Clinical Case Report

Anorexia nervosa: An Indian perspective

D. N. MENDHEKAR, K. ARORA, D. LOHIA,
A. AGGARWAL, R. C. JILOHA

ABSTRACT

Anorexia nervosa is a condition thought to be associated with the western culture. However, the recent publication of a case series from Asia suggests that it is a syndrome related to a changing culture. We present a detailed clinical form of this syndrome based on descriptive analysis of 2 cases of anorexia nervosa. Both these patients were adolescent, school-going girls from middle socioeconomic class of urban background. They were pre-morbidly non-obese and did not have any pressures to pursue slimness for beauty. However, there was an identifiable psychosocial stressor as a precipitant in both of them. Both the patients had symptoms of refusal to eat followed by weight loss. We could not identify any risk factor in our patients for anorexia nervosa. Our report illustrates the differences in developmental and psychodynamic issues related to the development of anorexia nervosa, though the clinical symptoms may be similar.

Natl Med J India 2009;22:181–2

INTRODUCTION

There has been a recent spurt in the recognition of patients with anorexia nervosa (AN) in non-western countries, with one study reporting the prevalence of women at risk of developing eating disorders to be 7.4%.[1] This suggests that the western concept of equating beauty with being slim is being accepted in some Asian countries such as Thailand.[2] Though there are few published reports,[3–7] a qualitative study probing the clinical form is lacking in the Indian literature. We focus on the clinical pattern of AN in India by providing a descriptive analysis of 2 cases.

THE CASES

Case 1

A 15-year-old girl, student of class X, living with her adoptive parents but unaware of her adopted status, belonged to an urban family of middle socioeconomic status. She presented with a 15-month history of a change in eating habits. Just before the onset of her illness, her adoptive mother was diagnosed with hypertension, which needed dietary restrictions. The mother perceived a change in eating habits around this time as the patient started asking for a piece of sweetmeat every day. After a few weeks, she started demanding one or more ice-cream scoops/ sweetmeat everyday. A few weeks later, she started reporting abdominal pain after ingestion of one of these items and therefore stopped having them altogether. After about 6 months, she started complaining of abdominal pain upon eating any kind of solid food, subsequently decreasing her food intake. She started having an essentially liquid diet and, as a result, her weight decreased. At the same time, she started getting complimented by her friends and neighbours for looking slim and attractive. Over a few months, her ingestion of liquids, especially those with a high calorie content such as cold drinks, also decreased, and by this time (about 4 months before presentation), she weighed 30 kg. The parents perceived her weight loss to be around 40% as evidenced by marked loosening of her clothes and comparison with her older photographs. She avoided all sweets, oily food, fruits and even beverages. Over 6 months after the onset of her symptoms, she also began taking immense pleasure in making elaborate meals for her family, which was beyond her regular fondness for cooking. There was no associated history of purging, binge eating, or use of laxatives or emetics. There was no significant personal or family history other than her adoptive status, of which the patient was not aware. She was treated by the parents as their own child.

A work-up for organic causes of weight loss was negative. She weighed 26 kg (body mass index [BMI]=10.2), and had amenorrhoea for the past 4 cycles. She appeared cachectic, pale, with lanugo hair over her face. She had prominent bones with a maxillary prominence. Her secondary sexual characteristics were poorly developed. She did not consider her weight abnormally low or her appearance too thin. Her higher mental functions were within normal limits.

The patient was started on supervised feeding of oral foods, given frequently in small quantities. The need for continuous vigilance was emphasized. A good therapeutic alliance was established with the patient. The patient gradually started gaining weight (3 kg over 4 weeks). Despite detailed evaluation, no evidence of weight phobia or preoccupation with pursuit of thinness was found. Gradually, she re-started monitoring her weight as well as caloric count but again decreased her food intake after reaching a weight of 31 kg. This time, she repeatedly verbalized not wanting to gain more weight, as she perceived herself to be well and healthy. Her weight stabilized for a while, but again started decreasing. At this time the patient was lost to follow up.

Case 2

A 15-year-old girl, student of class IX, resident of an urban area, of middle socioeconomic status, presented with an 18-month history of an eating disorder. The onset could be traced to a period when the patient's elder sister had a love marriage with a boy of a different caste, going against the wishes of the family and prevailing social norms. This marriage led to a social boycott of

Neuropsychiatry and Headache Clinic, Pratap Nagar, Metro Pillar 129, Delhi 110007, India

D. N. MENDHEKAR

Children First, Vasant Vihar, New Delhi, India

K. ARORA

Long Island Jewish Medical Center, Glen Oaks, NY 11004, USA

D. LOHIA Department of Child and Adolescent Psychiatry

G.B. Pant Hospital, New Delhi 110002, India

A. AGGARWAL, R. C. JILOHA Department of Psychiatry

Correspondence to D. N. MENDHEKAR; *dnmendhekar@vsnl.net*

the family. Since then, she gradually started decreasing cereals from her diet as she did not feel like eating them.

In the initial 6 months, her weight decreased to 30 kg. She increasingly began insisting on doing physically strenuous household chores all by herself, and would exercise daily. The patient gave no other reason for not eating other than 'not feeling like' eating certain items. Subsequently, she developed amenorrhoea and her weight decreased to 26 kg (BMI=11.1). She began complaining of nausea and abdominal pain. However, she did not acknowledge that she was underweight; in fact, she insisted that she was not thin enough.

She was admitted to a psychiatric unit 6 months before being seen by us, where she received parenteral nutrition, gaining 2 kg over 4 weeks. She began accepting cereals, vegetables and fruits, but still avoided oily preparations. Over the next 6 months, she slowly gained weight (33 kg), but subsequently began reporting 'feeling fat', and expressed a desire to decrease her diet. Her weight started decreasing again and she presented to us when her weight was 28 kg with a refusal to acknowledge that she was underweight or 'thin enough'. Her personal history was non-contributory.

On examination, she appeared cachectic, with facial lanugo hair and poorly developed secondary sexual characteristics. The patient was started on supervised feeding regimen consisting of oral foods in small quantities. Initially the patient refused to acknowledge having any problems, giving no reason for not eating, except for vague abdominal pain as the reason. However, after several sessions, a reasonable therapeutic alliance was established, and the patient reported a dread of becoming fat as the reason for refusal of food. She also appeared distressed because of her sister marrying against the wishes of the family. She was asked to self-monitor her food intake, and given appropriate nutritional advice for calories needed. The interpersonal issues were discussed during family meetings.

Over 6 weeks, the patient gained weight steadily, weighing 33 kg at the time of discharge. Her fear of becoming overweight remained unchanged though her intake improved. At follow up after 6 months, the patient had resumed menstruating and weighed 40 kg. She recently started reporting uneasiness at her 'excessive' weight while maintaining her earlier conviction that she was not thin enough.

DISCUSSION

These 2 patients share some characteristics: both are adolescent, school-going girls from middle socioeconomic urban background without a family history of any psychiatric disorder. Both had been interpersonally compliant, pre-morbidly non-obese without apparent pressure to pursue slimness for beauty or any other reason. Their families did not list any problem in psychosocial development nor reported any ties with the fashion world or any belief of being slim. Clinically, they had similarities in symptoms of refusal to take normal food, weight loss and ritualistic dietary habits. Both had a discernible psychosocial stressor evident as a precipitant for refusing to eat with a hint of concern about body image. However, the patients themselves did not acknowledge it initially. This may partly be explained by the ambivalence and denial frequently leading those with AN to minimize their symptoms. At the same time, initial preoccupation with calorie intake and later revelation of weight phobia could be due to greater exploration over time on our part or improved rapport with the patients. This suggests that clinical symptoms of AN in India may not be different from AN in western countries and it may not be a strictly western culture-bound syndrome.

Traditionally, cases of AN from India surmised lack of the fundamental characteristic, that AN is not accompanied by a 'fear of fatness' or desire to be thin,[4] but rather by a desire to fast for religious purposes or eccentric nutritional values.[8] Fear of fat, which is a feature of AN, occurs in the context of a culture that values slimness. As India becomes more industrialized, weight phobia may become increasingly common. Furthermore, Asian women who have lived in the West and developed AN also show weight phobia.[9] A case of restrictor AN in a 13-year-old girl raised in a traditional, sheltered Muslim home in Pakistan has been reported.[10] This disorder developed due to family concerns and preoccupations about weight and appearance, and desire to be attractive. The western media might have a profound negative impact upon body image and attitude towards eating in traditional societies in which eating disorders have been thought to be rare.[11] In contrast, an Iranian survey reported that women in Tehran who were more interested in the western culture were more likely to be satisfied with their body shape, which suggests that the hypothesis of cultural effects on eating disorders may be limited.[12]

The risk factors for AN include early feeding difficulties, symptoms of anxiety, perfectionist traits, and parenting styles, but none of these can be considered to have been conclusively demonstrated in our patients.[13,14]

These cases illustrate that although symptomatology may be similar to that of western AN, psychosocial developmental and psychodynamic issues may not be similar to those in the western culture as our patients developed AN as an unexpected crisis in response to a psychosocial stressor without any risk factors for AN.

In India, due to economic reforms, increased societal pressure and media bombardment that 'slim is beautiful', we are likely to see an increase in the number of patients with AN in the future.

REFERENCES

1 Ho TF, Tai BC, Lee EL, Cheng S, Liow PH. Prevalence and profile of females at risk of eating disorders in Singapore. *Singapore Med J* 2006;**47:**499–503.
2 Jennings PS, Forbes D, McDermott B, Hulse G, Juniper S. Eating disorder attitudes and psychopathology in Caucasian Australian, Asian Australian and Thai university students. *Aust N Z J Psychiatry* 2006;**40:**143–9.
3 Mendhekar DN, Arora K, Jiloha RC. Anorexia nervosa with binge eating. *Indian J Psychiatry* 2003;**45:**58–9.
4 Khandelwal SK, Sharan P, Saxena S. Eating disorders: An Indian perspective. *Int J Soc Psychiatry* 1995;**41:**132–46.
5 Srinivasan TN, Suresh TR, Jayaram V, Fernandez MP. Emergence of eating disorders in India. Study of eating distress: Eating disorders in India. *Indian J Psychiatry* 1995; **37:**26–30.
6 Chadda R, Malhotra AG, Bambery P. Socio-cultural factors in anorexia nervosa. *Indian J Psychiatry* 1987;**29:**10–11.
7 Avasthi A, Punnet, Das MK, Gupta S. Integrative approach to the management of anorexia nervosa: A case report. *Indian J Psychiatry* 1997;**39:**79–81.
8 Castillo RJ. Eating disorders. In: Castillo RJ (ed). *Culture and mental lllness: A client-centered approach.* Pacific Grove, California:Brooks/Cole Publishing; 1997:149–56.
9 Mumford DB, Whitehouse AM, Platts M. Sociocultural correlates of eating disorders among Asian schoolgirls in Bradford. *Br J Psychiatry* 1991;**158:**222–8.
10 Yager J, Smith M. Restricter anorexia nervosa in a thirteen-year-old sheltered Muslim girl raised in Lahore, Pakistan: Developmental similarities to westernized patients. *Int J Eat Disord* 1993;**14:**383–6.
11 Becker AE, Burwell RA, Gilman SE, Herzog DB, Hamburg P. Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. *Br J Psychiatry* 2002;**180:**509–14.
12 Nobakht M, Dezhkam M. An epidemiological study of eating disorders in Iran. *Int J Eat Disord* 2000;**28:**265–71.
13 Jacobi C, Hayward C, de Zwaan M, Kraemer HC, Agras WS. Coming to terms with risk factors for eating disorders: Application of risk terminology and suggestions for a general taxonomy. *Psychol Bull* 2004;**130:**19–65.
14 Striegel-Moore RH, Bulik CM. Risk factors for eating disorders. *Am Psychol* 2007;**62:**181–98.