Eating disorders: epidemology, risk factors and manifestations

ASSIGN BUSTER

Diagnostic Handbook 1

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) recognizes eight feeding disorders and EDs, including bulimia nervosa (BN) (Hail & Le Grange, 2018, p. 11). In DSM-5, bulimia nervosa is characterized by recurrent episodes of binge eating and recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting (Ioannidis, Serfontein, & Müller, 2013, p. 431). Bulimia nervosa is disorder that can encompass a devastating amount of shame and pain. Awareness and prevention can obviate any long-term adverse impacts bulimia nervosa will potentially have on social and occupational functioning.

Epidemiology

Epidemiological studies on eating disorders have some methodological issues. Eating disorders are relatively rare among the general population and patients tend to deny or conceal their illness and avoid professional help making community studies costly and ineffective (Smink, Van Hoeken, & Hoek, 2012, p. 406). There could essentially be more occurrence then there is currently accounted for making this a truly underdiagnosed disorder. Once the DSM-5 criteria were broadened the incidence rate of bulimia nervosa increased.

Bulimia nervosa was first described by Russell in 1979 as an “ ominous variant of anorexia nervosa” (Sharan & Sundar, 2015, p. S287). It is now characterized as an independent disorder, with pathological eating behavior at a normal weight. Most cases of bulimia nervosa show the individual with this disorder at a normal weight, not underweight. The perception of beauty

is believed to have a strong correlation with eating disorders such as bulimia nervosa.

The way eating disorders are perceived at times may prevent adolescents and young adults from seeking treatment due to fear of judgement. The lack of awareness, lack of education, and a distorted perception of bulimia nervosa creates a barrier towards seeking help. There have been studies that indicate some individual's perception believes bulimia nervosa is not as severe as anorexia nervosa. One study showed that both women and men considered AN to be a more severe condition – in terms of its health consequences – than BN (Mond & Arrighi, 2011, p. 42).

A study conducted by Mond and Arrighi showed men were more likely than women to consider BN to be a problem of ' lack of will-power or self-control' (Mond & Arrighi, 2011, p. 46). This study indicates that people with BN may be considered weak, flawed, defective and not really suffering from a disorder but just not strong enough to gain control of their eating habits. This can create a sense of shame, secrecy, and insecurity with the individuals who have bulimia nervosa and could in turn aggravate and enhance the symptoms of their disorder.

Gender

Based on the National Comorbidity Survey replication, lifetime prevalence estimates of bulimia nervosa are 3. 5% in women and 2. 0% in men (Sharan & Sundar, 2015, p. S290). The face of eating disorders that are plastered are often those of women and teen girls, however statistics show the gap isn't as big as many assume. Eating disorders are among the most gender-divergent

disorders in psychiatry, but the divergence is substantially narrower than previously believed (Sharan & Sundar, 2015, p. S290). Recent community-based epidemiological studies, however, found ratios of approximately 3 to 1 for both anorexia nervosa and bulimia nervosa. Men were surveyed and an astounding number thought bulimia nervosa was about having a lack of will power and not truly a disorder. This overall assumption may impact the frequency in which young boys and men seek help for this eating disorder as they feel an increasing level of shame and weakness for not being " man enough" to beat this on their own. Homosexual and bisexual males are at greater risk for developing bulimia than heterosexual males (Ouellette, 2015).

Ethnic

In the past, eating disorders have been characterized as culture-bound syndromes, specific to Caucasian subjects in Western, industrialized societies. Recent studies demonstrate that eating disorders and abnormal eating behaviors do occur in non-Western countries and among ethnic minorities (Smink, Van Hoeken, & Hoek, 2012, p. 412). Some researchers accredit the rollover of this disorder, if you will, to other ethnicities on the westernization of other countries. The western culture has trickled to other cultures; this includes the good and the bad. BN was more prevalent among Latinos and African Americans than non-Latino whites. Lifetime prevalence's ranged from 0. 51 % (non-Latino whites) to 2. 0 % (Latinos) (Smink, Van Hoeken, & Hoek, 2012, p. 410).

Racial

African Americans women show fewer eating disturbances and tend to be more satisfied with their appearance than white women and were significantly less likely than white women to meet lifetime criteria for BN (Sala, Reyes-Rodríguez, Bulik, & Bardone-Cone, 2013, p. 2). This may be due to the lack of treatment sought by certain racial and ethnic groups than others. White women are the typical face shown for eating disorders and so clinicians and the sufferer alike may overlook the possibility of an eating disorder being a diagnostic option. Individuals may hold the stereotype that eating disorders affect only white females because eating disorders have historically been perceived as disorders that affect only that racial and sex demographic, thus leading to suboptimal detection of eating disorders in diverse populations (Sala,

Reyes-

Rodríguez, Bulik, & Bardone-Cone, 2013,

p. 2). The stereotype that is assigned with this eating disorder may hinder

the validity of the data available on the occurrence of bulimia nervosa among other races. There has not been extensive research conducted on certain racial groups, such as African American's and Asians, to confidently make an educated analysis.

There is current research emerging that indicates African American women are just as likely to misuse laxatives as white women and that bulimia nervosa is present in this racial group but under treated, under detected, or under reported. One study suggests that more African American women report using laxatives, diuretics, and fasting to avoid weight gain as white women (McKinley, 2015). The use of laxatives to avoid weight gain is one of the diagnostic criteria for bulimia nervosa in the DSM-V. The DSM-V states, recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise (American Psychiatric Association, 2013, p. 345). The self-reporting by African American women of their misuse of laxatives is an indicator that bulimia nervosa may be more prevalent than research currently indicates at this time.

Risk Factors

Deliberate self-harm (DSH) is a risk factor of bulimia nervosa. In a study conducted the participants who said they deliberately self-harmed stated the first episode of DSH occurred within a brief period after the onset of BN, perhaps suggesting elevated levels of distress associated with the onset of the eating disorder (Day et al., 2011, p. 288). In incidences of DSH and BN the person can control the pain they are feeling in their body whereas they may feel like normally they cannot control the pain they feel in life. This is

something they may do to gain a sense of control over the pain they feel and their bodies.

Sexual abuse involving physical contact was reported by 35% of the cases of bulimia nervosa. It was more common among this group than among the normal controls. Physical abuse was also reported by a minority of the cases of bulimia nervosa and was more common among this group than among the normal controls (Welch & Fairburn, 1996, p. 633). More evidence and research need to be conducted to understand the correlation between sexual and physical abuse as a risk factor for BN. According to the DSM-V some temperamental risk factors for bulimia are weight concerns, low self-esteem, depressive symptoms, social anxiety disorder, and overanxious disorder of childhood (American Psychiatric Association, 2013, p. 348).

Internalization of a thin body ideal has been found to increase risk for developing weight concerns, which in turn increase risk for the development of bulimia nervosa (American Psychiatric Association, 2013, p. 348). Sometimes individuals get so consumed by a thin body ideal and will go to whatever means necessary to get it, even incorporating extreme measures such as taking laxatives or forcing themselves to vomit.

Prevalence

Eating disorders seem to have become more common among younger females during the latter half of the 20th century in Western cultures, during a period when icons of beauty became thinner and women’s magazines published significantly more articles on methods for weight loss (Sharan & Sundar, 2015, p. S290). There may be skewed results due to the possible

under reporting of eating disorders such as bulimia nervosa. The overall prevalence of bulimia nervosa is rare compared to other psychiatric disorders. Twelve-month prevalence of bulimia nervosa among young females is 1%-1. 5% (American Psychiatric Association, 2013, p. 347). Point prevalence is highest among young adults since the disorder peaks in older adolescence and young adulthood. Bulimia statistics tell us that the lifetime prevalence of bulimia nervosa in the United States is 0. 5% in men (Ouellette, 2015). That’s approximately 4. 7 million females and 1. 5 million males; 10-15% of people with bulimia being male.

A study was conducted on adolescents to see if there was a strong need for more public awareness of eating disorders such as bulimia nervosa. The study displayed that many participants recognized and understood the severity of BN, yet still considered bulimic behaviors as normative and even desirable (Mond & Marks, 2007, p. 91). This indicates the ambivalence towards eating-disordered behavior that pervades not only the belief systems of individuals treated for eating disorders, but those of adolescent and young adult women in the community. This is indictive that due to the diverse and complex feelings that people have towards eating disorders, the prevalence of bulimia nervosa may be extremely higher than is reported. Some individuals may feel these are normal behaviors, so they do not seek help or report it.

Behavioral Manifestations

Bulimics are consumed by eating- and weight-related thoughts. Just as drug addicts continuously seek their next fix, how they will administer it and all things related to the substance of their choice, so do bulimics. Their disorder

becomes all consuming. They often exhibit negative thoughts in relation to food. Individuals with bulimia nervosa are typically ashamed of their eating problems and attempt to conceal their symptoms, therefore binge eating usually occurs in secrecy or as inconspicuously as possible(American Psychiatric Association, 2013, p. 346). The binge eating often continues until the individual is uncomfortably, or even painfully, full. Those with bulimia nervosa utilize inappropriate compensatory behaviors to prevent weight gain, collectively referred to as purge behaviors or purging (American Psychiatric Association, 2013, p. 346). This may come in the form of making oneself vomit, another method is by administering laxatives. These behaviors of taking the laxative or making themselves vomit becomes a ritual in it of itself. An excessive emphasis on body shape or weight is placed on their self-evaluation, and these factors are typically extremely important in determining self-esteem (American Psychiatric Association, 2013, p. 346-347). This can cause manifestations of behaviors such as extreme exercise, or fasting, and even withholding of important medications needed for fear of weight gain.

Common Comorbidities

Based on similarities in psychopathology and high comorbidity, many authors have tried to classify eating disorders as subtypes of mood, obsessive-compulsive, or psychotic disorders, etc. However, eating disorders “ breed true,” and do not evolve into a mood or other disorders (Sharan & Sundar, 2015, p. S287). The DSM-V does not classify bulimia nervosa as a subtype of a mood disorder due to the research and evidence that often-eating disorders do not transition to any other disorder and also stand alone on their own. There is also a comorbidity between substance abuse and

bulimia nervosa. They both posses' tendencies of addiction. Recently the comorbidity of substance abuse and eating disorders has become a particular concern. Substance abuse and eating disorders have the highest mortality risks of all mental disorders, and half of all clients with eating disorders abuse alcohol or illicit drugs (Carbaugh & Sias, 2010, p. 126).

Self-harm is not only a risk factor of bulimia nervosa, but it also is a common comorbid condition affecting 34% of those with bulimia(Ouellette, 2015). There appears to be an extensive correlation of self-inflicting pain in individuals with either condition. Again, it could be a manifestation of controlling tendencies in those who often feel out of control or powerless. Further studies are needed to determine the correlation. Those prone to bulimia often have trouble regulating emotion and may be described by family as " all-or-nothing" people (Ouellette, 2015).

Differential Diagnoses

Overeating often times occurs in major depressive disorder, with atypical features, sometimes causing the diagnosis of bulimia nervosa to be misdiagnosed. However, when an individual solely has major depressive disorder they are not engaging in inappropriate compensatory behaviors and do not exhibit the excessive concern with body shape and weight characteristic of bulimia nervosa(American Psychiatric Association, 2013, p. 349). An individual could be diagnosed with both bulimia nervosa and major depressive disorder if the criteria is met for both disorders independent of one another.

Anorexia nervosa, binge-eating/purging type and bulimia nervosa are oftentimes mistaken for one another until more symptoms and characteristics are divulged. If binge-eating behavior occurs only during episodes of anorexia nervosa the individual should be given the diagnosis anorexia nervosa, binge-eating/purging type, and should not be given the additional diagnosis of bulimia nervosa (American Psychiatric Association, 2013, p. 349). Information should be gathered until the best possible diagnosis can be made. Individuals whom were initially diagnosed with anorexia nervosa, who binge and purge, but whose presentation no longer meets the full criteria for anorexia nervosa, binge-eating/purging type (e. g., when weight is normal), should then be diagnosed as bulimia nervosa (American Psychiatric Association, 2013, p. 349).

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