Five Cases of Male Eating Disorders in Central China

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ABSTRACT
Objective: Despite the recent surge of eating disorders among women in large Asian cities, male eating disorder cases remain rare. The current article described 5 male eating disorder cases that presented within a period of 2 years in Wuhan, a city in central China.
Methods: The authors described 4 cases of anorexia nervosa (2 restrictive, 2 bulimic) and 1 case of normal weight bulimia nervosa.
Results: Fear of fat was reported for all 5 cases, and none of the cases reported homosexuality.
Discussion: Socio cultural changes and westernization most probably accounted for the increasing incidence of eating disorders among male and female youngsters in China today.
Keywords: males; eating disorders; China; fear of fat

Introduction

Anorexia nervosa (AN) and bulimia nervosa (BN) have recently become more common in high income Asian societies, as well as in major cities in lower income Asian countries (Lee & Katzman, 2002). However, to the best of our knowledge, there has been no published report of male AN or BN cases from Asian. We report 5 male cases of eating disorders from central China that presented to Wuhan Mental Health Center (WMHC) between 1988 and 2000.

Case Reports

WMHC, the university psychiatric teaching hospital of Tongji Medical College in Wuhan, China, has more than 500 psychiatric inpatient beds and several specialized outpatient clinics including a psychotherapy clinic where patients with eating disorders are treated. WMHC is a private tertiary psychiatric care hospital and several of its faculty members have been trained in Germany, Australia, and the United States.

Wuhan, the provincial capital of Hubei Province situated near the Yangtze Gorges, is one of the largest cities in China (population: 8.5 million). Its gross domestic product has grown at an average rate of approximately 12% in the past few years. Wuhan is expected to become one of 10 mega cities in Asia by the year 2020.

Case 1: Restrictive AN

A, a 15-year-old high school student, had dieted and exercised excessively for 6 months and lost 12kg to reach, on presentation, 46kg (height 1.7m, body mass index [BMI]=15.9 kg/m^2). He described a fear of fatness stating that he did not want to eat because food "can make you fat and you would look awful if you are fat." A was born in a village near Shanghai to parents who were farmers. Soon after his birth, his parents started their own trading business. Because of their constant traveling, A was brought up by his maternal grandmother. When A was 5 years old, his mother was drowned while traveling on business. The maternal relatives believed that A's mother was pushed into the river by the father and A somewhat believed that also. At 13, he returned to live with his father and stepmother and their newborn baby, and tension rapidly mounted. He became withdrawn and moody and began to diet. Treatment including several hospitalizations were unsuccessful and eventually the parents brought A to WMHC, which had become famous as a center for the treatment of eating disorders.

On admission, A was given nortriptyline for depression, and nutritional treatment and individual psychotherapy (conducted by JT) were implemented. He was open and insightful and able to describe his loneliness and lack of belonging in his "reconstituted" family. He did not want to believe that his father murdered his mother but had never been able to talk about it openly. He recognized that his illness had brought the family much closer together. Family therapy was conducted to help A confront his father. The father, although shocked, was able to describe in detail the events surrounding the mother's drowning and his own grief over her death. A gained 3kg in 6 weeks and his mood and eating behavior improved. Follow-up in November 2002 by telephone found him to be at normal weight and studying at a prestigious university in Shanghai.

Case 2: AN-Bulimic Subtype

B, a 20-year-old high school drop-out, presented at WMHC with a 6-month history of a 12-kg weight loss, bulimia and self-induced vomiting, weight 45kg, height 167 cm, and BMI 16.1$kg/m^{2.}$

In the fall of 1998, he began having difficulty in falling asleep, frequent wakefulness, dizziness, poor concentration, and depressed mood. He became self-conscious and withdrawn. He dropped out of high school and spent most of his time with his mother who had just retired because of "poor health". In early 2001, he was prescribed antidepressants (most likely Paxil; Glaxo Smith Kline, USA) by a psychiatrist but he felt no improvement and discontinued its use. In September 2001, B began binge eating up to several times a day and would vomit afterwards because of guilt and remorse. His only relief was that he had stopped masturbating (which had been a source of great guilt and shame) after the onset of his eating disorder. B's earliest memory was that of his parents arguing and fighting and throwing things in anger. At age 10, his parents moved to live in the city and he had great difficulty in adjusting to his new environment. The relationship between his parents deteriorated and during their arguments, B would always side with his mother.
B responded well to cognitive-behavioral therapy after admission to WHMC. He also began to individuate from his mother who, at that point, began treatment for her depression. Follow-up in November 2002 found him to be eating normally, at normal weight, and attending school.

Case 3: Restrictive AN
C, a 16-year-old high school student, presented with a 1-year history of weight loss from 67kg (BMI 21.6kg/m^2) to 53 kg, height 176 cm., BMI 16.7kg/m^2. C was considered overweight since childhood (although by Western standards he would be considered normal weight). At 15, his classmates teased him for being fat and he began dieting rigorously. He weighed his food at each meal, studied the nutritional content of every food item, and refuse all fatty food. He explained to his parents that if he gained weight he would become very depressed. His parents brought him to treatment because of his weight loss and depressed mood. C slept with his parents until age 12 and he stopped only after he found out that none of his classmates were doing so. However, when his father was not home(his father traveled at lot on business) he would still sleep with his mother. After the onset of weight loss, he again slept every night with his mother and his father had to sleep in a separate bed. When the issue of C sleeping in the same bed with his mother came up during family therapy at WMHC, the mother became upset and terminated treatment. They refused follow-up.

Case 4: AN-Bulimic Subtype
D, a 20-year-old university student, began dieting at age 18(April,1997) after a classmate said he was too fat. His weight, height, and BMI were 64kg, 168cm, and 22.7kg/m^2, respectively. In addition, he began to binge/purge up to 10 times a day. In July1997, he entered university and his weight rapidly decreased to 39kg. His parents took him home from school and he was hospitalized. Despite gaining 6kg, he continued to binge and purge. He returned to Wuhan and sought outpatient psychotherapy at WHMC. With individual therapy, he gained better control of his bulimic behavior and maintained his weight at approximately 47kg. He refused follow-up.

Case 5: BN
E, a 23-year- old accountant, presented at WHMC with a 3-month history of binging, purging, and a weight loss of 13kg(from 66kg to 53kg, height 170cm, BMI 18.3kg/m^2). At the age of 20, he had obtained an accountant job through his father's "connections" but was overwhelmed by the demands of the job and problems with colleagues. In September 1999, during the mid-autumn

festival, he developed a craving for "mooncake" (a sweet pastry consumed in large quantities by the Chinese during this festival), and began binging and purging. E is the youngest of two brothers, and had experienced very little love and warmth in his family. His father had a violent temper and was often physically abusive to him and his mother. At 12, he underwent open heart surgery for mitral stenosis and had to take 1 year off school, during which time he read books on Freud and became convinced that he had a "neurosis" on account of his guilt over masturbation.

E began outpatient psychotherapy and improved after a few sessions but dropped out of treatment. He returned after 1 year (December 2000) complaining of depression despite improvement in his BN and a stable weight of 58kg. Follow-up in June 2001 found his BN to remain in remission.

Discussion

Richard Morton (1694) has usually been credited with the earliest description in the medical literature of a male case of eating disorder, possibly BN by current standards, in a 16-year-old boy who eventually made a partial recovery. Since then, several large series of male cases have been published (Andersen, 1992; Burns & Crisp, 1984; Carlat, Camargo, & Herzog, 1997). In clinical populations, the ratio of male to female cases of AN or BN is approximately 1:10, but the ratio in the community is unclear. This disparity in the prevalence may be related to differences in exposure to the pressure to be slim and to diet, and to differences in psychological maturation and identity formation during adolescence between the genders (Hsu,1989).

The recent surge in the incidence of AN and BN in Asia is well documented. Large series have been reported in Japan (Nakamura et al., 2000), Hong Kong (Lee, Ho, & Hsu,1993), and Singapore (Ung,2003). However, Asian men appear unaffected and the presentation of 5 male cases within 3 years (1998-2000) in central China is unexpected.

In contrast to the relatively high prevalence of non-weight phobic AN in Asian females (Lee & Katzman, 2002), all the 4 AN males in this series have demonstrable weight phobia, and have explicitly stated that the fear of fat is the reason for their self-starvation. Premorbid obesity and homosexual orientation are known risk factors for eating disorders in Western men (Carlet et al., 1997; Siever, 1994). None of our cases are in fact premorbidly overweight by Western standards, that is, none has a premorbid BMI of greater than 25KG/m^2. This fact, coupled with the young age of onset (case 1 was 14 and case 3 was 15 at onset), suggests that in large cities in China, body image has become an issue that young men must tackle. Homosexual orientation is not present in any of our cases, but we could not completely rule out the "fear of disclosure" given the strong social disapproval of homosexuality in contemporary China. Finally, the relatively larger number of AN versus BN cases suggests that weight loss and food refusal may trigger greater concern than binging and purging, particularly if the binge/purge behavior is done in secret (Lee & Katzman, 2002).

It would appear that the surge of eating disorders in large cities in China is related to the rapid sociocultural changes taking place in China today. Several factors may be pertinent. First, since the late 1970s, when China began to adopt the "Reform and Open" policy, economic growth has eliminated food shortage and starvation. In the current context of abundance and affluence, deliberate refusal of food can therefore take on a meaning and significance otherwise impossible when lack of food and involuntary starvation are widespread (Brumberg, 1989). Self-starvation has become a more commonly utilized idiom of distress or discount. Second, according to our patients, being fat is socially and psychologically unacceptable even for men in contemporary

China. This fear of fat may well be related to the slim body shape promoted by westernization. In a study of eating attitudes in three communities in China (HongKong, a cosmopolitan city until recently under British rule; Shenzhen, a city in southern China adjacent to HongKong; and rural Hunan in central China), Lee and Lee (2000)found a consistent gradient of female fat concern across the spectrum of modernization and westernization. Greater exposure to fear of fat generates greater pressure to be slim and to diet (Heinberg & Thompson, 1995), which, in turn, may precipitate an eating disorder in vulnerable individuals (Hsu,1997). Finally, the turmoil of social change may lead an insecure individual, male or female, to exercise control of eating and weight (Brumberg,1989). AN and BN have been conceptualized as problems of overcontrol (Fairburn, Shafran,& Cooper,1999).

We want to end on a positive note. The short-term outcome of male AN and BN cases in our series appears to be encouraging. Of the 5 cases, 3 appear to have recovered and 1 is substantially improved. Treatments that have been demonstrated to be effective in the West (cognitive therapy and family therapy) also appear to be effective in this group of patients.

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