are some comments that I kept hearing from Singaporeans—regardless of their occupations, ages, and genders—after they knew my research topic. Since I had heard the same comments from both Japanese and Americans, I have reached the conclusion that the phrase "appearance is unimportant" is a cross-cultural theme that exists at least in these three countries as a superior antithesis of "appearance is important."

It is important to remark that those with eating disorders also believe "appearance is unimportant," even though appearance is a central concern for the target informants, which will be shown in detail in Chapter Eight. This theme is found in the research of Asano (1996) who conducted ethnographic interviews to women with eating disorders in Japan, and also is found in my research. My sub-structured questionnaire did not include the question of whether the target informants think of appearance as unimportant; however, ten of the 16 target informants brought this issue to me by saying, for instance, "I want to accept myself as I am," and "Inside is more important than outside." This shows that the target informants are not blindly obsessed with appearance but rather struggle with the paradoxical thoughts of "appearance is important" and "appearance is unimportant" while believing the latter is more truthful.

This fact gives us a lead to answer why the target informants feel guilt. Although we cannot draw a strong conclusion only from this fact, we could assume that they may feel they should be blamed for being concerned with their appearances, since appearance is often considered a superficial, unimportant matter that persons should not be worried about. The next chapter will search for the origin of the stigma attached to fatness as well as the origin of guilt, and also will
explore whether Singaporean youth are living in a society where they can follow the "morally correct" cross-cultural norm of the unimportance of appearance.
The Origin of the Stigma Attached to Fatness

The previous chapter explored the situations that heighten individuals' weight consciousness and their interpretations of these events. It showed that the stigmas attached to fatness are cultural knowledge shared by both those with and without eating disorders; both the target and control informants hope to avoid gaining weight so that they can avoid associating themselves with the stigmas attached to fatness. From the previous analysis, however, three uncertainties remain: the origin of stigmas attached to being fat, the origin of guilt, and the dividing line between those with eating disorders and those without. Thus, this chapter explores from where these stigmas derive as the second step in the process of deconstructing the feelings of fear and guilt provoked by the possibility of gaining weight.

The Mass Media Responsibility for the Creation of the Stigma Attached to Fatness

As seen in Chapter Two, the mass media has been traditionally criticized as portraying medically underweight women and distorting women's healthy ideal body images, resulting in leading some women to suffer from disordered eating that can develop into eating disorders. Based on this criticism, we can assume that the mass media may contribute to creating the stigma attached to fatness through representing underweight women as the way women ought to look. To make this assumption valid in this research, the next section will test the following hypotheses: 1) the informants are influenced by the mass media portrayal of women who are, in fact, unrealistically emaciated but are presented as the way women ought to look. 2) the informants have
a medically underweight body image as their ideal, influenced by such mass media portrayal of women.

**The Mass Media Influences on Women's Body Images**

This section will investigate whether the target and/or control informants think that their ideal body images are influenced by the mass media portrayal of women and whether the target informants perceive women in the mass media differently from the control informants. I was initially anticipating that the target informants would at least strongly admire the mass media portrayal of thin women. However, this prediction was wrong.

The target informants (N=14)\(^1\) were asked if women in the mass media have affected their body images: 43% (N=6) of the target informants answered yes. 43% (N=6), answered ambiguously to the same question by saying, “to some extent,” “I believe so,” and “maybe.” Two informants answered no (14%). Although 86% (N=12) felt that they were influenced by the mass media, the number of those who avoided answering yes to the question (N=8) exceeds the number of those who answered yes (N=6). According to this result, it becomes doubtful as to whether the traditional criticism regarding the mass media portrayal of women is accurate, at least in this instance.

The analysis of the target informants’ perspectives of the mass media explains the reason for this outcome—the target informants are influenced by the mass media’s portrayal of women, but they also question and criticize it. For example, Yin-Ping, who avoided saying yes about the mass media’s influence on her body image, says, “When I look at posters, I think I want to be like

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\(^1\) One informant was not asked this question because the ethnographic method avoids using rigid questionnaires, and I could not have a second meeting with her. The other two informants are Sung. I excluded their answers from this statistic since Sung is male and this chapter examines female ideal body images, although he mentioned the mass media’s influence on his body image.
them, but I think that they also have their own problems.” Likewise, Sarah feels the mass media’s influence on her body image “to some extent.” She has a critical eye toward the mass media. She says that she liked Oprah Winfrey (before she lost weight), because she feels that Winfrey was comfortable with her body size. She is influenced by the image, but does not blindly accept it.

Surprisingly, those who became the most critical of the mass media’s portrayal of women are the three target informants who clearly answered yes about the mass media’s influence on their body images. For example, Beth says that she used to like Ally McBeal, but not anymore, because McBeal has become too thin. Ling, a 22-year-old bulimic Chinese who previously worked as a fashion model, points out that models are always externally evaluated. She criticizes this fact, since she knows that some models could not resist the pressure put on them by outside factors and ended up using illegal drugs to lose weight. Komala sounds very critical of the image of women in the mass media. She says with an angry voice, “[Women in the mass media] are so skinny. See the people on TV. They are so skinny!”

Ming and Melinda are the only two target informants who expressed their wish to be like the women in the mass media without showing critical comments of those women. Ming says, “Yes, [I am influenced by the media] a lot. I go for magazines and they are so skinny. I think, ‘I should not eat so much.’” Melinda says, “Their figures are so good. I feel that women on TV and in magazines are perfect.” She says that she wants to be like them even though she knows some of them are bulimic or anorexic. However, as I have shown, this type of answer is in the minority.

There are no distinctive differences between the target and control groups regarding the mass media’s portrayal of women. One of six women answered yes to the question about whether women in the mass media affected their body image. Yumi, a Japanese girl, says, “I really want to
be like them. My goal is to achieve the style of the models in magazines.” Three of the girls in the control group answered ambiguously. For example, Liou says, “Depends. Because some are too skinny... I wish to be like them because I can wear more clothes.” Xin says that she seldom reads fashion magazines, but she wants to be like the models; however, she would not pursue this desire. Two of the control informants mention that these images are “not a realistic portrayal of women.” For example, Roni says, “[They are] not a realistic description of women. They look like a cartoon.”

This section has investigated whether the target and/or control informants think that their ideal body images are influenced by the mass media portrayal of women, and whether the target informants perceive women in the mass media differently from the control informants. The results show that both the target and control informants—without striking differences—are influenced by the mass media portrayal of women: 85% (N=16) in both the target and control groups feel at least some influence on their body images. However, it does not mean that both the target and control informants blindly adore thin women in the mass media, since the majority of them—no matter if they suffer from eating disorders or not—question and criticize exceedingly thin female body images represented by the mass media, rather than blindly following these images.

Medically Legitimized Perceived Ideal Body Image

The hypothesis that the mass media contributes to creating the stigma attached to fatness through glamorizing medically hazardously thin women generates another variant: real women's ideal body images are medically unhealthy. This section will test if this variant is valid as well as if the target informants have a different perceived ideal body image from that of the control informants by looking at these informants' perceived ideal body weight and by calculating the BMI.
scores based on those ideals. As I have explained in detail in Chapter Two, the BMI \( \text{BMI} = \frac{\text{weight (kg)}}{\text{height (m)}^2} \) is used when researchers investigate if a person is underweight, normal or overweight. For Asians, a BMI score under 18.5 is defined as underweight, from 18.5 to 23.9 (or sometimes 22.9) is normal and more than 23.9 (22.9) is overweight. For Caucasians, a BMI score under 20 is considered underweight, from 20 to 25.9 is normal and more than 26 is overweight (WHO Western Pacific Region 2000).

Since the BMI is an index based on a ratio between height and weight, by using this scale, we can examine what kind of ideal body image a person has. For example, a person who is 165 cm [5'4"] tall might prefer 50 kg [110 lbs] as her ideal perceived ideal body weight, and another who is 155 cm [5'1"] tall might say 45 kg [99 lbs]. While the first person’s perceived ideal body weight is 5 kg [10.2 lbs] heavier, the first one’s BMI score based on this ideal perceived ideal body weight is 18.4 while the second one is 18.7. We can, thus, conclude that these two persons have a similar ideal body image.

In my research, there is a strong tendency for the target informants to wish to weigh from 45 kg [99lbs] to 50 kg [110 lbs], regardless their height. Shauna, a 21-year-old Chinese who has recovered from bulimia, describes the shared ideal body image among her friends by saying, “Girls want to be from 40kg [99 lbs.] to 50 kg [110 lbs.]. Fifty kilograms plus one or two kg is all right. More than 60 kg [132 lbs.] is ‘Oh my gosh!!’” Ai-Ling, a 22-year-old Malay treating her bulimia nervosa, shares the same opinion with Shauna. Whenever her friends ask her weight, Ai-Ling always lies by saying that her weight is 50kg [110 lbs.] and never that her actual weight is 53kg [116.6lbs]. This is because she realizes that women who weigh more than

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2 The average height in the target group (N=15) is 160.8 cm [5'3"] (SD 5.22), ranging from 150 cm [4'11"] to 170 cm [5'7'']
50kg [110 lbs.] are considered fat. Melinda went on an extreme diet that made her weight drop down from 68kg [149.6 lbs.] to 45kg [99 lbs.]. Based on this experience, she states, “I wish to be 50kg because when I weighed 45kg, I looked too boney. So I want to be 50 kg. I think 50kg still makes me look a bit thin though.”

Only two women mentioned more than 50 kg [110 lbs.] as their perceived ideal body weight: one is Komala, the tallest target informant who weighs 80 kg [170 lbs.] with a height of 170 cm [5’11”]. She said that her ideal weight is 65 kg [143 lbs.]. The other is Yan who wishes to have a BMI score of 20, for which she needs to weigh 51.2 kg [112.6 lbs.]. Her current weight is 60 kg [132 lbs.] with a height of 160.8 cm [5’3”]. To sum up, the average ideal perceived weight of the 15 target informants Asian3 is 48.4kg (SD 5.17) [106.8 lbs.]. To reach their ideal weight, the women whose actual average weight is 55.4 kg (SD 8.9) [121.9lbs] will need to lose about 7 kg [14.4 lbs].

This same tendency is seen in the six Asian women4 in the control group. Their average height is 163 cm [5’2”] which is about two centimeters higher than the target group, and the ideal perceived weight is two kilograms heavier than in the target group, which is 50.5 kg [SD 3.0].5 However, setting aside the fact that the sample numbers in both groups are too small to compare the results with each other, it is too early to conclude that the control group has a healthier body

3 Sung is excluded from these statistics because Sung is male. These data are about female ideal body image shared by Asian women.

4 Lisa was excluded from this statistical data, since her ethnicity is half Chinese and half Caucasian.

5 Due to the fact that my interviews with the control group were conducted in public where there are many people, or sometimes with their acquaintances sitting close to them, I did not ask them to tell me their actual weights. However, from the available data, the thinnest woman is Yumi who is 170cm tall and weighs 53 kg. In my perception, the woman with the most average body shape in the six control informants is Liou, who weighs 57 kg [125.4 lbs.] with a height of 159cm [5’3”]. The control informants’ body shapes are a little larger or smaller than Liou’s. Yumi and Liou both
image than the target group.

In both the control and the target groups, taller women who are more than 160 cm (5'3'') in height tended to state 50kg (110 lbs.) as their ideal weight while 45kg (99 lbs.) is likely to be reported as ideal by relatively smaller women (between 150 and 159 cm (4'11"-5'5'')). This result indicates that my informants may share a similar ideal body type rather than an ideal weight per se. In fact, while the average BMI of these 15 target informants is 21.4 (SD 2.90), their average BMI would be 18.6 (SD1.74) if they attained their perceived ideal weights, and this result is equal to the BMI score of 18.6 (SD 1.15) calculated from the perceived ideal weights and actual heights among the six Asian control informants. Again, the BMI is an index based on a ratio between height and weight; thus, the BMI score of 18.6, with noticeably small standard deviations of 1.74 (the target group) and 1.15 (the control group), indicates that those with and without eating disorders have a very similar ideal body type in proportion to their heights, rather than all be the same body weight. The ideal perceived body images shared by both the target and control informants are strikingly similar. Further, in terms of the BMI, their ideal perceived body images are medically legitimized—a BMI of 18.5 is borderline normal. In this research, real women do not have a medically underweight body image as their ideal.

Moderating the Hypothesis

Based on the literature, I hypothesized that the informants—at least the target informants—would be influenced by the mass media portrayal of women and have a medically hazardingly thin body image as their ideal. The first condition was validated by both the target and control informants’ accounts for the mass media influences on their body images. But, the second told me their weight without being asked.
condition was invalid, since both groups have medically legitimized body images and since the
target informants' perceived ideal body image is no thinner than the one shared by the control
group. Thus, I will modify my earlier hypothesis in such a way as to reflect my informants' perspective: The mass media contributes to creating the stigmas attached to fatness through glamorizing medically healthy, slim women. The following sections will examine whether this modified hypothesis is valid.

Singaporean Mass Media Presentation of Women

Section Two mainly will study the three popular fashion magazines among young Singaporean women, Female, CLEO, and her world published in June, 2002, and articles and advertisements in The Sunday Times, the most popular newspaper in Singapore, to investigate if the mass media contributes to creating the stigmas attached to fatness through glamorizing medically healthy, slim women.

The Implicit Determination of “Not Beautiful”

According to my informants, the first stigma attached to fatness is ugliness. Studying Female, CLEO, and her world, I came to the conclusion that the Singaporean mass media generated this stigma; however, the process of this stigmatization is implicit rather than overt. An article titled “SWIMSUITs that love your figure!” in CLEO exemplifies this implicit stigmatization of fatness.

“SWIMSUITs that love your figure!” in CLEO introduces to the readers swimsuits that are fit for “full & curvy” or “thin & boyish” women (Caddy 2002: 124-127). “Full & curvy” women are recommended to choose swimsuits in this manner:
You have the body of a sex bomb... so, milk it!
-Avoid graphic prints (zigzag lines, concentric circles, etc.)... They make you larger.
-Choose swimsuits with a low V-neck or a halter-neck—they will make your shoulders look broader... and your hips proportionately smaller.
-Always go with a high-cut bottom to elongate your legs. (125 my italics)

This advice indicates that "full & curvy" women had better choose swimsuits that can hide or deceive people about their actual body size so as to make themselves look nice.

The recommendation for "thin & boyish" women is:

**Lucky you! Almost anything goes with your figure.**
- Choose bikinis...[that] add curves and that sexy Lolita touch!
- Parade proudly in boy-cut bottoms. They were made for you.
- Go berserk with prints, colours and textures. You can wear a psychedelic swimsuit with tassels and still look fab! (127 my italics)

These recommendations imply that "thin & boyish" women should choose swimsuits that show their actual body sizes or add something to their already "fabulous" body size. They do not need to cheat or hide their body size at all. From these two types of advice, we can see that this article implies that slim women’s bodies should be visible while fleshy women’s bodies should be invisible.

This implication is also seen in the models’ poses as shown in a swimsuit advertisement for “full & curvy” women and for “thin & boyish” women. The woman in the “full & curvy” section is lying on a pool chair on the front of her body; thus, her actual body shape in this swimsuit is difficult to see. On the contrary, the model wearing a swimsuit for “thin & boyish” women is
sitting at the side of the pool facing the front of her body towards the camera; it is, therefore, very easy to see her body shape. No fashion models appearing in a variety of swimsuits in the accompanying “thin and boyish” article pose so that their bodies are hidden (128-136). They are all slim and show their actual body sizes. The model in the “full & curvy” section is the only one who hides her body size.

**CLEO** does not say that “full & curvy” women are ugly; rather, the section of “SWIMSUTS that love your figure!” attempts to tell readers that “full & curvy” women can look nice in swimsuits. However, after analyzing the magazine, it is clear that this section implies that “full & curvy” women had better make their actual body sizes invisible. “SWIMSUTS that hide your figure!” might be a more accurate title for this section.

In like manner, **Female, CLEO, and her world** repeatedly use slim women to model their clothing. This is the way the Singaporean mass media links fatness to ugliness. By repeatedly making slim women visible and fleshy women invisible, the Singaporean mass media has succeeded in stigmatizing fatness as “ugly” without explicitly criticizing fatness. Consequently, another question arises: How much of the mass media portrayal of women is realistic? According to the hypothesis, there must be women in the mass media who have realistic body shapes.

**How Much of the Mass Media Portrayal of Women is Unrealistic?**

There are TV stars who have unrealistically thin bodies in Singapore, and this depiction has been criticized by both the public and the experts of eating disorders. For example, Stefanie Yanzi, a Singaporean singer, weighs 43 kilograms [94.6 lbs.] at 163 centimeters [5’4”]. Her BMI score is 16.1, and she needs to weigh 6 kg [12.2 lbs] more to reach the medically healthy BMI score of 18.5. However, there are women in the mass media who do not have unrealistic body images. I
call these women “healthily slim women,” since their body shapes can to be labeled as medically healthy.

A healthily slim woman in the Singaporean mass media is Christy Chung, a Hong-Kong movie star very famous in Singapore and a long-term representative of Marie France Bodyline—The World’s Slimming Professionals, a biggest sliming center in Singapore. Chung says, “Thin is Kate Moss. I’ve got muscles” in an interview with The Sunday Times (Lye 03/12/2000), and her comment has some points. Kate Moss weighs 50 kg [110 lbs] with the height of 178 cm [5'11”]; her BMI score is 15.5, and she needs to gain 13.3 kg [29.3 lbs] more to reach the healthy BMI score for Caucasians of 20.0. On the contrary, Chung weighs 50 kg [110 lbs] with the height of 168 cm [5'6”], and her body is much more realistic than Moss.’ Chung’s BMI is 17.7 and needs only 2 kg [4.4 lbs.] more to reach the healthy BMI score for Asians of 18.5. Although Chung is classified as medically underweight, if we take into account that 16% of young Hong-Kong Chinese women have their BMI scores around 17.0 [underweight] (Lee 1996), we can conclude that Chung is slim but not unrealistically thin among Hong-Kong women.

Three other representatives of Marie France Bodyline have similar body shapes to Chung’s. They are all from Hong-Kong but are famous in Singapore, too. For example, Vicki Zhao, a movie/TV star, weighs 48kg [106.6 lbs.] with the height of 166 cm [5'5”]. Her BMI is 17.4, and she needs 3kg [6.6lbs] to reach the BMI score 18.5. Cass Pang, a singer, weighs 45 kg [99 lbs.] and is 161 cm [5'3”] tall. Her BMI is 17.4 and she needs 3kg [6.6lbs] to have the BMI score 18.5. Flora Chan, an actress, weighs 50kg [110 lbs.] with the height of 163cm [5.4’]. Her BMI score 18.8 is already in the medically normal range.
Among these three representatives in the Marie France Body Line, two weigh medically underweight; however, it is questionable if their body shapes deserve to be criticized as imposing unrealistic and medically unhealthy images on women. Like Chung, they are not like Kate Moss who needs to gain 13.3 kg [29.3 lbs.] to have a healthy BMI score; they are slim but not emaciated by Hong-Kong’s standards. Although these four women cannot completely represent the ideal female body image overall in Singapore, they are well-known among Singaporean youth and are representatives of the biggest slimming center which specializes in losing weight. Thus, we can assume that their body type would be a close to the ideal female body image shared by Singaporean youth.

Both the target and control informants share the BMI 18.5 body image, which is medically normal although only slightly above the borderline for being classified as underweight. Thus, it is assumed that although both medically healthy and unhealthy women help to propagate the preference for thinness in Singapore, my informants’ ideal body images reflect the body shape of the healthily slim women, rather than body images that are medically underweight. This finding is contradictory with the traditional criticism towards the mass media presented by both the experts of eating disorders and the public, that the mass media represent medically unhealthily slim women as ideal and distort real women’s body images. Do these medically healthy, slim women accidentally have these healthy body images? The next section will examine why healthily slim women keep their body weight in a healthy range or slightly lower.
Medically Healthy, Slim Women in the Mass Media and the Trend of Healthy Dieting in Singapore

Andrea De Cruz, a Singaporean TV actress, was near to death this summer, but her life was saved by an emergency liver transplant. People assumed that her liver failure resulted from her use of unregulated Chinese slimming pills (Takeuchi 08/12/2002). Many Singaporean women desire to be slim. However, using slimming pills and jeopardizing individuals’ health is not the way that the Singaporean mass media encourages women to conduct themselves when they try to lose weight. “Healthy” is, in fact, a keyword to understanding weight reduction programs presented by the Singaporean mass media, and the medically healthy women in the mass media reflect this trend in the country.

All three magazines, Female, CLEO, and her world, introduce weight reduction programs linked to the image of healthiness, and most programs are certified by experts such as doctors and physical trainers. For example, an article in Female entitled “Short cuts to a sun bod” (Tan 2002b:230-231) is based on the advice given by a sports gym manager and introduces four exercises that readers can do at home. The author of this article recommends that readers consume less fat and more protein with an abundance of fluids while doing this program. Likewise, CLEO featured a light weight training program designed by a trainer to get rid of “jiggly arms,” “jelly belly,” “wobbly legs,” and “droopy butt” (Lawrence & Tan 2002: 156-162). This article recommended the readers combine it with other types of exercises, such as swimming, push-ups, and stretching, to make the program most effective without going overboard, since they could harm themselves. her world introduces doctors’ concern about obesity in Singapore (discussed in the next chapter) and introduces the BMI to readers as a medically objective scale to assess their weights. This article suggests that readers whose BMIs are over 23 [borderline overweight],
conduct "the 10-20-30 Weight Management Concept." This program is also designed by experts and has three components: spending 10 minutes with a doctor in a consultation room to establish appropriate weight reduction plans, eating 20% less per meal without skipping them, and doing exercise for 30 minutes per day (her world 2002: 265-267).

The "Junk Food" diet in Female (Ping 2002:232) seems to be the most 'awkward' diet among the weight loss programs introduced in these three publications. This diet is basically composed of digestive biscuits, fruits, milk, prawn noodle soup, and Chinese prescribed medicines to control hunger pangs. Although no experts appear to support this weight reduction regimen, "healthiness" is emphasized in this article, too. Tan Swee Lee, a woman featured in the article who tried this program, states that she succeeded in losing seven kilograms in two months without having any of the side effects—headache, blurred vision, and hunger pangs—seen in dieting and has not regained that weight for two and half years.

"Healthy diet" is seen even in a beauty contest—the Miss Singapore Universe pageant of 2002, featured in CLEO (Su-Ling 2002). Although weight issues seemed to be a considerable concern among all contestants, as Nuraliza Osman, Miss Singapore Universe says, "Watching your diet becomes more important than it's ever been before—all eyes are going to be fixed on you!" (Su-Ling 2002:91), the contestants did not attempt to lose their weight in a blind way but rather in a healthy manner. Osman comments that 14 days before the contest, each participant was introduced to a nutritionist, and her diet was monitored (Su-Ling 2002).

"Healthy" also seems to be an advertising gimmick for slimming centers, a growing market in Singapore. For example, PrettiSlim, a French company, explains their slimming programs as "no more crash diet and strenuous exercises" but burning only extra fat with
scientifically constructed methods (her world 2002: 260-261). Similarly, the Beauty Express advertises its slimming program as using all natural products, burning extra fat, and working fast without a yo-yo effect (Female 2002:237).

The previous section showed that four representatives of Marie France Body Line are slim but not emaciated like Kate Moss and questioned if these representatives accidentally have medically legitimized body types. An advertisement of this company gives us a clue to answering this question:

And, of course, we’ll help you lose weight overall the 100% natural and easy way with no crash diets, pills or mean supplements [with a sensible nutrition plan]. It’s a safe way to lose pounds and inches fast, with no hunger pangs, no strenuous exercise (The Sunday Times 05/23/2001)

By studying articles regarding shape-up programs both in magazines and at slimming centers, we can see that healthiness is clearly the consistent theme in all weight reduction products and programs. And the advertisement above also reflects this trend. The representatives of Marie France Body Line are intentionally “healthy” to convince Singaporean consumers of the excellence of its programs. The bodies of medically healthy, slim women in the mass media interlocks with the current trend of dieting popular among Singaporeans—losing weight in a healthy manner.

**Meaning of Healthily Slim Women**

This section will test the hypothesis built in this chapter: the Singaporean mass media contributes to creating the stigma attached to fatness through glamorizing the medically healthy,
slim women. This hypothesis will be tested through analyzing what kind of meanings are attached to these medically healthy, slim women as represented in the mass media.

"Health is Wealth," an article by Susanah Cheok, a chief editor of Female, is about her recently finished medical checkup. This article will give us a clear picture of what the medically healthy, slim women in the mass media symbolizes:

‘You’ve maintained your health well,’ were her [her doctor’s] very words. Add to that ‘Everything is at desirable levels.’… ‘Do you have problems putting on weight?’ she asked, eyeing my spindly arms. I knew that was coming. Again, I don’t. In fact, I used to be plump. I’ve lost 10kg [22 lbs.] over a period of six months through eating carefully, and maintained my current weight for over a year. Why? Because I like how clothes sit on me when I’m thin. I don’t skip meals, I eat till I’m full and I eat when I’m hungry. I just eat the high-nutrient, low-fat, low sugar stuff, and I don’t puke it all out… That’s the skinny on my eating plan, which is really common sense and discipline… Which brings me to my point: health is wealth. Without this body that works 12-hour days, and a mind that has learned to relax and switch off at will, I would not be able to drive the team that brings you this fabulous magazine every month (22, my italics)

From this article, we first infer that Cheok is not a “brainless” woman who is obsessed with external beauty but is a successful career women who runs one of the most popular fashion magazines in Singapore. Like Cheok, medically healthy, slim women in the mass media often have succeeded in their careers. For example, Christy Chung is a very successful international movie star. Miss Singapore Universe is a lawyer, and another contestant who made it into the top five in that contest is an artist with a company in Singapore (Su-Ling 2002).
Medically healthy, slim women are often presented as not only intelligent in their careers but also in dieting. For example, in the article, Cheok continuously emphasizes that she healthily conducted dieting through using her common sense and self-discipline. And her intelligent method of dieting is proved by her doctor's comment that she maintains an ideal level of health. Her success is based on her intelligence, diligence, and discipline.

Likewise, an article called "Life is Beautiful" in Female (Tan 2002a:172) describes Christy Chung and Vicki Zhao as having both beautiful bodies and minds. Chung is presented as "staying in shape and maintaining beautiful health, [for her,] life and mind has become a matter of course" (172). The article explains that she maintains a healthy state of mind through her regular meditations and overcomes her hectic schedule by keeping a decent sleeping cycle (2002). In like manner, Zhao, says, "I eat vegetables and seafood and spend up to an hour walking every day no matter where I'm filming." Readers are able to infer from this article that both actresses are not superficial individuals but are disciplined, diligent, and intelligent ones who can maintain their health as well as their beautiful body shapes. And fifteen pages after this article, there is a one page advertisement for Marie France Bodyline with a big picture of Chung and Zhao, which says, "Christy's savvy choice has helped her to maintain her perfect figure" and "Vicki's savvy choice was the amazing new CPT\textsuperscript{6}, which helped her to lose 8 lbs. in only two weeks." (2002:187).

Healthy, slim women in the mass media symbolize individuals' superior inner qualities, intelligence, diligence, and discipline, rather than external beauty. This combination of intelligence, discipline, and diligence are the complete opposite of meanings often attached to fatness—stupidity and laziness—expressed by my informants. I have argued that the Singaporean

\textsuperscript{6} This is a new weight reduction program in this company.
mass media define who is beautiful or not by making slim women visible and fleshy women invisible. In like manner, the Singaporean mass media associates fatness with the meanings of lazy and stupid through the continuous association of its opposition—thinness—with intelligence, diligent, and disciplined. When the images of medically healthy women in the mass media are repeatedly represented as intelligent, disciplined, diligent, and beautiful, the stigma attached to fatness—ugly, stupid, and lazy—is implicitly but simultaneously reinforced. The Singaporean mass media, thus, contribute to creating the stigma attached to fatness through glamorizing the medically healthy woman.

Danger of Healthily Slim Women in the Mass Media & the Glimpse of Guilt

Healthily slim women participate in the stigmatization of fatness; however, this is difficult to be recognized and criticized, since their bodies can be legitimized by medical science. In fact, both the target and control informants seem to be unaware of the fact that healthily slim women stigmatize fatness, since both the target and control groups criticize and question the legitimacy of women in the mass media who become extremely thin; however, they do not do so towards medically healthy, slim women even though these informants’ ideal body image is identical with these women’s.

While hidden in the medical justification, the healthily slim women stigmatizes fatness more than emaciated women. The healthily slim women are represented as individuals who can choose an appropriate dieting program and keep to this regimen, since they are intelligent, diligent, and disciplined. When this implication is flipped, losing weight and/or damaging health in the process of dieting is considered an individual flaw, and so those who have failed in dieting are not
Medically unhealthily emaciated women are unable to stigmatize fatness in such a manner. Although they can show external beauty as well as their discipline and diligence by maintaining their thin bodies through keeping their strict dieting regimens, they are “stupid,” in a sense, because they have selected dieting regimens that jeopardize their health. The target and control informants wish to avoid gaining weight not because they are afraid of physically becoming unhealthy but because they dislike associating themselves with the stigma attached to fatness. This explains why they choose the healthily slim women’s body images rather than unhealthily emaciated ones as their ideals. My informants have chosen a body image that is not associated with the stigma of “stupidity.”

Furthermore, healthily slim women carry the message that “appearance is unimportant,” which is the superior antithesis of “appearance is important.” This implication is seen in the interview with Christy Chung done by Joshua Lye, a reporter for The Sunday Times. He sums up Chung’s stance as a representative of Marie France Bodyline as “promoting health and not external beauty per se.” And Chung herself says:

You want to maintain a healthy life. You want to be confident. Yes, health is all in your mind, and no, you don’t have to be thin in order to be healthy (Lye 03/12/2000).

Similarly, Suzan Cheok, the author of “Health is Wealth” introduced in the previous section, blurs the issue of appearance by focusing on how healthy she is, as seen in the article’s title. She briefly mentions the topic of appearance by saying, “I like how clothes sit on me when
I'm thin" (22) changes her focus to health, and states that she needs her slim body to run the magazine of which she is in charge. In this way, healthily slim women can take the stance that they are not just concerned with appearance but are concerned with their health first. And, by firmly linking their beautiful bodies to their health, not to the "superficial" concern over their appearance, healthily slim women can reinforce the message of "appearance is unimportant" and stigmatize those who are concerned with their appearance as "superficial." This method of stigmatization is also impossible for unhealthily emaciated women, since they cannot state that they try to lose weight to be healthy rather than look nicer.

Based on the finding above, we can assume why the target informants feel guilt about gaining weight that were uncertain in the previous chapter. In American psychology, guilt is defined as a feeling that "you ought to be blamed for something" (Lazarus 1991:122, as quoted in Pervin 1996:319). The way healthily slim women are presented in the mass media implies that those who are concerned with appearance and have jeopardized their health through trying to lose weight should be blamed for their "superficial" worry over their appearance and their lack of intelligence, diligence, and discipline that cause their failure in choosing and continuing an appropriate dieting regimen.

The BMI 18.5 Body & Apparent Universality of the legitimacy of Medical Science

I have shown that the representatives of Marie France Body Line have slim bodies that are medically legitimized by keeping their body weights medically healthy at the borderline normal BMI score of 18.5 or slightly lower. However, does this BMI 18.5 truthfully indicate healthiness? In the target group, eleven individuals have medically healthy weights in terms of the
BMI score. To reach their ideal body weight—the BMI 18.5—they need to lose more than six kilograms (12.4 lbs.). Assuming that they partially suffer from psychological damage by not having the BMI 18.5 body, and considering the implicit, strong stigmatization of healthily slim women through media representations, I question if the BMI 18.5 is an appropriate threshold for being medically underweight. In fact, the discussions around the BMI scores reveal that the BMI is not an absolute item to classify a person as underweight, normal, or overweight but is subjected to modification and influenced by the globalized sociocultural norm of the preference for thinness.

For example, Strawbridge et al. (2000) criticize the greater emphasis on the risk of obesity and the smaller emphasis on the risk of being underweight in terms of mortality rates measured by the National Heart, Lung, and Blood Institute (NHLBI) by assessing the credibility of the BMI classification for overweight (25.0-29.9) used by NHLBI. The researchers show that there is no sharp increase in mortality for persons with BMIs from 25-29.9 while the mortality rate increases for the persons whose BMIs are extremely high or low. Strawbridge et al. (2000) criticize that this BMI definition categorizes 55% of Americans as overweight, and it may have “the unintended consequence of supporting efforts to achieve and maintain an unrealistically lean appearance” that may increase the prevalence of anorexia and bulimia (342). The authors also disapprove of the suggestion of lowering the BMI cut-off score of underweight to 17.0 for non-smoking Caucasian women.

In Asia, more overweight people may be created in the near future because the changes of borderline overweight BMI scores for Asians. Currently, there are two definitions for the BMI normal range for Asians. The first one is from 18.5 to 22.9 and the other is from 18.5 to 23.9. The former is a recent suggestion made by the WHO Western Pacific Region
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(2000), although Singapore has not yet accepted it. Dr. Li is, in fact, concerned with the attempt
to bring the BMI cut-off score for overweight down from 24 to 23:

There is a strong pressure to push the BMI cut-off point for overweight down
from 24 to 23. If you do, more overweight people will be created and
pharmaceutical companies will get the profit...Medical knowledge is
sometimes exploited (Transcription 2001).

When we consider who will profit by this modification of the BMI score of overweight, we
can see that medical science is not an absolute truth that is unaffected by sociocultural
context.

In societies like Singapore, where science has significant authority, it is not
preferable for ideal beauty to be accused of being scientifically unhealthy; thus, becoming
anorexic in the process of dieting is not admirable anymore. "Losing weight in a healthy
manner" is becoming commonplace among Singaporeans; they are starting to know the
danger of anorexia nervosa; and, Singaporean dieting industry uses "healthy" as the most
important sales gimmick. My informants' ideal body weight has not accidentally fallen into
the healthy body weight range; instead, this ideal weight range is the consequence of
scientific control of the truth.

I am not, of course, criticizing the dieting methods that are safe for individuals'
health, which the healthily slim women represent in the mass media. However, I argue that
the healthily slim women's body image should not be free from criticism, since their body
image contributes to stigmatizing fatness but also allows the labeling of women who fail in
losing weight as stupid and lazy. What we should consider is not whether women in the
mass media are medically healthy or not, but how medical science is used to justify dieting programs and products in the mass media.

This chapter has investigated the origin of the stigma attached to fatness and has discovered that Singaporean mass media implicitly but strongly contribute to the stigmatization of fatness. A significant finding through the previous and current chapters is the striking similarity between those with and those without eating disorders in terms of their perceptions of weight related issues: how both groups perceive the stigma attached to fatness, how they perceive the mass media representation of women, and what kinds of ideal body images they have. We have not reached the point to be able to elucidate why only the target informants hold immense fear and guilt towards gaining weight. However, these two chapters at least find the seeds of their fear and guilt in the stigma attached to fatness and the mass media representation of the healthily slim woman.

I stated previously that the target informants suffer from a lack of understanding from those without eating disorders. However, from these findings, we must question if there is such an unbreakable barrier between those with and those without eating disorders that would make it impossible for those without eating disorders to understand the psychological pain shared by those with eating disorders. Before attempting to answering the final question of why only the target informants hold immense fear and guilt towards gaining weight, however, it is necessary for us to explore the link between thinness and Singaporean society because it would be simplistic to argue that the stigmatization of fatness in Singapore has only stemmed from the fact that the Singaporean mass media continuously represents thin women as beautiful. According to the body politic,
society regulates its member’s bodies according to its needs. Thus, there must be societal factors that make it a necessity for Singaporeans to prefer thin bodies. Thus, the next chapter will analyze the preference for thinness among Singaporean women in terms of the body politic.
Body and Society: Thinness and the Body Politic

"The traditional Indian culture is more forgiving of fat!" Loni, a 22-year-old Indian woman is angry with the preference for thinness in Singapore. Because Indian women’s bodies are usually bigger than the Chinese and Malay, Loni is a victim of the preference for thinness, even though she does not have an eating disorder. Hui, a 19-year-old Chinese woman says, "In Chinese culture, fat is a good thing for women. My father said, ‘Fat women are good.’" Among the total of 35 Chinese informants, there is no one who believes that the preference for thinness is an indigenous notion of their culture. Moreover, a street poll done by The Sunday Times (Mulchand 05/31/2001), investigated the ideal female body image shared by 50 Singaporean men. Although this article concludes that the preference for thinness is only shared by women, since 31 out of 50 men answered that they prefer fleshy women, I focus on another result of this poll—the men under 27 years old prefer thin women while men over 28 years of age prefer fleshy women. My informants strongly remember the traditional value of plumpness, and some Singaporeans still hold this value. The traditional value of plumpness, in fact, has not yet died out but co-exists with the preference for thinness, which implies that the traditional Singaporean culture¹ celebrated plumpness, but this norm has been replaced by its opposite—the preference for thinness—in the past few decades.

This chapter will explore the preference for thinness, the other side of the stigma attached to fatness, by shining the light of the body politic on the manner in which a society

¹ To be precise, there is no “traditional” Singapore culture since the republic of Singapore was just established in 1965. Throughout this thesis, I define “traditional Singapore culture” as the mixture of Chinese, Indian and Malay traditional cultures with a strong emphasis on the first. The ethnic demography in Singapore will be illustrated in the next section.
regulates its members' bodies according to its needs. Before investigating the social changes that triggered this change, however, a brief overview of Singaporean geography, demography, and history will be examined. This background information will give us a context for explaining the transformation of the ideal body image from plumpness to thinness that has recently occurred in Singapore.

Singapore Overview

**Singapore Geography & Demography**

Singapore is a South East Asian island located in a lower tip of Malaysia, 136 km north of the equator and 103° East. This place is warm and humid, and its temperature varies from 23-31°C because of the influence of monsoons. My Singaporean friends often describe Singapore as "a dot," and their comment is very true. Its total land area of only 640km² [240 mile²] is slightly more than three times as large as Washington D.C., and it is six-hundred times smaller than the state of Oregon. (Hammond World Atlas Corporation 1999; Singapore Department of Statistics 2000). You can cross the country in two hours by train. The bus takes you to the adjacent country, Malaysia, in just forty minutes from the center of Singapore. If you look at a map, its existence is often unrecognizable because the name of the country actually covers it.

The land is tiny; however, this country has four million people, which exceeds the population of Oregon by almost one million (Hammond World Atlas Corporation 1999). The urban population is 100% and it has a great ethnic diversity: 76.8% Chinese, 13.9% Malay, 7.9% Indians and 1.4% others (George Philip Limited 1999; Singapore Department of Statistics 2000).
Its patterns of production are 0% Agriculture, 55% Industry, and 54% Service (George Philip Limited 1997), which indicates that Singaporean infrastructure is highly capitalistic. This smallness results in a lack of natural resources, which makes one of my Singaporean friends say “Singapore has nothing!” In fact, Singapore even relies on Malaysia for more than 90% of its water (Turnbull 1989; Transcriptions 2001). The gigantic water pipes that connect Singapore to Johobal, Malaysia, are breathtaking.

The next section will trace the modern history of Singapore, which will give us some clues to explaining why the ideal body image in this country has recently transformed from plumpness to thinness.

The Modern History of Singapore

Singapore was a poor Malay fishing village that had approximately 1,000 dwellers when Stamford Raffles, a British official of the East India Company, embarked on a mission to establish a trading port on the Singapore island in 1819. At that time, no one could imagine that 170 years later this desolate island would accomplish amazing economic development, become the world’s 11th richest nation where four million people live, and earn the title of “Little Dragon” in Asia (Turnbull 1989; Lim 2001; Department of Statistics 2001).

Raffles’ great business skills and intelligence swiftly developed the island to a stable trading port for the British in South East Asia, and, five years later in 1824, when Raffles signed the temporary lease for the Singapore island, the island became a possession of the East India Company and subsequently became a British Crown Colony in 1867.

A basis for the “Chinese success story” in Singapore was established during those decades by a drastic ethnic make-up change (Tamney 1996:1). The Chinese population,
which was 31% in 1824, had increased to 65% by 1867 and outnumbered the indigenous Malay population. The British focus on trade prompted this shift. Malay, who preferred the traditional subsistence style of living, were pushed into the north of the Malay Peninsula. On the other hand, it attracted great numbers of Chinese who favored merchandise but suffered from poverty and unemployment in mainland China. Chinese who were willing to work diligently despite the cheap wages that they received were perfect laborers for the British who struggled with a lack of labor (Turnbull 1989; Tamney 1996). This community of interest between the two peoples further advanced the economic growth on the island.

The opening of the Suez Canal in 1869 and the expansion of the British colony over Malay promised that the Singapore island would become a crucial trading port for the British. Even after the agony of the four years of Japanese occupation, accompanied by a massacre of Chinese from 1942-1945, this island continued its economic development and finally became an independent country, the Republic of Singapore, in 1965 while allowing British troops to remain stationed there (Turnbull 1989). The eight-year boom after World War II made foreign capital flow into Singapore, and the American entry into the Vietnam War made Singapore an essential supply center for the American military. Taking advantage of these historical fortunes, Singapore achieved a nearly 100% employment rate at the end of the 1960s (Turnbull 1989).

The British played a crucial role in Singapore’s economic growth, especially because the British forces there provided 20% of its gross national product and had been a vital economic source for Singaporeans. The country’s dependency on the British, however, began declining due to the British troops’ withdrawal, which had started in 1968. The
United States, Malaysia, and Japan instead became the largest trading partners for Singapore; 40% of its exports in 1978 went to these three countries. In 1967, the United States invested 46% of the total new foreign capital and became Singapore's second largest trading partner after Malaysia (Turnbull 1989). Japan was the second largest investor for Singapore next to the US in the 1980s and "was the largest donor country to Singapore among [the Development Assistance Committee] countries" in the 1990s (Lim 2001:227).

Foreign investors were attracted by such factors as political stability, English as a first language, and well established communication networks in Singapore. Lim (2001) illustrates:

During the period of 1975-1984, foreign-owned establishments (with more than 50% of foreign capital investment) comprised 23% of establishments, but generated 55% employment, 73% of gross output and 65% of capital expenditure (46).

Singapore continued its economic growth by establishing a "outward-looking" and "trade-oriented style" (Lim 2001:46).

Singapore started changing itself from a mere developing country to a developed country in the 1980s. The International Monetary Fund, in fact, first discussed transferring Singapore from developing to donor country status in 1989 (Turnbull 1989). In the same year, Singaporeans’ average income increased eight-fold per capita since independence; in 1965, its per capita wealth was one-seventh of that of the U.S. and increased to one-half by 1989 (Tamney 1996). In 1997, Singaporeans annual income per capita was $32,940 US, which exceeded Americans annual income of $28,740 US (George Philip Limited 1997). Statistics even envisions Singapore becoming the richest country in the world by the year
2020 (Lim 2001). This Singapore success story is “a favored model for human investment strategy by both developing and industrialized nations” (Davidson 1999:74).

We see dramatic social changes in the country, especially in the 1980s when Singapore was becoming a developed country from a developing country. Are we able to infer the reasons of the transformation of the ideal body image from plumpness to thinness in Singapore from this change?

Thinness & Obesity

As mentioned in Chapter Two, obesity and the preference for thinness are “flip sides of the same cultural coin” since the emergence of the preference for thinness often follows the increase of obesity rates in a society. And the problem of obesity usually follows industrialization (Brown & Konner 1998:401). Indeed, this is exactly what happened in this country. Its economic success was mirrored in the sudden increase of obesity.

Singaporeans' Physical Growth

Mei, a 40 year-old Chinese mother remembers that in the 1970s her school distributed packs of milk to underweight students to help their growth. Singaporean's amazing economic success now makes the milk unnecessary because Singaporean youth have stopped having problems in their growth. Compared to 1970, in fact, Singaporean males at the age of 16 became 7.4% taller and 34.5% heavier in the 1990s; likewise females at the same age became 4.5% taller and 19.3% heavier. (Rajan 1992 in Jin-Jong 1999). In place of poor nutrition, obesity had become a problem in Singapore in the 1990's. The obesity rate among Singaporean
youth (6-18), which was 5.4% in 1980, has amazingly jumped to 14.8% in 1990 (Rajan 1992 in Jin-Jong 1999).

The government recognized the problem of obesity and swiftly established the National Committee on Prevention and Control of Obesity in 1990, and a ten-year campaign was started in order to bring down obesity rates (Jin-Jong 1999). For example, parents’ educational programs and Hawker\(^2\) center programs were launched to increase the awareness of health among adults. Likewise, “Big Walk” is an annual mass exercise to encourage Singapore citizens to do aerobic sports; it is conducted by the Singapore Sports Council. Participants of Big Walk choose to walk or run for about 5-10 km depending on their abilities, and every year, a few thousand people take part in the event (Transcriptions 2001).

The school environment also was changed to decrease the obesity rate among children. The government increased the numbers of water coolers to prevent students from taking soft drinks and also put labels on food at school shops to educate students about what foods are considered healthy. The Trim and Fit Program (TAF), introduced in Chapter Five, is actually a part of this governmental initiative (Jin-Jong 1999). Chung, a Singaporean dietitian, explains how overweight students are defined and required to go the TAF: Singapore has “a growth chart” that shows the average weight and height ratio of Singaporean children (6-18), which is made and revised in every decade by actually measuring these children’s heights and weights. Students who weigh more than 20% greater than the standard weights and heights ratio shown in “a growth chart” are considered overweight and required to go to the TAF program. Students who are 40% over the average weight receive additional counseling at the School Health Center.

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\(^2\) Hawker Centers are the traditional food courts that Singaporean enjoy eating at. They provide various types of food, such as Indian, Malay, and Chinese with reasonable prices.
(Transcriptions 2001). Although too early to make accurate conclusions, Chung considers that these governmental programs have been successful, since the obesity rate among children decreased from 15% to 10% in 2001. Some people may have thought that the TAF degrades overweight students; however, this program can also be seen as part of a governmental effort to solve a problem emerging from rapid social change (Transcriptions 2001).

Obesity and the Cultural Values attached to Food

Despite the governmental effort to solve the problem of obesity, Singapore society has certain conditions that make it difficult for its members to eat less. For Singaporeans, food is more than products to fill their stomachs. Food lubricates and mediates human communications and symbolizes love and hospitality; thus, refusing food that has been served can be considered rude, which is a custom generally seen in Asian cultures (Keesing 1981). Food is important for Singaporeans because of the cultural meanings attached to it. Taking an example from Chinese culture, which is shared by the majority of Singaporeans, food is understood “as a source of energy (qi) for the body”, and “being able to eat is to have luck” (Lee et al. 1992:549). Moreover, in Confucian ethics, nourishing children is considered an important parental duty, and grown children are expected to “respectfully nourish” their aged parents in return (Watson 2000:211).

Equally important, Singapore is “a food paradise,” borrowing Chung’s phrase. Located just above the equator, Singapore is full of tropical fruits, and its ethnic diversity offers authentic food from various cultures—Chinese, Indian, Malay, Indonesian, Thai, Japanese, and Western—with low prices. As Liou says, “It is almost impossible to avoid eating, if you go out with your friends.” Not only does the cultural emphasis on food make it difficult for Singaporeans to refuse eating, Singapore’s geographical location and demography also do so.
Therefore, Singaporeans have a difficult time dealing with the problem of obesity and the preference for thinness. For example, Si, a Chinese mother, felt sad to see her 16-year-old daughter trying to eat less and skip meals so as to stay out of the TAF program, since feeding children is a way for Si to express her love. Three of my target informants decided to lose weight by bingeing on food and purging it, rather than going on a strict diet. They did so because food was too tempting for them. On the other hand, Chung, a dietician, is concerned with the lack of awareness of the problem of obesity seen in older generations, that is, in people over 50 years old. She explains that these generations consider food to be very important and recognize "chubby" as a sign of being healthy; therefore, they tend to overfeed children and overlook the signs of obesity. My informants have different types of concerns about food, depending on their occupations and ages; however, their concerns all stem from a consequence of the dramatic societal changes in Singapore that have made the meanings of food a paradox—it symbolizes love and hospitality but can make individuals obese, which symbolizes stupidity and laziness.

Industrialization that largely started in the 1960s in Singapore had changed its infrastructure so that Singaporeans are sedentary and consume more fat. During the 1980s, when Singapore was becoming a developed country, the infrastructure that initiated the problem of obesity was established, and finally, this problem exploded in the 1990s. This social setting transformed the "correct" body from plumpness to thinness in this social setting. However, because the changes were dramatic, the traditional value of plumpness has not yet faded out but still exists in the old generations who lived with the problem of food shortage. Further, the
traditional cultural value attached to food and Singapore’s geographic/demographic conditions make it difficult for Singaporeans to deal with the problem of obesity.

The Meanings of Thinness: Diligence, Discipline, and Intelligence

According to the body politic, the ideal body shared by a society symbolizes desirable inner qualities to sustain that society. Based on the findings in the last chapter that thinness symbolizes intelligence, discipline, and diligence in Singapore, this section will examine whether Singaporean society actually requires Singaporeans to have such qualities to sustain itself.

Singapreans' restlessness—Lives of Singaporeans

Dr. Li describes Singaporeans in the following way:

Singaporeans are like people in a boat trying to go against the current of a river. You need to work hard to stay in one spot, but if you want to go forward, you need to row harder.

Her comment addresses the restlessness of Singaporeans’ lives. Finding its evidence is not a difficult task.

Brenda, a 10-year-old Indian-Singaporean, is one of my host family’s children. She needs to wake up at five in the morning every weekday because her school bus picks her up at 5:30. Schools in Singapore have two shifts because of overcrowded enrollment. Although her school finishes around two, her work is not yet finished. She often has extra classes after her regular schedule, or otherwise goes to her father’s house (my host mother was divorced) to study. Another child, Christine, is five-years-old and has a tutor for Chinese. She studies speaking
Chinese, as well as Chinese characters, even though her first language is English. My host mother explains to me that speaking Chinese as a second language will make it easier for her child to get a job in the future.

While Singaporean children are busy studying, the adults are busy working. It was often difficult for me to talk with my supervisor, Dr. Lee, because of her tight schedule. Not only is she responsible for the Eating Disorders Hospital at the IMH, but she also has clinical hours at another hospital at least twice a week. I sometimes needed to wait until she returned home after eight in the evening to call her. Their diligent lifestyle is culturally defined since Singaporeans, since the majority of whom are Chinese, traditionally hold strong Confucian ethics that value diligence, frugality, education, self-sacrifice, filial piety and loyalty to the nation (Fisher 1999). However, this inclination seems to go to extremes in Singapore's case, and its extremeness is expressed in a new-born Singaporean word, kiasu.

"What is it like to be Singaporean?" Singaporeans often answer this question by saying they have kiasu-tendencies. My informants explain that kiasu means a "fear to miss out" and reflects Singaporean success-driven and perfectionist mentalities. My Indonesian friend, who is a counselor in Singapore, describes kiasu as:

*Kiasu* is an unhealthy competition. Singaporeans don't want to miss out on anything in their lives. The competition is not limited to their jobs and schools. It happens everywhere. For example, if McDonald's started giving out a limited number of gifts to the customers who buy their products, Singaporeans would stand in a line the night before to get it.
All Singaporean medical professionals who I interviewed actually remark that this kiasu-like mentality easily drives Singaporean adolescent girls to pursue losing weight so as not to miss out on the perfection of thinness represented in mass media.

However, why was this word generated only in Singapore but not in other countries—South Korea, Japan, and China—which also value Confucian ethics? Dr. Shu gives us helpful leads to finding the answer by stating:

*Kiasu*—fear of failure, performance oriented and success driven—is a Singaporean cultural characteristic. Although Singapore’s government has tried to soften this tendency by conducting an event such as the ‘Kindness Movement,’ it is difficult to change it in reality. Meritocracy dictates people rather than accepting who they are. Singapore does not have any natural resources and there is no way to survive without relying on human resources. There is a need for people to excel.

Dr. Shu’s statement indicates that the kiasu-like mentality was generated out of necessity, since human beings are the only resource in Singapore, and depending on human resources is the only way for Singapore to compensate for its lack of natural resources. When human beings become the only resource in a society, what kinds of qualities are required of that society’s members? The next section will contextualize kiasu in Singaporeans’ lives to include Singapore’s larger economic and political landscapes so as to answer this question.

*Diligence, Intelligence, and Discipline*

Singapore’s economic success was founded on extraordinary human efforts and intelligence; otherwise, it would have been impossible to compensate for their geographical
deficits and to become the world’s 11th richest nation. C.M. Turnbull, a Professor at University of Hong Kong argues:

[The ethnic composition of Singapore], the lack of indigenous raw materials which her neighbors had in abundance, the limitations of water supplies and land for development, created a constant need for delicate balancing and quick wittedness. Singapore’s independent existence defied all accepted modern concepts of politics and economics. It is a place which found it hard to relax its continuing struggle for survival (1989:327).

Within this context, the pressure imposed on native Singaporeans—the only abundant resource—is immense, and the word, kiasu, has been created.

Although Dr. Shu states that Singapore’s government tries to “soften the kiasu-tendency,” it is more accurate to remark that the governmental policies are contradictory, softening the kiasu tendency but urging people to work hard. The government, in fact, has taken a central part in creating kiasu since its independence. Out of the need to depend on external force to fuel its economy, the priority of its national policy always resides in economic growth, and the government continuously reminds its citizens of the importance of diligence and self-sacrifice for the nation. For example, in 1968 new legislation allowed longer working hours, reduced holidays, restricted payment for overtime and bonuses, and curtailed white-collar workers’ fringe benefits. This legislation was aimed to overcome the economic crisis, which resulted from the British troops’ withdrawal in 1968, and also to attract more multi-national foreign investment (Tamney 1996; Turnbull 1989).

After Singapore accomplished extraordinary economic success, the government’s message to the Singaporean people somehow changed while maintaining the same underlying
intent—urging people to work hard. The government is now concerned that memories of hardship will fade out among young Singaporeans, and they will become less diligent. In 1991, the Prime Minister, Goh Chok Tong’s, statement in his manifesto for the future was, “All our plans depend on strong economic growth. Singaporeans will have to work hard, work smart and work together” (Singapore Government 1991:16, as quoted in Tamney 1996). Similarly, in 1992, The Sunday Times reported the governmental worry that if Singaporeans become too relaxed, for example, reducing working hours from five and half days to five days, it would result in the decline of economic growth (in Tamney 1996).

Since independence, Singapore has sought a way to survive in economic development; its dependency on foreign countries requires Singaporeans to achieve a paradoxical task: be harmonious but be competitive. Singaporeans always need to be aware of slight economic and political changes occurring outside of the country and to adjust to these changes effectively in order to compensate for having a lack of natural resources and a small internal market. It requires both intelligence and diligence, which are the very meanings attached to attaining and maintaining thinness. Singaporean society needs intelligent and diligent individuals to sustain itself, and the ideal female body image of thinness symbolizes these qualities.

Thinness & Women

Fatness has symbolized maternity in the traditional Singapore culture, as my informants express. As Brown and Konner state, this is not a rare symbolization of fatness; it is commonly seen in cultures where “a women attains her proper status only through motherhood” (1998:410). Thus, in order to explain the transformation of the ideal female body image from
plumpness to thinness, only focusing on the problem of obesity is insufficient. We also need to consider the definition of femininity in Singapore.

Women’s Status in Singapore

The traditional Confucian values taught women to fulfill their desires by being good mothers and submitting themselves to their husbands (Tamney 1996). The rapid economic development in Singapore, however, has changed the meaning of what it is to be a woman. Out of the necessity to keep up its economic development and avoid a dearth of labor in the workplace, women have been encouraged to go outside the home and to work (Tamney 1996; Davidson 1999; Goatly 1999). For example, during the 1960s, the government created an accessible environment for women to work, such as establishing factories near housing units. These policies were successful, and the numbers of women in the workforce dramatically increased. Only 16% of all workers were women in 1957; however, that number increased to 33% by 1990. In 1991, 50% of the workers were female (Tamny 1996). Women’s rights also were expanded at the time of independence. Women have been given the right to vote, and the government has declared no exploitation of women. Furthermore, in 1961, the Women’s Charter was promulgated, and it currently proclaims the abolition of arranged, polygamous marriages and the equal right for women of owning property and seeking a divorce³ (Tamney 1996). The meaning of femininity started shifting from motherhood to working outside of the home in late twentieth century Singapore.

Not only economic development but also the increase in the population of Singapore changed women’s socially expected roles and even made them contradictory. From the 1960’s

³ Different laws are applied to persons who commit themselves to Islam.
to the middle 1980’s, the government was concerned with future overpopulation in its tiny country and aimed at reducing fertility rates. Under the slogans “Stop at Two,” and “Two is Enough,” abortion was legalized, and sterilization was commonly practiced among Singapore’s citizens. Also, a set of incentives and disincentives were established such as the restriction of maternity leave after a family’s second child and the increase of infant delivery fees (Tamney 1996; Davidson 1999). This governmental program succeeded immensely in the 1980’s. The fertility rate that was 4.66 in 1965 dropped to 1.4 in 1986 (Teo & Ooi 1996 in Davidson 1999).

This fertility decline was beyond the governmental expectation and flipped the political message regarding population control. In the mid 1980s, the government instead started the fertility expansion program to sustain the population in Singapore. The new slogan was “Have three, or more if you can afford it” (Lazar 1999:147), and a series of incentives to families that have a third or fourth child was implemented (Goatly 1999). These incentives were more advantageous to educated women, underlain by the controversial governmental belief—“intelligence [is] inherited in particular from the mother” (Davidson 1999:82). Educated women were the main target of this campaign because of Singaporean economic growth in 1980’s, which started transforming Singapore from a developing country to a developed one. Singapore society needed to improve the quality of labor rather than merely increasing the numbers of workers (Davidson 1999; Goatly 1999; Tamney 1996).

Singaporean society needs to prepare women to fill the vacancies in the workforces but, at the same time, to maintain its population that promises continuous economic development (Tamney 1996). Singaporean women are, consequently, facing ambivalent values: “individual, partner/housewife, mother/breadwinner, contributor to the economy, and gene transmitter”
To fulfill the roles of mothers and workers at the same time, Singaporean women need to be intelligent, disciplined, and diligent.

*Beauty as a Competition*

We should consider why, while both male and female Singaporeans are exposed to the societal conditions that ask them to be intelligent, diligent, and disciplined, women have the preference for thinness stronger than men. To answer this question, we should take into account the fact that beauty has a competitive aspect in addition to the aspect of individuals enjoying themselves, and beauty pageants are not the only place in which this competition happens; it occurs everywhere in individuals' daily lives, such as at school and in the workplace. Since beauty is a competition, there are contestants and judges. In the current Singaporean society, who is who in this beauty contest?

Although Singapore's government claimed the equality between men and women in 1961, as seen in a previous section, it is clear that men have more power than women. For example, only 5% of Members of Parliament are female and there has been no female Cabinet Minister (AWARE 2002a). Likewise, women's enrollment in the national medical school is limited to one third of all the students. This restriction is justified based on the assumption that "women tend to leave the profession and that as doctors women tend to watch the clock and want limited work hours" (Tamney 1996:134).

Additionally, men's rights seem to be more protected than women's in Singapore. For instance, women's wages are one third less than men's, justified by the idea that men must serve in the military for a year (Transcription 2001). Male rights are even protected in the home, as there is a penal code that states, "sexual intercourse by a man with his own wife, the wife not
being under 13 years of age, is not rape.” Similarly, women can take a Police Protection Order only against a family member in the case of sexual harassment, including stalking, but not against the persons outside the family (AWARE 2002b).

Naomi Wolf (1991), a feminist, proposes that those who are (politically) weaker in a society should embody the socially ideal beauty more than those who are stronger, and that ideal will be selected by the strong. And from the facts I listed above, it is clear that men have generally more power than women in Singapore and have more opportunities to select and judge women in the workplace as well as in marriage. In Singapore society, women are the contestants of the daily beauty contest; they compete with each other for the perfection of the ideal body image of thinness that symbolizes intelligence, diligence, and discipline so as to be selected by men, the judges (Wolf 1991).

In the introduction, I mentioned the street poll done by The Sunday Times that concludes the preference for thinness shared among Singaporean women is a peculiar phenomenon that is unrelated to men. However, if this article had focused on the competitive aspect of beauty, it would have emphasized the generational gaps between the young and the old in terms of the ideal female body image shared by men—in which the younger generation prefers thin women.

This is not to say that if patriarchy goes away from Singapore, women would stop being concerned about their weight, since the emergence of the preference for thinness is a complex issue resulting from the interaction of multiple factors, as I have been showing throughout this chapter. However, stating that the preference for thinness among Singaporean women as unrelated to male perception would conceal the problem of body image concerns shared by these women, rather than solve it. According to the idea of the body politic, what is beautiful for a
society is decided in the social context of politics, economy, and gender roles. As long as men and women live together in a society, the issue of beauty always will be a matter concern to both genders.

Thinness & Westernization: the Condensed History of the Preference for Thinness in Singapore

As I argued in Chapter Two, Westernization, especially Western mass media, has long been connected to the emergence of the preference for thinness in non-Western countries. As I have illustrated, the West has taken a crucial role in Singapore’s development throughout its history. This section will expand the issue of the Western influence on Singapore and will attempt to answer how Western culture is connected to the preference for thinness in Singapore.

Language Dilemma

Combined with the kiasu-mentality, Singapore’s radical economic development had been accomplished through emulating several aspects of Western modernization styles such as the government, rule of law and parliamentary democracy, and reliance on Western capital flow into Singapore (Tamney, 1996). Additionally, the lack of both natural resources and an internal market to help its continuous economic growth still make it necessary for Singaporeans to create settings where foreigners can invest easily and comfortably. Thus, Singapore must adapt to other cultural policies—especially to Western ones, which are the most powerful in this globalized world.

A huge English-speaking population in Singapore is a factor that attracts Western investors (Tamney 1996). Singapore’s national language is actually Malay, and each
ethnicity has its indigenous language, such as Chinese, Malay and Tamil. Nevertheless, English is the most common language. English is officially used in the governmental sectors. The Sunday Times, the largest newspaper in Singapore, is written in English. Inter-racial and sometimes intra-racial conversations are conducted in English. Singaporeans' familiarity with English also is seen when English names are given to many Singaporeans, in addition to their ethnic names. More than half of my Singaporean friends, in fact, call each other by their English names without using the other names that indicate their ethnicities.

The government actually made an effort to preserve the traditional languages in Singapore, since the government considered that, while English was needed for economic benefits, "the mother tongue would provide basic values, without which Singaporeans would be completely deculturized [the author means that they lose their own culture] and lost" (Turnbull 1989: 300). Nevertheless, Singaporeans recognize English as the most useful language they can use in order to survive in their society. For example, in 1968, 300,000 students belonged to English-medium schools while only 135,000 students attended Chinese schools. Moreover, Nanyang University, which was traditionally a Chinese-medium school, could not help changing itself to a English-medium university in 1977 because its Chinese-speaking graduates had more difficulty securing jobs compared to their English speaking peers. (Turnbull 1989).

Western Mass Media in Singapore

The huge English-speaking population not only has been contributing to Singapore's economic growth but also easily allows Western mass media to flow into Singapore. I asked all of my 22 female informants in the target and control groups to name women that they think are
beautiful in terms of appearance. Out of 15 responses, only 3 women are Asians—a Singaporean, a Hong Kong, and a Japanese actress. The other 12 women are all Caucasians, such as Ally McBeal, Claudia Schiffer, Liv Tylor, Charlize Theron, and Princess Diana. No informants state that they hope to look like these Caucasian women, but they hold these Caucasian figures as beautiful.

This finding accords with the comments of two media professionals, Trina and Jacqueline, editors of the second biggest Singapore women's magazine. They mention the strong Western influence on their magazine. Their magazine targets women who are more than 25 years old and attempts to feature a variety of real women's issues, such as pregnancy and housing issues, rather than becoming a mere fashion magazine. Although they try to employ models of diverse ethnicities, their aims sometimes become difficult to achieve. Model agencies prefer to employ Western or Western-looking models. Jacqueline says, "It is difficult for Indian models to appear in fashion magazines since our skin is darker." Since less than one percent of the population of Singapore is Caucasian, it indicates that a Western-looking preference is not a matter of who is the majority in Singapore but a product of Westernization in Singapore.

The West has also played a significant role in shaping Singaporean mass media since the 1930s when the British established the first radio station in the country in 1936. The British maintained control over all radio and TV shows in Singapore until 1959; finally, in the 1960s, the Singaporean government gained ownership of all TV and radio broadcasting. Nevertheless, the Western influence on Singaporean mass media continued to be strong. For example, in the 1970s, 70% of the total TV programming hours on the two Singaporean TV channels were
foreign imports, mostly from the West. Singapore still needed to rely heavily on Western imported TV shows in structuring Singaporean mass media, since it lacked material resources and local expertise to produce local programs (Wong 2001).

The US mass media, in particular, dominated Singapore TV shows, especially from the 1970s to the 1980s. Major US TV corporations started globalizing their products by selling them at reasonable prices; thus, US TV programs became economically ideal imports to fill the gap in programming due to the lack of Singapore local TV shows. In the early 1970s, 80% of TV imports were produced in the United States. The 1987/1988 annual report of the Singapore Broadcasting Corporation (SBC) showed that 61% of available timeslots were filled by foreign programs and 48.5% of them were of U.S. origin (Wong 2001).

Over time, the numbers of imported TV programs have decreased; however, the West, especially the United States, continues to have a strong influence on Singaporean mass media. The ratio of local SBC productions to imports has been estimated at 3:2 since the 1980s. Two-fifths of TV programs in Singapore are still foreign products. The English-language Channel 5 broadcasts multiple programs from the four U.S. networks (ABC, CBS, NBC, and Fox) during prime time. Another channel, STV 12, often shows American popular programs such as 60 Minutes, 20/20, and Hollywood movies (Wong 2001).

The Western influence on Singapore mass media reflects the research result that Singaporean youth who speak English at home are more likely to be dissatisfied with their body image than their counterparts who do not speak English at home (Wang et.al.1999). The influence of Western mass media in Singapore is immense, and the ability to speak English makes Western mass media's conceptions of beauty familiar to Singaporeans' lives.
The sociocultural study of eating disorders has traditionally addressed Westernization—Western mass media, in particular—as largely responsible for the emergence of the preference for thinness in non-Western countries. Furthermore, the majority of my informants, including all Singaporean medical professionals, also agree with this perspective. Looking at the modern history of Singapore, including the emergence of a huge English speaking population and Western mass media that occupies two fifths of Singapore TV programming, we can clearly see the immense Western influence on Singapore. Thus, there seems to be enough evidence to conclude that Westernization is mainly responsible for the emergence of the preference for thinness in Singapore.

I, however, avoid this conclusion in this thesis, because I believe this perspective is a simplification of the complex influences that have led to the preference for thinness in Singapore. This preference is a result of the interaction of multiple social factors: the increase of obesity rates, the changes in women's status, the kiasu-like mentality, and power imbalance between the two genders; therefore, it cannot be explained by "Westernization" alone.

I admit that the Western culture has undoubtedly influenced these social factors mentioned above. However, what kinds of sociocultural changes are labeled as Westernization? Is the Western culture essential for the preference for thinness to emerge in non-Western countries? And, moreover, what do we actually mean by Westernization (Nasser 2001)? In the sociocultural writings on eating disorders, the definition of Westernization has been too unclear to determine that Western culture definitely has transformed the ideal body image from plumpness to thinness in Singapore.
Furthermore, because the sociocultural studies of eating disorders often discuss Westernization as the link between Western mass media and the emergence of the preference for thinness, the undefined word "Westernization" easily gives us the impression that non-Westerners start preferring thinness merely through watching Western TV shows. Thus, instead of claiming that Westernization has caused the preference for thinness in Singapore, I argue that the Western influence on Singapore has accelerated the emergence of the preference for thinness among Singaporeans and has quickened their adaptation to this preference.

The Condensed History of the Preference for Thinness in Singapore

When comparing the history of the Western preference for thinness with Singapore's, we will realize that Singapore has made a similar progression but in a condensed amount of time. The West has a century-long history of preference for thinness; obesity had started increasing among Europeans around the nineteenth century, and the preference for thinness followed this increase around the end of the nineteenth century (Brown & Konner 1998; Brumberg 2000). About a half-century later, in the 1960s, doctors recognized eating disorders as common mental disorders among adolescent girls, and the public knew of the disorders in the 1980s.

Singapore, in contrast, has a much shorter history of the preference for thinness than in the West. When exactly the preference for thinness emerged in Singapore is unknown. However, considering the sudden jump in obesity rates among Singaporean youth from 5.4% in 1980 to 14.8% in 1990, and the increase of obesity followed by the emergence of the preference for thinness in the West, we can assume that the preference for thinness in Singapore emerged sometime in the 1980s. Around 1995, doctors seemed to recognize the increasing number of patients with eating disorders, and in 2001 a conference on eating disorders was held in
Singapore. From these facts, we can conclude that Singapore seems to have only a twenty-year-long history of preference for thinness but has experienced the same events that the West took an entire century to undergo.

Singapore's history of the preference for thinness is condensed because this country has developed in part by incorporating archetypes of Western societies, such as political and economic systems, rather than inventing everything from scratch. This process of the development of the country has accelerated further due to a huge English-speaking population in Singapore which has *kiasu*-like mentalities and the Western TV programs broadcast in Singapore that represent thin women as beautiful. Within these social conditions, the preference for thinness in Singapore immediately emerged after obesity became a country-wide problem. Western culture, which keeps flowing into Singapore, has accelerated the emergence of the preference for thinness among Singaporeans and has condensed its history in this manner.

This condensed history, in fact, will explain why Singaporean mass media encourages women to go on dieting in a healthy manner through representing medically healthy, slim women as beautiful rather than continuing to show unhealthily emaciated women. It shows that the Singaporean preference for thinness is catching up with the ones seen in countries where thinness has been seen as a female ideal body image much longer than in Singapore.

For example, in the US and Japan, there was a "hazardous dieting" phase that was characterized by medically risky dieting regimens. For example, Yumi's mother, a Japanese, told me that in the 1980's, "cabbage dieting"—just filling the lunch box only with cabbage—was popular in her school. Eating cabbage substituted for eating sugar and satisfied hunger since cabbage tastes sweet. Another diet involved a person hanging from a bar and
asking her friends to pull her body down, since this was believed to make a person thinner. Similar diets were still popular in Japan in the early 1990’s when “apple dieting” and “yogurt dieting”—only eating apples or only eating yogurt for a week—were popular among my friends.

Such a phase was especially seen in the US from the 1970s and 1980s, and Japan experienced it from the late 1980s to the early 1990s. However, after the public in these countries became aware of the danger of extreme thinness shown through anorexic people, the “healthy dieting” phase came to these countries. Since healthiness is a status that people are told they should strive to attain in these affluent societies (Scheper-Hughes & Lock 1998), being unhealthy while trying to lose weight is not admirable anymore.

An article in People (Dam et al. 2000) entitled “Diet Riot” indicates that the US is already in the “healthy dieting” phase. This article attempts to assess whether diet regimens popular among American TV and movie stars are healthy or not through collecting experts’ opinions about these programs. Furthermore, Gordon (2001) remarks that the incidence of eating disorders seems to be leveling off in the West, at least the US. He assumes that women may become more cautious about conducting extreme dieting programs because public education has increased American public awareness of the serious health damage resulting from eating disorders. Additionally, feminist thinking taught in college and the anti-dieting movement have made women be more critical of the extreme focus on weight and dieting. Because of this newly developed awareness, eating disorders that were somehow glamorized in the 1970s and the 1980s were instead stigmatized in the 1990s, which may have caused a decline in the incidence of eating disorders (Heatherton 1995 in Gordon 2001).
Likewise, Japan entered the "healthy dieting" phase in the 1990s. In the middle 1990's, scientific dieting books certified by experts, such as doctors and athletic trainers, had started to emerge in the Japanese mass media; the experts commonly appeared in fashion magazines and certified the safety and healthiness of the dieting regimens suggested in these magazines (Asano 1996). The recent Japanese "healthy dieting" phase is peppered with scientific words more than before. For example, in May 2002, the popular Japanese magazine for females, OZ, featured healthy dieting plans throughout the entire volume. It introduced exercises for the slow twitch type of muscle fibers, which more effectively burn fat than the fast twitch type, and also showed a chart that enabled readers to know which appetite-related hormones—serotonin, adrenalin, leptin and histamin—might be out of control. In both articles, doctors gave readers the medical explanation of these dieting programs.

In like manner, Singaporean mass media represents healthy, slim women as beautiful, since this country is already in the "healthy dieting" phase, despite its short history of the preference for thinness. According to my informants' comments, Singapore seems to have undergone the "hazardous dieting" phase from the middle to the late 1990s. For example, Wei Chen tried three types of dieting: liquid dieting that involves only drinking water and fruit juice for three days, fruit dieting that is conducted by just eating fruits, and fiber dieting that requires a person to consume an abundance of food containing fiber. Sarah tried protein dieting—eating boiled chicken breast without salt and egg whites. Both women tried these dieting regimens around the mid 1990's. They did not invent these dieting regimens by themselves but knew about these programs through friends or the mass media.
There is no doubt that hazardous dieting still exists in Singapore, such as taking slimming pills that cause liver damage, as seen in Chapter Six. However, as seen in Chapter Six, Singapore also is in the “healthy dieting” phase after having experienced a “hazardous dieting” phase that was much shorter than the US’s and Japan’s. The danger of extreme thinness has been revealed to Singaporeans so that the unhealthy, slim body is becoming unappealing to them. Singapore has a very short history of the preference for thinness; however, this country has quickly taken the latest Western information about eating disorders written in English, modified it to fit Singapore’s cultural settings, and used it for its own benefits. Singapore is catching up with not only the Western economy but also the current Western preference for thinness, which now emphasizes health instead of extreme thinness.

In terms of the body politic, I have demonstrated the complexity of the preference for thinness in Singapore by situating it in the larger social context. Industrialization, the problem of obesity, fast economic growth, the kiasu-like mentality, the changes in women’s status, gender inequality, and the power of the West all have interacted with each other and have transformed the female ideal body image from plumpness to thinness, which symbolizes qualities that Singaporeans are asked to have—diligence, discipline, and intelligence. Neither Singapore’s mass media nor Singaporean women have generated the preference for thinness in Singapore; rather, it has been created by the entire Singapore society that is firmly tied together by the globalized economic system. Singapore’s mass media and Singaporean women merely practice this norm and reinforce it on a daily basis.

The next chapter will return once more to the insiders’ points of view. By using all the knowledge we have obtained so far, I will finally try to answer why only the target
informants show immense fear and guilt towards gaining weight. Furthermore, my aim is to explore whether their guilt and fear might be deconstructed so as to decrease the lack of understanding from others who do not suffer from eating disorders.
The Origin of Fear and Guilt: Voices of Women with Eating Disorders

This chapter will explore why those with eating disorders share immense fear and guilt towards gaining weight while these feelings are absent in those without eating disorders by bringing to light five stories told by five informants who have or have had eating disorders. These stories were told in response to my question, “Could you describe how you developed eating disorders?” These five stories were chosen because of the amount of time that I spent with the tellers of these stories. I interviewed all of them three times at least or had an interview that lasted more than ninety minutes, which seemed to help them more openly talk about themselves. Furthermore, after writing-up their interviews, I asked them to look over my transcriptions and to correct my mistakes. Based on these reasons, I concluded that these five case notes are accurate enough to be presented as insiders’ perspectives of eating disorders.

Other than searching for the origin of these people’s fear and guilt, I also endeavor to show a different face of eating disorders that we never see merely by reading the diagnostic criteria of eating disorders. I hope that readers will go back to the first part of Chapter Two, reread the diagnostic criteria for these conditions, and see how these informants account for their eating disorders without using any of the diagnostic criteria listed in the DSM-IV.

In the conclusion of this chapter, I will claim that, from the insiders’ perspectives, these informants’ serious involvement in the meanings attached to thinness and fatness play a crucial role in the generation of their fear and guilt towards gaining weight. I am mindful, however, that it is impossible to elucidate the components of their fear and guilt completely from an anthropological point of view, since feelings are complex made of biological, psychological, and sociocultural factors. I will also suggest that there is a gap between medical science’s and
insiders' points of view in terms of how to explain eating disorders and will segue into the next chapter by arguing that this gap may contribute to creating the lack of understanding from those without eating disorders.

Case Note 1: Jennifer

If you hear the word anorexia, you may think of a woman who cannot think of anything except being thinner even though her body is extremely emaciated. However, how much can this image tell about anorexic people's lives and thoughts? Do they just blindly follow their drives to be thinner? Jennifer's case note shows that anorexic people probably have more complex thoughts and inner struggles than the public image of eating disorders would lead us to believe.

Jennifer, a 22 year-old part time college student, is one of my few informants who actually recovered from anorexia nervosa after going through a period of bulimia nervosa and recalls her struggle with eating disorders by saying:

There were a lot of questions behind what I did. I externally felt happy but internally felt very stressed. I didn't want people to think I was not good-looking and hated when someone mentioned I gained weight. But at the same time, I wondered why people were so focused on the body. I had an inner conflict that external appearance was not so important.

Jennifer strongly wished to lose weight; however, it never meant that her heart was filled with joy by losing weight. If we focus on superficial images of eating disorders, we will probably miss seeing such internal conflicts. Here is Jennifer's story of anorexia and her recovery.

When she was close to 17 years old, her anorexic diet was triggered by people's comments about her body. Her father and relatives asked her, "How come you put on weight?"
Have you exercised lately?” Their comments were actually true; she had gained weight because her body had reached puberty and had started getting bigger. Nevertheless, such comments really annoyed her because she neither thought of herself as a fat girl nor did she have a sedentary life—she was an active student who exercised even though she was not very thin.

Having a boyfriend for the first time in her life prompted her to go on an extreme diet. She said, “He did not say I must lose weight, but I really remember he told me that girls should be below 50kg [110 lbs.]. I think part of me started dieting because of him.”

She started exercising and restricted food extremely. After school she ran and swam for hours, and she completely avoided eating fried food. The only food she ate was steamed fish, vegetables, and rice (only two spoons for each meal!). She lost more than 10 Kg (22 lbs.) and in several months her weight reached 42 kg [92 lbs.] with her height at 163cm [5’4”]. Her friends admired her for losing so much weight, but her close friends were worried, although she did not tell anyone about her anorexic diet because she did not think of it as a problem. Her perfectionist and determined characteristics—according to her self-description—kept pushing her until she became 18 years old.

She succeeded in keeping her weight down at the expense of her social life. A shocking and surprising thing for Jennifer was that her boyfriend—who said “girls should be below 50 kg [110 lbs.]”—did not care very much about her weight loss; his friends, in fact, noticed it quicker than he did. He was asked by his friends why Jennifer had lost so much weight, and then he noticed that she looked very different from her old pictures. He finally started to recommend that she eat more; Jennifer, of course, never followed through on this advice.
After entering a university, she injured her leg and needed to stop exercising. She was very depressed about this injury, since she could not lose weight anymore. She started binging on food and was terrified because she was having a difficult time repressing her appetite. Jennifer tried to throw all her food up so as to compensate for her binging, but after not succeeding at purging, she switched to taking laxatives, which did not work either, even though she took more than ten pills a day. She recalls, “It did not help to lose weight. I think I lost water instead.”

Jennifer was seriously distressed; however, she did not want to see a doctor nor did her parents try to have her get clinically treated. Jennifer did not feel like seeing anyone because of her depression, and she felt a continuous hesitation to face the problem. Her parents delayed their decision to have her see mental health specialists because of the stigma attached to mental hospitals. At the end of 1999, her auntie finally pushed her and her parents to see a psychiatrist. She was diagnosed with bulimia nervosa with a previous history of anorexia nervosa. By then, nearly two years had passed since Jennifer first became determined to lose weight.

After seeing a psychiatrist and psychologist for the first time, Jennifer started making tremendous efforts to recover from her illness. She forced herself to break down her bad eating habits and kept reminding herself of her decision that “I want to recover.” Her therapists were helpful, too. Not only did they give Jennifer professional treatments such as prescribing antidepressants and conducting cognitive behavior therapy on her; they also kept telling her that she was strong enough to fight against the disorder. Their attitudes gave a lot of hope to Jennifer who had long struggled with the thought, “I am useless.”
But, unfortunately, her parents and boyfriend seemed not to understand why she had become anorexic in the first place and what she struggled with even though she shared her problem with them. For example, anorexia nervosa appeared as an incomprehensible disease in her father’s eyes. Jennifer explained, “My father was totally against people who were dieting. He thought of my eating disorder as stupid,” although his comments were sometimes helpful. He once told Jennifer, “If you are obese, you need to lose weight, but you are not fat. How come you need to lose weight?” She thought, “Yes. That’s right.”

Her perfectionist and determined personality may have contributed to making her anorexic, but it also seems to have helped her recovery. After one year of treatment and effort, she finally stopped taking anti-depressants, and, in fact, when I interviewed her, she already had been discharged from her regular appointments with her therapists. Jennifer now weighed around 55 Kg [121 lbs] and told me:

I sometimes wish to be below 50kg [110 lbs] but I know it is impossible. So it’s all right. I don’t adorn my body but I like it...clothes sold in the city are lousy since they are too small and make me feel that I should be skinnier...But I think women’s natural shapes are fleshy, not skinny. The most important thing is feeling good about yourself.

Jennifer assumed that many things were related to her disorder, such as others’ comments about her body size—especially her boyfriend’s comment—maybe mass media presentations of thin women, and stress from her studies. Among many of these factors, she felt that her self-control issue had taken a crucial role in her development of anorexia: being fat had meant being lazy and failing to attain her goal; losing weight and keeping it down told her that her life was in control.
Furthermore, when asked if she thought her anorexia was biological, she said:

Genetic effects might be possible. But I cannot change [my genes]. I think situations that people experience and the environment that they live in are more important...You must know your inner-self.

Jennifer seemed to understand that her eating disorder was a struggle with her identity.

From Jennifer’s case note, we can see her strong involvement in the meanings attached to fatness and thinness, as she stated that eating disorders are about self-control since fatness means laziness and thinness means being in control. These meanings are exactly the same as the ones presented in the previous three chapters. Jennifer was a teenager during the decade when obesity became a problem among Singaporean school children and when the societal value of thinness as the ideal female body image became established. By continuously seeing the image of thin women on a daily basis, Jennifer seems to have unconsciously absorbed the symbolic meanings of fatness and thinness into her consciousness. It is not exaggerated to state that, for Jennifer, comments such as “Have you put on weight?” and “Have you exercised lately?” were not exactly about her body but, rather, became a criticism about her inner qualities, mainly that she was being lazy.

While obsessed by her weight, Jennifer continuously questioned whether appearance was truly important and wondered why people were very much concerned with their appearances. The fear of fatness (or the morbid fear of fatness), listed in the DSM-IV as a central feature of anorexic (or bulimic) individuals, only shows one side of Jennifer’s mind, since, in reality, she was pulled at once in two opposite directions - those of “appearance is important” and “appearance is unimportant” – and she became confused about the message to which she should
have listened. Such complex thoughts are not written in the DSM-IV; however, Jennifer’s case note shows that it was one of the hardest struggles that she faced. Jennifer’s motivation for dieting was a matter of what kind of person she wished to be rather than what kind of body type she wanted to have. She shows us the complex mind of an anorexic individual that the DSM-IV is unable to show.

Case Note 2: Wei Chen

Two plates of barbecued meat with chicken, fish, beef, two bowls of rice, two red bean breads, one large tub of ice cream, a half kilogram (1.1 lbs) of biscuits, one large bar of chocolate, two packets of instant noodles, nine pieces of chicken nuggets and two cups of Coke. This was the food Wei Chen consumed all at once. She never realized how much she ate, she just devoured and was angry with and ashamed of herself. “You were not supposed to binge today. Why did you suddenly start doing the opposite thing?” Wei Chen asked herself. “How can I stop binging? I am so fat. I don’t know what I’m doing.”

Wei Chen is a 22-year-old Chinese Singaporean woman who weighs 55kg [121 Lbs.] with the height of 156cm [5’2”]. Her perceived ideal weight is 45 kg, and the BMI score calculated from this perceived ideal weight is 18.5, which is equivalent to the target and control informants’ BMI based on their ideal perceived weight. She tells me that she does not have any problems finding clothing in Singapore but feels less beautiful when she needs to wear M and L sizes. She thinks that since she is short, she should wear the S size.

She has suffered with a restricting type of bulimia nervosa for more than three years and says that her family is the central cause of her eating disorder. She describes her family this way:
I felt no one listened to me since I am the youngest. My [older] sister would use her age to bully me whenever there was an argument. Nobody paid attention to my needs and they treated me and my sister with different standards and this made me hate them. I felt no one loved me. I felt that they disliked me and were very happy to see me miserable. There was no praise, but only punishment and scolding.

Her grandmother, particularly, had treated her badly, and it magnified her distress. She explained:

I grew up in a matriarchal family where my grandmother rules... She is abusing her authority and respect as she ages. Living with her is a misery and intolerable... My grandmother has been very fond of my sister and seemed to find pleasure in scolding me. I am always the second to my sister in everything. I feel I am a piece of worthless garbage at home.

There seem to be many logical reasons to explain her emotional damage at home; however, why did it manifest as an eating disorder and not another mental illness? The answer relates to the importance of food in Singapore society. Wei Chen recalls:

I am by nature a food lover. Eating is a way for me to relieve stress... I only remembered that I was ever praised as a child for finishing up my food. I would eat for comfort and to gain acceptance from my family. This was a very important recognition which I received from them.

However, as she grew, she had gradually learned that finishing her food was not enough to resolve her misery at home since her family always appeared to compare her with her sister based on behaviors other than eating habits. Since she knew that talking with her family would
never make her situation better, she started seeking other ways to show her distress to her family.

When she was 16 years old, she found the way. She explained:

I never knew how to please them and found it hard to obey. Hence I recalled... FOOD, which I thought could be used to show my protest: I starved [myself] to let them know I was unhappy and I was destroying myself to express out all my miseries... I wanted to inflict guilt in them [to let them know] that their unfairness had caused physical damage to me, and [try to show them that] behind the body there was a greater emotional damage.

Food, which was initially a tool to receive recognition from her family, instead became her “weapon.” (Remember, one of my informants felt very sad when her daughter refused eating to get out of the TAF program, since food symbolizes love for her.) Wei Chen started putting her part time job’s salary into slimming pills, swam every day, and took laxatives. After a month and a half, her weight went down to 41kg (89.2 Lbs.), and she felt great about her achievement, but no one prized her slim body, and, most importantly, her family was barely aware of the meaning of her starvation.

After a while, she was attacked by a side effect resulting from her extreme diet. She started craving food and her anorexic diet turned into a bulimic one. At first, she could maintain her slim body by fasting after bingeing, but her cravings for food gradually conquered her will to fast, and she started gaining weight. She thought about seeking treatment, but stigmas and her friends’ criticism of mental hospitals made her feel like she was “crazy.” She gave up considering clinical treatment.
Wei Chen explained her starvation as a protest against her family. However, why did she feel great inside when she slimmed down even though her family did not realize what she meant by her starvation? And why did she try to maintain her thin body even though she failed to let her family know her misery? In order to fully explain her feelings and actions, outside pressures must be considered. She mentioned the strong indirect peer pressure about her body at school. For example, when she entered a girl’s school at the age of 14, she realized that her female classmates always paid attention to their appearances, and she started asking herself, “Should I pay more attention to my body?” Fortunately, she grew taller without gaining weight at that time, so that she looked slimmer. Back then, her friends and relatives complimented her on her slim body, and Wei Chen was happy to hear those comments. She also noticed that she could rarely have a conversation without talking about weight. She said:

Everyone [her female friends] was going on a diet. I thought that it was normal for girls to go through the process of trying to be thinner; girls look better if they are skinner.

Wei Chen had started learning what thinness and fatness meant for girls in her teenage years. In the midst of strong peer pressure, she reached puberty, and she gradually started gaining weight. Her grandmother harshly criticized her body since it had started growing bigger. Even though her grandmother was born in the time when plump women were preferred, she herself was very thin along with her other family members, including Wei Chen’s sister and father. Thus, Wei Chen’s body must have caught her grandmother’s attention. She stared at Wei Chen’s body and said, “Your size is so huge. Your buttocks are getting bigger. You need to watch what you eat.” Wei Chen did not feel fat among her peers, but she could not help feeling fat
among her family members. Wei Chen recalls that she was occasionally jealous of her sister who could easily attain the thin body that she was never able to obtain even with great efforts.

Wei Chen started having great confusion about how she should handle food. While she used food as a weapon against her family, it was also a stress reliever which made her forget about her distress. However, if she gained weight, she felt criticized by a society that idealized the slim body and stigmatized fat. She was still unable to resolve her eating problem and was confused about food when she entered a university in England in 1998.

In England, she became more knowledgeable about eating disorders; however, she was stressed out by cloudy and rainy weather, pressure from her studies, and a lack of emotional support from her family. To relieve stress, she overate food and took laxatives and slimming pills, thereby causing her expenses to rise. Her family told her not to spend money very much and to study hard but did not realize that they were actually a central cause of her spending. Her eating eventually started disturbing her work; she started gaining weight and her bulimic cycle went out of control. She managed to graduate from college by taking anti-depressants.

Her graduation did not change her family at all. In fact, they appear to have given her a harder time than ever. For instance, no family members welcomed her at the airport when she came back after her graduation, and when she got home, no one was there. She says that the very next day was “a mental torture”:

Firstly, I was anticipating comments on my weight and shape, I was praying they said nothing, but my prediction was right. “You’ve put on weight” and “You need to exercise very hard” were some things they said. Secondly, my parents were expecting me to fetch lots of money home. They were urging me to get a job quickly so as to repay the kindness my
relatives gave me while I was abroad. I could hardly breathe hearing these...The whole night they were nagging [about] how much money they spent on me and how I should work like a slave to repay them. I felt no family atmosphere, no love, no warmth, no concern, and no care. They only thought about themselves and what I could do to make their life better. I am just a life-supporting machine they invested [in] for 23 years.

Unable to cope with this atmosphere, Wei Chen consulted her family doctor about her eating problem; he recommended for her to see a psychiatrist, but, after meeting one, she thought this psychiatrist was not helpful at all. When she told her aunt about her bulimia, her aunt was very concerned about her and told her uncle, who did not know about bulimia at all. Wei Chen just got embarrassed. Later, she saw a psychologist, but he was not helpful either. The lack of understanding kept making her feel isolated and depressed.

Hope, however, finally came in February, 2001, when she attended an eating disorders forum in Singapore where she met her current doctor and found that there was a support group for people who have eating disorders. Wei Chen felt understood and taken care of at last after two long years of struggling on her own. She explains her current situation:

I feel that I am participating in my own recovery; there is a dialogue in the treatment. I have the emotional support and encouragement that I never heard from my family...My family tries to interfere with my eating disorder, but I am very disappointed with how little they know. They still think the problem is in me, not them...They suppose that they are always right. I don’t need them to understand. I just want them to leave me alone. I don’t need them.

She says that she still has a hard time dealing with the stigmas attached to gaining weight and feels that it may be difficult to resolve her problems, including her disorder and family issues.
However, she seems on the right track to recovery by having a good support system.

Family issues underlie Wei Chen's bulimia nervosa, and she is different from Jennifer who went through extreme dieting motivated by the meanings attached to thinness and fatness. However, like Jennifer, Wei Chen also is involved in the meanings attached to fatness and thinness when she attempts to solve her family issues by starving herself, and we can see that this involvement clearly inhibits her recovery. Wei Chen's deep involvement in meanings attached to fatness and thinness become clear if we take into account the facts that she felt great inside when she succeeded in losing weight, even though her family did not realize the meanings of her starvation; she feels less beautiful when she wears M or L sizes; and she still does purging behaviors although she already knows that the starvation does not solve her misery at home.

Through talking with her, I had an impression that once she manipulated her eating cycle and attempted to shrink her body size in order to solve her problem at home, it became difficult for her to bring her general eating cycle back even after she realized that this did not make her situation better. And, in the midst of her starvation, she eventually submerged into the cultural meanings attached to thinness and fatness. Bulimia nervosa seems to be an unexpected layer that was put on her family problem and was created in her trying to solve her problem.

Case Note 3: Beth

The next woman is Beth, a 21 year old Chinese-Singaporean college student who suffers with the purging type of bulimia nervosa. Beth seemed to be a little suspicious of me when I first met her, but she gradually started sharing her story with me as we established trust in each other. Her body weight is 52 Kg [114 Lbs] and is 165 cm [5'5''] tall with the BMI score of 19.6.
Although she mentioned that she does not mind maintaining her current weight, as other informants say, her perceived ideal weight is 50 kg [110 lbs], which results in a BMI score of 18.4.

When I was about to close the first interview with Beth, she made a comment that I never will be able to forget; her face appeared to be filled with confusion, anger and pain so much that I lost the words to respond. She said:

[After I started seeing a doctor], my symptoms decreased a lot but I still don't feel like I am really recovering. I feel like giving up. Why am I restricting myself so much from bingeing? Why should I continue this fight? I am not sure how far I can go. I don't know what to do. I want to be normal. I cannot love myself. If I cannot love myself, how can I love others?

She has seen her current doctor now for three months and has taken an anti-depressant that has significantly reduced the frequency of bingeing and purging; her treatment staff is very caring and good at listening to her. However, she is unsure if she is truly recovering. What does it mean that she does not feel that she is recovering from her eating disorder even though her symptoms have decreased? Going back to the beginning of the interview, I will depict the history of her eating disorder in order to look for the answer to this question.

"Fat girl." That was what her father called Beth when she was in elementary school. Beth was hurt so much that she asked her older sister for emotional help. Her sister answered, "What is so bad about calling you 'fat girl'?" When she was in secondary school, her friend called her "elastic" to imply that her body was flabby. Another female friend teased Beth, saying in front of others, "She has so much fat in her stomach!"
Beth was embarrassed each time but never defended herself:

I just smile and treat what they say as a joke. I don't want to impose my view points on others. It is normal for people to talk about someone's body. It's just a joke.

Although she was unsure if those experiences were directly related to her eating disorder, she said that they certainly affected her body image.

In 1999, Beth, a 19-year-old college student at the time of the interview who majors in engineering, was enjoying three months of school holiday. During this vacation, an idea came across her mind—her friends were very active while Beth was being lazy and sleeping a lot. She thought, "If I continue it [this life style], I may get fat." This thought drove her to an anorexic diet—exercising excessively and severely restricting food.

When Memorial Year 2000 came full of welcoming ceremonies all over the world, her extreme diet became worse. Beth's mind was occupied with losing weight, and she was terrified to discontinue her excessive dieting because she believed, "If I stop dieting, I cannot lose weight and will get fat instead."

Her extreme dieting caught her parents' attention, since they were worried that Beth may have anorexia nervosa; however, their concern did not last for long because Beth started eating normally. They were happy to see her recovery from an anorexic diet and did not realize what Beth was actually doing. Beth actually changed her way of dieting into bingeing and purging in order to fulfill her desire to eat. She recalls, "My mother cooked a lot and these dishes were too tempting." Thus, we see the importance of food in Singaporean society again, as seen in Wei Chen's case. Behind her parents' relief, her binge/purge cycle had gone from bad to worse.
and got out of control. Beth decided to seek clinical treatment in a general hospital rather than a mental one to which strong stigmas were attached.

Beth has suffered with others’ blindness about eating disorders just as Wei Chen has struggled. Beth says:

Most people only know anorexia. In fact, most of my friends don’t understand what bulimia means. Nobody understands eating disorders. My friends don’t see the need for the treatment and told me, ‘If you want, you can make it.’ They recommended me that I eat regularly and eat normal foods. But if I can do that, I would not have an eating disorder!

Her voice rises and its tone implies how hard her struggle has been and how much she has been hurt by the lack of understanding from others. It sounded like that she does not need the taken-for-granted advice from her friends that she has already known for so long.

Beth actually has a lot of questions about a society that emphasizes thinness and disagrees with the extreme preference for thinness in Singapore. However, the strong peer pressure on body size always disturbs her whenever she tries to overcome her high bodily consciousness. She explains:

People are comparing [themselves] with others. On campus, both men and women are watching others’ appearances and commenting on girls’ bodies. I think women do more than men do. Girls complain of their weight even if they are not overweight. Guys talk about girls’ bodies. My guy friends asked me, ‘Why do you introduce those girls [to us]? They are not pretty.’ I am pissed off by those comments... I used to question myself before I binged and purged. ‘Do I really need that? Am I trying to satisfy other people’s needs?’ But I am paranoid about guys’ comments on girls’ bodies. It stimulates me to purge.
She also mentions the influence of mass media and clothing sizes sold in Singapore on her body image:

What is acceptable to boys and girls comes from mass media... It [body images in mass media] affects my view point of what is normal and average. It has changed all the time and ‘normal’ is getting thinner and thinner. You need to be skinny to be normal. BMI 20-22 is not legitimized in Asia.¹ It is the Western standard. 50kg is the margin of normal and overweight for girls in Asia. This is the benchmark... Clothing sizes also affect my body image. If I cannot fit into them, I feel that I am told, ‘you are not normal.’

Beth seems to be confused with the two contradictory societal messages I have mentioned: “appearance is important” and “appearance is unimportant.” She acknowledges that slimness cannot be a measure of her happiness in life, since, even though her body weight is in a “normal” range, her bulimia took her social life away and made her less cheerful and more depressed. Furthermore, she wishes to be like her friend who is heavier than Beth but accepts herself as she is. On the other hand, she also hears the criticisms against fatness on a daily basis and knows “appearance does count a lot in society.”

Restating the question that I suggested at the beginning of this case note, “why does she not feel like she is recovering from her bulimia even though her symptoms have decreased a lot? The answer seems to be that she is bound by a societal double standard that tells her to accept

¹ BMI 20-22 is actually considered “normal” for Asians in terms of medical science. I had an impression that she was trying to explain what body type is acceptable in Singaporean society.
herself as she is but also to conform to the set standard of ideal beauty at the same time. For her, a true recovery probably means to discover the way to create a compromise within this paradox.

Beth’s path to bulimia nervosa is unclear. It just seemed to happen from a thought that struck her during her vacation. Nevertheless, like the previous two informants, she also is involved with the meanings attached to fatness and thinness, although, differently from Jennifer and Wei Chen. Beth associates thinness with “normal” and fatness with “abnormal.” However, her case note shows that these associations are not created by Beth’s “abnormal” psychology but rather rooted in Singaporean sociocultural contexts. Considering her comments, such as “What is acceptable for guys and girls is shown in the mass media” and “Am I trying to satisfy other people’s needs [by staying slim]?” as well as Beth’s BMI of 18.4 based on her perceived ideal body weight, we see that Beth connects staying slim with gaining acceptance from others; in other words, she sees acceptance from others in the BMI 18.5 body, since this body embodies desirable inner qualities for a Singaporean.

Moreover, Beth is also bounded by the contradictory social messages of “appearance is important” and “appearance is unimportant,” with which Jennifer struggled, as well. When Beth took the first message seriously, she seemed to be crushed against its opposite. Beth’s case note tells us that it may be ineffective to say “appearance is unimportant” to those with eating disorders, since they know such a thing already and are confused by a society where “appearance does count a lot” while telling women to accept themselves as they are.
Case Note 4: Liou

Liou is a 20-year-old Chinese Singaporean college student who studies politics and economics in England and was spending her summer break in Singapore when I interviewed her. Her case is a little different from previous case notes. She was introduced to me by a friend, and I initially intended to interview her as a woman who did not suffer from eating disorders. However, I later found out that she had gone through a very strict period of dieting in 1993 when she was 13-years-old. If she were to be seen by a clinician now with the symptoms she had at that time, she would very likely have been diagnosed as having anorexia nervosa. Her story made me think that the people who I interviewed at the IMH must only be the tip of the iceberg of the prevalence of eating disorders in Singapore.

Liou realized, "I was not doing well in my life," when she was 13 years old. She decided to change her life and started dieting. She does not know why dieting struck her as a way of changing her life, but she remembers that she had a strong image of being thin as "a way of doing well" and as "one of the successful life styles." This is not an unrealistic thought, if we consider how much Liou had been hurt by having a big body during primary school. What she tried to do was eliminate a perceived cause of her suffering. Her logic was simple but made sense.

Liou had matured early, weighed 62 Kg [136.4 lbs.], and was 156 cm [5' 2''] tall by the fourth grade. She disliked this reality because she was bigger and taller than her friends, including boys. Furthermore, she was categorized as 30% overweight by the height and weight chart for Singaporean children; this was another hard reality for her. Not only did she perceive her body as "big" but also she was given the objective label of "fat" by school officials.
When she was in the sixth grade, a male friend called her “fat” in Chinese everyday. She hated this nick-name and was embarrassed with it all the time, but she never defended herself; she thought, “It is true.” Liou remembers the big argument that she had with her mother that same year. Liou’s mother got really angry with her and said, “Even if you went somewhere to advertise yourself for a husband, nobody will marry you because of the way you look.” Although Liou understood that this was not what her mother truly thought, she was very deeply hurt.

Liou started an extreme diet to change her life when she entered secondary school; she gave herself very strict exercise schedules and menus. She swam everyday for about three hours after school while she was taking slimming pills. Her only proper meal was breakfast. She spent her whole lunch hour studying, and stayed away from home during dinner times so as not to eat a full dinner; she would tell her family that she had already eaten dinner outside with her friends.

She strove to weigh 40 Kg [88lbs.]. Liou says, “A teenage magazine was a guide book for me. I picked out a model from it who was as tall as I was [165 cm = 5’ 4”] and tried to achieve her weight [40 Kg].” Since Liou had a very severe eye on her weight, she needed to weigh herself a few times a day, such as after going the bathroom, after going up stairs, and after meals to make sure she had not gained weight.

Her exertion was rewarded within a year. She lost 20 Kg [44 Lbs.] and weighed only 42 Kg [92.4 lbs.]. Additionally, her grades in this year became very good because she was studying instead of eating, and she also was glad that she did not need to participate in the TAF program. Surprisingly, no one realized that all of this was a result of her anorexic diet. Liou kept disguising her intentional weight loss as occurring naturally because she did not want
anyone to think “she has a problem”; she went out as much as possible, especially during meal
times; when there were family gatherings, she ate normally.

Liou had been able to deceive people around her but not her body. Her body had been
overwhelmed by her extreme diet, and finally it failed when Liou succeeded losing 20 Kg [44
Lbs.]; her body pled with her to discontinue this excessive diet by giving her a very severe
gastric attack. It was so painful that she could hardly move. Her secret came to light at last. All
adults around her immediately knew about this incident. Her doctor was shocked by the amount
of weight that she had lost in a year. Her teachers and even her swimming instructor started
worrying about her. It was an embarrassing experience because Liou felt that people started
seeing her as a student who had a problem.

Liou started eating more afterwards because she did not want to have the same gastric
attack; she knew that it would be too hard to stand. She gradually recovered her weight
throughout the rest of her secondary school years and her life in junior college. In junior college,
she had a boyfriend who was never concerned with her body image and told her, “I like you as
you are.” His comment subdued her extreme bodily consciousness.

Liou is neither obsessed with her body image nor follows an excessive diet anymore,
but it does not mean that she is completely stress free about her body image. There is an indirect
peer pressure that she often feels. She explains:

My relatives and my family say, ‘You are tall’ but never say, ‘You are fat.’
I feel that it is another way of saying, ‘You are fat.’ I know that they try to
be nice to me. My family and relatives are good people...My friends
never say, ‘You are fat’ but say, ‘You are okay.’ But I heard that they
mentioned others’ bodies [that were not much different from her body] as
‘fat.’ So, I indirectly feel that others think of me as ‘fat’... I am not teased directly but feel a pressure because all of my friends are thin.

Liou always wears long-sleeve shirts even under bright sunshine in Singapore to hide her arms, which she feels are “flabby” and “big.” Liou is now 165 cm [5'5"] tall and weighs 57 Kg [125.4 lbs.]. With this body size, it is difficult for her to find clothes in Singapore that she can fit into. When she perceives this fact, she feels like losing weight (her ideal is 50 Kg [110 lbs.]). If she were slimmer than she is now, it would be much easier for her to wear many types of clothes, although she does not think that she will actually go on a diet. Liou already learned how hard it is to lose an immense amount of weight and knows the suffering it can cause.

Liou’s desire to change her life underlay her anorexic dieting, and we can see her strong involvement in the meanings attached to thinness and fatness, as she says that thinness meant success for her. Her bitter experiences at elementary school including being labeled as an overweight student and teasing experiences on a daily basis were important events to her and help us understand why she believed that if she lost weight, her life would change. In fact, after she lost weight, her life was changed; she diligently studied, her grades improved, and she was not targeted by the TAF program because of her disciplined dieting schedule; however, she lost her health as a result of her extreme dieting.

She now has recovered from her anorexic condition. However, when we consider that she always wears long-sleeved shirts to hide her “flabby” arms, it would be difficult for us to state that she accepts herself as she is. From this behavior, we can assume that, although we do not know whether she would have suffered from clinical anorexia nervosa, her recovery from her
eating disorder may not necessarily indicate that those with eating disorders completely accept themselves as they are but, rather, find ways to balance between the contradictory messages of “appearance is important” and “appearance is unimportant.”

Case Note 5: Ai-Ling

Ai-Ling is a 21 year-old Chinese Malay who works as a pharmacist. When I first met her, she was so depressed that she did not want me to stay at her consultation with Dr. Lee. However, from her second visit onward, she allowed me to interview her and be present at her clinical consultations. Ai-Ling is 164 cm [5'4''] tall and weighs 53 Kg [116 lbs.] and has suffered from a purging type of bulimia nervosa for five years. Her ideal perceived weight is 47 kg, based on which, the BMI score is almost 17.5, equal with that of Christy Chung.

Ai-Ling often described herself as quiet. I met Ai-Ling several times during my fieldwork and agreed with her opinion. Whenever I asked questions to her, she paused for a while and slowly answered my questions with carefully-chosen words; her answers were always short and concise. Her gentle way of answering and her use of words were strong enough to catch my attention and impress me. But, for Ai-Ling, this is a source for trouble and a seed for her bulimia. She says, “I am quiet in nature. I don’t talk a lot and speak out. So, if I am not attractive, no one [will] realize me and see me.”

Ai-Ling has tried to compensate for her quietness by being attractive and believed that thinness is deeply linked to beauty before she actually commenced bulimic behaviors. For example, she remembered that her male friend told her that thin women looked more attractive. Her father’s relatives complimented her on the beauty of her appearance; she felt happier and
wished to maintain a body that was slim enough to be beautiful. Her best friend was highly bodily conscious even though she was skinnier than Ai-Ling. Ai-Ling gradually learned that to be attractive, being slim was necessary.

When she was 16 years old, she watched a TV show called “Models, Inc.” It introduced a fashion model who used bingeing and purging as a way to maintain her slim body. Ai-Ling thought of the actress as being very attractive and decided to start bingeing and purging to fulfill her desire to be like her. This was when her bulimia was triggered.

It has been five years since she first saw “Models Inc.” Her trials did not bring an attractive body but did bring an uncontrollable appetite and the heaviest weight that she has ever been, 53kg [116 lbs.]. “You’ve put on weight, haven’t you?” her family pointed out — all except her mother, who knows her problem. It was a tormenting experience for Ai-Ling, who binged and purged to be attractive. Such a comment was almost the same as being told, “You are not attractive enough.”

Ai-Ling feels threatened and guilty with the amount of food that she binges on; her current weight makes her feel fat and big; she is deeply depressed and often has suicidal thoughts. Ai-Ling has endeavored to correct her eating cycle in several ways over the last five years, but her efforts have not worked well. When she went to England to seek her degree in pharmacy, she saw a therapist. However, Ai-Ling did not feel comfortable with him because of the cultural differences between them. When she sought treatment in Malaysia after graduation, her doctor did not know much about eating disorders and asked her a lot of questions out of curiosity. This made her feel that she was a strange person who had “awkward” habits. Reading a lot of books
about eating disorders helped her become very knowledgeable about the issue, but this knowledge did not cure her bulimia.

Her cultural setting adds another difficulty to her struggle with bulimia. Ai-Ling says:

People in Malaysia look down on those who have eating disorders. People think eating disorders are vain—wanting to be attractive...In Malaysia, there are three ethnicities, Malay, Chinese and Indian, and Chinese are the thinnest. All of my Chinese friends are thin and I want to be the same...there is an ideal that girls should be under 50 Kg [110 lbs.]. So when my friends ask about my weight, I tell them, 'I weigh 49 Kg [107.8 lbs.] and don't say my true weight [53 Kg = 116 lbs.].

For Ai-Ling, who already thinks of her eating habits as “shameful” and “not normal,” this environment is probably too difficult to enable her to disclose her problem and to restore her bodily esteem.

There is another reason why Ai-Ling hesitates to show her pain to others; she believes that she will make others unhappy if she expresses her inner feelings. She explains:

Showing my negative feelings means showing my weaknesses and bad points. People expect you to be happy with ‘who you are’ and ‘what you look like.’ If I show my unhappiness, I feel like I have no self-control. I sometimes want to explain my pain, but I am still the same; I have no self-control in my eating habits.

She seems to blame herself by thinking that she does not have a right to show her distress on the outside because it is her own fault that she cannot accept herself as she is.

Although the lack of understanding from others, her slim Chinese friends, and the cultural emphasis on thinness keep hindering her recovery, it is fortunate that Ai-Ling’s boyfriend,
who lives in Singapore, has been very supportive in her battle against bulimia. He tries to
remind her that "appearance does not show your inner qualities." He also comes to the IMH with
her and has had his own consultation with Dr. Lee about how to help her. Ai-Ling also
appreciates Dr. Lee, who is very understanding and knowledgeable about eating disorders. Even
though she needs to take a night train in order to travel down from Kuala Lumpur to Singapore
where the IMH is located, this trip seems worthwhile for her.

In September, 2001, I attended a meeting held by the Eating Disorders Support Group
where I last saw Ai-Ling. When the meeting was finished, she and her boyfriend came over to
me. Without saying anything, Ai-Ling shook my hand with her both hands and smiled at me.
Through listening her story and getting to know her, it was impossible for me to think of her as
"vain." I could not help feeling resentment towards this public belief about eating disorders that
has kept harming her.

Ai-Ling's underlying problem is her quietness, and her story shows that losing weight is
her tool to be attractive, and being attractive is also her tool to compensate for her quietness.
From her ideal body weight of 49 kg [118 lbs] and the BMI 17.5 based on this weight, we can see
that, like other informants, Ai-Ling also is involved in the meanings attached to thinness. Ai-
Ling sees her ideal attractiveness in a Christy Chung-like body type, which is not associated with
the image of those who injure their health by losing weight; rather, it is an image that symbolizes
intelligence, discipline, and diligence. Ai-Ling also is bounded by those contradictory messages
"appearance is important" and "appearance is unimportant"; however, as she states, such an inner
conflict seems to be unknown to the public, which instead sees those with such conditions as
"vain." As she states, she recognized that public image and hesitated sharing her problems with
others. Ai-Ling's case note seems to tell us that the lack of understanding that she suffers from will not be solved unless those without eating disorders know about inner struggles such as these that are unlisted in the DSM-IV.

The Origin of Fear and Guilt: The Involvement in the Meanings Attached to Fatness

These five informants have different underlying problems inside and took different paths to their development of eating disorders. However, what is consistent among them is their serious involvement in the meanings attached to fatness and thinness. For four out of the five informants, being thin is not their ultimate purpose; instead, becoming and remaining thin is their tool to embody the symbolic meanings that they attach to thinness. For Jennifer, thinness symbolizes being in control; for Beth, it is linked to being normal and accepted by others; for Liou, it is a way to change her life; for Ai-Ling, it means being attractive and is a way to compensate for her quietness. Although Wei Chen starved herself to solve her family problems, rather than to embody the meanings attached to fatness and thinness, her purging behaviors are motivated by the fact that she dislikes associating herself with "bad words" connected with fatness, such as stupidity and ugliness. These associations are all linked to the meanings attached to thinness and fatness that I have discussed in the previous three chapters: thinness symbolizes diligence, intelligence, and discipline, which are desirable qualities for Singaporeans; fatness is a symbol of ugliness, laziness, and stupidity. For Singaporeans who entirely internalize these meanings, losing weight becomes more than an act of changing body size; it becomes an endeavor to carve their identities in a socially desirable matter. Gaining weight then becomes a process of dehumanizing themselves.
When individuals take such meanings seriously, being fat certainly would provoke fear, since it implies the possession of undesirable qualities to Singaporeans. Moreover, as Chapter Six shows, Singaporean mass media implies that those who are intelligent, diligent, and disciplined are able to lose weight without ruining their health. Destroying one's health while losing weight likely would provoke guilt, since fatness is considered the fault of the individual. The norm "appearance is unimportant" would complicate these individuals' problems and enlarge their feelings of guilt, since this idea implies that those who are concerned with their appearance are superficial human beings.

I, thus, claim that, while the target and control informants share a similar mindset about gaining and losing weight, the target informants are more involved in the meanings attached to fatness and thinness to the extent that they experience fear and guilt. I believe that this is a crucial perspective to help understand their fear and guilt, although I do not think that such sociocultural factors alone explain their fear and guilt, since feelings are generated by the interaction of biological, psychological, and sociocultural factor. Here I focus on cultural factors of their feelings. I also cannot answer why only the target informants are more involved in the meanings of fatness and thinness than the control group, since this question leads me to specify the multiple causes of eating disorders that have remained undefined, and I am not qualified to define them.

However, I emphasize that all five informants, as well as the rest of the target informants, never explained that their eating disorders were a result of either their own psychological or biological abnormality; in their accounts, cultural meanings attached to both fatness and thinness play a central role in their disorders and loomed large in their recovery.
From a Western psychiatric point of view, such cultural meanings are edged out from the etiology of eating disorders; however, in the insiders' perspectives, they become central. There is a significant gap between medical knowledge of eating disorders and insiders' knowledge. Assuming that this gap may contribute to creating the lack of understanding from others that the target informants greatly struggle with, in the conclusion of this thesis, I will suggest a way to reduce this lack of understanding.
Towards an Increased Understanding

This thesis has analyzed the fear and guilt towards losing weight from which patients with eating disorders suffer so as to identify a way to reduce the lack of understanding from others with which the target informants clearly struggle. As a conclusion of this thesis, I claim that this lack of understanding is an additional pain that the target informants do not need to experience, and I will suggest two ways to increase empathy from people who do not have eating disorders. First, current medical science should include culture as a possible "true" cause, rather than merely a trigger, of eating disorders. My research shows that from the target informants' perspectives, cultural meanings attached to fatness and thinness play a crucial role in their development of, as well as their recovery from, eating disorders; however, since the informants' descriptions of their disorders include discussions of culture, their points of view are regarded as illegitimate, unreal, or pathological by a medical science that excludes culture from the etiology of eating disorders. By discounting the target informants' perspectives as unreal, medical science may justify indirectly other people's lack of understanding; because people with eating disorders perceive their reality "abnormally," according to medical science, "normal" individuals without these conditions naturally would not and should not be able to understand them.

My research shows that the target informants are much more "normal" than they are described in medical texts. As I presented in the preceding chapters, they perceive issues evolving from weight and body size in strikingly similar ways to the control informants. Further, the target informants' perspectives are made reasonable by examining them through the theories of interpretive anthropology and the body politic. By presenting the target informants' points of view in a collective manner, rather than seeing them as pathological, their perspectives become a form of knowledge that can explain the function of their culture and society in their eating disorders. However, such standpoints have not been highlighted in the study of eating disorders,
since current medical science often sees significance in discovering and presenting how those with eating disorders are different from “normal” individuals. I am not denying the importance of discovering the differences between those with and those without eating disorders so that doctors can specify factors that should be treated and conduct effective treatments on their patients; however, only focusing on differences would abnormalize those with eating disorders more than necessary.

As I clarified in Chapter Three, it is not necessary for all individuals to develop eating disorders in order to justify the inclusion of culture in the etiology of eating disorders, since culture exists by transcending individuals’ minds. No one has discovered why some individuals internalize the preference for thinness more strongly than others. It might be biological or psychological; there may be other sociocultural reasons; or there may be an interaction among all these factors. At this point, no discipline, including medical science, has a right to determine where exactly this individuality comes from. I claim that at least until a miracle treatment that cures eating disorders is created, medical science should be relativistic about the causes of eating disorders without excluding culture. By excluding culture from the etiology of eating disorders, medical science is restricting its understanding of and shifting blame for these phenomena. This would be like it claiming that the health of some Victorian corseted women was injured not because of the corsets themselves but because the women’s bodies could not tolerate the restriction of corseting. Blame would fall on the women rather than on the troubling culture of corseting.

There will be individuals with eating disorders who explain that their conditions have nothing to do with culture. I claim that this group should be considered within a sub-type of eating disorders that is different from the first group where culture takes a crucial role in their conditions. Including culture in the etiology of eating disorders does not increase the vagueness of the concept of eating disorders, but rather clarifies the concept by highlighting the specific
cultural power that affects human bodies, especially those of adolescent girls. It would be impossible for someone to understand the target informants’ struggle completely; however, including culture in the etiology of eating disorders provides the common ground between those with and those without eating disorders through which both groups can understand each other.

Secondly, I suggest that those without eating disorders question whether they truly accept themselves as they are without being influenced by their culture at all. If they contemplate everyday choices related to their appearances, such as why they wear formal attire to their important job interviews, why they wear make-up or do not, and how they feel when they lose weight or gain weight, they would know that it is very unlikely for individuals—regardless of whether they have eating disorders or not—to accept themselves as they are without being influenced by their culture. People with eating disorders who acknowledge the role of culture in the development of their condition are not the ones who are blindly obsessed with their appearances, but they are the ones who face the reality that expects them to accept themselves as they are while stigmatizing fatness and glamorizing the benefits of being slim. To increase their understanding, those without eating disorders should, instead of asserting how unimportant appearance is, consider how they are influenced by appearance. They can then consider how they strike a balance between the two contradictory norms of “appearance is important” and “appearances is unimportant.”

Before closing this thesis, I also have three recommendations, based on the findings of this research. First, Singaporean clothing sizes must be made bigger than they are now. In Singapore, clothing stores have become the sphere where many Singaporean women wish to shrink their body sizes, rather than enjoy themselves. This is not because the women are overweight but because these clothing are unrealistically small, as seen in Liou. She is 165cm [5’5”] tall with the weight of 57kg [125.4lbs.] and has difficulty finding clothing. I recommend
that apparel companies in Singapore shift their sizing scale, for example transferring size small to size medium. Clothing sizes should serve Singaporean women’s body sizes, not the reverse.

Secondly, the administrators of the TAF programs should consider that, by labeling students as overweight, they risk causing the participants in this program to dehumanize themselves through their association with the stigmas attached to fatness. I recommend that the selection of the students should not only be based on weight but should include other factors, such as their physical activeness. Also, all of the instructors should make the purpose of this program very clear to all the participants and should not use the stigmas attached to fatness in order to encourage students to lose weight, such as, “You will be very pretty if you lose all that weight,” as Lisa was told by her instructor. Such a comment may encourage the participants to lose weight; however, making these students feel ugly about themselves deviates from the purpose of the TAF, and accelerate their internalization of the stigmas attached to fatness.

Appearance pan-culturally takes an important role in human lives, as it symbolizes various human qualities such as occupations, beliefs, and social-status; thus, both the administrators and instructors of the TAF should recognize that Singaporean youth live in a society where they cannot accept themselves as they are, even though they may want to.

Thirdly, I recommend that medical professionals consider how the dieting industry in Singapore uses medical science to justify its products. Since “being healthy” is a common sales gimmick in Singapore, dieting industries advertise their products by representing medically healthy women who have BMI scores around 18.5, rather than glamorizing unhealthily emaciated women. Their sales strategy seems to have already influenced Singaporean young women’s ideal perceived body image. As seen in Chapter Six, both the target and control informants have an ideal body image that is medically legitimized, by having the BMI score of 18.5. However, according to my research, 11 target informants who already have a healthy weight need to lose more than six kilograms (12.4 lbs.) to attain this body image. “Being
"medically healthy" should include both physiological and psychological health; I thus doubt whether the BMI 18.5 is an appropriate threshold for being medically underweight. The risks of obesity and underweight should be of equal concern.

Throughout this thesis, I have endeavored to present eating disorders from sufferers' perspectives by bringing their voices to the forefront, and, as I have shown in the last chapter, each of the target informants often have an "underneath problem." These problems are diverse, such as questioning their existences, searching for their places of belonging, and pursuing love that appeared to be disconnected from their "odd" drives for thinness and their enormous appetites. Through listening to their struggles, I started to have the impression that eating disorders are mere manifestations of such problems that are probably shared by innumerable human beings. The majority of people do not suffer with eating disorders when they deal with such problems, but my informants do. In my eyes, their lust for being thin is just a tool to be attractive; their desire to be attractive is also a device to solve their "underneath" problems. By being thin, they try to repair their relationships with the rest of a world that has become dysfunctional.

This thesis cannot offer a way for individuals to recover from eating disorders, since I am not qualified to make claims about such cures, and I also believe that individuals take different paths in overcoming their conditions; however, I hope that this thesis at least succeeded in reducing the target informants' inner pain resulting from the lack of understanding from others by presenting a different face of eating disorders that has been, until now, under-represented.
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APPENDICES
Appendices

Appendix A: Questionnaire to the Informants with Eating Disorders

Interview No. ( )
Date ___
Place ___

Patients Background
Age _____
Ethnicity _____
Gender _____
Religion _____
Occupation _____

Height ( ) I.H. ( )
Weight: ( ) I.W. ( )
BMI:

1. Could you describe to me how you have developed an eating disorders?
2. Could you tell me how do you feel when you eat?
3. Have you ever been teased about your body?
4. How did you react? Did you actually defend yourself?
5. Do you like your body?
6. Could you tell me what kind of body type you prefer to have?
7. Do you think other people understand your problem?
8. Have the women on magazines and in TV affected your body image?
9. Can you think of some actress or singers who you think of as beautiful women?
10. What do you think of clothes sold in the city?
11. Can you think of any Singapore or Chinese cultures that affect your body image?
12. Could you tell me how your doctor helps you?
Appendix B: Questionnaire to the Control Group

Interview to the women ( )
Date:
Location:

1. Age ( ) Occupation ( )
   Ethnicity ( )
   Religion ( )
   Weight ( ) Height ( )
   Ideal W. ( ) Ideal H. ( )

2. Do you like your body?

3. If so, could you describe how you like it? If not, could you tell me why you dislike your body?

4. Could you tell me if you have an ideal body type?

5. What do you think about the bodies of women on TV, in magazines and movies?

6. Do you think you want to be like them?

7. What do you think about the clothes sold in the city?

8. Has someone ever teased you about your body?

9. Are there any cultural values attached to the body in your culture?

10. Do you know the TAF program?
Appendix C: Questionnaire to the Medical Professionals

Date
Location.

Age: Ethnicity: Occupation:

1. Could you tell me the nature of your work?

2. What have you perceived about eating disorders in Singapore so far?

3. Is that following the western style?

4. Do you think people have just started being aware of anorexia and bulimia recently, or you think of these as modern diseases?

5. What do you think of the fact that many people blame society as a cause of eating disorders?

6. Do you think Westernization has affected the increase of eating disorders in Asian?

7. Is the way to treat eating disorders following the Western style?

8. Are there any ways of treatment, which differ from Western way?

9. Are there any particular Singaporean cultural norms, which influence your patients?

10. What have you found to be effective treatments for eating disorders in Singapore?
Appendix D: Informed Consents

Informed Consent Form for the Patients with Eating Disorders

The research project, “Eating Disorders in Singapore” will be conducted by Maho Isono, a MA student at the Department of Anthropology at Oregon State University. The purpose of this research project is to understand in what way a support group for eating disorders can be effective to prevent and treat eating disorders.

I understand that as a participant in this project, the following procedure will be taken; I will consent to being interviewed by Maho Isono and will sign on the consent form signifying that I consent to be part of the study with a forty minutes. Next, I will be asked about my body image, eating disorders and the messages related to my body from my peer and family, and the influence of the mass media on my body image. I understand that I will be asked sensitive questions related to my private life, but I can refuse to answer these questions anytime.

I voluntary participate in this project and understand that I am able to refuse to participate of this research without no penalty or loss of benefits to which I am entitled and have a right to terminate interviews whenever I want. Any information obtained in connection with this project that can be identified with me will be kept confidential. Neither my name nor any information from which I might be identified will be used anywhere beyond this research. I understand that a pseudonym will need to use to protect my identity.

I am able to contact of Maho Isono: maho_isono@hotmail.com/275-2585<c/o Pauline Anthony> or Dr. Lee Ee Lian or Maho’s major professor at OSU, Nancy Rosenberger: Nrosenberger@orst.edu, or her internship organization Association for Woman Action and Research: aware@pacific.net.sg/779-7137for answers of my questions about this project.

Print Name _______________________

Date _______________________

Signature ______________________
Informed Consent Form for the Medical Professionals

The research project, “Eating Disorders in Asia” will be conducted by Maho Isono, a MA student at the Department of Anthropology at Oregon State University. The purpose of this research project is to understand in what way a support group for eating disorders can be effective to prevent and treat eating disorders.

I understand that as a participant in this project, the following procedure will be taken; I will consent to being interviewed by Maho Isono and will sign on the consent form signifying that I consent to be part of the study with a forty minutes. Next, I will be asked about my perception of eating disorders, the effective treatments for those diseases, the current preference of thinness and the influence of the mass media, the family and the peer on the patients’ body image.

I voluntary participate in this project and understand that I am able to refuse to participate of this research without no penalty or loss of benefits to which I am entitled and have a right to terminate interviews whenever I want. Any information obtained in connection with this project that can be identified with me will be kept confidential. Neither my name nor any information from which I might be identified will be used anywhere beyond this research. I understand that a pseudonym will need to use to protect my identity.

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Print Name _______________________

Date _______________________

Signature _______________________
Informed Consent Form to the Control Group

The research project, "Eating Disorders in Asia" will be conducted by Maho Isono, a MA student at the Department of Anthropology at Oregon State University. The purpose of this research project is to understand in what way a support group for eating disorders can be effective to prevent and treat eating disorders.

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Print Name ______________________

Date ______________________

Signature ______________________