‘Spirituality and clinical care in eating disorders: a qualitative study’.

Patricia Marsden, MA, and Efthalia Karagianni, BSc

Division of Mental Health, St George's Medical School, University of London; St George's Eating Disorders Service, London UK

John F Morgan, MD, MA, MRCPsych, MB BChir

Yorkshire Centre for Eating Disorders, University of Leeds, Leeds, UK

Key words: spirituality, qualitative research, treatment adherence

Abstract

Objective: Historical and contemporary research has posited links between eating disorders and religious asceticism. This study aimed to examine relationships between eating disorders, religion and treatment.

Method: Qualitative study using purposeful sampling, applying audiotaped and transcribed depth interview subjected to Interpretative Phenomenological Analysis.

Results: Participants were 10 adult Christian women receiving inpatient treatment for anorexia or bulimia nervosa. Five dominant categories emerged: locus of control, sacrifice, self-image, salvation, maturation. Appetitive control held moral connotations. Negative self-image was common, based more on sin than body-image. Medical treatment could be seen as salvation, with religious conversion manifesting a quest for healing, but treatment failure threatened faith. Beliefs matured during treatment, with prayer providing a healing relationship.

Conclusions: Religious beliefs impact on attitudes and motivation in eating disorders. Clinicians’ sensitivity determines how beliefs influence clinical outcome. Treatment modifies beliefs such that theological constructs of illness cannot be ignored.

Spirituality and clinical care in eating disorders: a qualitative study.

The authors presented a Western case series [1] in this journal, in which we described clinical and ethical issues arising from management of Christian patients, some of whom understood *'their eating disorder in religious terms that may be difficult to challenge without seeming to undermine faith'*. A plethora of responses suggested that overlaps between spirituality and eating disorders are significant for clinicians, while calls for greater rapprochement between spirituality and mental health have been increasing [2]. In most instances, awareness of patients' spirituality is simply a component of holistic care, but links between religious asceticism and eating disorders suggest that interactions between faith and illness can be inseparable. For example, drawing on our case series, a recent epidemiological study [3] noted religious justifications as common in anorexia nervosa in Ghana. We wished to extend our research in a clinically meaningful way, responding to suggestions that qualitative research methodologies *'provide helpful detail about spirituality in clinical practice'* [2] . Using Interpretative Phenomenological Analysis (IPA) techniques and procedures [4] we aimed to examine the relationship between eating disorders and religion, and the impact of that relationship on treatment.

Method

Participants and sampling method

Eleven inpatients treated at St George's Eating Disorder Unit and the Priory Hospital, Roehampton, with DSM-IV anorexia nervosa or bulimia nervosa cited their religion as 'important' via standard questionnaire. They were invited to participate in a semi-structured depth interview, of whom 10 accepted. The 'refuser' did not give permission for further demographic details to be explored for research purposes. All participants were female, 9 had anorexia nervosa (6 restricting, 3 binge eating) and 1 bulimia nervosa (purging). Two participants were being treated for co-morbid 'impulsive' behaviours [5]. Median length of treatment was 10 months, (range 2-19), age was 33 (18-56) and age of onset was 15 (11-35). All were Christian. There were 4 Roman Catholic, 1 Orthodox, 1 Congregational, 1 Salvation Army, 1 Baptist, 1 Evangelical and 1 Pentecostal. Four had converted from one Christian denomination to another or from atheism to Christianity. The local research ethics committee approved the study.

Qualitative Interviews

The research question was the relationship between eating disorders and religion, and its influence on treatment, based on the clinical relevance elicited from our own experiences as eating disorder specialists, those of respondents to our original paper [1] and the existing literature. We chose a qualitative methodology for the reasons cited above [2] as better able to illuminate the subjective experiences of the research participants than a quantitative approach.

We developed semi structured 'depth' interviews covering themes arising from the original study [1] and literature review, refined in a focus group of eating disorder specialists. The following interview topics were covered:

> background information, history of eating disorder, religious background, current religious practice, perception of God, attitudes to emotions, attitudes to sin, attitudes to penance, influence of faith, opinion of this research.

As a 'depth' interview, questions were based on interviewee response and covered in detail [6]. PM conducted 9 of the interviews and JFM conducted 1. The interviewer for any one participant was not directly involved in her treatment. Interviews lasted approximately 80 minutes, being audio taped and transcribed in their entirety, available for external scrutiny within the limits of confidentiality. Interviews covered the key, structured topics but were also responsive to the subjects' narratives.

Analysis

The protocol for data analysis is shown in Box 1. Emerging hypotheses were checked against any potentially contradictory evidence and, where appropriate, the analysis was modified to take account of this evidence. Individual text was selected by JFM to exemplify themes. PM and TK then read the selection to check that it was representative.

Protocol for data analysis

PM and EK independently read the first 8 interview transcripts and highlighted themes. Themes were defined as 'primary topics relevant to religion and eating disorder'. PM and EK independently re-read transcripts and codified primary topics throughout, amalgamating data on the themes. PM, EK and JFM agreed definitions of themes. PM and EK coded the first 8 transcripts according to those definitions, and all subsequent transcripts. Throughout the process, definitions were refined on discussion between PM, EK and JFM. JFM re-read a random sample of transcripts to assess the construct validity of theme definitions. PM, EK and JFM independently determined categories of the emerging themes, representing clusters of inter-related themes. These second-level themes and categories emerged from repeated textual analyses conducted independently by the researchers PM and EK, with use of representative flow charts and Venn diagrams to link themes and categories. Repeated analyses ensured that no new major themes were ignored and text was also analysed horizontally, grouping clusters of text by theme. Independent re-appraisal of themes and categories against transcripts by JFM was used to minimise bias.

RESULTS

Five main categories emerged from the second-level analysis: locus of control, sacrifice, self-image, salvation, and maturation.

Locus of Control

Issues of religious and familial control were central for all participants. Within the family, food and religion were arenas in which these issues were played out.

> *"My religion…I feel that I had no way out. I was brought up with my parents and they brought me up that way and if I didn't really stick by their rules…they weren't going to love me any more, I was going to be out of the house."* (Participant 3, aged 36, anorexia nervosa– restrictive type)

Self-control concerning food and emotion reflected childhood experiences within the family. Just as some participants craved the rules of the Church, others explored the meaning of their illness through rebellion against those rules. Questioning of ecclesiastical authority mirrored attempts to redefine parental authority. In the early stages of treatment, the two were often mingled in a dichotomous manner, with God construed as a disciplinarian

> *"I think in one respect God is going 'she's done it again, she's messed up.' Just tutting with his arms crossed thinking I'm never going to get it".* (Participant 5, aged 30, anorexia nervosa – binge eating type)

Anorexia nervosa was portrayed as a form of moral as well as physical self-control and its opposite seen as "greed", but this was also contaminated by ethical constructs beyond hunger, including "lying", "anger", "bad thoughts", "sexual feelings" and even "sadness":

> *"The two emotions ... have been important to not show them are anger and sadness …anger can get out of control …can lead to violence and hurting ... even feeling it is wrong ... sadness ... because it seems very self pitying ... they're kinds of emotions that are out of control I suppose, they' re not right".* (Participant 5, aged 30, anorexia nervosa – binge eating type)

However, whilst the majority struggled to control aggression, guilt around sexuality was less evident for most participants. One participant used prayer to ward off fears in the same way as obsessive-compulsive behaviours:

> *"Sometimes I get annoyed with myself because the prayers that I say are, I feel that they're ritual prayers … and sometimes I don't even want*

> *to do it … but I feel as if I have to do it...and if you don't something will happen..."*(Participant 3, aged 36, anorexia nervosa– restrictive type)

Religion provided containment of co-morbid impulsive behaviours (Lacey, 1995) through its own moral code, though behavioural lapses reinforced poor self-image.

Self-image

Negative self-image was common to all participants. While denigratory views of body image were unsurprising, participants more often grappled with the moral dimensions of self-image in a spiritual framework, akin to that described by Bennett *et al* (2004). Shame, guilt and self-hatred were recurring themes:

> *"Whenever I do things wrong, I think of it as being a sin …. Sometimes I wonder if it is wrong to feel hungry. If I am hungry before I think I should do, then that seems like a sign of weakness and that means I am greedy".* (Participant 10, aged 18, anorexia nervosa – restrictive type)

In their struggle for control of unruly sensations and emotions, perceived as "sinful", some participants had welcomed the regulations of their church or the supposed attitudes of an authoritarian God. This was particularly true for those who used impulsive behaviours such as alcohol abuse or self-harm. However, when they were unable to live up to the supposed standards of their God figure, their sense of guilt, shame and failure was exacerbated:

> *"By that time I was in a bit of a mess, but I mean I was in a mess inside with guilt…I knew what I was doing was not in accordance with the church's rules…I knew I wasn't really living right "* (Participant 8, aged 48, anorexia nervosa-binge eating type)

This sense of shame sometimes led to a desire for self-punishment or reparation through sacrifice.

Sacrifice

The concept of self-denial or sacrifice was meaningful to participants but was variously interpreted. Several felt a need to make up for imagined wrongdoing:

> *"Lots of things that I've done in my life, that I deserve to be punished as well. I think that one of the ways that I try and make amends is to punish myself through food…eating as little as possible, or it's the other extreme of punishing my body and exerting myself"* (Participant 5, aged 30, anorexia nervosa – binge eating type)

This need for reparation was sometimes seen in religious terms as self-denial or fasting and so thought to be sanctioned by the church. Although most participants did not, at the time of the interview, see their dietary restriction in

terms of a self-imposed penance pleasing to God, a minority did describe early anorexic behaviour in terms of fasting:

> *"I had the idea that fasting was good and so I did, I literally gave up everything…I really felt that I was doing God's will…that not eating was what he wanted me to do."* (Participant 9, aged 56, anorexia nervosa – restrictive type)

For some, self-sacrifice approached the extremity of a death wish. Death from starvation was variously presented as the "ultimate punishment" whilst also offering redemption and escape from "sinning" and "greed":

> *"I wouldn't have been frightened if I knew I was going to die…I knew that if I died at that age, that I couldn't make any more mistakes…because that's my greatest fear…I'm just worried that I might become more sinful"* (Participant 2, aged 50, anorexia nervosa – restrictive type)

Salvation

Participants believed God offered recovery from eating disorder and rescue from death:

> *"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".* (Participant 8, aged 48, anorexia nervosa – binge eating type)

Religious conversions occurred within the context of established eating disorder in a quest for healing. However, some participants lost faith when religion seemed to fail

> *"You're a Christian and it's supposed to be enough …that you cope with anything through God and through Christ. Well, I couldn't, I just needed this as well…the eating disorder and food and weight became my god".* (Participant 1, aged 28, bulimia nervosa – purging type)

Others, however, saw medical treatment as God's will:

> *"I mean for me to come into the Hospital…was the most amazing blessing….. I think the fact that I opened myself up and made myself very vulnerable in here was very painful and very difficult but unless I'd done that I don't think anything would have got to the core of what was going on"* (Participant 4, aged 21, anorexia nervosa – restrictive type).

Maturation

In the early stages of illness, some saw self-starvation as God's will but, surprisingly, several participants came to see the eating disorder itself as displeasing to God:

> *"But now I look back I realise that I must have got all that wrong because it isn't God. God doesn't want you to destroy yourself or starve yourself to death …Maybe I've grown up a bit in that relationship I suppose."* (Participant 9, aged 56, anorexia nervosa-restrictive type)

Shifting towards respect for appetitive function was key in participants' recovery, and was sometimes aided by priests and chaplains:

> "*He* (the priest) *said "…you must look after yourself. It is very important to get help if you need it"… and I thought that I would have a little bit extra to eat today then."* (Participant 2, aged 50, anorexia nervosa – restrictive type)

Many participants discussed spiritual and clinical journeys using similar terminology, with similar roles for prayer and psychological therapies. Prayer provided a dialogue and healing relationship with God. For some, the search for meaning through prayer and through psychotherapy led to maturing of religious ideas:

> *"It's* (relationship with God) *changed a lot since I've been here (treatment) actually because my relationship with my dad's changed…there is a lot more acceptance…now and a lot less battle, a lot more understanding both ways…Before I think I would just expect to be punished."* (Participant 1, aged 28, bulimia nervosa – purging type)

DISCUSSION

Novel screening instruments [7] and treatment algorithms have helped the early identification and treatment of eating disorders, but may ostracise patients by reducing eating disorders to curable diseases, rather than a complex amalgam of biological, psychological and moral factors. Culliford [2] has cogently argued that biopsychosocial care encompasses the '*spiritual values and skill…recognised as necessary aspects of clinical care'*. In accordance with our previous findings [1] this study suggests that motivational interviewing may be enhanced by consideration of patients' spiritual constructs of their illness, varying between respect for God-given appetitive functions to extreme asceticism. It also accords with historical commentaries [8] postulating eating disorder psychopathology among early fasting saints. The strength of spiritual constructs may be under-estimated where clinicians feel uncomfortable in a spiritual domain through deficits in education, resources and conflicting personal beliefs.

Methodological issues

Qualitative interviewing can be superior to respondent-centred studies in ascertaining core beliefs, but requires methodological rigour [6] . Issues of validity, reliability and generalisability are comparable to those of quantitative studies, and it is crucial that researchers seek to falsify emergent hypotheses by theoretical sampling and awareness of deviant cases, as is demonstrated in Box 1. Nonetheless we acknowledge that the study's principal limitations arise from potential sampling bias.

Firstly, as with much eating disorder research, the study was limited by only including participants in current treatment. All subjects had been treated on an inpatient eating disorders treatment programme and were receiving treatment at the time of the interview. There is evidence that their attitudes both to their religion and to their eating disorder had altered during the course of treatment. Therefore, our findings may not be generalisable to the untreated population.

Secondly, despite a broader sampling strategy, all subjects identified themselves as Christian and the need for further studies of other religious affiliations and secular beliefs is recognised, particularly noting the difference between spirituality and religion. Thus, as with all qualitative research, there is merit in caution in regarding the sampling strategy as sufficiently comprehensive to ensure the generalisability of the conceptual analysis. Nonetheless, fieldwork notes, interview transcripts and documentary analysis are open to independent inspection.

Categories

The category of 'sacrifice' exemplifies that fear of death may not always motivate recovery. Patients can regard the prospect of death as an opportunity to be reunited with loved ones or with God. Once engaged in treatment, spirituality may enhance patients' motivation, provide containment and improve treatment adherence. For patients with strong religious faith, spiritual practice is helpful in recovery, and spiritual maturation goes hand in hand with positive psychological changes, reflected in the category 'maturation'. Conversely, psychological maturation may challenge spiritual beliefs and either result in failure of treatment or loss of faith.

Some participants struggled to disentangle religious practice from illness. Pastoral counselling and involvement of hospital chaplaincies may assist in placing religious experience in context, "*neither rejecting it out of hand, nor accepting it completely at face value*" [9]. However, this study challenges two basic preconceptions in the existing literature. Firstly, religious beliefs did not generally translate into sexual guilt. Secondly, it was more common for participants to view their eating disorder as against God's will and "sinful" than as a display of virtue. This contrasts with our previous report [1] that people with anorexia nervosa perceive the illness in religious terms, but may be explained by sampling differences, since all participants in the current study had accepted treatment and established a therapeutic alliance with the treatment team.

The category of ‘salvation’ runs throughout the textual analysis, and accords with cultural commentaries on the female beauty myth, including notions of a *“salvation myth of female slenderness”,* in which attainment of slenderness solves all problems [10]. Most participants described chronic problems within their families, with the eating disorder as a salvation from discord. Similarly, several turned to their existing faith or converted to a new faith in a quest to resolve or understand discord. For some, these attempted solutions were sequential; when the eating disorder failed to provide relief, they turned to God for help. For others, the two paths ran parallel. Awareness of the spiritual dimensions of patients’ beliefs was essential to avoid forcing patients into a choice between psychological therapies and religious faith. Similarly, the category of ‘salvation’ highlights both the risks and benefits of health care professionals being cast in the role of saviour. The powerful moral dimensions of eating disorders require doctors to be sensitive to shame and guilt, particularly at the point of the first consultation as it sets the scene for future doctor-patient relations.

The purpose of the current study was to explore the interrelationships between religion, eating disorders and treatment. Spiritual practice appears to be helpful for some patients in recovery from eating disorders, and spiritual development is synchronous with positive psychological changes. This is particularly evident in the category of ‘maturation’, and is in accordance with our previous findings [1]. However, other participants experienced difficulty in untangling aspects of their religious practice from their illness, again consistent with previous findings. For example, one woman used ritualised prayer to assert a sense of autonomy and control.

All participants described difficulties within their families of origin, including, for different participants, sexual abuse, physical abuse, bereavement and difficulties in the process of separation-individuation [11]. These factors tended to lead to a sense of lack of control and low self-esteem, evident in the categories of locus of control and self-image. The emergence of locus of control and self-image as central concerns is in accord with previous research into attitudes associated with eating disorders [12, 13], although this study throws new light on the links between these attitudes and Christian beliefs.

Self-concept anomalies in anorexia nervosa have been shown to cluster into three groups [14]. The ‘perfectible self’ includes the potent cocktail of asceticism and perfectionism. The ‘unworthy self’ includes conflict over authority versus autonomy, as well as low self-esteem. The ‘overwhelmed self’ includes a preference for certainty and simplicity, with avoidance of complex social situations. These core schematic deficits are evident throughout the emerging categories in this study, but are also effectively challenged in the course of treatment.

Similarly, several turned either to their existing faith or to a new faith in the hope that God or the church community could offer temporal as well as eternal salvation. Joughin *et al* [15] found that subjects reporting a religious conversion experienced less severe weight loss than those who had not converted. They suggested that *“conversion provided a channel within which*

subjects found a supportive structure and set of moral guidelines", hence lessening the illness severity. This view of the psychological role of conversion is consistent with the current study.

Clinical Relevance

Clinicians need to be aware of the spiritual dimension of eating disorders in their patients. This may present an obstacle to treatment, or may be harnessed to improve motivation and treatment adherence. Where relevant, consideration of spiritual issues in patients with eating disorders should be part of routine biopsychosocial formulation, and repeated throughout treatment.

Fear of death is not always a useful clinical motivator for recovery and this spiritual dimension may render the sacrifice of death welcome. Where health care professionals feel uncomfortable in dealing with spirituality, hospital chaplaincies may play a role in resolving conflicts between illness constructs and theological constructs. In such cases, it is useful that multi-faith chaplaincies and clinical teams liaise closely. Chaplains' contribution to multi-disciplinary mental health services requires adequate resources, not always evident in the modern health service.

Treatment of any disorder with biological, psychological and social components may modify patients' religious beliefs. As the treatment progresses, it is important to revisit these areas of concern to assess the continuing interplay between psychopathology and religious attitudes. This is particularly relevant in eating disorders, where schematic deficits in self-concept may overlap with religious constructs. Health care professionals need to be sensitive to the effect of changing beliefs, including spiritual crises, and not dismiss them as incidental to medical treatment.

ACKNOWLEDGMENTS

We gratefully acknowledge the help of Professor J Hubert Lacey in the development of this study. His guidance was invaluable.

References

Bennett D, Sharpe M., Freeman C, Carson A. Anorexia nervosa among female secondary school students in Ghana. B J Psych 2004; 185:312-317.

Britten N. Qualitative Research: Qualitative interviews in medical research BMJ 1995; 311:251-3.

Culliford L. Spirituality and clinical care BMJ 2002; 325:1434-1435.

Joughin N, Crisp AH, Halek C, Humphrey H. Religious belief and anorexia nervosa. IJED 1992; 12:397-406.

Lacey JH. Anorexia nervosa and a bearded female saint. BMJ 1982; 285:1816-1817.

Lacey JH. In-patient Treatment of Multi-impulsive Bulimia Nervosa. In Brownell KD, Fairburn CJ, eds. Eating Disorders and Obesity. Guilford; 1995.

Lelwica M. Starving for Salvation: The Spiritual Dimensions of Eating Problems. Oxford University Press. New York; 1999.

Mahler M, Pine P, Bergman A. The psychological birth of the human infant. London: Karnac; 1975.

Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ 1999; 319:1467-1468

Morgan JF, Marsden P, Lacey JH 'Spiritual Starvation?' - a case series concerning Christianity and eating disorders. IJED 2000;28(4):476-480.

Slade P. Towards a functional analysis of anorexia nervosa and bulimia nervosa. B J Clin Psychol 1982; 21(3): 167-179.

Smith JA, Jarman M, Osborn M. Doing Interpretative Phenomenological Analysis. In: Murray M, Chamberlain K, eds. Qualitative Health Psychology. London: Sage, 1999.

Sutherland M. Mental illness or life crisis? - A Christian pastoral counselling contribution. In: Bhugra D, ed. Psychiatry and religion - context, consensus and controversies. London: Routledge, 1996.

Vitousek KB, Ewald LS. Self-representation in eating disorders: a cognitive perspective. In Z. Segal & S. Blatt (eds.), The self in emotional disorders: Cognitive and psychodynamic perspectives (pp. 221-257). New York: Guilford Press, 1993.

Williams GJ, Power KG, Millar HR, Freeman CP, et al. Comparison of eating disorders and other dietary/weight groups on measures of perceived control, assertiveness, self-esteem, and self-directed hostility. IJED 1993; 14(1): 27-32.

Correspondence to:
Dr John F Morgan
Yorkshire Centre for Eating Disorders
Seacroft Hospital, York Road,
LEEDS LS14 6UH, UK
email: john.morgan@leedsmh.nhs.uk