

An Analysis and Treatment of Eating Disorders in Jamaican Adolescents

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Abstract

This paper is a case study that describes the prevalence of eating disorders in Jamaica. The purpose of the case study is to assess whether there is an increase in eating disorders in Jamaica and the wider Caribbean. A review of eating disorders “then” and “now” is undertaken and an analysis of two cases presented. Treatment for eating disorders is expounded and the Cognitive-Behavioural approach along with Family Therapy is highlighted as the treatment of choice. Recommendations are made and a follow-up of the cases are presented.

Introduction

Eating disorders are not new to the mental health world and is said to have been around from as early as the 13th centuries. Although, not exhibited in its current form, anecdotal data speaks to women during the Middle Ages practicing rituals such as: self-starvation, using feathers to tickle their throats to induce vomiting or harnessing their waist to achieve a thinner more attractive body image. Eating disorders are most prevalent in industrialized/western societies, among Caucasian females with an onset of late adolescence or early adulthood, however the trends are changing. There have been reports of eating disorders among other ethnic groups, among males (although not as common) and an earlier onset of ages 11 to 13. Although previously believed to be disorders of young women, researchers such as Bellafonte (2003), Forman (2005) and Gimlin (2002) (as cited in Hinz, 2006) have noted an increase in the numbers of middle-aged women developing first time eating disorders. Consistent with these findings, however, is that persons suffering from eating disorders become obsessed about their bodies and subsequently develop “abnormal attitudes and behaviours with food” (Homeier, 2005), including Anorexia Nervosa, 307.1 or Bulimia Nervosa, 307.51.

According to the Diagnostic Statistical Manual for Mental Disorders – Text Revision (American Psychiatric Association, 2000), persons suffering from Anorexia Nervosa exhibit the following symptoms: refusal to maintain body weight or above a minimally normal weight for age and height; intense fear of gaining weight or becoming fat; disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and the absence of at least three consecutive menstrual cycles in postmenarcheal females. Bulimics on the other hand, display symptoms such as eating at discrete period of time; feeling that they could not stop eating or did not have control over what or how much they ate; evaluating self based on body shape and weight; displaying compensatory behaviours in order to prevent weight gain such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting or excessive exercise.

The widely held belief is that eating disorders only impact persons physically. Although the most glaring and probably the most talked about are the physical changes, the truth is that persons with eating disorders will experience physical, emotional and personality changes. Physical changes according to Fursland, Byrne & Nathan (2007), “... are both internal and external changes.” External changes include hair loss, dry skin and brittle nails; while the internal changes include electrolyte abnormalities, cardiovascular problems, gastrointestinal changes, hormonal imbalances and dental damage caused by excessive vomiting, misuse of laxative and malnutrition. These physical changes are at times irreversible and can cause death. According to reports given by the American Psychiatric Association (2000) Anorexia Nervosa is associated with death among 5 to 10 percent of those suffering from the disorder which is one of the highest mortality rates among mental disorders.

Further to this, eating disorders impact persons emotionally; persons become preoccupied with food that it is “impossible to concentrate on anything else” (Fursland, Byrne & Nathan, 2007). This preoccupation can become obsessive whereas food and eating, or not eating, takes over the person’s life and replaces other activities.

This preoccupation with food, along with being malnourished and hungry, may lead persons to feel grumpy, irritated, anxious and depressed, all of which may represent a change in personality.

Analysis

Although the statistics on eating disorder indicates increasing rates of eating disorders in the United States and Europe, there has been little evidence to show that this is a major mental health concern for Jamaica and the larger Caribbean (White & Gardner, 2002). Caribbean females are known to be less likely to express dissatisfaction about their bodies and embrace a plumper physique (Hodes, Jones & Davies, 1996). In fact, “nice and round” or “fatty” have been terms of endearment and the Jamaican man’s expectation for his woman from as far back as I can remember. Dancehall culture promotes girth and celebrates the “big body gal” while scorning the “maaga gal”. This is heard repeatedly in songs such as “Original Fat Thing” and “Under Mi Fat Ting” where Echo Minott and Anthony Red Rose, affectionately calls attention to all fat women; while Red Dragon renames all maaga gal “Krukrumkrum”, which is the unflattering sound of bones rattling. Jamaican women in trying to live up to this ideal have attempted to increase their weight through the use, and sometimes abuse, of “fowl pills” or other unorthodox and dangerous means, hence highlighting the importance of the right size in the Caribbean.

These cultural beliefs about body image and the ideal woman served as protective factors for Caribbean women; however, Pumariega (1986) & Batson-Savage (2005) suggests that these beliefs have dissipated because of the enculturation and the adoption of American culture. With the import of cable and international fashion magazines to the Caribbean, adolescents who are at a developmentally influential stage, begin to change their definition of “perfection”. They trade in their once acceptable, more natural heavier and taller physique for a leaner, hollower body type; thus, eating disorders are becoming more prevalent within Jamaica and the wider Caribbean.

This trade, although alarming, need to be understood from an adolescent’s point of view. Adolescence, said to be the most difficult (both emotionally and physically) developmental stage, is described by Erikson (Baron, 2001) as a time of identity and role confusion. Erikson purports that during this period the adolescent is trying to discover self which automatically leads him to evaluate his self-esteem, self-concepts, self-worth and self/body-image. Adolescents become more aware of their physical selves and equate self-worth and self-esteem with having the ideal self/body-image. That is, their judgment of themselves and their worth are based on their physical appearances (Fursland, Byrne & Nathan, 2007). Therefore adolescents with eating disorders make great efforts to control their eating, as mentioned earlier they may become preoccupied with food and eating, in order to control their weight and shape and overall physical appearance.

This evaluation of self is also influenced by friends and the need to belong. In an effort to identify self and their roles, adolescents distance themselves from parents and increase their contacts with their friends. Adolescents are more likely to associate with persons who share similar interests and values as them. Subsequently, the adolescent suffering with problems of body-image may bond with others with similar concerns, therefore, increasing the need to control their weight and shape as a way of fitting in/belonging to a group. This is substantiated by Field, Camargo, Taylor, Berkey & Colditz, 1999; Stice, 2002, who states that peers influence girls’ attitudes and behaviors around weight and eating. Peers model poor eating habits, contributing to their friends’ adoption of these problem behaviors (Byely, Archibald, Graber & Brooks-Gunn, 2000).

It should also be noted that this distancing from parents may cause disruptive family relationships, which too influences how adolescents evaluate themselves and their need for control. Parents who may not understand this change may react negatively to their adolescent’s declaration for independence from them. They may become restrictive and try to control their adolescent’s whereabouts, friends and activities. The adolescent who may not know how to deal with these intense feelings and negative emotions may “use particular ways and means to manage their emotions and achieve short-term relief by avoiding or getting rid of intense negative feelings by drinking alcohol, self-harming, binge eating, vomiting or excessive exercise” (Fursland, Byrne & Nathan (2007). In the long-run these actions don’t prevent the negative emotions and may in turn lead to greater problems such as the comorbidity of an eating disorder with depression. Therefore, it is important when analyzing and treating eating disorders in adolescents that one considers the developmental stage of adolescence, peer influence, family relationship and the comorbidity of other psychiatric disorders which may be a direct result or causative factor of the eating disorder. As is seen globally, the presentations of eating disorders in adolescents within the Caribbean are comorbid with other psychiatric disorders.

Depression, one of the most prevalent psychiatric disorders diagnosed in adolescence, is associated with many psychosocial factors such as, substance abuse, low self-esteem or negative body image and lack of social support from friends and family (Hibbs & Jensen, 2001). The disorders that were most often comorbid with adolescent depression were eating disorder, anxiety disorder, disruptive disorders and substance use disorders. Further, boys are more likely to be disruptive when depressed, while girls are more likely to develop eating disorders (Connelly, Johnston, Brown, Mackay & Blackstock, 1993). In other words, the adolescent who is presenting with depression may be facing various psychosocial challenges that are later identified as causative factors. One such case comes to mind as an example: A 16-year old female, Paula, presented to me with a diagnosis of Bulimia Nervosa, Purging Type. Paula had clear symptoms such as eating at discrete period of time; feeling that she could not stop eating or she did not have control over what or how much she ate; evaluating self based on body shape and weight; and displaying compensatory behaviours in order to prevent weight gain, which for Paula was self-induced vomiting (American Psychiatric Association, 2000).

After several sessions, Paula was also diagnosed as having Major Depression and was placed on anti-depressants. Paula revealed that because she was overwhelmingly “sad” about her life, specifically, her relationship with her parents, who were no longer together and “hated” each other, she started controlling the part of her life that she could – her body. Paula also spoke about all her friends being thin and her wanting to be like them and accepted by them. Another case serves to support the link between family relationships, peer influence and the comorbidity of eating disorders with other psychiatric disorders. A 14 year old female, Anna, was referred to me by her physician who reported that Anna was suicidal, depressed and suffering from Bulimia. Anna’s history is one of never fitting-in with her peers and a perception of not being liked by her mother. Anna reported having a very difficult time making friends in school. She recalls one attempt when she joined the swimming team only to be made fun of for being “fat”. Anna’s history also revealed a very tumultuous relationship with her mother who she stated “never liked her” and her never getting along with. It was later discovered that Anna’s parents often fought in the home exposing Anna and her sibling to their disruptive relationship. This fighting between her parents at times lead to cruel attacks on Anna and her brother who were both told that they were fat. In therapy Anna spoke about being uncomfortable eating in front of her parents for fear of being watched and scrutinized. She reported eating little to nothing at the family table, but then overeating and vomiting in privacy. She also stated that the disruption in her home left her feeling out of control, which lead her to control what she could – her eating.

Treatment

In my own practice I have seen an increase in eating disorders among adolescents. The cases mentioned above are two of the cases that I have treated in Jamaica. Among the cases there are several common characteristics: disruptive family relationships, peer influences and irrational perceptions of self to include body-image and self-worth. With this in mind my approach to treatment as always been multifaceted to include individual Cognitive-Behavioural Therapy (CBT) and Family Therapy. According to Ellis (2004) it is not an activating event (A) that leads to a consequence (C), but our beliefs/thoughts (B) about the event. “CBT is designed to change beliefs/thoughts that help to maintain a maladaptive behavior, in this case an eating disorder. Being conscious or aware of one’s thought is vital in order for change to occur” (Fursland, Byrne & Nathan, 2007). The purpose of becoming aware of your thoughts, which for persons with eating disorders may be automatic and out of their control, is to gain control and change behaviours.

For Paula it was important that she became aware and gain understanding of how her parents’ relationship as well as her relationship with her parents was impacting her mood and consequently her behaviour. Paula spoke about feeling as if she had to choose between her parents and worrying about being disloyal based on her choice. She stated that she lived between both parents and had experiences of one parent speaking negatively about the other in her presence (A). She stated that this lead her to feeling sad, locking herself in her room, speaking to her friends more frequently on the phone then later eating and throwing up (C). After gaining insight (see Appendix A – Thoughts Diary) on her irrational thoughts (B) about her familial relationship and her need to be in control, Paula was able to identify the relationship between her thoughts and how they were impacting her mood (Major Depression) and behaviour (Bulimia Nervosa, Purging Type); she was later able to stabilize her mood and control her behaviours. Paula’s proposed treatment was to supplement her individual therapy with family therapy. However, family therapy was met with much resistance as it was clear to me that the family regarded Paula, not the family, as the problem.

Although Paula's father willingly came to family therapy when requested (there was no involvement of the mother, even after numerous attempts on my part) he refused to acknowledge his (and his ex-wife's) influence on Paula's behavior. Interestingly, even after his son was referred to me for exhibiting disruptive behaviours, he (Paula's father) continued to externalize the issues refusing to talk about the families' disruption. Gopaul-McNicol (1993) speaks to the issue of West Indian families remaining resistant to therapy despite the therapist attempts to foster a therapeutic alliance. She equates this to the cultural belief of most West Indian families that what happens in the family should remain in the family or what she terms "family secrets". Every child is told at an early age that family business remains in the home. Therefore, discussing personal and more specific, family issues with a stranger is difficult and at times forbidden. Further to this, the Jamaican family and the West Indian family as a whole will deny family problems because they believe there is nothing that they cannot solve themselves within the family (Gopaul-McNicol, 1993). Gopaul-McNicol (1993) also talks about the danger of pushing the family to tell the "family secrets" too early in therapy. She warns that this may provoke mistrust and resistance and jeopardize the therapist's position. Therefore, the Jamaican mentality regarding therapy is largely one of closed-mindedness as individuals generally believe that problems must be solved within the family system and there is much resistance to accessing the services of an "outsider". In the cases that therapy is accessed, one individual is often identified as the problem, thus enabling the other family members to maintain their denial of the breakdown in the family system, while "scapegoating" this individual.

Anna's case although similar, presented some unique challenges. Not only was there a disruption in the spousal relationship, but there was much turmoil in the parental relationship, specifically between Anna and her mother. Anna's constant exposure to her parents' arguments impacted her thoughts and subsequently her feelings and behaviours. For Anna her parents fighting and attacks on her about her weight (A) lead her to feelings of depression and becoming bulimic (C). It was clear after speaking with her, that her beliefs/irrational thoughts (B) – "maybe my parents are right and I am fat", "my dysfunctional family is rendering me out of control", and "it is my fault that they are fighting" – were what lead to the depression and bulimia (C), and not the actual activating event (A). Her peers' rejection of her (A) (laughing and calling her fat) also contributed to Anna's diagnosis. Anna's understanding of her thoughts, in this case, being fat, unworthy of friendship and not fitting in at school, was paramount in her treatment. Along with getting Anna to become aware of her thoughts it was also necessary for her to understand how she does have control over herself (thoughts, feelings and behaviours) and that she was choosing her consequences.

In this effort Glasser's Reality Therapy often times called Choice Theory, was incorporated in her treatment. The basic premises of Reality Therapy are that we are responsible for what we choose to do and that the only person whose behavior we can control is our own. Glasser (1998) states, "What we decide to do is our choice, and the goal is to help clients figure out and put into practice better choices than those they have been making." Therefore, the reality therapist helps clients see that they are choosing that which they are complaining about and that it is up to them, and would be more beneficial, if they chose more effective behaviours. Having control over our behavior means understanding our total behavior which includes acting (things that we do), thinking (thoughts, and self-statements), feeling (anger, joy, depression, etc.) and physiology (psychosomatic symptoms, sweating, headaches) all of which are interrelated. According to Glasser (1998) we can't choose total behavior without all the components. However, it is only thinking and acting (as it is related to our thoughts) that we have direct control over, therefore, in order to change our total behavior we have to change what we are thinking (and doing); that is, change thinking and acting then physiology and feeling components will change too.

With this in mind Anna was taught the WDEP techniques of Reality Therapy. [W] - Wants - Exploring Wants, Needs and Perceptions – Anna was asked to state what she wanted. This allowed her to choose how to meet her needs. [D] - Doing and Direction - After Anna identified her wants (to be happy, to be cared for, to lose weight) we assessed her current behavior to determine if she was "doing" what she should to get what she wanted. The question asked here is "Will this choice get you where you want to go?" (Wubbolding, 1991). The next step was helping Anna judge her own behaviour in an effort to answer the above question - [E] - Self-Evaluation. After she evaluated the quality of her behavior she then identified what was contributing to her failures and what she needed to do to change. [P] - Planning and Action the last phase is geared at helping clients identify specific ways to change their failure choices into success choices. Once Anna made an evaluation about her behavior and decided to change it, I helped her develop a plan for behavioral changes, which included practical short-term goals with a high probability of success,

(i.e. keeping a thoughts diary to help her become aware of her thoughts as well as refuting her negative thoughts by replacing them with more rational/positive thoughts; changing her diet to increase her intake of healthy foods; and joining a sports team at school (Anna reported that she enjoyed swimming). Joining a sports team would also give her an opportunity to increase her peer relationships). Although family therapy in conjunction with Anna's individual therapy was the ideal, this approach was abandoned when it was clear that Anna's treatment was being sabotaged because of the unresolved issues in the family. Therefore, the focus remained on helping Anna gain an understanding of the root of her behaviours and her thoughts, but also teaching her how to adapt (survive) in a dysfunctional environment.

Conclusion

Jamaica has seen an increase in diagnosable cases of eating disorders. It is believed that this is due to the adoption of Western standards and ideas brought to the forefront by the international media. Analysis of eating disorders in Jamaican adolescents should include an understanding of the interdependence of the family relationship, peer influence, developmental stage of adolescence and comorbidity of eating disorders and other psychiatric disorders. Treatment is multifaceted to include individual and family therapy, however, when working with Jamaican families one should be prepared for family resistance and subsequently tailor therapy towards empowering the adolescent.

Follow-up

Paula is now 18 years old and is a first year University student. She reports that she is no longer bulimic, that she is happy, and no longer living at home (Paula resides in University housing). Anna, now 15 ½ years old, continues to struggle with her weight and her emotions. She reports being unhappy and dissatisfied with her life and her relationship with her mother. Anna occasionally shows signs of improvement as she is trying to eat healthier, and although she has not yet initiated the process, she still reports an interest in joining the school's swimming team. Therapy continues to be geared around Anna's thoughts and helping her gain control over her total behavior.

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