"Spiritual Starvation?": A Case Series Concerning Christianity and Eating Disorders

John F. Morgan,* Patricia Marsden, and J. Hubert Lacey

Eating Disorder Unit, Department of Psychiatry, St. George's Hospital Medical School, London, United Kingdom

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Abstract: **Method:** *We describe the cases of four patients with eating disorders in whom complex interactions occurred among religious faith, pathogenesis of the eating disorder, and clinical management.* **Results:** *In some of the cases, religious beliefs seemed to provide a containment of maladaptive behaviors, partly through prayer and through a sense of belonging to the religious community. In other cases, it proved difficult to separate the concept of a punitive God from the illness process.* **Discussion:** *The cases are discussed with reference to a limited empirical literature. Similarities are noted between some religious institutions and eating disorder treatment regimes. This paper explores management issues, including the use of pastoral counseling and the ethics of addressing religious beliefs in therapy. We note the benefits of a rapprochement between psychiatry and religion. © 2000 by John Wiley & Sons, Inc.* Int J Eat Disord 28: 476–480, 2000.

Key words: *spiritual starvation; religious faith; eating disorders*

> "Thus grant that the body be subjected from without by abstinence in order that the sober mind may fast completely from the stain of sin" (Lenten hymn attributed to Gregory the Great, d. 604).

INTRODUCTION

Sociocultural perspectives of eating disorders have begun to encompass the historical antecedents of asceticism in equal measure with the 20th century feminist perspective (Bell, 1985; Rampling, 1985). However, the empirical literature on eating disorders and religion is surprisingly sparse. In an uncontrolled study, Joughin, Crisp, Halek, and Humphrey (1992) created the Religious Beliefs Questionnaire and profiled symptoms in 851 subjects with eating disorders against personal/family belief. They concluded that "asceticism is used by individuals to justify . . . the anorectic defense of weight loss," (pp. 404) but did not feel that a religious upbringing predisposed to anorexia nervosa. Elsewhere,

Correspondence to: Dr. John Farnill Morgan, Department of Psychiatry, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, United Kingdom. E-mail: jmorgan@sghms.ac.uk

there is little consistency in reported distribution of religious affiliations among eating-disordered patients. In Germany, Jacoby (1993) has suggested that Protestant affiliation is associated with anorectic abstinence and Catholicism with bulimia, whereas Wilbur and Colligan (1981) found that indices of "religious fundamentalism" on the Minnesota Multiphasic Personality Inventory (MMPI) discriminated anorectic patients from controls. Sykes, Leuser, Melia, and Gross (1988) found an increased prevalence of eating disorders among Jews and Catholics, whereas other studies suggest religious affiliation reflects population norms (Rowland, 1970; Garfinkel & Garner, 1982). These studies fail to consider causal relationships, for example, the tendency for sick people to turn to religion for solace, or subcultural context, for example, being a Catholic in a predominantly Lutheran country. Greater insights are derived from case studies such as Banks (1992), who described anorexia nervosa in Christian fundamentalist families in which there was a perceived split between spirit and body, subduing the latter through fasting and suppression of sexuality. However, like Joughin et al. (1992), Banks does not implicate religious upbringing in pathogenesis.

Against this background, we describe the complex interaction between religious faith and eating disorders in patients treated in our hospital, with reference to pathogenesis, clinical management, and pastoral counseling (Lartey, 1997). In each case, faith was a core aspect of psychic structure. In some cases, the relationship with God offered containment of impulses that might otherwise have been expressed behaviorally. In other cases, it proved difficult to separate the concept of a punitive God from the process of the illness itself. The skilled input of the hospital chaplain as a member of the clinical team allowed these issues to be addressed and challenged more vigorously than the lay perspective might allow.

REPORT OF CASES

Case 1

Case 1 was a middle-aged non-Catholic woman brought up in a Catholic rural community. As a child, she believed her congenital hearing impediment was God's punishment, but found solace in prayer. Despite lifelong social isolation, she only began to decompensate in middle-age, responding to interpersonal conflict at work by neglect of her needs and appetites. She displayed punitive religious devotions involving self-starvation, ingestion of rotting food, and eventually anorexia nervosa, while feeding vagrants with her fresh food. She was assessed and diagnosed with anorexia nervosa of late onset (American Psychiatric Association [APA], 1994). She responded to behavioral parameters of inpatient treatment combining cognitive-behavioral and psychodynamic psychotherapy. However, weight gain was accompanied by existential despair and questioning of faith, with awareness of lost reproductive years. Nonetheless, she achieved long-term weight maintenance and her religious beliefs became more sustaining than punitive. One year after discharge, she continued to hold a steady weight appropriate to the mean matched population, and had sought pastoral counseling.

Case 2

Case 2 presented with a brief history of anorexia nervosa (APA, 1994). Her illness arose from escalation in social anxiety and low self-esteem at adolescence following her first serious relationship. Parental anxiety in dealing with her emerging sexuality exacerbated

her own anxieties and she resolved the maturational conflict by weight loss. The patient came from a nonpracticing Christian background, describing herself as "not really religious," but became preoccupied with theological themes following hospital admission. She struggled to articulate her fear of normal body weight, instead using moral terms, with weight gain labeled "evil," whereas low weight was seen as being "near God." She saw herself as personifying evil, using religious arguments to justify low weight, which beliefs had the quality of overvalued ideas. The clinical team wished to respect her faith but believed it to be partly derived from her anorectic psychopathology and it did not seem possible to aid recovery without challenging some of her ideology. The hospital chaplain was invited to join the team and offered pastoral counseling, allowing her to delineate areas of faith that were anorectic defenses. She engaged more fully in the treatment program, with adequate weight gain. However, following resumption of menses, she became depressed and elected to be treated by her local psychiatric service instead.

Case 3

Case 3 presented with a 6-year history of bulimia nervosa (APA, 1994) with additional features of multi-impulsivity (Lacey, 1993) in the form of repeated deliberate self-harm, substance misuse, and shoplifting. However, these behaviors diminished when she was converted as a Jehovah's Witness in late adolescence. Her disorder arose from a history of chaotic parenting, with a strong family history of substance abuse. She agreed to standard inpatient treatment, based on Lacey's approach to multi-impulsive bulimia (Lacey, 1995). Staff were struck by the disparity between her severe psychopathology and her behavior, which was readily modified, her religious beliefs providing internal restraint. However, she saw psychodynamic therapies as a challenge to her faith and ultimately she was unable to make full use of the treatment. She remained surprisingly free of behaviors on discharge.

Case 4

Case 4 was a nun who presented with anorexia nervosa and was unsure whether she should remain in religious life. She gave a history that she had been unprepared for menarche and that her puberty was marred by her father's death. Consequently, her mother became melancholic and was admitted to a psychiatric hospital. She and her brother took on parental roles, caring for junior family members, while beginning a sexual relationship with each other. Overwhelmed with guilt, she starved herself in expiation and anorexia nervosa emerged. She escaped the situation by entering a convent and her anorexia nervosa remained untreated for many years. Her presentation to our clinic stemmed from a fear that she had misinterpreted her religious calling. Brief weight gain prior to assessment had led to return of libido. She felt drawn toward her village priest and her sexual feelings were reciprocated. Minor sexual activity led to a belief that her sexuality was destroying her priest as it had destroyed her relationship with her brother. She believed that the only resolution was to return to anorexia nervosa. However, she was able to make sense of her experiences in the context of psychotherapy and weight restoration, albeit at the expense of her faith.

DISCUSSION

These cases demonstrate complex interactions between religion and mental disorder, in which neither component could be ignored. For some, religion was containing or repara-

tive. In Cases 3 and 4, the moral code of their religion gave a sense of safety, whereas the social aspects of the church group offered the experience of belonging and nurturing, which was denied in the family. Russell and Marsden (1998) suggest that bulimic patients with comorbid borderline personality traits have not felt securely contained in childhood and have experienced difficulties in what Mahler, Pine, and Bergman (1975) described as separation-individuation. This leaves them with an unstable sense of body boundaries and lack of a sense of mental space to contain feelings. Case 3 exemplifies this pattern, initially acting out painful feelings through her body, but restraining her impulses after her conversion. This is not to suggest that she was cured by religion, but it did provide her with greater internal restraint. Likewise, Cases 1 and 4 appeared to be contained by prayer. Indeed, there are many similarities between containment offered by some religious institutions and eating disorder treatment regimes, including a process of initiation or assessment, a declaration of faith or treatment contract, use of group processes, confession of wrong-doing, and the possibility of absolution. Some of these cases demonstrate reparative effects common to both institutions.

In Case 2 and in the early stages of treatment of Case 1, belief in a punishing God derived from the eating disorder, sharing features with Banks' cases (1992) including a split between bad and good in terms of body versus spirit. Cases 1, 2, and 4 attempted to subjugate their bodies by restraining hunger in the name of their faith. For Case 1, starvation and the ingestion of rotting food were penitential exercises also seen in Banks (1992). However, unlike Case 2, Cases 1 and 4 were able to question this expiation through therapy and modified their beliefs so that religion might become a more positive influence in their lives.

CONCLUSIONS

Some patients understand their eating disorder in religious terms that may be difficult to challenge without seeming to undermine faith. In these situations, pastoral counseling by a hospital chaplain may be beneficial, being better prepared than lay therapists to place religious experience in context, "neither rejecting it out of hand, nor accepting it completely at face value" (Sutherland, 1996, pp. 215). For some patients, containment offered by supportive church groups or prayer may allow painful feelings to be tolerated without resulting in maladaptive behaviors. In these cases, a rapprochement between psychiatry and religion seemed more beneficial to patients than Freud's belief (1927/1985) that religion is an immature defence against human helplessness.

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