SOCIO-CULTURAL FACTORS IN ANOREXIA NERVOSA

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SUMMARY

Socio-cultural factors are one of the important variables involved in development of anorexia nervosa. The prevalence of the illness has shown a definite increase in last few decades. Certain other important socio-cultural variables like familial interaction patterns, parental attitude towards weight control, desirability for slimmness and thinness also have a deciding role. Stress of any kind can act as a precipitating factor. We report here a patient of anorexia nervosa, in whom the above mentioned factors, accompanied by a recent stress played an important role in the development of illness. Role of socio-cultural factors in the genesis and management of anorexia nervosa have been discussed.

Introduction

Socio-cultural factors are one of the foremost variables involved in the development of anorexia nervosa (Garner and Garfinkel 1979, 1980). The prevalence of the disorder has shown a definite increase in last few decades (Duddle 1973, Kendell et al. 1973, Crisp et al. 1976). One of the reasons for this increase is that thinness is taken as a symbol of beauty and success in contemporary thinking. The increase in advertisements for slimming procedures in the media bear testimony to this. Anorexia nervosa is mainly seen in females, the reason being a demand for maintaining traditional standards for attractiveness in women and heightened demands for professional performance and success from them (Branch and Eurman 1980, Garner et al. 1980). Apart from this, certain other important social variables like familial interaction patterns, parental attitudes towards weight control, shape or fitness also have a deciding role (Crisp 1977, Bruch 1978, Garner and Garfinkel 1980). Stress of any kind can act as a precipitating factor. These factors should be taken into consideration in the management of this relatively rare condition.

Case Report

The patient M.S., 13 years old female, was a student of 8th standard in an army public school. Patient came from upper socio-economic status, the father of the patient was a senior army officer whereas mother, a Post-graduate diploma holder in business management, was a housewife.

In June 1984, the patient developed joint pains, fever and rash over face. At the time of presentation to our hospital, she had alopecia, leucopaenia, amenorrhoea and a vasculitic rash over limbs. With a clinical diagnosis of Systemic Lupus Erythematosus (SLE) she was investigated. Blood was found positive for antinuclear factor and LE cells confirming the diagnosis, for which Prednisolone was started in dose of 100 mg/day in August 1984. She started gaining weight which gradually increased.

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to 43 kg. in October 1984 from her previous steady weight of 38 kg. Her friends, teachers, physicians and siblings casually commented on her being fat upon which she gradually reduced her eating by missing meals, especially avoiding foods with high carbohydrate and fat content and taking only biscuits and fruits. Her mother told her not to do so but she did not comply. Her weight started decreasing gradually and by mid-August 1985 she was 22 kg in weight. Between April and August 1985 she lost more than 12 kg, and had suffered a pneumonic and diarrhoeal illness testifying to the consequences of malnutrition. At this point in time, psychiatric referral was sought and she was admitted on 24 August 1985.

In addition to above mentioned features she showed irritability, obstinacy, decreased social interest, demanding behaviour, mild depression and physical weakness. She had intense fear of gaining weight and developed peculiar food habits. She would hide different food items in a basket or suit-case to avoid eating those or else she would eat very small amounts and then walk vigorously to avoid gain in weight.

On further interviews, it was found that the mother of the patient had an overcritical attitude especially towards her increasing weight, while she was on treatment for SLE. She was often quoted as 'ugly' 'obese' 'fatty' and was told that she would not be able to do anything unless she reduced her weight. Often she was compared with her elder sister, who was slim. The father of the patient would not spend much time with her due to his official assignments. In her school, she was frequently commented adversely by her schoolmates and was a part of joke for her relatively sudden increase of weight. Her brother and sister also remarked on her being fat during those days. Her parents often advised her to restrict her diet.

All these factors led the patient to restrict her diet. She started avoiding fatty meals and would often escape from lunch or dinner. In this period, she was praised for her self control and discipline. This resulted in fall in her weight, which won her recommendations from the family, as well as school. However this reduction in diet continued and she became underweight. Now she was scolded by her family members for her refusal to eat to which she would retort back.

The patient expressed hostility, defiance and anger towards parents particularly the mother. The parents especially the mother often found faults with patient and tried to force authority on her, which led to a tug of war over food and other things. The patient was often forced to eat at home.

Premorbidly, the patient had a few obsessional traits mainly regarding cleanliness. She had always wanted to look beautiful. She used to wash her face and comb her hair many times a day and was very particular about her dress. She did not admit her being underweight and would say that she was normal.

On physical examination in August 1985, there was generalized emaciation and liver was palpable by 1 cm. Secondary sexual characters were present. Mental status examination showed irritability, hostility towards family especially the mother and secondary depression of mild severity. Blood for LE cells was negative but positive for anti nuclear factor. The patient fulfilled the DSM III criteria for diagnosis of Anorexia Nervosa.

Taking into consideration the various factors playing an etiological role in this patient, a comprehensive management plan was chalked out. It included family therapy, supportive psychotherapy, behaviour therapy, medical treatment and supportive physical management. A multi-dimensional approach
was used considering the severity of illness and equivocal evidence for the effectiveness of any individual therapeutic strategy.

In family therapy, the mother was asked to avoid any conversation related to food and to develop an attitude of acceptance and regard for the patient and to exercise control over her own emotional outbursts. She needed supportive psychotherapy herself to be able to do this.

The behaviour therapy included contingency contract. A full day schedule for the patient was made with reinforcements to be given at various steps on fulfilment of specified targets, i.e., increase in weight by 2-3 kg. per week. Both tangible and social reinforcers were used.

Medical treatment included prednisolone for her physical ailment SLE, the dose being gradually reduced from 40 mg/day to 10 mg/day during her inpatient stay. Cyproheptadine 4 mg. tid and Chlorpromazine 100 mg/day were also given as these were reported to be useful in anorexia nervosa by some workers (Dally and Sargent 1960, Crisp 1965 and Goldberg et al. 1979).

The supportive management included general nursing care, high protein diet (1800 Cal) and education about normal body weight and diet.

The patient showed improvement and there was gradual increase in weight averaging 2-3 kg. per week and it steadily reached 33 kg. in October 1985 at discharge. Weight went on increasing even after discharge to 47 kg. in February 1986. Menstruation had been resumed and was normal.

Discussion

This patient came from a social background, in which considerable stress is laid on body figure, beauty and slimming. She was a young female and was in the age group, which is most vulnerable to develop anorexia nervosa. Development of chronic illness in form of SLE, which warranted long term treatment and complications of the treatment i.e., steroid obesity acted as precipitating factor for the illness. The family had always been beauty conscious and patient was also very particular about her looks. The rapid increase in patient's weight while she was on treatment for SLE was a great concern for the family and the patient, which resulted in dietary restriction by the patient. In the earlier period of weight reduction, the patient won praise from the family and her school peers, which encouraged her for further reduction in the diet. In the later period, an ongoing battle started between patient and her family especially her mother leading to a vicious cycle and development of the illness. The pathological family interaction played sustaining role on the illness and was a negative influence on the treatment. The treatment was aimed at all these factors and was successful.

Socio-cultural factors are often in background in genesis of anorexia nervosa. The anorexic patient is described as 'Slender', 'Neat', 'Well-groomed' and is 'the most envied one' in a social circle. In the recent past there have been cultural pressures for the women to diet and to assume a thin body figure. The recent cultural expectation for thinness is specially directed towards women and particularly those of higher class. This is a reflection of contemporary thinking where thinness is often taken as a symbol of beauty and success. The data from magazine centrefolds and beauty contests also reveal significant trends towards thinner standards (Garner and Garfinkel 1980). There has also been a significant increase in diet articles in women's magazine over the past 20 years (Garner et al. 1980).

Sub-cultures in which there are pressures to be slim and to diet may give rise to a greater expression to the disorder.
in vulnerable adolescents. It has been seen
that anorexia nervosa is more common in
dance and modelling students than in other
women of a similar age and social class. This
supports the hypothesis that individuals,
who focus increased emphasis on body size
are at greater risk to develop anorexia
nervosa and related disorders (Garner and
Garfinkel 1978-80).

In addition to increasing slimness conscious­
ness, there has also been changing voca­
tional roles for the women in the recent past. This also poses adjustment problems
for at least some of them. These new roles
are also a potential factor in increase in ano­
xenia nervosa. The struggle to live up to
perfectionist or unrealistic performance
standards is a common characteristic of
such patients and may be one of the deter­
ninants of the disorder (Bruch 1974). The
pressure for thinness augmented by high
performance expectations is the ideal social
medium for the development of anorexia
nervosa.

Anorexia nervosa may be viewed as
multi-dimensional disorder with indivi­
dual, family and possible cultural predispos­
ing factors (Crisp 1977). Individual pre­
disposing characteristics include personality
characteristics, perceptual-conceptual dis­
turbances and a proclivity towards over­
weight or early maturity. Family interac­
tion patterns, personality features in parents
and parental attitudes towards weight con­
trol, shape or fitness also play a significant
role. A number of precipitants have been
identified such as inter-personal separation
or loss, sexual conflicts, heightened achieve­
ment demands or distressing pubertal
shape changes. All these factors could be
identified in our patient and were impor­
tant in the genesis of illness.

Anorexic patients tend to over estimate
their body size and do not consider them­selves to be thin and under-weight (Crisp
and Kalucy 1974). This disturbance starts
diminishing, if the patient gains weight as a
result of treatment (Slads and Russell 1973).
Food intake anorexia-nervosa is depend­
ent on the patient's perception of her body
size. As this perception is a distorted one,
the patient starves herself in an attempt to
return to what she considers to be normal.
This starvation leading to further loss of
weight may worsen the already distorted
perception and a self-perpetuating vicious
cycle is formed (Russell 1977). Thus abnor­
mal attitudes to eating and body-size are
responsible for the illness or its perpetuation.

A number of bodily disturbances found
in patients with anorexia nervosa are a re­
sult of hypothalamic dysfunction. But most
of such disturbances are a direct conse­
quency of the patient's malnutrition and show
improvement, as the patient starts gaining
weight. This has been clearly seen in our
patient. Cessation of menstruation in ano­
xenia nervosa is one of the diagnostic
features of the illness and also supports the
hypothesis of hypothalamic dysfunction
(Russell 1977).

Short term treatment successes are
quite common in patients with anorexia
nervosa by restoring the body weight to
normal and thus correcting malnutrition
and its consequences (Russell 1977).

The prognosis can be improved by
means of skilled psychotherapy aimed at
psychopathology that is characteristic of
anorexia nervosa (Bruch 1974). Misconcep­
tions regarding body size, body weight and
normal diet need to be corrected during
treatment. These were the predominant
disturbances in our patient.

Although SLE may be associated with a
large variety of psychiatric symptoms,
symptoms of anorexia nervosa as
psychiatric manifestations of SLE have not
been described. In this case SLE may have acted as a nonspecific stress or may have produced such metabolic/hypothalamic dysfunction as would be seen in anorexia nervosa. However, to conclude, socio-cultural factors have been found to play an important role in the genesis and management of anorexia-nervosa.

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