

# Assessing Eating Pathology in Asian Americans

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## Overview of Cultural Considerations

Relatively little research has been conducted on eating disorders (EDs) among Asian and Asian American (AA) women. In recent years, some researchers have found that Asians and AAs have equal or greater rates of disturbed eating (Wildes, Emery, & Simons, 2001), and body dissatisfaction (Grabe & Hyde, 2006) as do Whites, and that AAs may be more concerned with shape or body parts than with weight (Mintz & Kashubeck, 1999).

Much of the existing ED research with Asian women in Asia or AA (or Asian British) women consists of survey research on attitudes, behaviors, and risk factors for ED with nonclinical convenience samples, using different measures and criteria, leading to contradictory results (Cummins, Simmons, & Zane, 2005). Furthermore, researchers found that clinicians were less likely to give ED diagnoses or referrals to ethnic minorities (Becker, Franko, Speck, & Herzog, 2003; Franko, Becker,

Thomas, & Herzog, 2007). In a qualitative study, therapists working with this population reported that subclinical and atypical EDs were more common in their practices and clients often had a mix of subclinical features, and that EDs were not always the presenting issue (Smart, Tsong, Mejía, Hayashino, & Braaten, 2011).

An additional population that is relevant to this chapter is Asian Pacific Islander (API) Americans who comprise approximately 4.8 % of the U.S. population (Humes, Jones, & Ramirez, 2011). Over 48 different ethnic groups fall under the "Asian" racial group and there are large differences in language, religion, and values (Sandhu, 1997). In fact, more than half of Pacific Islanders endorsed multiple races and over 2.5 million additional census respondents checked Asian and one other ethnic group. Complicating things further, more than 60 % of AAs are immigrants, with more than two thirds speaking a non-English language at home and about 40 % not speaking English "very well" (U.S. Census Bureau, 2012). The diversity in ethnic cultures and the within-group differences (acculturation levels, immigration experiences, SES, family structure, degree of adherence to country of origin values, religious beliefs, and more) further compound the difficulties in assessing and working with this population based on any over-generalization of the "Asian American" stereotypes, and miss the possible important distinctions between different Asian ethnic group eating disorder patterns, as well as risk and protective factors.

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It is also unclear if the current ED assessment measures are culturally appropriate for Asian Pacific American women of different religious practices, dieting, and family traditions. Current assessment measures originally developed for Western populations may not, for example, accurately distinguish between culturally appropriate fasting behaviors and ED behaviors (Ahmad, Waller, & Verduyn, 1994b). Data resulting from Western measures could be reflecting issues such as the willingness to disclose, cultural definitions of thinness or attractiveness, or cultural differences in eating behaviors (Lucero, Hicks, Bramlette, Brassington, & Welter, 1992). In addition, the stereotype that API women are well adjusted and naturally petite may lead mental health professionals to be less likely to assess for an ED. Further, it may be more culturally acceptable for some API women to have their ED symptoms manifest more somatically (e.g., indigestion and stomachaches), which can further confuse diagnosis (H.-Y. Lee & Lock, 2007; Ting & Hwang, 2007). Controversy exists as well regarding the commonly used DSM-IV criteria for anorexia because the required "fear of fat" criterion may not occur or present differently in Asian women (H.-Y. Lee & Lock, 2007; S. Lee & Katzman, 2002) (Table 16.1).

## Assessment Measures

### Eating Disorder Examination (EDE)

The EDE (Fairburn & Cooper, 1993) is a 62-item semi-structured interview designed to assess the specific psychopathology of EDs and correct for some of the inherent difficulties of self-report questionnaires. The advantage of the EDE is that the interviewer can provide specific explanations of the complex behaviors in question and obtain more detail from participants. The EDE is one of the most widely used semi-structured interviews for the assessment of specific ED behaviors; it can be used to provide a diagnosis and track treatment outcomes (Kashubeck-West & Mintz, 2001). It has four subscales: *dietary restraint*, *eating concern*, *shape concern*, and *weight concern*.

The global EDE score is obtained by taking the average of the four subscales. Most items are rated on a 7-point scale (ranging 0–6) to assess either frequency (0=absence of the feature, 6=presence to an extreme degree) or severity (Anderson, De Young, & Walker, 2009). The EDE assesses frequency over the previous 4 weeks and arrives at the diagnosis of AN, BN, and BED measuring behaviors over the past 3–6 months. The internal consistency reliability ranges from 0.67 to 0.96 (Cooper, Cooper, & Fairburn, 1989; Stice & Fairburn, 2003) in overall populations.

*Research with Asian Americans.* Specific reliability and validity data for AAs are not available. However, a number of researchers have used the EDE with AA girls and women. One study found that AA adolescent girls (12–18 year olds) scored significantly lower on the *Restraint* subscale ( $M=1.48$ ) and the *Weight Concerns* subscale ( $M=1.35$ ) than did their non-Asian peers (H.-Y. Lee & Lock, 2007). In another study comparing AA, Hispanic, and White adolescent girls and young women (13–20 years), it was found that all three groups had similar ED symptom scores in a Cognitive Dissonance-based program ( $M=15.45$ ,  $SD=14.92$ ) (Rodriguez, Marchand, Ng, & Stice, 2008). When comparing AA female undergraduate students with their White counterparts, it was found that AA women reported more *Shape Concerns* ( $M=16.62$ ,  $SD=11.6$ ) (Haudek, Rorty, & Henker, 1999). Shaw, Ramirez, Trost, Randall, and Stice (2004) used the EDE to compare multiple ethnic groups, both adolescents and young adults across four data sets (8 % AA), and found no statistical difference in ED symptoms across groups.

*Languages available.* A Cantonese-Chinese version for the Eating Disorder Examination (CC-EDEI) was validated by Lau and her colleagues (Lau, Lee, Lee, & Wong, 2006) with young women at a university-affiliated psychiatric clinic in Hong Kong. They found satisfactory and comparable internal reliability for both the global scales and the subscales: 0.81 (*restraint*), 0.89 (*eating concern*), 0.95 (*shape concern*), and

**Table 16.1** At-a-glance summary of measures

Assessment name	Disorder assessed	Administration	Has been used with	Format and languages available in
Eating Disorder Examination (EDE)	Specific ED psychopathology ( <i>restraint, eating concern, shape concern, and weight concern</i> )	Semi-structured interviews (30–60 min)	AA Adolescent girls, Cantonese-Chinese version validated for AN psychiatric patients	Cantonese-Chinese
Eating Disorder Examination Questionnaire (EDE-Q)	Core pathology of EDs ( <i>Dietary Restraint, Eating Concern, Weight Concern, and Shape Concern</i> )	Self-report version of the EDE	AA college students, Singaporean women, Chinese secondary school students in Hong Kong	Chinese (Hong Kong)
Eating Attitudes Test (EAT): EAT-40, EAT-26	Attitudes, thoughts, and behaviors associated with AN ( <i>Dieting, bulimia, and oral control/food preoccupation</i> )	Questionnaire	AA college students, South Asian U.S. women, South Asian British women, Asian Australian girls	Chinese, Japanese, Korean, Pakistan
Eating Disorder Inventory (EDI, EDI-2, EDI-3)	Psychological, behavioral, and cognitive behaviors and symptoms common to AN and BN	Self-report measure	Asian Australian young women, South Korean and Chinese female college students, South Korean and Chinese early adolescent boys and girls	Japanese, Chinese, Korean
SCOFF	ED screening	Screening instrument for nonspecialists	AA graduate students, Japanese women currently in treatment, Chinese secondary school students	Japanese and Chinese
Yale Brown Cornell Eating Disorder Scale (YBC-EDS)	Process-oriented approach for measuring the presence, type, and severity of ED-related preoccupations and rituals	Semi-structured clinician-administered interview	AA adolescent girls	
Bulimic Investigatory Test, Edinburgh (BITE)	Attitudes and behaviors associated w BN	Self-report questionnaire	South Asian adolescents in U.K., Chinese, Taiwanese women clinical patients	Mandarin Chinese
Dieting Peer Competitiveness Scale (DPC)	The degree to which individuals compare themselves to their peers in relation to their physical appearance and eating habits, especially in social situations	Questionnaire	Australian adolescent girls, Chinese, Chinese Australian	Chinese
Restrainted Eating Scale (RES)/Dutch Eating Behavior Questionnaire (DEBQ)	Evaluate <i>restrained, emotional</i> (in response to diffuse emotions, and in response to clearly labeled emotions), and <i>external eating behaviors</i>	Self-assessment scale	AA adolescents, nonclinical female Korean adults	Korean

0.81 (*weight concern*) compared to the other studies conducted (e.g., Cooper et al., 1989). The CC-EDEI also provides good discriminant validity for BN and AN (Lau et al., 2006) using the global scale and three out of the four subscales (i.e., all except weight concern).

*Special considerations.* Because the EDE uses a semi-structured interview protocol and allows the interviewer to follow up and also rate the reported experiences, some suggest that the EDE may be less susceptible to self-report biases than questionnaires or other self-report assessment tools. However, it also has been suggested that shame, social desirability, and other factors may prevent individuals from fully disclosing their psychopathology and disordered eating behaviors (Anderson, Simmons, Milnes, & Earleywine, 2007). For AAs, the tendency to minimize pathology to avoid the danger of "loss of face" may be even more salient (B. S. K. Kim, Brenner, Liang, & Asay, 2003), particularly for those who adhere to more traditional values of avoidance of shame and embarrassment. Lee and Lock's (2007) study, mentioned earlier, may be a case in point: the AA adolescents with anorexia had lower scores on the EDE, even though their illnesses were just as severe as those of their non-AA counterparts, possibly due to less fat phobia, denial, or a presentation influenced by cultural factors. This may indicate a disadvantage to using the EDE with AAs; however, given that the gold standard for ED diagnosis remains a clinical interview and the paucity of interview data with AAs, it is strongly recommended that more research is done in this area. Researchers who are trained in cultural competency, aware of the cultural context of ED behaviors, and aware of some of the cultural differences in ED presentation and symptoms, could likely make good use of the EDE and its interpretations. For example, in their cross-cultural validation study of the EDE in Cantonese, Lau et al. (2006) took note of people who met all the DSM IV criteria for anorexia, except for fat phobia. The EDE also requires the administrator to have training and it is noted by the authors that training is essential if it is to be used for research purposes (Fairburn, 2008). In conjunction with the

relatively lengthy administration (30–60 min), it may be less practical than self-report measures for many clinicians and researchers.

### **Eating Disorder Examination Questionnaire (EDE-Q)**

The EDE-Q (Fairburn, 2008; Fairburn & Bèglin, 1994) is a self-report version of the interview-based EDE. It has thirty-six 7-point (0–6) Likert-scale items and measures ED pathology in the past 28 days, with scores of 4 or higher considered to be in the clinical range (Anderson et al., 2009). It assesses the core pathology of EDs using four subscales (*Dietary Restraint, Eating Concern, Weight Concern, and Shape Concern*), produces a global score, and ED diagnoses can be generated from the participants' ratings.

The four subscales and the global score have been found to have acceptable internal consistency reliability with 0.70, 0.73, 0.72, 0.83, and 0.90 respectively in the overall population (Peterson et al., 2007). The sixth edition was published in 2008 (Fairburn, 2008), and a modified form for adolescents along with normative data was published in 2001 (J. C. Carter, Stewart, & Fairburn, 2001). Numerous studies have demonstrated good agreement between the EDE and the EDE-Q; however, the EDE-Q, like other self-report measures, struggles to adequately capture behaviors that are left open to interpretation, such as bingeing (Anderson et al., 2009). There is some indication that the EDE-Q results in higher levels of pathology than does the EDE and it may be better used as a screening measure rather than a diagnostic one (Kashubeck-West & Mintz, 2001).

*Research with Asian Americans.* No studies on the psychometric properties of the EDE-Q with Asian Americans, to the best of our knowledge, have been conducted. However, the EDE-Q has been used to compare AA and non-AA students (Akan & Grilo, 1995; Shaw et al., 2004; Tomiyama & Mann, 2008). High internal consistency was reported with AAs as part of the sample with  $\alpha$  of 0.95 (Tomiyama & Mann, 2008). One study found that AA female college students

had lower scores on *dietary restraint* and *eating concerns* subscales and a lower global score than their White peers (Akan & Grilo, 1995). Normative means for the four subscales and the global score were 0.80 for *dietary restraint*, 0.54 for *eating concern*, 1.66 for *shape concern*, 1.47 for *weight concern*, and 1.14 for the global score (Akan & Grilo, 1995).

**International Research.** A comparative study examining ED behavior between Australian and Singaporean young women (18–20 years old) found that there were no differences on their EDE-Q subscales (Mond, Chen, & Kumar, 2010). However, at the item analysis level, Singaporean women had more fear regarding weight gain and loss of control over eating. Normative data for the four subscales and the global score were 0.96 (SD=1.07) for *dietary restraint*, 1.06 (SD=1.03) for *eating concern*, 2.31 (SD=1.44) for *shape concern*, 1.96 (SD=1.36) for *weight concern*, and 1.57 (SD=1.07) for the global score. Internal consistency reliability  $\alpha$  were 0.72, 0.67, 0.86, 0.77, and 0.92 respectively for the Australian and Singaporean young women population.

In another study examining ethnically Asian women in Australia and Singapore, after controls, Singaporean Chinese had more ED symptomatology than did European Australian, East Asian Australian, or European women living in Singapore (Soh et al., 2007).

**Languages available.** It has been translated into Chinese and validated with secondary school students in Hong Kong with good internal consistency reliability (0.69–0.89), and normative descriptive data for females and males separately have been provided (Leung et al., 2009).

**Special considerations.** A modified form of the EDE-Q for adolescents with normative data for the age group has been published by Carter and her colleagues (J. C. Carter et al., 2001). In addition, a modified version of the EDE-Q with instructions (EDE-Q-I) is available to improve its validity for assessing binge-eating behaviors, which provides definitions and examples of “unusually large amount of food” and “sense of

loss of control” (Goldfein, Devlin, & Kamenetz, 2005). Since there is preliminary evidence that the EDE-Q and EDE were equally appropriate across a cross-cultural sample (see Shaw et al., 2004), this measure may have promise for use with AAs. However, only small samples of AAs have been included in just a handful of studies, with no interviews to back up the results. Reliability and validity studies with AAs and specific subgroups of AAs are sorely needed.

### Eating Attitudes Test (EAT)

The EAT (Garner & Garfinkel, 1979), considered the first self-report questionnaire developed to assess ED symptoms, is a 40-item questionnaire (EAT-40) with 6-point Likert scales (1=never, 6=always). It was originally designed to measure attitudes, thoughts, and behaviors associated with anorexia nervosa. A shortened 26-item version (EAT-26) was developed later (Garner, Olmsted, Bohr, & Garfinkel, 1982) and assesses three factors: restrictive attitudes and behaviors (*dieting*), bulimic attitudes and behaviors (*bulimia*), and social and practical control over intake (*oral control/food preoccupation*). Both versions are used widely. They are scored by summing scores of each item from 3 points (most extreme response) to 0 point (the three least extreme responses). A cutoff score of 30 on the EAT or 20 on EAT-26 is used to indicate the presence of clinically significant eating pathology (Garfinkel & Newman, 2001). However, it has been suggested that EAT-26 is best used as a continuous score (Kashubeck-West & Mintz, 2001).

The EAT has satisfactory internal consistency of 0.79 (Garner et al., 1982) and good test-retest reliability ( $r=0.84$ ) (P. I. Carter & Moss, 1984). When used as a measure of symptom severity, the EAT-26 has been shown to correspond to full-threshold, subthreshold, symptomatic, and asymptomatic diagnoses (Mintz & O'Halloran, 2000). Garner and his colleagues published norms for the EAT-26 (Garner et al., 1982) based on early definitions of the disorder, which is different from the current diagnostic criteria in DSM-IV-TR or DSM 5 (American Psychiatric

Association, 2000). Norms for women in the community (e.g., Dolan, Evans, & Lacey, 1992; Dolan, Lacey, & Evans, 1990) have been found to be between 11 and 15, and typically 10–15 % of women screened with EAT report above the cut-off EAT score (Garfinkel & Newman, 2001).

*Research with Asian Americans.* There are no studies on the psychometric properties of the EAT with Asian Americans, to our knowledge. Even though the EAT has been widely used around the world and has been used in numerous U.S. studies comparing European Americans and African Americans, relatively few (e.g., Akan & Grilo, 1995; Bisaga et al., 2005; Iyer & Haslam, 2003) have used the EAT in studies that included AAs.

Akan and Grilo (1995) found that AA female college students had lower scores on the EAT than did their White peers but were similar to African American female college students. The normative mean for AA female college students found in this study was 53.62 (SD=15.35). In a study on South Asian American female college students (Iyer & Haslam, 2003), history of hurtful racial teasing was found to be associated with disturbed eating behaviors, even after controlling for body mass. The EAT-26 had satisfactory Cronbach's alpha value of 0.91 in this study.

The EAT has been used with other Western populations of Asian descent, notably in Britain and Australia. For example, Asian British women were compared with Afro-Caribbean and White women living in London (Dolan et al., 1990), and South Asian female adolescents living in the U.K. were compared with their White counterparts (Furnham & Patel, 1994).

Jennings, Forbes, McDermott, and Hulse (2006) found no differences between Asian and Caucasian Australian young women (18–24 years old) in their EAT-26 scores, which had Cronbach's alpha of 0.87. However, in adolescent girls (14–17 years old), Asian Australian girls reported significantly higher eating psychopathology in the Dieting subscale ( $M=27$ ) of the EAT-26, but not other areas (Jennings, Forbes, McDermott, Juniper, & Hulse, 2005).

*Languages available.* The EAT has also been used as a measure of disordered eating in non-Western populations. It has been translated into Chinese (S. Lee, 1993), Japanese (Mukai, Crago, & Shisslak, 1994; Ujiie, Kono, Eisler, & Dare, 1990), and Korean (Ko & Cohen, 1998), as well as Urdu, Hebrew, Turkish, Arabic, and numerous European languages (Anderson et al., 2009).

Its Chinese version exhibited good reliability and validity among undergraduates (S. Lee, 1993), and high school students in Hong Kong (A. M. Lee & Lee, 1996). S. Lee (1993) modified several of the items to better provide cultural equivalents. For example, "cut my food into small pieces" was used instead of "eat very slowly" because Chinese people use chopsticks; "aware of how much weight the food that I eat will cause me to put on" was used instead of "aware of the calorie content of foods that I eat" because it was uncommon for people to count calories in Hong Kong. And as "diet food" was not a popular Chinese term, examples ("diet coke and artificial sweeteners") were given for eat diet foods (A. M. Lee & Lee, 1996, p. 178). Lee (1993) also reported a similar factor structure using data from bilingual Chinese university students in Hong Kong.

The Japanese version showed acceptable internal reliability (0.79) and validity (Mukai et al., 1994) with the mean total scores of 16.66 (SD=7.76) in a nonclinical sample of Japanese high school female students.

The Korean version (K-EAT-26) was adapted and translated from the EAT-26 for Korean-speaking populations. It has a suggested clinical cutoff of 21 in the Korean population, slightly higher than the English North American version (Jackson, Keel, & Lee, 2006). Previous studies have supported the cross-cultural validity of the scale (Rhee, Go, Lee, Whang, & Lee, 2001), with reported Cronbach's internal consistency of 0.81 (Rhee et al., 1998). In a study comparing eating attitudes between Native Koreans and Korean American women, it was suggested that Native Koreans had more disordered eating attitudes (Jackson et al., 2006).



It was translated into Urdu for school girls in Mirpur, Pakistan (Choudry & Mumford, 1992). The factor structure of the EAT in Mirpur differed substantially from those obtained in studies among Western populations (Garner et al., 1982) and from Asian Pakistani school girls living in Bradford and Lahore in the U.K. (Mumford, Whitehouse, & Choudry, 1992; Mumford, Whitehouse, & Platts, 1991) suggesting that the eating disordered beliefs, attitudes, and behaviors may present and cluster differently for Pakistani girls (whether living in Pakistan or the U.K.) than their Western counterparts.

*Special considerations.* It has been used with adolescents, and the Children's Eating Attitudes Test (ChEAT) was developed for Children (Maloney, McGuire, & Daniels, 1988) to assess four factors: (a) *dieting*, (b) *overconcern with eating*, (c) *social pressure to increase body weight*, and (d) *extreme weight control practices*.

In a study (Stark-Wroblewski, Yanico, & Lupe, 2005) with international students studying in the United States from Taiwan, People's Republic of China, Hong Kong, and Japan, participants indicated that the translation would not be particularly helpful. However, they did find some items to be confusing in the English version (e.g., "preoccupied with"). This may suggest that if no adequate translated versions are available, researchers and clinicians should provide additional explanations or synonyms to terminologies or phrases in the questionnaire.

Although the EAT has been translated into numerous languages and has demonstrated various degrees of reliability and validity across cultures, many researchers have reported difficulty with the wording and cultural misunderstandings, so we believe it is best to check whether norms have been created for the measure in that specific country and to conduct pilot studies using alternative wording. Given that symptom presentation can differ across cultural groups and total scores may obscure the subtleties, it is suggested that researchers examine the separate factors (subscales) when possible.

The advantage of the EAT is that it is the most widely used self-report measure in the field, it is easy to use, and it has been used across cultures. It is best used as a screening tool for EDs in general (but not to differentiate among EDs or predict them) or as a continuous measure of problematic eating for European American women (Kashubeck-West & Mintz, 2001). Since small samples of AAs have been included in studies that used the EAT, it can provide a point of comparison for future studies and may be a good self-report option for researchers. However, reliability and validity studies with AAs, and specific subgroups of AAs, are greatly needed; at this point, it is not clear whether the EAT is valid and reliable for AAs.

### Eating Disorder Inventory (EDI)

The EDI (Garner, Olmsted, & Polivy, 1983) is a self-report measure developed to assess psychological, behavioral, and cognitive characteristics and symptoms common to AN and BN. The first EDI had 64 6-point items and eight subscales: *Drive for Thinness*, *Bulimia*, *Body Dissatisfaction*, *Ineffectiveness*, *Perfection*, *Interpersonal Distrust*, *Interceptive Awareness*, and *Maturity Fears*. The items scores range from "always," "usually," to "never." The revised EDI, or the EDI-2 (Garner, 1991), added three additional subscales (*Asceticism*, *Impulse Regulation*, and *Social Insecurity*). The second revision, the EDI-3 (Garner, 2004) increased from 11 subscales to 12 scales, and added six composite scores and three response style indicators. There are three eating disorder-specific scales (*Drive for Thinness*, *Bulimia*, *Body Dissatisfaction*) and nine general psychological scales (*Low Self-Esteem*, *Personal Alienation*, *Interpersonal Insecurity*, *Interpersonal Alienation*, *Interceptive Deficits*, *Emotional Dysregulation*, *Perfectionism*, *Asceticism*, and *Maturity Fears*). Out of the six composite scores, one is ED specific (*Eating Disorder Risk*), and the other five are general psychological constructs (*Ineffectiveness*, *Interpersonal Problems*, *Affective Problems*, *Overcontrol*, *General psychological maladjustment*). The three response-style

indicators to gauge response style and profile validity are *Inconsistency*, *Infrequency*, and *Negative Impression*. Internal consistency reliabilities are high (over 0.80) for all the scales and composite score for U.S. adults, international adults, and U.S. adolescent samples (Anderson et al., 2009).

*Research with Asian Americans.* To our knowledge, there are no studies that have examined the psychometric properties of the EDI with AAs specifically, even though, similar to the EAT, the EDI has been used across numerous populations. Using EDI-2, a prevalence rate of 0.78 % for BN ( $M=41$ ,  $SD=26$ ) was found with AA female college students (Tsai & Gray, 2000), which is similar to the rates of 1.10 % in China (Chun, Mitchell, Li, & Yu, 1992) and 0.46 % in Hong Kong (S. Lee, 1993). However, Ting and Hwang (2007) noted that if only three of the four criteria for BN in DSM-IV were used (rather than all the diagnostic criteria), 5.10 % of the AA women in this study would be characterized as bulimic, suggesting that prevalence rates among AA women may be higher than we currently think, if we consider the subclinical nature of this group. In another study comparing AA female undergraduate students with their White counterparts, AA women reported more *Body Dissatisfaction* ( $M=35.08$ ,  $SD=8.63$ ) and *Drive for Thinness* ( $M=23.12$ ,  $SD=8.19$ ) (Haudek et al., 1999).

The EDI has also been used with other Western groups of Asian descent. No differences were found between Asian and Caucasian Australian young women (18–24 years old) in their EDI-2 scores, which had Cronbach's alpha of 0.93 (Jennings et al., 2006). However, in adolescent girls (14–17 years old), Asian Australian girls reported significantly higher EDI-2 scores ( $M=26.9$ ) than did their Caucasian counterparts, as well as in *Interpersonal Distrust*, *Maturity Fears*, *Impulse Regulation*, and *Social Insecurity* subscales (Jennings et al., 2005).

*Languages available.* The EDI has been translated into Japanese and back translation was used to obtain item equivalence (Ujiie et al., 1990). The EDI-2 was also used in a study comparing clinical and nonclinical groups of Japanese women in

Japan and clinical and nonclinical groups of North American women (Pike & Mizushima, 2005) that provided descriptive data of the EDI-2 and a profile of eating pathology for both Japanese women with and without DSM-IV EDs.

The EDI was also translated into Chinese to examine the prevalence of AN and BN among college students in China (Chun et al., 1992), and while no case of AN was found in this study, the “fear of being fat” was very common (78.1 %) in these female college students, which may suggest that the EDI may not be very useful in identifying Asian women with EDs because the “fear of being fat” is prevalent in nonclinical populations, while it is often not found in AN patients in Asia (e.g., S. Lee, 1994; S. Lee, Ho, & Hsu, 1993). More discussion on the phenomenon of “fear of fat” can be found at the end of this chapter. Another Mandarin Chinese version of the EDI was developed and validated with a Taiwanese ED clinical patient sample (Tseng & Hu, 2012) that demonstrated internal consistency reliabilities above 0.70 for all scales.

The *Drive for Thinness Scale* (EDI-DTFS) and the *Bulimia Scale* (EDI-BS) of the EDI were translated into Korean to compare the eating pathology of female college students in South Korea with those in the United States (Jung & Forbes, 2006), and it was found that South Korean college women reported more disordered eating on the EDI *Bulimic* scale, but no differences were found on the *Drive for Thinness* scale. Cronbach's alpha coefficients for the Korean sample were 0.86 for EDI-DTFS and 0.82 for EDI-BS, with normative descriptive data of a mean of 22.70 ( $SD=6.36$ ) and 18.66 ( $SD=5.78$ ) respectively. When comparing these South Korean college women to those in China and the United States using the same two scales in the EDI (*Drive for Thinness* and *Bulimia*), alpha coefficients were found to be similar (0.91 and 0.85 for the EDI-DT China and U.S. samples, and 0.75 and 0.82 for the EDI-B China and United States samples) (Jung & Forbes, 2007). The authors found that the Korean and Chinese female college women had more eating disordered behaviors than those in the United States. Similarly, when comparing early adolescents in



South Korea and the United States (Jung, Forbes, & Lee, 2009), South Korean girls reported the most disordered eating, followed by South Korean boys, then girls in the United States, and then boys in the United States.

*Special considerations.* The *Bulimia* subscale of the EDI is not a diagnostic tool, but rather measures the behavioral and cognitive features of the disorder, and can be used as a screening instrument. In fact, many researchers only use specific subscales of the EDI. The advantages to the EDI and its revisions are that they are easy to administer and score, and take only approximately 20 min to administer. Its usefulness is as a screening tool in nonclinical populations and to track treatment progress; however, it remains unclear as to whether this usefulness applies to AAs. Although the EDI, like the EAT, is widely used in other countries and has been translated into other languages, no research exists examining the validity and reliability of the measure with AAs. Given this, although using specific subscales is potentially useful, it is recommended that researchers utilize multiple measures (ideally with pilot studies or interviews as a second step) and keep in mind that culture may influence factors such as *perfectionism* and *drive for thinness*.

## SCOFF

The purpose of the SCOFF (Morgan, Reid, & Lacey, 1999) is typically to serve as a quick and simple screening instrument for EDs used in medical settings by nonspecialists. There are five Yes/No questions that can be administered orally or in written format (Perry et al., 2002). Scores of two or greater (answering "yes" to two or more questions) were originally suggested as the cutoff scores for detecting AN and BN. However, it was suggested later that a cutoff of 3 was the "best compromise between sensitivity and specificity" (Siervo, Boschi, Papa, Bellini, & Falconi, 2005, 81). The original SCOFF used words that were specific to the U.K. (e.g., "lost more than one stone in a 3-month period," vs. "14 pounds"), but adaptations have been made to the U.S. version (Morgan et al., 1999).

Test-retest reliability was found to be high in a sample of previously undiagnosed ED patients over a 2-week interval. Normative data for both adult patients with EDs as well as for nonclinical community samples can be found in a summary by Anderson and his colleagues (Anderson et al., 2009).

*Research with Asian Americans.* The SCOFF was validated as a "moderately effective" (p. 105) screening tool with a graduate student sample that included 19.2 % AAs as participants (Parker, Lyons, & Bonner, 2005). Other than that, we know of no research that provides psychometric data on the use of the SCOFF with AAs.

*Language available.* The SCOFF has been translated into Japanese and was found to be correlated with EAT-26; the detection rates for AN or BN and EDNOS (not otherwise specified) were 96.2 % and 48.1 % respectively (Noma et al., 2006) of the patients receiving treatment in Japan. It was translated into Chinese and validated with secondary school students in Hong Kong with acceptable internal consistency reliability (0.44–0.57), and normative descriptive data was provided for females and males separately (Leung et al., 2009).

*Special considerations.* It is important to keep the purpose of the SCOFF in mind: With only five questions, it is very easy to administer and is moderately useful in adult primary care environments as a screening tool. Given that medical complications are common with EDs, it is potentially quite important; however, this cannot replace the need for additional questions and follow-up. It is not clear whether it reliably screens AAs with EDs. However, researchers are encouraged to conduct reliability and validity studies of the measure with AAs because there is some evidence that it is culturally more acceptable for some AAs to seek help for physical symptoms (rather than psychological issues) and indeed that ED symptoms may manifest physically (e.g., stomach aches, nausea) in some AAs (Ting & Hwang, 2007).

## Yale Brown Cornell Eating Disorder Scale (YBC-EDS)

The YBC-EDS (Mazure, Halmi, Sunday, Romano, & Einhorn, 1994) is a semi-structured clinician-administered interview that provides a process-oriented approach (e.g., "How much of your time is occupied by these symptoms?" p. 426) for measuring the preoccupations and rituals common to people with EDs in those who have already been diagnosed. The first part consists of 65 items associated with *preoccupations* with food, eating, appearance, and more, as well as *rituals* associated with eating, bingeing, purging, exercise, and more. The second part rates those symptoms on a 0–4 Likert scale, and the third part assesses for *Time Occupied*, *Interference*, *Distress*, and *Degree of Control* regarding the preoccupations and rituals.

The YBC-EDS takes approximately 45–60 min to administer. A self-report version has been developed (Bellace et al., 2012). The Yale-Brown-Cornell Eating Disorder Scale Self-Report Questionnaire (YBC-EDS-SRQ) provides a *Preoccupation Subtotal*, *Rituals Subtotal*, and *Total score*; takes only 20–25 min to complete; and it provides good test–retest reliability and strong convergent validity between the YBC-EDS interview and the YBC-EDS-SRQ (Bellace et al., 2012).

*Research with Asian Americans.* H.-Y. Lee and Lock (2007) reported on the YBC-ED descriptive data of AA adolescent girls (12–18 year olds) diagnosed with AN and found the AAs in their study resembled the non-Asians in demographic and clinical presentation. However, most studies using the YBC-ED have either not reported the ethnicity of their participants or have not included AAs.

*Languages available.* No other language is available.

*Special considerations.* The YBC-ED and YBC-EDS-SRQ are relatively newer assessment tools for ED pathology. The unique advantage of them is that they assess the nature and severity of

people's preoccupations and rituals related to their ED, and so are potentially quite useful in measuring response to treatment and nature of recovery. It is suggested that the YBC-EDS can effectively distinguish healthy eating controls from restrained eating dieters and ED patients who had recovered for at least 6 months (Sunday & Halmi, 2000) and the ED preoccupations and rituals may help in understanding the onset and maintenance of ED.

AAs, as discussed earlier, may feel more comfortable disclosing their problematic symptoms and less likely to minimize them by completing a questionnaire independently, rather than talking to an interviewer, and so the questionnaire version may be more helpful in this case. However, there are no data available on the psychometric properties of these measures with AAs. Nevertheless, more research using these instruments with AAs is encouraged, importantly to ascertain whether they are reliable and valid, but then also to further the state of research regarding EDs in AAs beyond prevalence and correlational data and into examining the expression and severity of ED symptomatology, as well as treatment response.

## Bulimic Investigatory Test, Edinburgh (BITE)

The BITE (Henderson & Freeman, 1987) is a 33-item self-report questionnaire used to measure attitudes, behaviors, and severity of bingeing, purging, and dieting in the previous 3 months. It consists of a *Symptom* subscale with a maximum score of 30 and a *Severity* subscale that uses frequency to measure the severity of disordered eating behavior with a maximum score of 39. A cutoff score of 20 or more on the Symptom scale indicates a likely BN diagnosis (using DSM III criteria); and a cutoff score of 5 on the Severity scale and a total score of 25 suggest symptoms that are clinically important.

The internal consistency for the *Symptom* subscale is very good (0.96), and for the *Severity* subscale it is moderately good (0.62) (Henderson & Freeman, 1987). A copy of the instrument and

other psychometric information can be found in the original article (Henderson & Freeman, 1987). Norms can be found in a review by Anderson and his colleagues (Anderson et al., 2009).

*Research with Asian Americans.* Although the BITE has been used across different countries (e.g., Turkey, India, Spain, Taiwan), we are not aware of any studies that have utilized it with AAs. The BITE has been used with South Asian (Indian, Bangladeshi, Pakistani, and Sri Lankan) adolescent students (age 13–15) in East London, U.K. (Bhugra & Bhui, 2003), and it was found that these students, compared to their Anglo and African-Caribbean peers, were more likely to fast and eat compulsively. It was unclear whether the fasting behaviors were related to religious practices, only one example of how difficult it is to discern ED behavior from normal cultural practices in a questionnaire.

*Languages available.* The Mandarin Chinese version of the BITE had good internal consistency (0.95 for the Symptom Scale and 0.77 for the Severity Scale) in a Taiwanese women clinical patient sample (Tseng & Hu, 2012). No normative descriptive data are available.

*Special considerations.* The BITE can be administered by untrained individuals for assessing the clinical significance and severity of the symptoms and provide a screening for BN. The advantage is that it more specifically targets binge and purge behaviors than do most other measures. However, as has been discussed earlier, the subjectivity and personal interpretations of questions regarding bingeing make accurate assessment notoriously difficult. Because there are no psychometric data available for use with AAs and few studies, if any, that have used it with AA samples, there is very little basis on which to recommend it. Reliability and validity studies are greatly needed; in the meantime, if researchers specifically want to screen for bulimic behavior, it is recommended that they perform pilot studies, or use additional measures, such as the bulimia subscale of the EDI, and ideally follow up with interviews.

## **Additional Diet-Related Assessments**

### **Dieting Peer Competitiveness Scale (DPC)**

The DPC (Huon, Piira, Hayne, & Strong, 2002) focuses on the degree to which girls compare themselves to other girls regarding their bodies, appearance, and eating habits, particularly as those manifest in social situations. It is also useful in distinguishing between serious and non-serious dieters. There are nine items and they are on a 5-point Likert scale (“not at all like me” to “extremely like me”). Although the instrument has not, to our knowledge, been validated with U.S. populations, it has been validated with Australian girls 12–17 years old (Huon, Piira et al., 2002) and has been used with Asian and Asian Australian groups (Huon et al., 2002). Its internal consistency (above 0.76), test–retest reliability (above 0.70), and split-half reliability (above 0.70) were all high (Huon, Piira et al., 2002). Higher scores indicate that the individual is competitive with her peers about weight control issues.

*Languages available.* A Chinese version was developed to compare peer competitiveness in dieting between Chinese, Chinese Australian, and non-Chinese Australian girls (12–16 years old), and found that Chinese girls ( $M=24.01$ ,  $SD=5.77$ ) were significantly more competitive than were the Chinese Australian girls regarding their dieting behavior ( $M=21.40$ ,  $SD=5.46$ ) (Gunewardene, Huon, & Zheng, 2001).

### **Dutch Restrained Eating Scale (DRES)/Dutch Eating Behavior Questionnaire (DEBQ)**

The DRES is from the Dutch Eating Behavior Questionnaire (DEBQ) (Van Strien, Frijters, Bergers, & Defares, 1986). The DEBQ is a 33-item, self-assessment scale developed to evaluate *restrained* eating (ten items which ascertain

people's attempts to deliberately control their weight), *emotional* (13 items which ascertain people's eating in response to negative emotions), and *external eating behaviors* (ten items which ascertain people's susceptibility to environmental cues that increase eating) (Lowe & Thomas, 2009). It has been shown to have reliability in early adolescent and ethnically diverse samples (Stice, 1998; Weiss, Merrill, & Gritz, 2007). The DRES is one of the three most commonly used restraint measures and has excellent internal consistency and is reliable both for people who are considered normal weight or obese (Lowe & Thomas, 2009). Restraint is of interest to some ED researchers because dieting behavior can be a precursor to binge eating and bulimia (Kashubeck-West & Mintz, 2001) or it can be separate from EDs but range in its severity and impact. Items are measured on a 5-point Likert scale (1=never, 5=very often), with items like, "Do you try to eat less at mealtimes than you would like to eat?" and "Do you deliberately eat foods that are slimming?" (Van Strien, Frijters, Van Staveren, Defares, & Deurenberg, 1986, p. 752).

*Research with Asian Americans.* A study with eighth and ninth graders used a modified version of the DRES to assess weight concerns and found that AA adolescents reported the lowest weight concerns compared to their African American, White, and Hispanic counterparts (Weiss et al., 2007). The DEBQ was used to assess restraint, emotional eating, and external eating in a large-scale study of Korean American adult twins and their families (Sung, Lee, Song, Lee, & Lee, 2010). Internal consistency reliabilities with this AA sample were 0.92 for the Restrained Eating subscale, 0.94 for the Emotional Eating subscale, and 0.86 for the External Eating subscale.

*Languages available.* A translated Korean version of the DEBQ (H.-J. Kim, Lee, & Kim, 1996) was developed with nonclinical female Korean adults (average age 19.3 years).

*Special considerations.* This measure shows preliminary promise for use with AAs, given that it has been used in a couple of studies that included an AA sample. However, given that specific

reliability and validity data are not available, it is not clear whether cultural factors regarding eating, overall restraint, or response bias (particularly the desire to present as having restraint) may impact use of this measure with AAs. As with all the other measures, more research is needed.

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## **Additional Assessment Considerations**

It should be noted that while some of the assessments and measures discussed above have been translated into different Asian languages and validated using Asian populations it does not mean that they are valid for AAs. For example, the definition of "excessive" regarding exercise food consumption may be different for Asians and AAs (Adkins & Keel, 2005). There is also evidence suggesting that the manifestation of EDs may vary with cultural context. Lee's work with Hong Kong's Chinese population has suggested that while "fat phobia" has been an essential criterion in diagnosing AN in the United States in DSM-IV, it only presents in a minority of AN inpatient participants in Hong Kong (S. Lee et al., 1993), and a similar phenomenon has been observed in India, Malaysia, Singapore, and Japan (S. Lee, 1994).

One major limitation in the current ED literature on AAs is the definition and interpretation of "Asian American" samples. As described above, more than 48 distinct ethnic groups with different language, histories, cultural practices, and physical features are included in the group of "Asian American." Eating disordered presentations and levels of severity cannot be assumed to be the same for this broad category of "Asian heritage." For example, South Asian British young girls were found to report eating problems seven times more likely than East and South East Asian American college students (Dolan et al., 1990; Lucero et al., 1992; Mumford et al., 1991). Other contextual factors, such as age, place of residence, experiences with discrimination, adherence of traditional Asian or family cultural values or practices, must also be taken into consideration when making assessment and planning treatments with this population.

Comparing results from international research on ethnically Asian individuals is particularly

problematic because the same “Asian” category is given to individuals with varied immigration histories, food and diet practices, etc. For example, most of the individuals given the “Asian” category in the ED research from the U.K. are South Asian (e.g., Indian, Pakistani), while the individuals in the “Asian” category in the United States are usually East Asians (e.g., Japanese, Korean, Chinese) and sometimes South East Asian (e.g., Vietnamese).

### **Sociocultural Factors**

*Discrimination.* APIA women experience both sexism (“beauty” for women is considered to be more important than for men, within the API community) and racism (many standards of beauty are racially based, e.g., eyes, breast size, skin color, etc.) and may be more vulnerable to body image distortion and disordered eating behaviors (Hall, 1995).

Research found that ethnic minority women who have endured racist and oppressive aggressions can experience lowered self-esteem, helplessness, and a loss of the sense of control (Fernando, 1984). Teasing based on racially and ethnically distinctive attributes (e.g., being shorter, single-fold eyelid, low nose bridges) may exacerbate the struggles that some API women already encounter as they navigate the process of integration into the dominant culture, and may contribute to eating and body image disturbances, as found in a study on South Asian American women (Iyer & Haslam, 2003).

*Acculturation.* Acculturation is a complex process in which immigrants adopt and adapt, to varying degrees, the values and customs of the host culture. Research has examined the role of acculturation with EDs, hypothesizing that higher levels of acculturation to Western values and behaviors are associated with more incidences of EDs. However, the results have been inconclusive (Cummins et al., 2005). In addition, the traditional Asian Confucian values, such as an emphasis on self-restraint and conforming to the norm, may provide their own thinness ethic and standards (Jackson et al., 2006), and the standard of thinness may be even higher than that of

Caucasian women (Smart et al., 2011). In a study in the United States examining Pakistani immigrant girls, those who were classified as being more traditional also reported a greater risk of eating disordered behaviors (Mumford et al., 1991). Similarly, when comparing U.S.-born non-Korean-speaking Korean American female college students with native Koreans female college students, women in South Korea reported more disordered eating behaviors in both dieting and bulimia, even after controlling for their BMI (Ko & Cohen, 1998). Nevertheless, some studies have compared rates of disordered eating among adolescents and young women residing in their country of origin with those who have recently immigrated, and found that immigration to a Western society was a risk factor for ED. For example, female South Asian immigrants to the U.K. were found to have more disordered eating attitudes than their counterparts who were not immigrants (Mumford et al., 1991, 1992).

### **Role of Family**

Several familial factors (e.g., parental bonding, family history) have been found to be associated with EDs. For AA women, parental control and overprotection also have been found to be associated with EDs (Ahmad, Waller, & Verduyn, 1994a; Furukawa, 1994). Therapists who worked with API women with EDs believed family dynamics as a relevant factor to their clients’ EDs, such as parents’ sense of self being linked to the children’s achievement, using traditional Asian authoritarian parenting styles with more U.S. acculturated daughters, and the blunt expressions commenting on the clients’ physical appearance and need for improvement (Smart et al., 2011), even though the implicit understanding was that these comments came from love and care.

### **Individual Factors**

*Perfectionism.* Perfectionistic tendencies have been found in people with AN (Hewitt & Flett, 1991) and body dissatisfaction (Kiemle, Slade, & Dewey, 1987). Therapists who have worked with

API women with EDs observed their clients were often under extraordinary pressure to achieve in academics, career, and appearance (Smart et al., 2011). It was hypothesized that AA women may be more vulnerable to EDs due to their adherence to collectivism and may feel a heavy burden to correct the negative image of their culture in the United States, and work to become the "perfect Asian Woman" in behaviors, image, and appearance (Hall, 1995; Root, 1990).

*Fear of fatness/Desire for Thinness.* Intense fear of fatness, a central criterion in the DSM-IV diagnosis of AN, has been questioned in its usefulness in assessing Asian and AAs and indeed, criteria in DSM-V are now more flexible. Several studies in Asia (e.g., Hong Kong, Japan, Singapore, and India) found that many AN patients engage in strict dieting without self-reporting "fat phobia" (Khandelwal, Sharan, & Saxena, 1995; S. Lee, 1991, 1995, 2001; Pike & Mizushima, 2005). However, nonclinical studies found a high prevalence (78 %) of "fear of fat" among Chinese female college students (Chun et al., 1992), greater "fear of fat" amongst AA female college students within healthy BMI limits compared to their White counterparts (Sanders & Heiss, 1998), and high prevalence of weight concerns and dieting practices in a nonclinical sample of Japanese high school girls (Mukai et al., 1994).

S. Lee and his colleagues (S. Lee, Lee, Ngai, Lee, & Wing, 2001) suggested that AN patients may switch to nonfat-phobic rationales because they are not as challengeable as fat-phobia rationales as these patients are visibly emaciated. The high prevalence of "fear of fat" in nonclinical samples may also be explained by other cultural-specific factors, such as the pursuit of thinness in Japan being linked to the "culture of cute" (Pike & Borovoy, 2004) or as cultural practices of conforming to the norm of a higher standards of thinness (Smart et al., 2011).

## Summary

This chapter provided clinicians and researchers with a brief overview of some of the issues pertinent to the assessment of EDs for AAs, and an

examination of the most frequently used eating pathology assessments that have been validated with AA samples. The chapter reviewed research conducted in the United States on AAs, ethnically Asian individuals in other western countries (e.g., U.K., Australia), and also Asians living in Asian countries. Finally, the chapter provided additional considerations when assessing ED or eating disordered behaviors.

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# Guide to Psychological Assessment with Asians

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