

Transcultural Psychiatry

<http://tps.sagepub.com/>

Clinical, Psychological, and Personality Correlates of Asceticism in Anorexia Nervosa: From Saint Anorexia to Pathologic Perfectionism

Secondo Fassino, Andrea Pierò, Carla Gramaglia, Giovanni Abbate Daga, Marina Gandione, Giovanni Giacomo Rovera and Goffredo Bartocci

Transcultural Psychiatry 2006 43: 600

DOI: 10.1177/1363461506070785

The online version of this article can be found at:

<http://tps.sagepub.com/content/43/4/600>

Published by:



<http://www.sagepublications.com>

On behalf of:

Division of Social & Transcultural Psychiatry, Department of Psychiatry, McGill University



McGill

World Psychiatric Association



Additional services and information for *Transcultural Psychiatry* can be found at:

Email Alerts: <http://tps.sagepub.com/cgi/alerts>

Subscriptions: <http://tps.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations: <http://tps.sagepub.com/content/43/4/600.refs.html>

Clinical, Psychological, and Personality Correlates of Asceticism in Anorexia Nervosa: From Saint Anorexia to Pathologic Perfectionism

SECONDO FASSINO, ANDREA PIERÒ, CARLA GRAMAGLIA,
GIOVANNI ABBATE DAGA, MARINA GANDIONE, &
GIOVANNI GIACOMO ROVERA
University of Turin

GOFFREDO BARTOCCI
World Psychiatric Association

Abstract This study investigated the personality and clinical correlates of asceticism in 154 anorectic patients. Multiple linear regression models showed that asceticism was related to angry temperament, high control over anger, perfectionism, maturity fears, and number of vomiting episodes per week. These results suggest that the self-discipline and hypercontrol of anorectic patients are related to a temperament prone to angry feelings in subjects with a fear of becoming adult and with a trait of pathologic perfectionism.

Key words anger • anorexia nervosa • asceticism • maturity fear • perfectionism

Social and cultural issues have an important role in the onset and expression of eating disorders (EDs) (Gordon, 1991). Prince (1985) suggested that Anorexia Nervosa (AN) might be a western culture-bound syndrome. In many nonwestern cultures, health, strength, and high social

status have traditionally been associated with a more obese nutritional state. However, the spread of EDs (particularly AN) in women throughout all social classes in western societies, together with their recent emergence in nonwestern populations, supports the concept of culture-change syndrome (Di Nicola, 1985). This definition is based on the fact that current EDs seem due to westernization and that differences in their phenomenology between western and nonwestern cultures are fading.

EDs, and AN in particular, started being considered illnesses in the 18th century, when Gull and Lasegue described the first cases of anorexia from a medical viewpoint (Vandereycken & Van Deth, 1995). Even in earlier times fasting never passed unnoticed. It had different meanings from the medical one in different historical and cultural periods, but the most important was the religious meaning. Fasting belonged to ascetic practices, being a means to avoid evil influences and to achieve sacred purposes.

Most major world religions have special ascetic cults or ideals. From the religious viewpoint asceticism (from the Greek *askesis*, exercise) indicates spiritual exercises (self-denial, renunciation of immediate or sensual gratifications) in the pursuit of virtue, its object being the attainment of perfection. Prior to enlightenment, models of personality development were expressed exclusively in religious terms; from this viewpoint the most important methods to facilitate personality growth were meditation and asceticism. Asceticism has often been referred to as a deviant behaviour motivated by subconscious guilt or masochism. Ascetic practices are connected with the significance of the original sin with respect to both eating and sex (Huline-Dickens, 2000).

Bell (1987) studied 170 Italian saints, finding that almost 50% could be diagnosed as suffering from AN. Other authors have highlighted the similarities among the saints' asceticism and some psychological traits of anorexics (diagnosed according to DSM-IV criteria; American Psychiatric Association [APA], 1994), particularly self-discipline, self-denial, rituals, social protest, frustration of physical needs, closeness to death, control over instincts, and aspiration to immortality (Lacey, 1982). Despite these similarities, the asceticism of anorectic patients is different from that of the saints in some features that characterize it as pathological: It is not finalistic or self-limiting and seems to represent the common final pathway for an intrapsychical, family, and social disorder (Gabbard, 2000). It has been suggested that religious themes in anorexia may not be strong, but that ethical codes of sacrifice, loyalty, and sexual denial are relevant in the families of anorexics (Huline-Dickens, 2000). Moreover, fasting in AN is always based on a disorder of body image, or at least on placing excessive importance on body shape and weight for self-esteem (APA, 2000). Ascetic saints and anorexics are connected conceptually in the process of idealization (Huline-Dickens, 2000) and are similar in their pursuit of

perfection through the aforesaid methods, but there seems to be a change from a teleologic viewpoint. The saints attained perfection to be similar to the God of Christianity; anorectics seem to pursue perfection to model themselves in the shape of an internal ideal God (Anamadin, as in pro Ana Web sites). New directions in psychological anthropology challenge the dichotomy between culture and the individual mind, suggesting they should be viewed as a moving continuum; sometimes patients use cultural symbols in imaginative ways to give meaning to their personal concerns (Banks, 1997).

Apart from perfectionism, another perspective in the understanding of asceticism has been proposed. Menninger (1938) identified four dimensions of asceticism: Aggression, a desire to be punished, an erotic motivation, and a self-destructive impulse. Anger thus seems to play a relevant and often underestimated role in ascetic behaviours. In particular, excessive asceticism (*epaskesis*) has been considered a consequence of anger, inhibited in its outward expressions and turned toward oneself.

The importance of ascetic tendencies in AN is confirmed by the fact that one of the most widely used questionnaires for the study of EDs – the Eating Disorders Inventory-2 (EDI-2; Garner, 1984) – includes a specific subscale for the assessment of asceticism. Asceticism measures the tendency to pursue spiritual ideals such as self-discipline, self-denial, self-limitations, hypercontrol over body needs, and self-sacrifice (Garner, 1984). In a recent study, asceticism, as assessed with the EDI-2 was correlated with outcome in AN: Patients with higher degrees of asceticism were more likely to belong to the not improved group of patients after 6 months of multimodal treatment (Fassino, Abbate Daga, Amianto, et al., 2001).

Despite several investigations of this issue (Banks, 1992, 1997), it is still not clear which personality and psychological features underlie asceticism in AN, as it is expressed in current western culture. Specifically, it is not clear what kind of relationship exists between asceticism and perfectionism, whether asceticism depends on less specific disorders in personality development, on psychosomatic alterations due to low body weight and illness duration, or on the individual's cultural background.

The present study investigated the psychological substratum of asceticism in AN, considering also those features correlated to symptomatology, clinical conditions, personality, and anger management.

MATERIALS AND METHODS

SUBJECTS

A total of 154 anorectic outpatients applying to the Eating Disorders Centre of Turin University from January 1, 2000 to December 1, 2003 were

involved in the study. All female patients diagnosed with AN (restrictor or binge/purging subtype, according to DSM-IV criteria; APA, 1994) during the first session were included in the study.

A total of 51 patients with AN applied to the Centre but were excluded for the following reasons: (1) Comorbidity of a full-syndrome Axis-I disorder ($n = 45$), including mood ($n = 21$), anxiety ($n = 16$), and other ($n = 8$) disorders; or (2) refused to participate in the study ($n = 6$). These patients were excluded because an Axis-I comorbidity, particularly with psychotic and depressive disorders, can influence the scores on psychometric tests. Axis-II disorders were not excluded to select a more representative sample of eating-disordered patients (Mitchell, Maki, Adson, Ruskin, & Crow, 1997). Given the high rate of comorbidity between EDs and Personality Disorders (PDs) (Milos, Spindler, Buddeberg, & Cramer, 2003) about half the patients would have been excluded. Moreover, personality was not assessed from a categorical viewpoint (e.g., Structured Clinical Interview for DSM-IV [SCID II]), but instead according to a dimensional model (psychobiologic model by Cloninger). Finally, Axis-II diagnosis (Milos et al., 2003), but not the Temperament and Character Inventory (TCI; Cloninger, 2000), is strongly influenced by the stage of the disorder and of treatment.

Diagnostic assessment for Axis-I disorders was performed with the support of the Structured Clinical Interview for DSM-IV (SCID-OP; First, Spitzer, Gibbon, & Williams, 1996). All subjects were asked for informed written consent to participate in the study and were granted anonymity.

ASSESSMENT OF NUTRITIONAL STATE AND ED SYMPTOMATOLOGY

Body Mass Index (BMI)

The BMI, an index of body mass (kg/m^2), is related to the nutritional state of the subject. Female subjects with a BMI between 18.7 and 23.8 are considered to be of normal weight (Mitchell, 1997).

Eating Disorder Inventory-2 (EDI-2) and EDI-Symptom Checklist (EDI-SC)

The Eating Disorder Inventory-2 (Garner, 1984) is a self-report interview that measures disordered eating attitudes and behaviours and personality traits common to individuals with EDs. The EDI-2 is a 91-item inventory composed of 8 subscales (Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, Maturity Fears) and 3 provisional subscales (Asceticism, Impulse Regulation, Social Insecurity). The EDI-SC (Garner, 1984) is a self-administered questionnaire used to collect clinical data about EDs: Age at

onset, physical exercise, binges, purges, menses, and use of laxatives and diuretics.

The assessment of asceticism is based on the EDI-2 subscale of asceticism, which measures the tendency to pursue spiritual ideals as self-discipline, self-denial, self-limitations, hypercontrol over body needs, and self-sacrifice to increase one's worth. From a conceptual viewpoint, asceticism is strongly correlated to perfectionism and to drive for thinness (Garner, 1984).

State-Trait Anger Expression Inventory (STAXI)

The STAXI (Spielberger, 1996) consists of 44 items that are divided into 6 scales and 2 subscales. It measures the intensity of anger as an emotional state (State-anger) and the disposition toward anger as a personality trait (Trait-anger). The Trait-anger scale contains 2 subscales, T-Anger/T, which measures the general disposition toward angry feelings (angry temperament), and T-Anger/R, which measures the tendency to express anger when one is criticized (reaction to criticism). Additional scales include Anger Expression-In (AX-IN), which measures the frequency with which angry feelings are suppressed; Anger Expression-Out (AX-OUT), which measures the frequency of the expression of anger toward other people or objects in the environment; and Anger Expression Control (AX-Con), which measures the frequency of attempting to control the expression of anger. The final scale, AX/EX, gives a general index of the expression of anger. Participants rate themselves on 4-point scales for each item, assessing either the intensity of their angry feelings or the frequency with which anger is experienced, expressed, suppressed, or controlled. In each case, higher scores indicate a greater level of anger and its suppression or expression. The STAXI has been validated on a variety of normal and clinical populations and has good psychometric properties (Spielberger, 1996).

Temperament and Character Inventory (TCI)

The TCI (Cloninger, Przybeck, & Svrakic, 1993; Cloninger, Przybeck, Svrakic, & Wetzel, 1994) is a temperament and character inventory based on a psychobiologic model of personality. The TCI is divided into seven independent dimensions. Four of these dimensions assess temperament (Novelty Seeking [NS], Harm Avoidance [HA], Reward Dependence [RD], and Persistence [P]). Cloninger (2000) defines temperament as partly heritable emotional responses, stable throughout life, mediated by neurotransmitter functioning in the central nervous system and providing a clinical description of opposite extreme scores.

Briefly, NS expresses the level of activation of exploratory activity. Low NS means low explorative activity, poor initiative, insecurity, and unresponsiveness to novelty and change, whereas high scores on this dimension

indicate the opposite characteristics. HA reflects the efficiency of the behavioural inhibition system. Highly HA individuals are described as extremely careful, passive, and insecure. RD reflects the maintenance of rewarded behaviour. Highly RD individuals are described as attached and easily influenced by others. P expresses maintenance of behaviour as resistance to frustration. High P expresses the tendency to maintain unrewarded behaviours and correlates with rigidity and obsessiveness.

The other three dimensions test character (Self-directedness [SD], Co-operativeness [C], and Self-transcendence [ST]), defined as the overall personality traits acquired through experience. SD expresses the degree to which the self is viewed as autonomous and integrated. C reflects the degree to which the self is viewed as a part of society. ST expresses the degree to which the self is viewed as an integral part of the universe. Low SD and C appear as a common denominator extending across subtypes of PDs and the most important predictor of categorical diagnosis of a DSM Axis-II disorder (Cloninger, 2000). The TCI displays good internal consistency (range = .76–.89; Cloninger et al., 1993).

STATISTICAL ANALYSIS

All data analyses were performed using the Statistical Package for Social Sciences (SPSS, 2000). First we compared the two subgroup of patients affected by AN (restrictor and binge-purging types) through Bonferroni's t-test (corrected for multiple comparisons). A level significance of alpha .05 was considered acceptable (2-tailed). Bivariate correlations among the variables of the tests were examined with Pearson's coefficient.

After this first step, all continuous variables – psychometric (EDI-2, STAXI, TCI scales and dimensions), clinical (BMI, illness duration, episodes of vomiting/week), personal (age, schooling) – and the dichotomous variable 'diagnosis' (AN-R, AN-BP) were entered in a stepwise multiple linear regression analysis (forward). This analysis allows the study of the relation among the variable 'Asceticism' (dependent variable) and independent variables (predictors), avoiding the risk of spurious correlations. A level significance of alpha < .05 was considered acceptable (2-tailed).

RESULTS

COMPARISON BETWEEN RESTRICTOR AND BINGE-PURGING ANORECTICS

The results of the comparison between restrictor (AN-R) and binge-purging (AN-BP) anorectics and the sample description are reported in Table 1 (clinical features and scores on the EDI-2) and Table 2 (scores on the STAXI and TCI).

TABLE 1
 Comparison between AN-R and AN-BP anorexics and sample description:
 Clinical features and EDI-2

	AN-R		AN-BP		<i>t</i> -test	<i>p</i> -value
	Mean	SD	Mean	SD		
BMI	15.98	1.45	16.55	1.57	-2.32	.02
Age (years)	24.28	7.24	24.62	5.32	-.32	ns
Binge/week	0.17	0.45	6.95	10.44	-6.29	< .001
Purge/week	0.10	0.69	6.33	8.55	-6.62	< .001
DT	10.80	7.94	12.35	6.91	-1.25	ns
BU	2.19	3.38	7.50	6.11	-6.91	< .001
BD	10.45	7.07	12.41	7.20	-1.68	ns
IN	8.78	7.48	11.51	7.65	-2.20	.03
P	4.93	4.16	5.03	3.66	-.15	ns
ID	6.54	5.14	7.17	4.94	-.76	ns
IA	8.48	6.33	10.87	6.15	-2.32	.02
MF	7.19	5.97	7.58	5.73	-.40	ns
ASC	6.53	4.77	8.04	4.34	-2.00	.05
IMP	6.19	5.49	8.25	5.78	-2.24	.03
SI	7.22	5.15	8.09	4.73	-1.06	ns

Note. AN-R, restrictor anorexia; AN-BP, anorexia binge-purging; Eating Disorder Inventory-2 = DT: Drive for Thinness; BU: Bulimia; BD: Body Dissatisfaction; IN: Inadequacy; P: Perfectionism; ID: Interpersonal Distrust; IA: Interoceptive Awareness; MF: Maturity Fears; ASC: Asceticism; IMP: Impulsiveness; SI: Social Insecurity.

As regards clinical features, AN-R and AN-BP show differences in BMI ($p < .021$) and weekly binge ($p < .001$) and purge ($p < .001$) frequency. The comparison between the two diagnostic subgroups on the EDI-2 highlighted significant differences on the following scales: Bulimia, Inadequacy, Interoceptive Awareness, Impulsiveness, and Asceticism. Differences emerged also on some STAXI (AX-OUT, AX-EX) and TCI (NS, SD) scales.

CORRELATION ANALYSIS

Asceticism correlated directly with Harm Avoidance ($r = .25, p < .002$) and Self-transcendence ($r = .24, p < .002$) but not with Novelty Seeking on the TCI. Inverse correlations were found between Asceticism and Co-operativeness ($r = -.21, p < .01$), Self-directedness ($r = -.28, p < .001$), and Reward Dependence ($r = -.19, p < .02$).

Asceticism correlated directly with all of the EDI-2 scales and with the weekly frequency of purging behaviours ($r = .23, p < .001$) (but not with that of binge episodes): Drive for Thinness ($r = .56, p < .001$); Bulimia ($r = .41, p < .001$); Body Dissatisfaction ($r = .42, p < .001$); Impulsiveness

TABLE 2
Comparison between AN-R and AN-BP anorexics and sample description:
STAXI and TCI

	AN-R		AN-BP		<i>t</i> -test	<i>p</i> -value
	Mean	SD	Mean	SD		
S-Anger	13.70	5.52	15.24	6.39	-1.59	ns
T-Anger	20.47	5.21	21.80	5.71	-1.49	ns
T-Ang/T	7.41	2.53	8.19	2.79	-1.78	.08
T-Ang/R	9.38	2.83	9.85	2.81	-1.01	ns
AX-IN	19.54	5.99	19.95	4.69	-.44	ns
AX-OUT	15.67	4.80	17.35	5.54	-2.00	< .05
AX-CON	20.39	6.19	18.87	8.50	1.28	ns
AX-EX	30.24	11.53	34.70	9.96	-2.48	< .05
NS	17.07	6.38	19.72	6.09	-2.57	< .05
HA	22.22	7.28	23.53	6.13	-1.16	ns
RD	14.41	3.91	15.43	4.13	-1.56	ns
P	4.92	1.98	4.98	2.62	-.16	ns
SD	23.57	8.41	19.67	7.07	3.00	< .01
C	30.76	7.45	32.06	4.13	-1.25	ns
ST	13.14	6.29	14.98	6.48	-1.76	ns

Note. AN-R, restrictor anorexia; AN-BP, anorexia binge-purging; S-Anger: Stage-anger; T-Anger: Trait-anger; T-Ang/T: Angry temperament; T-Ang/R: Reaction to criticism; AX-IN: Anger Expression-In; AX-OUT: Anger Expression-Out; AX-CON: Anger Expression Control; AX-EX: Expression of Anger; NS: Novelty Seeking; HA: Harm Avoidance; RD: Reward Dependence; P: Persistence; SD: Self-directedness; C: Cooperativeness; ST: Self-transcendence.

($r = .51, p < .001$); Social Insecurity ($r = .37, p < .001$); Inadequacy ($r = .43, p < .001$); Perfectionism ($r = .45, p < .001$); Interpersonal Distrust ($r = .38, p < .001$); Interoceptive Awareness ($r = .64, p < .001$); Maturity Fears ($r = .31, p < .001$). Furthermore, Asceticism correlated with state anger ($r = .27, p < .001$), trait anger ($r = .23, p < .01$), anger expression ($r = .23, p < .01$), and with the tendency to suppress anger ($r = .37, p < .001$).

None of the scales was significantly correlated with age. Only Social Insecurity (inverse correlation), Interpersonal Distrust (EDI-2) and Reward Dependence (direct correlation) correlated with the BMI. The correlations among EDI-2, STAXI and TCI scales have already been widely discussed in literature and are not reported here, being beyond the aims of the study.

PREDICTORS OF ASCETICISM

Table 3 shows the results obtained from the stepwise multiple linear regression (forward): Five statistical models of regression were obtained,

TABLE 3
Regression analysis: Association among psychological and clinical variables and asceticism in AN

<i>Model</i>	<i>Variables</i>	<i>R²</i>	<i>B (parameter estimate)</i>	<i>p-value</i>
1	Perfectionism	.18	.49	< .001
2	Perfectionism	.26	.47	< .001
	T-Anger Trait		.50	< .001
3	Perfectionism	.31	.45	< .001
	T-Anger Trait		.41	.001
	Maturity Fear		.18	.002
4	Perfectionism	.34	.44	< .001
	T-Anger Trait		.40	.001
	Maturity Fear		.17	.002
	Vomiting/week		.12	.011
5	Perfectionism	.37	.41	< .001
	T-Anger Trait		.57	< .001
	Maturity Fear		.17	.002
	Vomiting/week		.12	.008
	AX Control		.13	.009

Note. Multiple linear regression analysis, stepwise forward.

the strongest of which included five variables identified as independent predictors of Asceticism: Perfectionism and Maturity Fears (EDI-2 scales), T-Ang-T and AX-Con (STAXI scales), and vomiting frequency (number of vomiting episodes/week). TCI variables are not significant in the final models. The fifth model explained about 40% of the total variance of the 'Asceticism' variable. TCI dimensions were not significantly associated and independently correlated to the Asceticism scale of the EDI-2.

DISCUSSION

The objective of this study was to identify some clinical and psychological correlates of ascetic tendencies in AN, which may be relevant for the development of treatment strategies (Fassino, Pierò et al., 2004). The sample included both restrictor and binge-purging anorectics. The comparison of the clinical features and questionnaires scores between the two subgroups of patients revealed some differences which were expected as a consequence of the diagnostic subtype. AN-R patients had a lower BMI and weekly binge/purge frequency than AN-BP patients, and they scored lower on the Bulimia and Impulsiveness scale of the EDI-2. Further, restrictor compared to binge-purging anorectics scored lower on the AX-OUT and AX-EX scores of the STAXI and lower on NS but higher on the SD scale of the TCI, as reported in previous studies (Fassino,

Abbate Daga, Pierò, Leombruni, & Rovera, 2001; Fassino, Amianto, Gramaglia, Facchini, & Abbate Daga, 2004).

As expected, a significant correlation between Asceticism and Perfectionism was found. Perfectionism is widely acknowledged to be one of the main factors involved in the onset and maintenance of AN (Fairburn & Harrison, 2003) and seems to have a strong inherited and transgenerational component (Halmi et al., 2000; Woodside et al., 2002). Because of its association with ritualism, self-discipline, and absolute self-control, Asceticism could be considered a reflection of the perfectionism characteristic of western cultures which have experienced an apparent increase in the prevalence of AN in recent years (Fairburn & Harrison, 2003; Gordon, 1991). Perfectionism is associated with high expectations with regard to oneself and one's life, and with depressive feelings (Bizeul, Sadowsky, & Rigaud, 2003). Failure in pursuing perfection intensifies the feelings of poor self-esteem and, at the same time, leads to an avoidant attitude toward those situations that cannot be managed in a perfect way (Shafran, Cooper, & Fairburn, 2002). As a consequence, a strong need to control every issue of one's life develops in the subject, from obsessive traits to comorbidity with full criteria Axis-II PDs (Anderlueh, Tchanturia, Rabe-Hesketh, & Treasure, 2003).

Moreover, in this sample a strong correlation emerged between Asceticism and Maturity Fears, the last being a typical psychological trait of EDs, which is also related to outcome in AN (Fassino, Abbate Daga, Amianto, et al., 2001). Maturity and adulthood imply that the subject has to face new social roles (including the sexual one), strong impulses, and instincts. These last need to be managed, and asceticism may be used for the attainment of self-control and for the inhibition of lower-level impulses (Dabrowski, 1967).

Anger also seems to strengthen ascetic behaviours. An angry temperament and excessive control over anger characterize those anorectic patients scoring high on Asceticism. From this viewpoint it can be understood why the fasting of anorectic patients resembles that of many medieval saints: In both cases fasting represents an 'angry protest' against expectations, pressures, and the social role imposed on women (Katzman & Lee, 1997). These contents are indeed difficult to express, and both religious asceticism and illness seem to allow a socially and culturally acceptable way to 'protest' (Morgan, Marsden, & Lacey, 2000).

Last, an association between Asceticism and vomiting behaviours was found among patients with binge purging AN. In a sample of bulimic patients, more severe vomiting was associated with higher degrees of Asceticism (Abbate Daga, Pierò, Gramaglia, & Fassino, 2005). This result may seem contradictory because asceticism is a struggle for control and vomiting is instead an impulsive behaviour. However, vomiting usually

follows binges (objective or subjective ones) and should be considered a means to compensate for the release of 'lower impulses' seen in the binge, as well as physical exercise and dieting. In religious language, vomiting becomes a type of expiation.

The relationship between symptoms like perfectionism, anger, and maturity fears (on the one hand) and asceticism (on the other) may be explained as follows. Asceticism has been considered positively for its creative and adaptive implications (Fallon & Howath, 1993) and as a means to achieve personality growth and perfection. But when the subject shows high perfectionism and maturity fears, there may be difficulty accepting and integrating some impulses. Fasting and self-control exercises may then be turned against oneself aggressively with the aim to disintegrate lower personality structures and inhibit lower-level impulses (Dabrowski, 1967).

Personality variables did not enter the linear regression models. Thus Asceticism does not seem to be specifically and independently correlated to one or more TCI dimensions. This result might be explained as follows: Ascetic tendencies can be the consequence of more or less severe deep structural psychological disorders related to perfectionism, self-destructiveness, and fascination with death (Adler, 1920). These psychological problems could be related to both cross-cultural and intracultural features (Banks, 1992). This supports the importance of a transcultural approach in EDs, together with a biologic and psychodynamic approach. Asceticism is difficult to define *tout court* as a personality trait or a cultural value. The relationships between culture and the individual mind can be considered as a moving continuum, with culture constantly worked and reworked by the individual imagination (Banks, 1997). Anorectic patients may use cultural symbols to give meaning to their personal concerns with growth, separation, and sexuality (Banks, 1997) and to communicate their suffering in a socially acceptable and understandable way.

In other studies, Asceticism has been found to correlate with outcome (Fassino, Abbate Daga, Amianto, et al., 2001) and high levels of Asceticism are associated with a greater likelihood of treatment drop-out in AN, though stronger predictors are temperament and character dimensions, and management of angry feelings (Fassino, Abbate Daga, Pierò, & Rovera, 2002).

LIMITATIONS

This study has limitations due to the lack of specific and multidimensional methods for the assessment of ascetic tendencies in AN and to the complexity of the issue studied. In this study no correlation emerged between asceticism and personality features assessed with the TCI;

perhaps the use of another instrument for personality investigation (e.g., the NEO-PI) would have given different results.

The cross-sectional design and lack of a control group in this study did not allow us to examine the role of asceticism in the onset and course of anorexia. Moreover, the composition of the sample (Italian patients applying to our ED outpatient service) did not allow us to study comparative cultural aspects of AN but instead allowed assessment of a single social context, the urban area of Turin. Studies involving multiethnic populations performed in different countries are needed to properly address the transcultural aspects of anorexia.

CONCLUSION

The present study supports the value of a transcultural viewpoint in the approach to AN because it allows identification of issues in psychological functioning that have recurred across the centuries and also of larger social issues regarding gender roles in modern and postmodern society. Asceticism seems to be based on specific ways of thinking and behaviours that might be the target of treatment approaches aimed at decreasing rituality, self-discipline, and ascetic hypercontrol. Part of this asceticism may be restrained working on the fears regarding adulthood and maturity and on the expression of angry feelings. Another part might benefit from an intervention focused on perfectionism (Shafran et al., 2002), which seems independent of specific personality deficits, but is more likely influenced by media and environment.

REFERENCES

- Abbate Daga, G., Pierò, A., Gramaglia, C., & Fassino, S. (2005). Factors related to severity of vomiting behaviors in bulimia nervosa. *Psychiatry Research*, *134*, 75–84.
- Adler, A. (1920). *La psicologia individuale*. Rome: Newton & Compton.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). Working group on eating disorders: Practice guideline for the treatment of patients with eating disorders. *American Journal of Psychiatry*, *157*, 1–39.
- Anderlueh, M. B., Tchanturia, K., Rabe-Hesketh, S., & Treasure, J. (2003). Childhood obsessive-compulsive personality traits in adult women with eating disorders: Defining a broader eating disorder phenotype. *American Journal of Psychiatry*, *160*, 242–247.
- Banks, C. G. (1992). 'Culture' in culture-bound syndromes: The case of anorexia nervosa. *Social Science & Medicine*, *34*(8), 867–884.

- Banks, C. G. (1997). The imaginative use of religious symbols in subjective experiences of anorexia nervosa. *Psychoanalytic Review*, 84, 227–236.
- Bell, R. (1987). *La santa anoressia*. Bari: Laterza.
- Bizeul, C., Sadowsky, N., & Rigaud, D. (2001). The prognostic value of initial EDI scores in anorexia nervosa patients: A prospective follow-up study of 5–10 years. *European Psychiatry*, 16, 232–238.
- Cloninger, C. R. (2000). A practical way to diagnosis personality disorder: A proposal. *Journal of Personality Disorders*, 14, 99–108.
- Cloninger, C. R., Przybeck, T. R., & Svrakic, D. M. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry*, 50, 975–990.
- Cloninger, C. R., Przybeck, T. R., Svrakic, D. M., & Wetzel, R. D. (1994). *The Temperament and Character Inventory (TCI): A guide to its development and use*. St. Louis, MO: Center for Psychobiology of Personality, Washington University.
- Dabrowski, K. (1967). *Personality-shaping through positive disintegration*. London: J. & A. Churchill.
- Di Nicola, V. F. (1985). Family therapy and transcultural psychiatry: An emerging synthesis: Part II: Portability and culture change. *Transcultural Psychiatric Research Review*, 22, 151–180.
- Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. *Lancet*, 361, 407–416.
- Fallon B. A., & Howath E. (1993). Asceticism: Creative spiritual practice or pathological pursuit? *Psychiatry*, 56, 310–316.
- Fassino, S., Abbate Daga, G., Amianto, F., Leombruni, P., Garzaro, L., & Rovera, G. G. (2001). Nonresponder anorectic patients after 6 months of multimodal treatment: Predictors of outcome. *European Psychiatry*, 16(8), 466–473.
- Fassino, S., Abbate Daga, G., Pierò, A., Leombruni, P., & Rovera, G. G. (2001). Anger and personality in eating disorders. *Journal of Psychosomatic Research*, 51, 757–764.
- Fassino, S., Abbate Daga, G., Pierò, A., & Rovera, G. G. (2002). Dropout from brief psychotherapy in anorexia nervosa. *Psychotherapy and Psychosomatics*, 72, 126–134.
- Fassino, S., Amianto, F., Gramaglia, C., Facchini, F., & Abbate Daga, G. (2004). Temperament and character in eating disorders: Ten years of studies. *Eating and Weight Disorders*, 9, 81–90.
- Fassino, S., Pierò, A., Levi, M., Gramaglia, C., Amianto, F., Leombruni, P., & Abbate Daga, G. (2004). Psychological treatment of eating disorders: A review of literature. *Panminerva Medica*, 46(3), 189–198.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1996). *Structured clinical interview for DSM-IV Axis I disorders: Patient edition (SCID-I/P, version 2.0)*. New York: Biometric Research, New York State Psychiatric Institute.
- Gabbard, G. O. (2000). *Psichiatria psicodinamica*. Milan: Cortina Editore.
- Garner, D. M. (1984). *Eating Disorder Inventory 2*. Florence: Organizzazioni Speciali.
- Gordon, R. (1991). *Anoressia e bulimia: Anatomia di un'epidemia sociale*. Turin: Cortina.
- Halmi, K. A., Sunday, S. R., Strober, M., Kaplan, A., Woodside, D. B., Fichter, M., Treasure, J., et al. (2000). Perfectionism in anorexia nervosa: Variation by

- clinical subtype, obsessionality, and pathological eating behaviour. *American Journal of Psychiatry*, 157(11), 1799–1805.
- Huline-Dickens, S. (2000). Anorexia nervosa: Some connections with the religious attitude. *British Journal of Medical Psychology*, 73, 67–76.
- Katzman, M. A., & Lee S. (1997) Beyond body image: The integration of feminist and transcultural theories in the understanding of self starvation. *International Journal of Eating Disorders*, 22(4), 385–394.
- Lacey, J. H. (1982). Anorexia nervosa and a bearded female saint. *British Medical Journal*, 285, 1816–1817.
- Menninger, K. (1938). *Man against himself*. New York: Harcourt, Brace & World.
- Milos, G. F., Spindler, A. M., Buddeberg, C., & Cramer, A. (2003). Axes I and II comorbidity and treatment experiences in eating disorder subjects. *Psychotherapy and Psychosomatics*, 72(5), 276–285.
- Mitchell, J. E. (1997). Managing medical complications. In M. G. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 383–393). New York: Guilford Press.
- Mitchell, J. E., Maki, D. D., Adson, D. E., Ruskin, B. S., & Crow, S. (1997). The selectivity of inclusion and exclusion criteria in bulimia nervosa treatment studies. *International Journal of Eating Disorders*, 22(3), 243–252.
- Morgan, J. F., Marsden, P., & Lacey, J. H. (2000). ‘Spiritual starvation’: A case series concerning Christianity and eating disorders. *International Journal of Eating Disorders*, 28(4), 476–480.
- Prince, R. H. (1985). The concept of culture-bound syndromes: Anorexia nervosa and brain-fag. *Social Science & Medicine*, 21(2), 197–203.
- Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, 40(7), 773–791.
- Spielberger, C. D. (1996). *State-trait Anger Expression Inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Statistical Package for Social Sciences. (2000). *Application guide*. Chicago: Author.
- Vandereycken, W., & Van Deth, R. (1995). *Dalle sante ascetiche alle ragazze anoressiche*. Milano: Raffaello Cortina.
- Woodside, D. B., Bulik, C. M., Halmi, K. A., Fichter, M. M., Kaplan, A., Berrettini, W. H., Strober, M., et al. (2002). Personality, perfectionism, and attitudes toward eating in parents of individuals with eating disorders. *International Journal of Eating Disorders*, 31(3), 290–299.

SECONDO FASSINO, MD, is Professor of Psychiatry at the University of Turin. He is a member of the International College of Psychosomatic Medicine and of the Eating Disorders Research Society. *Address*: Department of Neuroscience, Psychiatric Institute, University of Turin, Via Cherasco 11, 10126, Turin, Italy. [E-mail: secondo.fassino@unito.it]

ANDREA PIERÒ, MD, is a psychiatrist and contract researcher at the University of Turin. *Address*: Department of Neuroscience, Psychiatric Institute, University of Turin, Via Cherasco 11, 10126, Turin, Italy. [E-mail: andrea.piero@unito.it]

CARLA GRAMAGLIA, MD, is a psychiatrist in the Department of Neuroscience at the University of Turin. *Address:* Department of Neuroscience, Psychiatric Institute, University of Turin, Via Cherasco 11, 10126, Turin, Italy. [E-mail: carla.gramaglia@fastwebnet.it]

GIOVANNI ABBATE DAGA, MD, is a psychiatrist and Professor of Medical Psychology in the Department of Neuroscience at the University of Turin. *Address:* Department of Neuroscience, Psychiatric Institute, University of Turin, Via Cherasco 11, 10126, Turin, Italy. [E-mail: abbadaga@hotmail.com]

MARINA GANDIONE, MD, is a neuropsychiatrist and researcher at the University of Turin. *Address:* Department of Pediatric and Adolescence Sciences, Neuropsychiatry Section, University of Turin, Italy. [E-mail: marina.gandione@unito.it]

GIOVANNI GIACOMO ROVERA, MD, is Honorary Professor of Psychiatry at the University of Turin. He is President of the Italian Society of Transcultural Psychiatry. *Address:* Department of Neuroscience, Psychiatric Institute, University of Turin, Via Cherasco 11, 10126, Turin, Italy. [E-mail: giovanni.giacomo.rovera@unito.it]

GOFFREDO BARTOCCI, MD, is a psychiatrist and psychoanalyst. He was a Clinical Professor at the University of Turin and Head of the Transcultural Psychiatry Unit in Rome. He is Past-President and Honorary Advisor of the Transcultural Psychiatry Section of the World Psychiatry Association and President-elect of the World Association of Cultural Psychiatry. [E-mail: tpsection@quipo.it]