Eating Disorders: common misconceptions and links to the early years

Eating disorders are a group of pervasive food-related mental health illnesses that can affect people of all genders, ethnicities and ages. There are, however, many misconceptions about the prevalence of eating disorders in populations other than Caucasian adolescent females. In this article **Daniel Isaacs** aims to address these misconceptions by citing current research to illuminate the universality of eating disorders.

I recently asked a friend what they knew about eating disorders and their response went something along the lines of "that illness that teenage girls get when they see lots of very skinny women in the media and don't want to be fat, so stop eating". Whilst this view may be less informed and more generalized than many, the stereotypes associated with eating disorders are not far removed from this. Even within academic circles, it is believed that eating disorders occur with far greater frequency in "Western, Caucasian, female populations"[1, 2]. In fact, from my experience of working in a CAMHS (Child and Adolescent Mental Health Services) clinic, a large proportion of patients presenting with eating disorder symptomology do fit these stereotypes. However, this does not tell the whole story.

In 2011, after completing an MSc, I began work as a Therapeutic Care Worker on an Eating Disorders inpatient unit. After only a month or two in the job a young boy, aged only 10, was admitted to the ward. I can remember clearly the surprise of nursing colleagues that a boy, and a boy of so few years at that, had been admitted for an eating disorder. In the following year that I spent working there, I met boys and girls ranging from 9 up to 18, of all classes and ethnicities. I was struck by how universal eating disorders really are, a perception that I too did not have when I began my post there.

Prevalence and Misconceptions

A leading eating disorders charity, b-eat (beating eating disorders) have published figures on their website stating that approximately 1.6 million people in the UK are affected by eating disorders, with approximately 10% of these suffering from anorexia and 40% from bulimia. The remaining 50% fall into the EDNOS and BED categories. Of this 1.6 million, 11% are male[4]. However, a recent NHS survey[5] has indicated that 6.4% of the population is suffering from an eating disorder and that as many as 25% of these are males. These figures are supported by research reported in a current peer-reviewed publication[6].

If these figures are correct, that would imply that approximately four million people in this country suffer from an eating disorder of one form or another. Moreover, one million of those would be males. Furthermore, a body of research is developing that highlights an emergence of eating disorders in societies and cultures in which these were previously thought to be rare: the Middle and Far East, South America and Africa. Moreover, an increase in prevalence has been found in certain ethnic-minority communities in both the USA (Hispanic and Native American) and the UK (Asian and African-Caribbean)[7].

This paints a stark contrast to the stereotypes that many hold in mind and it is important to consider why there might be such a discrepancy between reported and estimated prevalence rates in males and ethnic minorities.

Raisenan and Hunt[6] suggested that the misconception that eating disorders are a "women's illness" makes it harder for men to recognise the symptoms

What are Eating Disorders?

There are four recognized diagnostic categories under the psychiatric umbrella of eating disorders. In a publication commissioned by the National Institute for Clinical Excellence (NICE)[3] the four categories were defined as follows:

Anorexia Nervosa; maintenance of "…low weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness … weight is maintained at least 15 per cent below that expected."

Bulimia Nervosa; "…recurrent episodes of binge eating and secondly by compensatory behaviour (vomiting, purging, fasting or exercising or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating."

Binge Eating Disorder (BED); similar to Bulimia however binges occur without subsequent compensatory purging behaviours, and are associated with eating large amounts very quickly when not physically hungry, by oneself, and feeling embarrassed, disgusted and guilty after overeating.

Atypical Eating Disorder (Eating Disorder Not Otherwise Specified; EDNOS); disorders that are very similar to anorexia and bulimia however do not meet the specific diagnostic criteria and therefore are classed as atypical.

Continued from previous page

early on, and as a result they do not present for treatment until the eating disorder is entrenched and more difficult to treat. In addition, there are a vast number of men that do not seek treatment due to anxieties about cultural and societal assumptions based on the aforementioned misconception. This would suggest that a large proportion of men that would receive a diagnosis do not seek treatment of any kind, thus significantly reducing prevalence rates in men.

Similarly, as highlighted by Nasser[7], cultural and societal misconceptions that eating disorders are a "westernized" illness, based on a fundamental lack of published research investigating prevalence in non-western cultures and societies, have only served to stoke the stereotypical fire. The authors identified a number of factors that they believe to have played a role in the emergence of eating disorders in these ethnic groups: "identification with western cultural norms", "consumerism", a "shift from collectivist to individualist patterns", "changing gender roles" and "increased alienation of the individual". They observed that these result in a state of cultural confusion and distress that is expressed by the individual via an eating disorder.

Eating Disorders and the Early Years

We now know that eating disorders are significantly more universal than previously thought, however the age at which the warning signs for eating disorders can become visible may still come as a surprise. Significantly less is known and understood about eating disorders in younger children and therefore diagnoses are less common[4]. However the youngest child I met with a diagnosis during my time on the unit was 9, and children as young as 5 have been treated in hospital for eating disorders[8]. By the age of 10 approximately 33% of girls and 22% of boys claim that their body image is a primary concern, and 10 is also the average age for the onset of childhood dieting[9].

What seems to be clear is that an unhealthy relationship with food early on in life may act as a risk factor for the development of eating disorders in later childhood and adolescence. In an innovative prospective study Stice and colleagues[10] followed up a community sample of children from birth to 5 in an attempt to identify risk factors for potential disordered eating. A small proportion of the sample were found to exhibit behaviours such as inhibited eating, secretive eating, over-eating, and over-eating induced vomiting. The authors found a range of parental predictors that showed a significant relationship with these disordered behaviours, and interestingly the majority of them related to parental or maternal attitudes towards, and relationships with, food and eating. For example, for every unit increase of maternal body mass index, the risk of inhibited eating in the young children increased by 8%; in addition maternal body dissatisfaction and bulimic-like symptoms significantly increased the risk for secretive eating. These findings suggest that parental attitudes towards food and eating can have a significant impact upon their child's attitudes and behaviours.

Perhaps then it is possible to extend this and suggest that families that promote healthy, well-balanced, and normalized eating may help protect their children from some risk factors for developing eating difficulties. Practically speaking, this may include some of the following suggestions: providing well-balanced meals i.e. a range of macronutrients, fruits and vegetables and treats and desserts; positive and healthy attitudes towards food and food preparation i.e. inviting children to help with cooking; social experiences related to food and eating i.e. meals at the dinner table with family and friends, and fostering a general enjoyment of food and eating.

These findings pose interesting questions for all education practitioners, whether early years, primary or secondary. For example, what can be done in nursery and school settings to help foster healthy relationships with food and eating, and how can the sorts of ideas suggested above be incorporated into the school setting in order to try and support the development of this relationship.

However, even with the best possible environmental influence, some children still develop eating disorders[3]. Therefore, awareness of early warning signs both in families and in school settings is important. Research suggests that early intervention is associated with a better prognosis and subsequent recovery outcomes[11]; therefore we all have a responsibility to look out for these warning signs. These can range from changes in attitudes, feelings and behaviours towards food and eating, to a significant decrease or increase in body weight. A comprehensive list for each main diagnostic category is provided on the b-eat website, as well as advice and guidance for those suffering from eating disorders, or those concerned about a child or adolescent: *www.b-eat.co.uk/get-help/about-eating-disorders/do-i-have-an-eating-disorder/*

Eating disorders are an all inclusive, pervasive mental health disorder that can affect any of us from very early on in childhood, and it is very important that we keep this in mind.

What seems to be clear is that an unhealthy relationship with food early on in life may act as a risk factor for the development of eating disorders in later childhood and adolescence.

References

1. Wildes, J.E., Emery, R., & Simons, A.D. The roles of ethnicity and culture in the development of eating disturbance and body dissatisfaction. Clinical Psychology Review 21 (4) 2001: pp 521-551
2. Crago, M., Shisslak, C.M., & Estes, L.S. Eating disturbances among American minority groups: a review. International Journal of Eating Disorders 19 1996: 239-248
3. National Collaborating Centre for Mental Health. Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia

nervosa, and related eating disorders. London: The British Psychological Society & Gaskell, 2004, pp 13-21

4. b-eat. (2010). Facts and Figures. Available: http://www.b-eat.co.uk/about-beat/media-centre/facts-and-figures/. Last accessed 18 May 2014

5. Bebbington, P., Brugha, T., Coid, J., Crawford, M., Deverill, C., et al. Adult psychiatric morbidity in England, 2007. A household study. Leeds: The NHS Information Centre for health and social care, 2009, pp 138

6. Räisänen, U., & Hunt, K. The role of gendered constructions of eating disorders in delayed help-seeking in men: a qualitative interview study. BMJ Open 4 2014: 1-9

7. Nasser, M. Eating disorders across cultures. Psychiatry 8 (9) 2009: 347-350

8. Boseley, S. (2014). Rise in hospital admissions for young people with eating disorders. Available: http://www.theguardian.com/society/2014/jan/30/rise-hospital-admissions-young-people-eating-disorders. Last accessed 18 May 2014.

9. Moorhead, J. (2012). Children start dieting as young as 10. Available: http://www.theguardian.com/education/2012/may/07/body-image-anxiety-primary-school-pupils. Last accessed 18 May 2014.

10. Stice, E., Agras, W.S., & Hammer, L.D. Risk factors for the emergence of childhood eating disturbances: a five-year prospective study. International Journal of Eating Disorders. 25 (4) 1999: 375-87

11. Treasure, J., & Russell, G. The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. The British Journal of Psychiatry 199 2011: 5-7

Daniel Isaacs is currently studying at the Tavistock and Portman Clinic. He is also working as an Assistant Child and Adolescent Psychotherapist in a CAMHS clinic and as a Research Assistant at the Anna Freud Centre after experience in early years settings during his undergraduate studies.