

Spirituality and clinical care in Eating Disorders: a qualitative study'

by

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Response by Professor Andrew Sims

Like many psychiatrists working in general Teaching Hospitals, through the middle of my career much of my time was taken up managing patients with eating disorders, especially severe anorexia nervosa. When these patients were seriously underweight, it was 24-hour, life and death care looking after them. I attended national and international meetings and conferences on anorexia nervosa, and gave papers. In all that time, in the 1970s and 80s, neither I, nor anyone else I read or listened to, ever mentioned the spiritual or religious aspects of eating disorders.

What a good thing that the spiritual notions and beliefs of our patients are now 'given' as an essential part of the psychiatric history and examination. Marsden, Karagianni and Morgan, and the other authors whom they quote in their paper, are to be congratulated on not only enquiring about the spiritual and religious beliefs of their eating disorder patients, but also analysing the meaning of belief for patients who cited religion as being 'important'. They investigate *locus of control*, *self-image*, *sacrifice*, *salvation* and *maturation*, and consider how these factors could be included in more effective treatment.

Strangely, eating and food have become moral issues today; perhaps they were the harbinger of post-modernism in our society, giving substance to the idea that the era of valueless rationality was now over. Ordinary people, journalists, 'celebrities', for the last couple of decades have talked about 'good' and 'bad' food: lettuce and muesli are *good*, burgers and chips are *bad*. This has come to mean not only 'good for you', but morally good. *Sin* is eating cream buns or treacle pudding. Being slim is commendable and gives such a person a buzz of self-righteousness; being obese (the word usually used) creates feelings of moral inferiority. The whole process of buying, preparing and eating food has become value-invested, and evokes a multitude of guilt feelings and prohibitions. The medical and other health care professions constantly reinforce these ideas.

It is not surprising, therefore, that in our society, in those who have religious belief and are also prone to eating disorders, notions of food, eating and fasting develop into a moral issue, and religion and eating become intertwined. An advantage of gaining some understanding of your patients' beliefs is that the therapist can incorporate this into treatment. The late Dr Nagoub Bishay, a Coptic Christian psychiatrist, who, through his earlier work in Egypt, had a good understanding of the beliefs of Muslim, Christian and Jewish patients, developed cognitive behavioural therapy for people with religious beliefs (Bishay & Ormston, 1996). He obtained an account, both

descriptive and historical, of the patient's symptoms, and then allowed his patients to express their religious beliefs in their own words in the context of these symptoms. He then helped each patient to challenge their cognitive errors by using their own religious belief, to set up an argument within themselves to demonstrate that their pathological response was unnecessary, and false to what they themselves believed. For eating disorders this could involve, as some of the cases of the article by Marsden et al. suggest, helping the patient apply her own beliefs about God and His love to change her *schema* concerning food, eating and refraining from eating; the patient coming to realize that God does not require sacrifice to death by starvation.

Each of their five symptomatic categories provides a portal for treatment. Some patients saw God as a 'disciplinarian'; **out there not in here, an external locus of control**. There is evidence that in general, people with religious beliefs, compared with those without, have greater sense of **internal locus of control**; they consider that God is within them, not outside (Jackson & Coursey, 1988). Treatment, using the patient's own Christian belief, would be directed towards helping the person realize that God being inside her and within implies that she is better able to control outside circumstances.

Similarly, with negative **self-image**, shame, guilt and self-hatred were recurring themes. Treatment, which includes both psychiatric principles and the incorporation of religious beliefs, would work towards the patient understanding for herself that if God loves her, which she accepts, she does not need to hate herself. In practice, of course, it will not be quite that simple, but that is the model. Shame and guilt in eating disorders come from both eating against their self-control and from starving themselves to cachexia. It is helpful to take self-image into account, including how religious notions are interwoven with misconceptions about ingestion. This involves working with the person and her belief in resolving the psychiatric symptoms rather than challenging her religious belief, which would result either in causing severe and destructive ambivalence in her, or her rejecting treatment altogether.

In Christian theology, **sacrifice** has been made once for all by Jesus Christ in his dying for the sins of the world for all time. Thus, within the religious belief of the patient herself is the assurance that her sacrifice is not required. She can use this to challenge her preoccupation that 'I deserve to be punished'. Anorexia nervosa of itself, and particularly when severe, produces changes in cognition, feeling a need to starve oneself. Combine this with religious notions of sacrifice and atonement for sin, and there is a potent stimulus towards exacerbation of the disorder. Helping the patient deal **from inside** with her condition through her religious belief is a valuable way of working towards improvement.

For psychiatrists who regard the spiritual aspects of our patient's condition as important, this paper is heartening. It combines psychiatric treatment with acknowledgement of the patient's faith: "*to come into hospital...was the most amazing blessing*"; accepting that faith contributes to recovery: "*I do know what the peace of God is...you can really give in all your worries and He'll give you His peace. I think I'd be dead otherwise, I think I would have done myself in.*" **Salvation** involves the whole person, neither just their physical state with the individual not dying from starvation, nor saving their eternal soul at the expense of a diseased body. Christian belief does not

see spirit as something superior and more exalted floating above mind and body, but all three as essentially integrated for a whole person.

By **maturation**, the authors imply the patient integrating thoughts about her condition, and eating disorder, with her religious beliefs. Faith then becomes an instrument towards recovery. We are indebted to the authors for an interesting and thought provoking paper, which could lead to helpful approaches towards the treatment of our patients, not only those with eating disorders, but also other mental illnesses. Almost all psychiatric disorder affects mental, physical and spiritual aspects of the person and their capacity for relationship. Ideally, treatment should therefore incorporate all three aspects.

References:

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