Introduction abuse. according to swain (2006) there

Introduction

Eating disorders are rarely seen by the layman as being psychological in nature. However, as different researches have confirmed, there is a strong correlation of eating disorders with psychological disorders. A study done by Kaye et al (2004) for example established that both bulimia nervosa and anorexia nervosa are associated with anxiety disorders. To understand these two eating abnormalities further and their effects on the affected population, this study will review some of the existing literature publishing on the two.

Definitions

Anorexia Nervosa

According to Eysenck (2004) anorexia nervosa " is an eating disorder in which the individual is very frightened of becoming fat in spite of having very low body weight" (p. 840). Accordingly, the anorexia nervosa sufferer has body weight which is less than 85 percent of what would be their normal body weight.

People with this condition are known to have a distorted thinking about their body weights and often dismiss any dangers that may arise from being underweight. According to Eysenck (2004), females are more concerned about their body weights and are therefore at an increased risk of suffering from anorexia nervosa. This explains why in the United States 90 percent of anorexia nervosa sufferers are female. According to the American Psychiatric Association (2000, cited by Eysenck, 2004), the age group most affected by this eating disorder falls between ages 14 and 18. Although people with the condition are able to recover if the disorder is properly managed, Eysenck

(2004) states that the near starvation state that most anorexics live with during the period of the disorder can be life threatening.

Bulimia nervosa

Bulimia Nervosa is defined as " an eating disorder in which there is binge eating and compensatory behavior (e. g. self-induced vomiting) with the intention of preventing weight gain" Eysenck (2004). The criterion used to diagnose Bulimia nervosa includes the presence of binge eating where a person eats too much food within a specific period. Most people who adopt such behavior say they cannot control this kind of eating. Once the eating is done, a person will adopt an inappropriate behavior for purposes of compensating for all the food eaten. The most common compensatory behavior is induced vomiting.

Other people however choose to go for long periods without taking another meal. Just like the anorexics, Eysenck (2004) observes that bulimics have a distorted way of self-evaluation, which mainly depends on their body weight or body shape. While anorexics are able to control their eating patterns, bulimic do not usually have control on their eating habits. Before engaging in binge eating, they experience great physical and emotional tension, which quickly goes away after they indulge in eating.

Eysenck (2004) however notes that the tension is easily replaced by feelings of guilt, depression and self-blame, which often leads them to adopting the compensatory behaviors discussed above. Just like in anorexia nervosa, Bulimia nervosa is most prevalent in teenagers with most suffered aged

between 15 and 21 years old. Women also form the highest number of bulimics.

Case studies

Swain (2006) conducted a study into the behaviors of people suffering from both Bulimia Nervosa and anorexia nervosa. In her study, she discovered that “ individuals suffering from the two eating disorders commit suicide more often than their counterparts in the general population” (p. 1). In total, Swain estimated that the two eating disorders accounted for 1. 8 percent to 7.

3 percent of all suicides in the country. The risk factors associated with suicide among people suffering from both bulimia nervosa and anorexic nervosa include major depression, low body mass index, lack of control of their impulses, obsession with specific things, purging, frequent chronic illnesses and drug abuse. According to Swain (2006) there are several studies that clearly show that most anorexia related deaths do not actually occur due to the long starvation periods that anorexics put up with, but most such deaths are suicide related. Although the study did not identify specific studies where bulimia nervosa related deaths were analyzed, Swain (2006) states that suicide attempts were easily found among bulimic patients. The study identified this as a risk factor that would contribute significantly to completed suicides. According to this study, the general population perceives anorexics and bulimics as a people who are intent at destroying their bodies gradually. This means that even the would-be caregivers do not think suicide is an immediate consideration to people suffering from the two eating disorders. Swain (2006) holds the opinion that the mere fact that the

two eating disorders are associated with depression is evidence enough that there is a risk of suicide.

The evidence by Swain is supported by Ratnasuyira et al (1991), who in a study conducted on anorexia nervosa sufferers discovered that 1 out of the 7 patients treated in a specific hospital had died of suicide within a five-year period of treatment. Another patient had died due to nutritional deficiency. When their follow-up was extended over a 20 year period, the number of deaths by suicides among six patients treated for the eating disorder increased to three, while two patients died from electrolyte imbalance in their bodies. The studies by Swain (2006) and Ratnasuyira et al (1991) concluded that patients with eating disorders should have their psychopathology analyzed as one way of preventing the suicide that occur within them.

In addition to the use of pharmacological interventions, the author recommends the use of psychotherapy and self-esteem enhancing interventions amongst the youth.

Discussion

Katzman & Golden (2008) argues that both Bulimia Nervosa and Anorexia nervosa are bio-psychological syndromes which involve the intertwining of a person’s physiological and psychological manifestations. The development of the two disorders in different people is fuelled by varying reasons. Anorexia nervosa for example is caused by a combination of socio-cultural, psychological and biological influences to it.

Katzman & Golden (2008) argues that a biologically vulnerable person can be easily influenced by psychological predispositions and other influences emanating from the socio-culture thus precipitating unhealthy weight loss. This argument is supported by Strober et al (2000) who found out that there was evidence that partial syndromes of the two eating disorders could be shared among family members. According to Katzman & Golden (2008), specific personality traits like low self-esteem, perfectionism, social isolation, self-doubt and obsessive behavior predate the development of anorexia nervosa and often persist even after the patient has been treated. The two authors further claim that " researchers have found disturbances in neurotransmitters such as serotonin, norepinephrine and dopamine in patients with anorexia nervosa" (p.

477). Nienstein (2008) argues that while adolescent girls are at increased risk of developing bulimia nervosa, the risks are higher if a person had persistent eating problems in childhood. A negative body image, dissatisfaction with one's body and the pressure imposed by society for one to be thin increases the chances of people developing bulimia. Having suffered stressful events in one's family, family disputes and impulsivity also places one at an increased risk of developing bulimia. Neinstein (2008) also draws a connection of family history where teenagers in homes where someone has a history of eating disorder are more likely to develop bulimia.

Conclusion

The psychiatric conditions identified with Bulimia nervosa include the Kleine-Levin syndrome, borderline personality disorder, depression, binge-eating disorder and purging or anorexic tendencies.

Psychologist contends that both bulimia nervosa and anorexia nervosa share similar characteristics in that patients experience fear of gaining weight. In addition, their self-evaluation is based on their weights or body shapes. Once they are dissatisfied with the way their bodies are, then they persist with the eating disorders. The body is usually a source of human satisfaction especially in a society where an ideal body size is popularized in the media.

People with what is perceived as ideal body sizes have a reason to preserve their bodies and life. Those who think their bodies do not meet the ideal standard however usually have a rough time trying to fit in and may engage in self-destructive behaviors. As observed in the case study analyzed herein, there is quite significant of suicides that happen in bulimic and anorexic patients. The treatment for the same would therefore have to be psychological in nature.

References

Eysenck, M. (2004). Psychology: an international perspective.

New York: Taylor & Francis. Katzman, D. & Golden, N. (2008).

Anorexia Nervosa and Bulimia Nervosa. In Neinstein, L. Adolescent health Care: a practical guide.

New York: Lippincott Williams & Wilkins. Neinstein, L. (2008). Adolescent health Care: a practical guide. New York: Lippincott Williams & Wilkins. Ratnasuyira, R. H., Eisler, I.

, Szmukler, G. I & Russell, G. (1991). Anorexia nervosa: outcome and prognostic factors after 20 years. British Journal of Psychiatry 158: 495-502.

Strober, M et al. (2000). Controlled family study of anorexia nervosa and bulimia nervosa: evidence of shared liability and transmission of partial syndromes.

The American Journal of psychiatry 157: 393-401. Swain, P. (2006). Anorexia nervosa and bulimia nervosa: A new research.

New York: Nova publishers