Anorexia Nervosa in a Pakistani Adolescent Girl
A Case Report with Literature Review of Anorexia Nervosa in Asia

IMRAN N.[1], ASHRAF A.[2]
Address For Correspondence: *Dr Nazish Imran. MBBS, MRCPsych. (Lon), Assistant Professor, Child & Family Psychiatry Department, King Edward Medical University/ Mayo Hospital, Lahore, Pakistan*

A case of Anorexia Nervosa in a Pakistani Adolescent girl is reported. This is in the background of impression that due to changes in cultural norms and concepts of feminine beauty, illnesses previously thought to be rare in Asian societies might be becoming more prevalent. Various similarities to presentation of Anorexia Nervosa in western countries were found. A brief overview of Anorexia Nervosa in Asia is also described.

The syndrome of anorexia nervosa, first identified in Europe during the seventeenth century, was considered a comparatively rare condition, until the last few decades. Although there has been a gradual increase in its incidence in western world, it was believed that anorexia and bulimia nervosa are uncommon in non-western societies.[1-4] The etiology of eating disorders is often linked with value placed on slimness in western cultures.[5] However many Asian countries including Pakistan are undergoing rapid social and economic changes. There is also widespread adoption of western styles, habits and attitudes perhaps due to increasing exposure to media and internet. As a result of changes in cultural norms and concepts of feminine beauty, illnesses previously thought to be rare in these societies, might be becoming more prevalent.[6]

In our country, we have been given anecdotal reports of anorexia nervosa from some Psychiatrists and Psychologists, but we were able to find only one published case report of anorexia nervosa from Pakistan.[7]

Case

Miss M was a 12 year old girl referred by a Pediatrician because of concerns about her weight loss, for which no organic cause was found. In the year before the referral, she became very fussy about eating, and for six months was reported to be eating very little at home. Her daily diet at the time of referral comprised of 8-12 bananas and half glass of milk. Weight loss over a year before the referral was around 7 kilograms. Parents mentioned that she expressed fear of becoming fat and had distorted body image, looking in mirror for hours. Recently, patient had been expressing guilt feelings about eating. There was no history of her being engaged in self induced vomiting, laxative abuse or excessive exercise. Menstruation which had started a year ago had stopped shortly afterwards.

She attended a school which placed a strong emphasis on academic success. Parents described her in the past as a highly conscientious pupil but she was not attending school for about six months as she was not able to cope with the demands of studies and parents were concerned regarding her diet. There was six months history of prolonged weeping spells, irritability and anger outbursts with social withdrawal, sleep disturbances and occasional suicidal ideations when forced to eat. She also displayed a number of obsessional features at home, centered on food.

Miss M was born after a planned pregnancy She was diagnosed with Wheat allergy at age of 1 ½ years, when she failed to gain adequate weight and was failing to thrive. She appeared to respond well to wheat restriction. Pediatricians had reintroduced wheat in her diet after excluding wheat allergy, about a year prior to her referral to us. All other aspects of her development appear to have been normal.

Both Parents had achieved high standards of Education. There was history of marital conflicts in parents and children had mostly stayed with mother in her parental home. Father had been living abroad for 4 years and was not too involved with children's lives. His return to Pakistan roughly coincided with the time of onset of Miss M illness. It was a difficult year for the whole family as patient's mother was reported to be very depressed following deaths of her immediate family members (mother & brother). Also the family moved to their own home and had to make significant adjustments. Patient had one elder and one younger sister. Eldest sister was found to be severely depressed and rebellious towards father in particular and expressed wish for him to return abroad. There was very little interaction with anyone outside the nuclear family setup.

On examination, Miss M was severely emaciated and dehydrated. Her BMI was 12.8.She had tachycardia with poor peripheral pulses and cold extremities with blood pressure of 100/70 mm Hg. Secondary sexual characteristics were absent. She was severely depressed with no active suicidal thoughts. Her investigations showed her to be anaemic (Hb 10.8) and hypokalaemic. (Potassium levels of 3.1).

Following assessment, patient was referred to Pediatricians due to severe risks to her physical health and admission was strongly recommended. Unfortunately the family refused and very reluctantly agreed to come for intensive outpatient therapy in Child Psychiatry Department. Due to lack of Mental Health Act Provision in Pakistan, admission against patient and parental consent was not practically possible. The level of concern by parents especially father

was minimal and he attended the family sessions irregularly. Treatment was mainly family therapy as patient refused to be seen for individual sessions. She was also started on antidepressant due to her severe depression and antipsychotic to help with her beliefs as well as to stimulate her appetite. Despite all the efforts, family appeared to be reluctant to take responsibility for patient weight gain neither agreed to get Miss M admitted. Her physical health has been stable and there is ongoing liaison with Pediatricians for managing this case. Prognosis at present appears to be poor, although family is engaged to some extent with our services at the time of writing this report.

Discussion

This case of undisputed anorexia nervosa along with others reported in Asian children do not support the view that this illness is restricted to white patients and add to reports of Anorexia Nervosa in other racial groups.

Sociocultural factors are important in development of Anorexia Nervosa in psychologically vulnerable young females, although other factors may also be implicated.

Anorexia Nervosa has frequently been associated with difficulties imposed by developmental demands of adolescence. Crisp's view of anorexia nervosa as essentially a psychological disorder resulting from an avoidance of adolescence is a well known example of such a developmental theory.[8] The common tasks of adolescence which includes the formation of an integrated sense of self, the emergence of an independent self and the acceptance of a sexual self are undoubtedly problematic for many young people, just like our patient.

The family dynamics in our patient was extremely complicated within the nuclear family setup. There appeared to be limited contacts outside the restrictive, tense and at times hostile environment. This observation is in line with T Buchan & L.D Gregory who proposed the hypothesis that pathological family interaction patterns in anorexia may operate only with framework of nuclear family.[9] Such interaction may occur in extended family, but it seems a tenable view that there are compensating or ameliorating integration which prevent or modify the development of processes such as enmeshment.

As in many other Psychiatric disorders, significant events in the individual's life have been reported to have preceded the manifestation of anorexia nervosa. Our patient had many important events in her life just prior to onset of her illness which perhaps appeared as threats to her self esteem and control over her world.

Depression is frequently a feature of anorexia nervosa and suicide the most common related cause of death.[10,11] Our patient was severely depressed with expression of occasional suicidal thoughts therefore admission was recommended. But in cases like these where family refuses, it creates a very difficult situation for the treating medical professionals as Mental Health Act do not exist in Pakistan.

Presence of severe weight loss, abnormal electrolytes levels, comorbid depression, conflicts in parental as well as parent-child relationships, irregular attendance for sessions are poor prognostic factors in our patient.

Literature Review: Anorexia Nervosa with Particular Reference To Asia

Cultural factors in the aetiology of Eating Disorders have been clearly operative. In Asia, a postal survey was conducted by Buhrich 1981 among Psychiatrists in Malaysia: 30 cases of anorexia nervosa were reported (19 Chinese, 8 Indians, 2 Eurasians &1 Malay).[12] A similar postal survey in Japan by Suematsu et al (1986) found 1312 cases of anorexia Nervosa, a doubling of prevalence in 10 years.[13] Ong et al (1982) reported 7 cases of anorexia nervosa in Singapore.[14] AN is almost absent in the Chinese population-with only a few cases being reported from HongKong.[15] Three cases of Anorexia Nervosa have been reported in Vietnamese refugees.[16] There is some evidence that outside western culture, the disease may be restricted to prosperous backgrounds and the upper social strata.

It is not known how common eating disorders are across the Indian subcontinent although their prevalence is probably very low. Private conversations with Psychiatrists in several major cities of India & Pakistan indicate that sporadic cases of anorexia Nervosa occur among Western – oriented social groups.

In Pakistan, Choudry & Mumford conducted a survey in a large provincial Urdu Medium school in Pakistan and found one case of Bulimia Nervosa which met DSM III criteria.[17] Another two stage survey (Questionnaires and interview) of three English Medium girls school in Lahore was conducted in 1992 by Mumford, Whitehouse & Choudry; one girl met DSM III R criteria for Bulimia Nervosa, and 5 subjects had Partial syndrome Anorexia Nervosa.[18] There was evidence that most westernized girls were at great risk of developing an eating disorder. There was also support for the hypothesis that the effects of Westernization on eating attitudes were mediated thru greater dissatisfaction with body shape.

The only published case report of anorexia Nervosa from Pakistan which we managed to find was of an academically perfectionist and interpersonally compliant 13 year old girl raised in traditional sheltered Muslim home in Lahore. Patient developed restrictive Anorexia Nervosa in the context of being teased about her weight by her closest friend and younger brother in a context of family weight occupation. Authors found many similarities to hypothesis of anorexia in western adolescents.[7]

In our view, we might expect to find an increasing incidence of eating disorders with widespread adoption of western styles, habits and attitudes. Psychiatrists working in Pakistan need to be aware of existence of anorexia nervosa in young people and of the possibility of an increasing

incidence, for delay in diagnosis is far too common, with the danger of subsequent poor prognosis.[19]

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