Eating Disorders and Disordered Eating: Socio-Cultural and Familial Perspectives

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Editorial

Eating disorders (EDs) and disordered eating behaviors are considered a major disease of the modern World, being among the most prevailing public health problems in female adolescents and young adults in recent decades, and reaching in many Western countries an epidemic proportion (1). EDs are a complex, often misunderstood, bio-psycho-socio construct, likely reflecting an inter-dependent interaction of antecedent genetic, biological, psychological, familial and socio-cultural parameters (2).

The different EDs are grouped into several well-known clinical entities. According to the most updated diagnostic criteria of the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revised (DSM-IV-TR (3), the different EDs are categorized into anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) and eating disorders not otherwise specified (ED-NOS), also termed partial, or sub-clinical, ED syndromes. The latter group includes a variety of maladaptive eating-related preoccupations and behaviors that do not reach the severity of full-blown ED (4), but are distinct from mere dieting and disturbances in body image in having the potential to induce significant morbidity. Furthermore, almost half of individuals with ED-NOS may progress to the full syndrome within several years (5). Binge Eating Disorder (BED) is currently considered a separate provisional category in the DSM-IV-TR (3), although formally it is still diagnosed within the ED-NOS spectrum.

EDs can be differentiated according to weight (low in AN, normal in BN and often overweight in BED), and the presence or absence of bingeing and
weight reduction compensatory purging behaviors (vomiting, or use of supposedly anti-weight medications, primarily, but not only, laxatives) (6). Both classifications are subject to considerable controversy (7), as many patients may fluctuate among the different ED categories during the course of their illness (8,9).

Another caveat relates to the considerable similarity found between fully-diagnosed AN patients and restrictive ED-NOS patients who share all the diagnostic criteria of AN with the exception of amenorrhea (4), not to mention the growing evidence in recent years of an elevated incidence of AN in prepubertal girls and in boys (1). The ED-team, who is part of the multi-professional group currently working on the construction of the new DSM-V, focuses already on these and other important diagnostic conflicts, and will have to deal with these conflicts even more within the next years.

AN appears primarily during adolescence, whereas BN and BED appear primarily in young adults; all EDs occur primarily in females with 5-10% of the patients being male (1). The prevalence of AN, BN and BED in young females is estimated as 0.3%, 1%, and 3% respectively (1). The prevalence of partial ED (ED-NOS) syndromes is in the range of 3 to 22% (4), depending on whether the disorders are diagnosed according to standardized clinical interviews (lower prevalence) or standardized questionnaires (higher prevalence). Both AN and BN have shown an increase in their incidence in the second half of the 20th century, particularly among young women (1), although at least some studies argue that what is raised is actually the frequency of treatment use rather than a genuine increase (10).

The standardized mortality ratios in AN are between 5-10 times greater than in normal controls (11), and considerably higher than those reported for most other psychiatric disturbances, being the highest in bingeing-purging type AN. By contrast, low crude mortality rates in the range of 0.3-3% have been reported in BN (11).

AN and BN represent chronic disorders with recovery occurring mostly after 4-10 years from the start of the illness (12). Recovery in terms of maintaining normal weight and regular menstrual periods and abstaining from restricting, bingeing and purging behaviors occurs in 40-50% of AN (12) and BN patients (13), and a subclinical course in 30-35% of these patients. Despite treatment, around 20% of AN (12) and BN (13) patients will show a chronic non-remitting course over time. Relapse rate is often high; for example, 30-50% of BN patients may relapse within a few months to several years (13).

About This Special Issue

The first article in this special edition reviews the evolvement of EDs throughout history (Witztum et al). Symptoms and syndromes of self-starvation have been known and observed for hundreds of year, before our modern era. By contrast, BN, as it is currently defined, is a relative new syndrome that is not akin to descriptions of bingeing behaviors in previous eras that have usually not included compensatory purging and fear of fatness. The main message of this review article is that self-starvation has not been conceptualized as a unified entity throughout history, being rather interpreted according to the prevailing beliefs and cultural norms of each era. Two central themes relevant to deliberate self-starvation have been described throughout history: an ascetic-religious aspect of fasting, in which self-starvation has served as a means of purifying the body of the sins of the flesh, and a physical, esthetic aspect focused on appearance and the ideal of beauty, as it is usually conceived in our era.

Witztum and his colleagues go on to propose that in both types of motives, disordered eating can be conceived as representing an idiom of distress in times of conflict and confusion. As such, self-starvation can serve women as a mean to express their pain, to build a sense of identity in front of considerable external pressure and internal confusion, and to cope with issues related to individuality, autonomy, equality, and social position. In our era, turning to self-starvation receives mainly a personal individualized meaning, in which the focus on appearance and the thin body ideal represent an idiom of distress in the struggle of women for appreciation and acknowledgement.

The central historical theme concerning the importance of ascetic-religious aspects in the genesis of self-starvation, represents one example of the complex interactions existing between religion and
health-related problems (14), including those related to EDs and disordered eating (15, 16). These relationships are the focus of another article in this review (Weinberger et al.). In modern religious practice it is suggested that greater level of religiosity may protect the individual from disordered eating. In particular, women characterized as intrinsically religious, i.e., incorporating the role of religion as guiding important aspects of their life (17), have been found to have less ED pathology in comparison to extrinsically religious women, in whom security and solace are the result of belonging to a specific religious community (18). Weinberger et al. strengthen and support this conceptualization. In their study of 301 adolescent and young Jewish women in New York, participants with an intrinsic religious orientation have had less pathology on measures of body dissatisfaction and eating disturbances as compared to women with an extrinsic orientation, whether pro-religious, or anti-religious. Additionally, high levels of spiritual well-being have contributed above and beyond the effect of religion per se to reduce body dissatisfaction, but not disordered eating. These findings have led Weinberger et al. to conclude that an intrinsic spiritual religious orientation may potentially serve to protect women from eating-related and body image disturbances.

The likelihood of EDs to represent an idiom of distress for women in the face of socio-cultural pressures and the protective role of religion in the development of body dissatisfaction highlight the relevance of socio-cultural processes in the development of maladaptive eating and weight-related attitudes and behaviors (19). This brings into the forth the important role of prevention programs in regulating the influence of such processes. Prevention is the topic of another two articles in our special issue (Levine and Smolak, and Steiner-Adair). At the start of their article, Levine and Smolak relate to the seemingly never ending controversy as to the advantages and disadvantages of ED—related primary vs. secondary prevention programs. They conclude that secondary targeted programs are effective in the case of adolescents identified as being at a very high risk to develop an ED (e.g., having dieting behaviors and/or very negative body image despite being in normal or low weight). Nevertheless, only the combination of universal programs (aimed to influence government policies) and selective interventions (geared for non-symptomatic youngsters considered at risk to develop future EDs because of some broad factors, e.g., being female and/or on at the verge of puberty) can potentially prevent the development of EDs in non-clinical or incipient cases.

Levine and Smolak further argue that whereas targeted interventions are best aimed for adolescents older than 15, universal selective programs should be geared for children under the age of 11 years and early adolescents (ages 11-13). In these age groups, adequate interventions have a good chance to intervene with precursors for the development of EDs, both personal precursors, e.g., body dissatisfaction, weight concerns, and/or dieting behaviors, and socio-cultural precursors, primarily exposure to the thin ideal in the media, peer teasing, sexual harassment, and parental weight and shape-related comments. Such programs can additionally alter the actual environments (home, school) in which children may develop problematic eating, and promote eating-related protective factors, for example healthy nutrition and exercising. Finally, Levine and Smolak argue that the combination of several endeavors might improve the functioning of universal-selective programs for children and young adolescents: 1) Enhancing ED-related knowledge and literacy, 2) Promoting the value of feminism and empowerment in young girls, 3) Development of interactive preventive interventions that take into consideration both the developmental stage of the participant and the potential towards change during periods of developmental transitions and 4) Collaboration of experts of different professions towards improving preventive interventions on a political/environmental level.

Steiner-Adair describes in her article the adaptation of an effective primary prevention program for EDs, "Full of ourselves" (FOO), originally developed for public school girls (ages 8-15), to a modern-orthodox Jewish American population. "Full of ourselves", conceptualized as a “Wellness program advancing girl power, health and leadership”, aims to reduce disordered eating and body image disturbances in the context of empowerment of women. This novel program has been shown to promote girls’ self-and body-esteem and to decrease negative body talk and the risk of developing disordered eating (20).
The Jewish Guide to "Full of ourselves", termed "B’ishvili", ("For me" in Hebrew), has been recently developed in the US by Steiner-Adair for reform, conservative and orthodox Jewish Day Schools, summer camps and youth programs. The development of a culturally and religiously sensitive ED prevention program geared specifically for Jewish youngsters in USA reflects the growing concern in the American Jewish community in recent years of an increase in disordered eating among young Jewish girls. Indeed, "B’ishvili" draws on Jewish culture, values and rituals to strengthen Jewish girls’ resistance to dominant cultural values, as a means to reduce their vulnerability to develop EDs. This guide includes empowering Jewish texts specifically chosen to address risk factors for disordered eating, in particular texts aiming towards nourishing and respecting one’s body and soul, taking a stand for oneself and others, and assuming personal responsibility.

The last group of articles in the present issue explores the place of another aspect of prevention, namely the role of families as a potential source for either increasing the risk for the development and maintenance of an ED, or protecting against such processes. This is a highly controversial issue, as the tendency of both lay people and professionals to blame the family in relation to the development of an ED in their offspring seems to be highly integrated in the human nature. We, as most other researchers, believe that rather than being blamed, families should be encouraged that their words and actions do have a potential to reduce at-risk precursors for the development of EDs, and to promote healthier attitudes and behaviors towards eating, weight and shape.

Neumark-Sztainer deals in her article with the conflicts and confusion that parents often have as to the types of messages they should give, or not give, to their children regarding eating and weight. This becomes ever so relevant in our modern weight-obsessed era, when even young children are increasingly exposed to mixed societal messages that make it difficult for them to maintain both a healthy body and a positive body image, and to intentional and non-intentional weight-related teasing and comments of family and peers. Based on research done by her group and teams in other countries of the Western world, Neumark-Sztainer outlines four strategies for parents to deal with potentially harmful eating-related societal pressures and to decrease their child’s risk for becoming overweight or developing an ED.

The first strategy, “model healthy behaviors for your children,” emphasizes that parents should model behaviors they wish their children to emulate, particularly engaging in healthy eating of a variety of foods and exercising at an appropriate level (21). On the other hand, parents should refrain from comments encouraging unhealthy eating and weight related behaviors (e.g., dieting). The second strategy, “provide an environment that makes it easy for your child to make healthy choices” proposes that instead of trying to restrict and control their child’s dietary intake, parents should provide a home environment that includes an abundance of fruits and vegetables and a minimal number of televisions, and that encourages family meals. The third strategy, “focus on adaptive attitudes and behaviors rather than on weight”, encourages parents to assist their children in developing an identity that goes beyond physical appearance to non-appearance rated traits and accomplishments, moderating their children’s interest and preoccupation with weight and dieting. The fourth strategy, “provide a supportive environment”, encourages parents to support their children when harassed and teased outside home in relation to their weight.

Hughes et al focus in their article on the role of parental control in the eating-related attitudes and behaviors of their children. This bears on studies showing that although being the most frequent parental eating-related intervention, focusing solely on restrictive approaches to feeding interferes with satiety cues and regulation of eating, endangers preferences towards unhealthy food, and unfavorably affects children’s ability to consume moderate amounts of food when restriction is no longer present (22). Moreover, highly directive restrictive strategies have been actually found to be consistently associated with increased intake of undesired food and higher weight status in children (23).

Bearing on these findings, Hughes et al have attempted to widen the concept of parental control form mere restriction. For this purpose, they adopted Baumrind’s (24) hypothesis defining parenting style as the combination of attitudes and the emotional
climate created by parents, and Macoby and Martin’s (25) transformations of this hypothesis to measurable operational constructs of parenting style: authoritative (highly demanding, highly responsive), authoritarian (highly demanding, low responsive), permissive (low demanding, highly responsive) and neglectful (low demanding, low responsive). Accordingly, authoritative parenting style has been found to have the most favorable effects on children’s eating behaviors and weight, followed by the permissive parenting style, whereas both the authoritarian and neglectful styles have shown unfavorable results (26).

Another two articles focus on families of children with disordered eating. Treasure et al deal with the need to share relevant eating-related information with caregivers of children with EDs to make them aware that family factors can inadvertently maintain ED symptomatology in their children. The authors give evidence from naturalistic studies and randomized controlled trials that interpersonal family factors can have an adverse impact on an ED. This relates primarily to the influence of high expressed emotion in the form of criticism, hostility, over-involvement and overprotection. Secondly, families can inadvertently be drawn in by the highly affectively-laden nature of the illness to organize and accommodate their lives around the ED symptoms.

These ED-maintaining processes, combined with the experience of caregivers that they often lack information and skills to handle their child’s ED, have led Treasure and her colleagues to recommend the provision of information on ED-related maintaining factors and of skills training interventions to promote early effective interventions and reduce the burden and distress of managing treatment resistant cases. Sharing information and skills with family members can additionally correct maladaptive judgments and unwanted reactions of family members to the ED and can empower them to become active members of the treatment team.

In line with the philosophy proposed by Treasure et al, Mazzeo et al have applied in their study a treatment approach that targets the parents of overweight children to reduce pediatric overweight, without involving the children themselves. The authors argue that there are several reasons why parents’ involvement in treatment for pediatric overweight is vital. First, parental obesity is associated with overweight in children (27). Additionally, parents can model eating attitudes and behaviors as well as sedentary and exercising behaviors for their children, and provide structure and routines for eating, all likely influencing children’s eating and weight-related behaviors. Involving exclusively the parents in the treatment of pediatric overweight has been found superior to treating only the children (28) or the entire family (29) in promoting improved eating behaviors and greater weight reduction.

The authors have evaluated a parents’ only intervention specifically tailored for African Americans, a group that despite being at specifically high risk for developing pediatric overweight, has limited access to obesity treatment (30). This intervention, the NOURISH (Nourishing Our Understanding of Role Modeling to Improve Support and Health), has been evaluated in a pretest-posttest control group design, in mainly Caucasian or African American parents of overweight 6-11 years old children.

Results indicate that this intervention was credible, feasible and well-received by the parents. At post-testing, parents in the intervention group showed an increase in fiber intake and in physical activity and a reduction in sedentary behavior, eating-related disinhibition, and susceptibility to hunger compared with control parents, and they were less likely to pressure their children to eat. Despite these benefits, no change in weight was found for either children or adults, potentially attributable to the small sample size and the relatively short duration of the study.

Two articles deal with familial and socio-cultural influences on disordered eating in specific societies. Genders et al assessed this issue in UK and Georgian-born women and in women born in Georgia, but living in the UK. Georgian women were found to have elevated restraint, eating concerns, subjective bulimic episodes and frequency of laxative use compared to both, or one of the other groups. For all groups, shape concern emerged as the most pathological feature, suggesting that cross-culturally, it is of paramount importance in the development of disordered eating (31).

Concerning familial eating and feeding habits, UK women were more likely to report that their family tended to eat meals at set times on the day, that
meals were seen as a social event, and that they were included in such events. Restriction of snacks and using food as reward or restriction for punishment were also more prevalent in the UK. For UK women, disordered eating was predicted by dieting in the family, exemplified by the preparation of specific food for a family member. For Georgian women, disordered eating was predicted primarily by factors related to parental control over feeding, including eating meals at set time of the day, restricted access to snacks, and frequency of eating snacks, although attitudes towards food and the frequency of food used as a reward were also significant predictors.

Based on these results, Genders et al propose a cultural transmission model to account for the influence of parental eating and feeding patterns on the development of disordered eating in their offspring. Accordingly, in the UK, representing a prototype of modern Western culture, parental eating behaviors (e.g., dieting) during childhood predict the development of maladaptive eating related concerns and behaviors in their adult daughters. On the other hand in Georgia, being only recently exposed to Westernized cultural ideals, it is more the feeding practices in the family that exert the most prominent ED-related predictive potential.

Lastly, Forcano et al attempted to determine whether there would be culturally-dependent differences in eating-related symptomatology and eating-related personality attributes between Spanish-born females and Latin-American first-generation female immigrants to Spain diagnosed with bulimia nervosa (BN). Whereas Spanish-born women were previously found to be influenced to a greater extent by the Westernized slim body ideal and experienced more body dissatisfaction in comparison with Spanish speaking Latino-American women (32), only a few such differences emerged in the present study between Spanish-born and Latino-American first-generation BN women, with the Spanish—born group reporting elevated levels of body dissatisfaction and ineffectiveness. Whereas the authors acknowledged their small sample size (only 40 women were studied) as precluding meaningful between group-differences, they nevertheless associated the greater disturbance of Spanish-born BN women in body dissatisfaction and ineffectiveness to their greater exposure to the Westernized slim body ideal and to their difficulty to resist this influence.

Conclusions

This issue is the first of two issues dealing with diverse aspects related to EDs and disordered eating. Whereas the next issue is expected to focus on clinical and treatment-related aspects, this issue has concentrated mainly on diverse socio-cultural dimensions considered of importance in the development, course and outcome of EDs.

Current research emphasizes primarily the genetic and biological context of EDs, with heritability estimates of AN and BN, and of eating-related behaviors and attitudes, ranging between 0.5-0.8, and 0.3-0.7, respectively (33). Our review suggests, nevertheless, that socio-cultural processes do have a place in the field of EDs, likely combining with the robust genetic and biological influences. The main messages to be taken from this issue are:

- EDs are not an illness of the modern era; rather, they have existed throughout history, primarily in the form of self-starvation, and have been associated with varied socio-cultural and personal motivations.
- Diverse socio-cultural processes can have an influence on EDs and disordered eating. The present review has related in this respect to the relevance of religion, migration, and the extent of exposure to the Westernized thin-body ideal.
- Whereas the family is not the source and cause for the development of EDs, parents, in particular, have a considerable influence in reducing at-risk precursors for the development and maintenance of disordered eating, and in promoting healthier attitudes and behaviors towards eating, weight and shape. This issue deals with the role of the family in the course and outcome of EDs and disordered eating from a conceptual and empirical viewpoint, emphasizing the role of parents in modeling, promoting and changing of attitudes, perceptions and behaviors.
• Parents should be involved as active members in the treatment of their ED children.
• Primary prevention programs have an important role in regulating and modifying socio-cultural processes that may potentially increase the risk for the development of EDs and disordered eating.
• In our modern era, changing prevailing socio-cultural attitudes toward women and the empowerment of women may have an important role in reducing the risk of maladaptive attitudes and behaviors related to eating-, weight- and body image and perception.

References

