Anorexia Nervosa and Religious Ambivalence In A Developing Country

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Abstract

The aim of this study is to report the first case of the primary nuclear form of anorexia nervosa in Trinidad and the West Indies in an 18-year-old Islamic student attending a Roman Catholic Convent. Ambivalent values due to development in a strict Muslim home with Catholic influence and contemporaneous exposure to a Western society are explored. The dynamics of family interaction in a dual religious home are investigated. Similarities are noted from reports from western countries that link ritualistic fasting to the month of Ramadan. The influence of the Roman Catholic period of fast, Lent, and the dynamics of family interaction are discussed. We wish to propose religious ambivalence as an etiological factor in anorexia nervosa in a developing country.

INTRODUCTION

Anorexia nervosa is an eating disorder characterized by self induced weight loss of at least 15% below that expected, avoidance of fattening food, body image distortion and amenorrhoea [1]. Crisp [2] has suggested that the primary nuclear form of anorexia nervosa is characterized by a central symptom of phobia of normal adolescents weight following the growth changes of puberty. Two types have been identified: the Restricting Type without regular engagement in binge eating or purging; and the Binge Eating / Purging Type [3].

Biological, social and psychological factors have been implicated as causative factors in anorexia nervosa [4]. Existence of genetic vulnerability has been proposed for decades on the basis of aggregation studies, treated twin samples and twin studies from the general population [5]. Social factors include a focus on family environment [6] and parental conflict [7]; while depression, unstable self-perceptions and negative self evaluations have been cited as psychological risk factors for anorexia nervosa [8, 9]. Among these etiological factors, anorexia nervosa has been described as a culture bond syndrome, rare in non-western people [10].

Attempts have been made to link anorexia nervosa to religion. In Germany, a correlation was found between type of eating disorder and religious affiliation. Protestants had a higher incidence of anorexia nervosa while Roman Catholics presented with bulimia with vomiting [11]. Rates of eating disorders for Muslim countries are not widely available, but there is evidence that cases of anorexia nervosa, though rare, do exist in these countries. Yager & Smith [12] presented a case of restrictor anorexia nervosa in Pakistan. The disorder had developed due to the patient and her family having a preoccupation with weight. In a later study, [13], 180 female nursing and medical students at the Aga Khan University Hospital in Karachi were assessed for anorexic behaviour and attitude. Total proportion of anorexic behaviour was 21.7% which was recognized by the authors as much higher than rates reported for studies conducted in Asia.

Huline-Dickens [14] has examined the religious and ascetic features of anorexia nervosa. It is argued that there exists many connections between the religious ascetic and the anorexic, and that there are many psychopathological features common to both. Whilst empirical evidence for religious themes in anorexia is not strong, in the family therapy literature there are indications of ethical codes of sacrifice, loyalty and sexual denial. Anorexia and asceticism are considered to be connected conceptually in the process of idealization. Clinicians working with women with anorexia have pointed out their abstinence from worldly comfort and pleasures through the process of self-denial, heightened morality, asexuality and immortality [15].

Other researchers have attempted to link anorexia nervosa to

sociocultural factors [16,17,18]. Khandelwal et al. [19], took an Indian perspective in describing five cases of young women who presented with anorexia nervosa in India; and discussed sociocultural reasons for its atypical presentation. Case reports of anorexia nervosa in subjects of Asian (Indian subcontinental) have been rare. Bhadrinath [20] discussed three cases of Asian adolescents, two of which describes the impact of the Muslim festival of Ramadan.

The Republic of Trinidad and Tobago comprises a non-secular population of 1.3 million people with a ratio of approximately two Africans to two Indians to one mixed and others. Two-thirds of the population belong to Christian-based religions, the majority being Roman Catholics while others belong to a variety of denominations. One third subscribe to Hinduism and Islam, the latter though only ten percent exerts tremendous socio-religious and political force. Over the last decade Islam has been on the rise.

The religion of Islam encompasses religious duties such as Salah (prayer), Hajj (pilgrimage), Sawm (fasting) and Zakat (charity). Fasting takes place every lunar year from the first of Ramadan to the first of Shawwal (the following month) and entails restraining from food, drink, smoking and sexual pleasure from dawn until sunset. Fasting is a religious obligation on every Muslim who has attained the age of puberty and who is sane and able.

Fasting is also a long procedure of obedience and for very day for that prescribed month, the individual has to get up before dawn, stop all eating and drinking precisely at the breaking of dawn, do work during the day, break fast at the time of sunset and then hurry up for Taravih (night prayers). According to A'la Maudoodi [21] every year for one month, the dutiful Muslim from dawn to dusk is kept continuously tied up with rules and regulations like a solider in the army and then he is released for eleven (11) months so that the training he has received during that one month may show its effects. If any deficiency is found it may be made up in the training of the next year.

Fasting occurs in other religions besides Islam, such as Christianity. The most common motives for fasting are religious ones. In a religious fast there are three primary purposes: self control over the body and appetites, focusing the mind on God or prayer and making sacrifice to God for offences committed. The religions of Islam and Christianity have from their inception, set aside certain times in the year for regular fasting observances. Early Christianity developed a number of fasting periods: food was not eaten on Fridays in commemoration of the death of Jesus. Later a period of forty days before Easter, called Lent, was set aside to allow Christians to meditate on the sufferings of Jesus.

The season of Lent is the time of preparation for Holy week. It is a sacred and spiritual time for every Christian. No matter how far removed an individual might be from their studies of Lent, most Catholics know that the 40 days of Lent remind them of giving up something that is a sacrifice, acts of self denial, acts that are geared to remind them of Christ. During the Lenten season, dietary restrictions are implemented with abstinence from meat. Many people also perform acts of penance or mortification, such as giving up sweets, or it may be a time for some to attend Mass more frequently.

Fasting regulates the desires of the lower physical self and trains the higher moral self to control them; it has a direct effect on a person's psychological, social and physical being by changing his/her habits and emotional attitude toward exercising patience in virtually every aspect of life.

The aim of this study is to report the first case of the primary nuclear form of anorexia nervosa in Trinidad and the West Indies in an 18-year-old Islamic student attending a Roman Catholic Convent. Ambivalent values due to development in a strict Muslim home with Catholic influence and contemporaneous exposure to a Western society are explored. The dynamics of family interaction in a dual religious home are investigated.

METHOD

CASE REPORT

Patient D, an eighteen-year-old post pubertal Muslim girl, was referred to a psychiatrist after completing Advanced level exams. The patient had previously been treated by a psychologist through counselling sessions including programmes in weight gain and mantras to repeat to develop her self esteem.

The last of four female siblings of a middle class, Indo-Trinidadian family, Patient D has never been away or been exposed to Western culture. The family structure is rigid along the lines of Islam (mother) and Roman Catholicism (father). Due to the home being dual-religious, two periods of fasting takes place for the year: for Ramadan (30 days) and for Lent (40 days). During these periods of fasting, meals are centred and planned around the fasting person. For example, during Ramadan chick peas and chutney are often prepared while during Lent, meals are centred around fish.

Patient D has a three-year history of body image disturbance, morbid fear of fatness and an abnormal attitude to food and periods of amenorrhoea. At the age of 15, her height was 5' and weight 118 lbs. The patient decided to lose 5-10 lbs., but later decided to lose more and lost 30lbs within a 4-month period falling to 88 lbs. The month of Ramadan coincided with this 4-month period. She began exercising heavily with a strict routine of one hour daily.

At school, even though she was a model student, her weight continued sliding and caused concern among her classmates, as they were aware that she used to throw away her food. They reported it to a teacher who called in her father at school. Within the family, the patient's body weight misperception caused family conflict especially with her mother. Her mother is described as controlling, overpowering, dominant and intrusive while father is passive.

During the months of Ramadan, between the ages of 15-17, the patient started to fast but was stopped by her mother, as her mother did not see her fit enough to do so. She however performed 3 of the 5 daily salats required by the religion. During the Lenten period for these years, the patient restricted her diet to a fish only intake, similar to her father's Lenten fasting regime. During the next year, she manipulated her weight and was in constant conflict with her mother who insisted that she should eat. Her exercise routine also became more vigorous as, she now exercised for two hours every day and joined a Tai-Chi class which had interested her greatly. Her mother continued to blame her for causing her immense stress.

At the age of eighteen, she zealously fasted for 10 days before being stopped by her mother. Also, she now performs all of the five daily prayers, not missing any. She suffers from feelings of sadness, hopelessness and unhappiness. In therapy for 6 months with the psychiatrist, she was treated with a combination therapy involving antidepressants, journal recording of daily calorie intake and weekly weight and psychotherapeutic sessions with a culturally sensitive therapist. She improved well and now with difficulty maintains an acceptable target weight of 108lbs.

DISCUSSION

Reports from Western countries [[20], [22]] seem to support our view that ritualistic fasting during the month of Ramadan sensitizes young Muslim girls to weight manipulation through fasting and binging and provides a religious sanctioned substrate for eating disorders. It is interesting that this Muslim girl's problems began at Ramadan and worsened over subsequent Ramadans where she was forcibly exempted from fasting. It appears therefore, that this religiously motivated behaviour is linked to ascetic components of control, self-denial, sacrifice and loyalty, rather than the secular western concept of physical beauty and the pursuit of thinness which is frowned upon in Islam.

Notwithstanding her Islamic lifestyle, there have been extraordinary influences from Roman Catholicism both at home and at school. At the age of 10 years, the patient's father rejected Islam and embraced Catholicism. Her father's decision was triggered by constant criticisms from his wife's extended family who viewed him as a Kafir (i.e. a non-believer). Her schooling at a Roman Catholic Convent between the ages of 11-18 years must have subconsciously reinforced her identification with her father. She had described her father as passive and avoiding conflicts while her mother was dominant, overpowering and intrusive. She has therefore incorporated cultural symbols both from her mother, a devout and zealous Muslim and her father, a religious convert to Catholicism. Her religious ambivalence is manifested by her preoccupation with fasting. The atmosphere of fasting is very prominent in this family as it occurs twice for the year: at Ramadan and at Lent. This culture reinforces indulgence in food intake, or abstinence by the patient as she fasts with both her mother for Ramadan and her father for Lent. The eating patterns of the family have influenced her choice to abstain from meat, as she is mostly vegetarian using fish as her only intake of animal protein.

The patient utilizes symbols from both religions that are highly ritualistic in their customs. Selective symbols are transformed to express her anxiety, pain and schisms with the family. She ritualizes her behaviour through starvation, a form of self-inflicted penance to cope with her religious ambivalence. This view is supported by psychological anthropologists who are of the opinion that culture and religion as symbolic systems have underpinnings in deep motivation [[15]].

Of particular interest, this 18 year-old Muslim student has lived a very sheltered life adhering steadfastly to the pillars of Islam. She has never lived away from home or visited relatives abroad and has not been actively exposed to western customs. She perceives herself as a devout, practicing Muslim, traditional in belief and dress with no confusion of identity. Significant findings of the family dynamics along the lines of the McMaster model of family

functioning [23, 24] revealed dysfunctions in resolving problem, communication, roles, clarity of rules and concern for each other. Like many West Indian families, flight into religion provided a coping mechanism for members of the family. It is known that dysfunctional family interaction is linked to anorexia nervosa [25,26,27]. In our case study, family disagreement arose from non-adherence or over indulgence in selective religious mores. Food became the common acceptable form of communication.

Religion is an important factor in the daily lives of Caribbean people. Trinidad and Tobago like other West Indian islands is influenced by diverse religious and cultural practices. Inter-religious practices are common and religion has become a thriving business peddling a wide range of arcane supported by religious quotations and spiritual injunctions with an elaborate system of ritualization. It is possible that religious-based behaviour with clear cut injunctions masks a number of psychiatric disorders including anorexia nervosa. As in the case of our Muslim student these disorders can be treated by a religio-cultural based therapy. Not only the ambivalence of religious or inter-religious practices will generate family based disorders, but in any society where there is a high rate of teenage pregnancy, it is expected that the incidence of anorexia nervosa will be low.

Despite the similarity in clinical presentation, the pathogenesis of anorexia nervosa in developing countries appears to be different to those in western countries. Needless to say, the interplay of Third World traditional practices based on religion, superstition and folk medicine and the influences of Western culture will result in a borderline cultural state. Individuals may therefore have difficulties in conceptualizing the culture or religion they belong to inter-phasing between the traditional or home culture and the modernizing or host culture.

In this case report there is greater amplification of the problem since there is the further splitting within the home culture resulting in a confusion of archetypal references. Within the West Indian community, each family appears to be a medley of religious and cultural diversity. Attitudes to religion and food are major determinants of sociability and adaptability. Ambivalence to these will result in psychosocial stress and disease.

The suggestion that ‘holy anorexia' may be associated with religious prescriptions of eating does not find favour with either the Muslim or Catholic clergies. The emphasis of fasting or food restriction at Ramadan or Lent is based on notions of spiritual cleansing of the body and mind. The Western pursuit of thinness and body image is not the goal. Crisp [28] highlighted the theme that there seems to be a clash between broadcast-invasive Western behavioural norms and value systems and the variety of societal and self-regulatory mechanisms of other cultures. In fact, Muslim laws forbid an emphasis physical beauty further discouraged by the mode of wear. Lent, is unlike Ramadan in that there is no restriction of the intake of food but restriction on the type. The case presentation of anorexia nervosa may be quite different in single patient who has a dual restriction at both these times.

Anorexia nervosa is rare in Trinidad and Tobago and other Caribbean countries. While the core symptoms of the disease remain constant; etiological and psychodynamic factors are variable. The non-secular nature of Trinidad and Tobago with religio-cultural fusion has resulted in a form of holy anorexia or religious ambivalence. The emphasis is different from the West obsessed with the pursuit of thinness. It appears as though those in developing countries place more emphasis on their religious practices than their perceived physical attractiveness.

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