

Eating disorders in black South African females

A series of cases

C. P. Szabo, M. Berk, E. Tlou, C. W. Allwood

Eating disorders are generally associated with westernised white populations. Isolated cases of anorexia nervosa have been described in blacks in Africa. A series of cases is presented documenting the existence of eating disorders in young black South African women. This has implications in terms of both conceptualising these conditions as culture-bound with respect to 'westernisation' and planning health service delivery in an increasingly westernised future South Africa.

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Eating disorders, especially anorexia nervosa, have traditionally been conceptualised as culture-bound syndromes,^{1,2} and other than in Western (First-World, urbanised) adolescent or young adult white females of upper-middle socio-economic class these conditions are uncommon.^{2,3} Cultural attitudes appear to play an important role in the development and expression of eating disorders.⁴ Owing to the increasing homogenisation of aesthetic values across cultural barriers,⁵ it would seem logical to expect increasing numbers of patients with eating disorders to present in cultures not traditionally associated with such conditions. This would appear to be the case in certain Asian countries,⁵ and it also appears that eating disorders are becoming more common among Afro-Americans.⁶ This has specific implications for South Africa, given our heterogeneous population, comprising elements of both First- and more traditional Third-World cultures, and the potential for cultural fluidity.

While anorexia nervosa has been described in black Africans,⁷⁻⁹ neither this condition nor other eating disorders seem to have been reported in blacks in South Africa. Nash and Colborn¹⁰ reported in a recent local study that at the time of writing no black patient had been referred to their centre, either for inpatient care or for outpatient consultation.

We describe a series of young black South African women who presented with features of eating-related psychopathology, encompassing a spectrum of *DSM-III-R*¹¹ eating disorders.

Eating Disorders and Adolescent Unit, Tara the H. Moross Centre, Johannesburg

C. P. Szabo, M.B. B.Ch., F.F. PSYCH. (S.A.)

E. Tlou, M.A. (CLIN. PSYCHOL.)

Department of Psychiatry, University of the Witwatersrand, Johannesburg

M. Berk, M.B. B.Ch., M.MED. (PSYCH.), F.F. PSYCH. (S.A.)

C. W. Allwood, B.A., M.B. CH.B., F.F. PSYCH. (S.A.), M.MED. (PSYCH.), M.D. (PSYCH.)

Case reports

Case 1

A 22-year-old unmarried university student was referred for assessment by her mother, who was concerned about her altered eating pattern and associated weight loss. The parents were divorced and the patient lived with her mother and younger siblings. Both parents were professionals and self-employed. While the patient had a close relationship with her mother, at the time of assessment her relationship with her father was somewhat distant, although it was reported that previously they had been close. The patient's mother was interviewed to obtain a collateral history.

The patient's height was 1,52 m and her weight 42 kg. She was only 7% underweight on assessment, but 3 weeks previously she had weighed 38,5 kg and had been 15% underweight. During the interview she stated that she would be happy to weigh 45 - 46 kg (deemed appropriate), that she was not overly concerned about her weight, and that she weighed herself infrequently.

The eating problem had started at the time of the patient's final exams in 1992, when she weighed 48 kg. She had begun restricting her food intake in terms of quantity and variety, cutting out starches and sugars as well as switching from full-cream to skim milk. She had continued to eat meat, but ate few vegetables and avoided 'junk' food. After an initial weight loss (the patient could not recall the exact details) she had begun using herbal laxatives in an attempt to maintain the weight loss, but had stopped after 2 months because of stomach cramps. Her food intake remained restricted and she consumed large amounts of diet soft drinks, water and coffee, as well as chewing gum excessively.

On confrontation by her mother the patient had dismissed all this as secondary to exam pressure. She described herself as determined, persistent, strong-willed and ambitious, with a tendency towards being rigid and perfectionistic. The collateral history supported this.

The patient was unable to explain why she should have wanted to maintain her weight at a lower level, denying any fear of being overweight. She mentioned feeling uncomfortable socially because people kept enquiring if she was ill because she was so thin. Her social activities were not curtailed. During 1992 she had been swimming and playing squash for 'enjoyment', not weight control. She was currently unable to continue her sporting activities because she felt weak.

Towards the end of 1993, the patient's mother confronted her again about her eating habits and weight, which she once again dismissed. In December 1993 appetite suppressants were discovered among her belongings. She denied that they were hers, saying that they belonged to her sister, but ultimately acknowledged taking them for a 2-week period only, for the purpose of attempting to avoid eating. However, she said that she had felt nauseous and dizzy while taking them and therefore stopped. Episodes of binge eating (consuming a whole chicken) occurred during this period of restriction, but no vomiting.

The patient never experienced loss of appetite and expressed a love for and enjoyment of food. In terms of her body image there did not appear to be any distortion, and she claimed to perceive herself as thin and needing to gain

weight. She reported irregular menstruation and had been amenorrhoeic for 2 months when interviewed. However, she had been receiving a depot contraceptive since 1991.

Between the initial interview with the mother and the clinical interview with the patient 3 weeks elapsed, during which the patient gained 3.5 kg.

The patient's reporting of symptoms was rather superficial and her reliability was questionable in view of the collateral information obtained. She felt that there was no problem, and it was decided not to pursue intervention beyond the assessment.

Case 2

A 26-year-old woman with two children and living with her family, referred herself to the Eating Disorders Unit. She was unemployed but in the process of completing a university degree.

On admission she reported bingeing 8 - 10 times per day. During such binges she would consume excessive quantities of rapidly digestible food while feeling out of control. Self-induced vomiting would follow immediately and provide relief. She also reported laxative abuse. Her weight was 44.2 kg and her height 1.6 m.

On the basis of a goal weight of 55 kg, the patient was 19.6% underweight. She reported no menstrual irregularities; she felt that her admission weight was ideal and did not perceive herself to be thin. She felt more attractive when thin and said that weight gain would depress her.

She claimed that her family were always on diets and that she had been dieting since the age of 13. She described a pattern of alternating periods of restricted intake and normal eating with intermittent vomiting — not more than once a day — since the age of 16. At this time she was also abusing laxatives.

After matric, while the patient was studying at university, she had begun to restrict her intake of food excessively and her weight fell to 38 kg ($\pm 30\%$ underweight). She became amenorrhoeic. She had returned home and restored weight, but had dropped out of university. Over time her eating pattern had consolidated into an alternating restricting/binge-purge pattern associated with concurrent alcohol abuse and numerous suicide attempts from overdoses. This behaviour had culminated in her first admission. While her eating behaviour was documented, it had not been addressed at that time; the focus of that admission had been on the substance abuse and development of appropriate coping skills.

The patient's subsequent admission resulted in her participation in the bulimia programme.

Case 3

A 24-year-old university student of upper middle-class background had attended a private school. Her father was a general practitioner and her mother a nursing sister. She described her relationship with her mother as being closer than that with her father, whom she described as 'emotionally distant'. Her presentation was characterised by three symptom complexes related to eating, mood and personality.

The first symptom complex related to a lengthy and persistent history of distinctive relationship problems

characterised by intense distrustful and destructive patterns of interaction. Impulsivity was a notable feature of the patient's behaviour. Mood swings were particularly distressing and prominent. She had made numerous suicide attempts, usually in response to difficulty in coping with interpersonal conflict. Chronic feelings of emptiness associated with periods of boredom compounded the presentation.

Approximately 2 months before initial assessment the patient had noted more persistent depressive feelings, with initial and middle insomnia, loss of appetite, loss of energy and diminished concentration.

Despite her reported loss of appetite, she described regular episodes of binge eating followed by purging (self-induced vomiting), which appeared to be related to and exacerbated by interpersonal difficulties. This behaviour had in fact commenced in her teens after numerous failed attempts at dieting. She had a marked concern about her weight and food intake, which had been present for many years.

On the basis of this presentation the patient was assessed as having features of bulimia nervosa, borderline personality disorder and major depression. She was treated as an outpatient with psychopharmacological (fluoxetine) as well as psychotherapeutic (cognitive-behavioural) interventions.

Discussion

The above case reports give rise to questions regarding the extent to which eating disorders are culture-bound, whether they are culture-bound, and to which culture they are bound — the culture of ethnicity or the culture of society, which may be multi-ethnic. Eating disorders have emerged in so-called 'traditional' societies both in the Western world and sporadically world-wide.¹² Their sporadic nature may reflect restriction of research efforts to those traditional societies where modern technology, values and research infrastructure facilitate such investigation. Alternatively, the acceptance that eating disorders exist outside the stereotypical parameters has in some way impeded recognition. It has to be acknowledged that these conditions may take forms that are culture-specific, within the context of ethnicity, and may not be recognised. Lastly, the role of the traditional healer in dealing with such patients cannot be underestimated — affected individuals may not ever present to a medical facility for treatment.

The importance of addressing cultural issues is that, through establishing and controlling for ethnic differences in presentation, we may ultimately arrive at the core pathology, i.e. features present whatever the setting. More recently, it has been asked to what extent weight phobia is an essential criterion in the diagnosis of anorexia nervosa, given its rarity in non-Western patients with the condition.¹³ Since all criteria in the *DSM-III-R* are required to be met before making a diagnosis of anorexia nervosa, the absence of weight phobia may to some extent account for the rarity with which the conditions is diagnosed in non-Western cultures and hence render the apparent low prevalence a misrepresentation.¹²

The African literature on eating disorders to date comprises 3 case reports,⁷⁻⁹ describing 3 Nigerians and 1 Zimbabwean, all with anorexia nervosa. In reviewing the

description of these patients, their presentations are in no way unique and do not specifically identify the patients as black Africans. While the cases do share certain common features, i.e. university education (3/4), conflict with their fathers (4/4) and comorbid major depression (4/4), it is interesting to note that according to the proposed subtyping of anorexia nervosa in the *DSM-IV*, 3 of the 4 cases would potentially have been diagnosed as having the bulimic subtype of anorexia nervosa.¹⁴

With regard to the local cases, there is no presenting feature that identifies them as being black African. Furthermore, they had a number of features common to the earlier case reports mentioned, i.e. university education (3/3), conflict with their fathers (2/3) and a potential diagnosis of anorexia nervosa, bulimic subtype (2/3). Only in 1 case was weight phobia reported to be absent.

It seems clear that black African patients with eating disorders do not seem to differ in terms of presentation from their white counterparts. While certain features are common to all the cases described so far, the absence of any large-scale studies exploring this further means that such observations cannot yet be considered significant.

Studies of this nature are warranted to establish culture-specific presentations and ultimately the core pathology of eating disorders.

Conclusions

Do all non-Western cultures still cherish plumpness? In Hong Kong, which represents an intermediate between Western and developing societies, it has been noted that fatness is tolerated rather than accepted by young Chinese women, with the pattern of body weight distribution of female subjects changing from that typical of developing countries to that in developed countries, in which socio-economic reversal of fatness in females occurs — the wealthier, the thinner.⁵ The pattern of eating disorders beginning to emerge in Hong Kong may serve as an indicator of what happens when traditional people follow Western ways. This phenomenon has also been documented, albeit to a limited degree, in a Zimbabwean sample.¹⁵ It was found that the drive for thinness that leads to the onset of dieting behaviour was present in black schoolgirls, although less intense than in white and mixed-race schoolgirls attending the same private schools. The authors commented that among urban, affluent black Zimbabweans a degree of fatness is tolerated. However, in traditional Zimbabwean society fatness is equated with success and is not perceived as unattractive.

It appears that increasing numbers of black South African females are likely to present with eating-related disorders as our society becomes more homogeneously westernised. We need to anticipate this and be adequately informed and prepared. To this end, it is imperative that future research should also focus on establishing emerging eating attitudes in this population. More specifically, attention should initially be directed towards specific situations where black girls and young women are directly exposed to Western culture and value systems at a time of vulnerability, i.e. schooling and university. Given the limitations of our present facilities for patients with eating disorders,¹⁶ failure to anticipate an

increased demand on these services and act accordingly will obviously have negative consequences in terms of health care delivery.

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