Podcast Recording:

https://riverside.fm/dashboard/editor/preview/0650691c-4dc4-4e4d-b88d-d9edf5b3be12/67a67846454d534082d08272?share-token=04194118066c71a49cd3&content-shared=recording-preview

Annotated Bibliography

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). https://doi.org/10.1176/appi.books.9780890425787

The DSM-V was important to get the specific diagnostic criteria for each of the eating disorders I mentioned in the podcast. While other articles acknowledged the diagnostic criteria, I went to the source to get the most up-to-date criteria. Since some of the articles I used were published according to the DSM-IV, it was especially crucial to understand the differences between the requirements in the fourth version compared to the fifth. Through this, I recognized key differences in the criteria for weight, frequency, and duration of some of the eating disorders.

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research review: What we have learned about the causes of eating disorders – a synthesis of sociocultural, psychological, and Biological Research. *Journal of Child Psychology and Psychiatry*, *56*(11), 1141–1164. https://doi.org/10.1111/jcpp.12441

One section of my podcast will address the misconception that eating disorders are a lifestyle choice. To rebut this point, I decided to look up different factors that impact the development of an eating disorder. This article discussed the biological, psychological, and sociocultural risk factors for developing an eating disorder. While there isn't a direct cause of eating disorders, the presence of certain factors increases the chances of developing such a

disorder. For example, disturbances in serotonin and dopamine functioning, and genetics create biological predispositions to the onset of an ED. Additionally, eating disorders are associated with personality traits such as perfectionism and other psychological disorders like anxiety and depression. Lastly, sociocultural factors can influence the likelihood of an individual developing an ED. One topic that I addressed in the podcast episode was the culture of the United States that equates thinness with attractiveness and success, therefore creating an idealization of being in a smaller body. This article was useful in showing that eating disorders can be a result of environmental and biological predispositions rather than a lifestyle choice.

Kazdin, A. E., Fitzsimmons‐Craft, E. E., & Wilfley, D. E. (2017). Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders*, *50*(3), 170–189. https://doi.org/10.1002/eat.22670

This article was informative on the issues regarding the treatment of eating disorders, the barriers to accessing treatment, and the impact on those with the disorder. I was enlightened on the lack of treatment that individuals with eating disorders receive. One such statistic that less than 30% of college students with eating disorders report receiving treatment helped me understand the significance of the impact of stereotypes and stigmas on individuals with this disorder. While this article went into depth about the physical and cultural barriers to accessing treatment, such as the cost of mental health services, policy, and legal constraints, and issues in case identification, I realized how the misconceptions of eating disorders could also be possible causes for the lack of getting treatment. More importantly, the article discussed bias on the part of medical providers who, due to beliefs that eating disorders are uncommon in ethnic minority groups, fail to detect the disorder in a client. Additionally, I learned that there is a general lack of training in primary care providers in eating disorders even though most individuals who do

receive treatment are first seen by their doctor. Overall, this article was important for understanding the impact that misconceptions have on eating disorders.

Truu, M. (2022, January 1). *The really old, racist, and non-medical origins of the tool we use to measure our health*. ABC News. https://www.abc.net.au/news/2022-01-02/the-problem-with-the-body-mass-index-bmi/100728416

While I knew there were issues with the use of the BMI for diagnosing eating disorders, through this article I discovered how and why BMI is problematic specifically for eating disorders. This article went into depth about the history behind the creation of the BMI, starting from a Belgian mathematician in the 1830s to its promotion by an American physiologist in the 1970s. In both studies looking into the effectiveness and use of the BMI used only men, a majority of which were Western European, white, and 'healthy'. This information made me realize that this scale for determining the overall 'health' of an individual was not created for women or individuals of ethnic or racial minorities. I questioned how effective the scale is for determining if an individual can be diagnosed with an eating disorder. If the BMI scale is flawed in determining health, then it would also be so in determining what is unhealthy. This article mentioned places where the BMI falls short, such as with athletes, and people of various ethnicities, genders, and ages. While there was a lot of focus on the issues of the use of BMI for identifying obesity and misidentifying healthy individuals, it was very helpful in understanding the history that created a flawed system and how that can lead to the misconceptions seen today.

Walsh, B. T., & Devlin, M. J. (1998). Eating disorders: Progress and problems. *Science*, *280*(5368), 1387–1390. https://doi.org/10.1126/science.280.5368.1387

Since my research is focused on the misconceptions of mental illnesses, in this case, eating disorders, I decided to look into this article that specifically addressed some of the problems and the progress that has been made in regard to the development and diagnosis of this category of disorders. I learned about some of the biological risk factors for eating disorders, specifically in serotonin function, which I looked into later in a different article. I also learned about the long-term outcomes of having an ED. In general, they are not great as social functioning is often impaired and many individuals continue to be irrationally concerned about weight gain. Additionally, this article informed me about some of the cultural factors related to eating disorders, and statistics about the view that adolescent girls have on their own bodies. The information I got from this article was important for understanding the severity of eating disorders, and some of the etiology, which I included in my recorded discussion.

Zam, W., Sijari, Z., & Saijari, R. (2018). Overview on Eating Disorders . *Progress in Nutrition*, *20*, 29–35. https://doi.org/10.23751/pn.v20i2-S.6970

This article was really informative regarding the general characteristics, diagnoses, and severities of each of the eating disorders I will discuss in the podcast. These included anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorders not otherwise specified (EDNOS). This provided me with general knowledge about eating disorders and got me thinking about issues with diagnoses and possible research directions. Additionally, I found helpful visuals about the cognitive and physical effects of having each of the eating disorders, prompting me to include a small list in my podcast to help inform the listeners about the complexities of this mental illness. Throughout the article, useful statistics were provided that showed the severity and prevalence rates of eating disorders. Lastly, information about treatment options and etiology led me to research other articles which I used later on.

Talking Points

A. Introduction:

a. **Misconception #1:** Eating disorders as a lifestyle choice
    i. Rebuttals:
        1. ED is associated with risk factors
            a. Biological:
                i. Disturbances in serotonin function
                ii. Inherited/genetic - higher chance of developing an ED if relative has/had one
            b. Familial-sexual abuse (increases the chances of developing BN)
            c. Psychological
                i. High rates of comorbidity with other psychological disorders - anxiety, depression
                ii. Personality traits - negative emotionality, perfectionism, negative urgency
            d. Sociocultural
                i. Values and beliefs regarding dieting, idea of beauty, and body image through media exposure
                ii. Thinness is equated with attractiveness/pressures for thinness/ thin-idealization and thinness expectancies
                iii. In the US, 27% of adolescent girls who view themselves as the 'right weight' are still trying to lose weight
    ii. Impact
        1. Increases feelings of shame, guilt, disgust
        2. "Just eat"

b. Severity/side effects of eating disorders

    i. Severity:
        1. 30 million people in the U.S in their lifetime
        2. About 13% of youth will experience at least one eating disorder by age 20 with a large proportion (between 15 and 47%) endorse significant disordered eating cognitions and behaviors
        3. MI with highest mortality rate - 7,000/yr
        4. Poor long-term outcomes - many remaining irrationally concerned about weight gain
    ii. Cognitive effects - Distorted body image, preoccupation/obsession with food and weight, anxiety, depression, distress, guilt and shame

iii. Physical effects - low blood pressure, cardiac arrest, heart attack, anemia, thin hair, kidney failure, osteoporosis, irregular or absent periods, chronic sore throat, ulcers, high cholesterol, Type 2 diabetes, gallbladder disease

B. Definitions

a. Anorexia nervosa (AN):

i. Characterized by:

1. Restricting type - restricting and exercising; NO binge eating/purging
2. Binge-eating/purging type - restricting and exercising; YES binge eating and/or purging

ii. Diagnosis (according to DSM V):

1. Significant low body weight for age, sex, developmental trajectory, and physical health
2. Intense fear of gaining weight
3. Disturbed by one's body weight or shape, self-worth influenced by body weight or shape, persistent lack of recognition of seriousness of low bodyweight
4. Severity is based on BMI

b. Bulimia nervosa (BN):

i. Characterized by:

1. Cycle of bingeing and compensatory behaviors which can be either:
    a. Purging type - Self-induced vomiting, or misuse of medications or laxatives
    b. Nonpurging Type - Fasting, excessive exercise

ii. Diagnosis (According to DSM V):

1. Recurrent episodes of binge eating:
    a. Eating within any 2-hour period, an amount of food larger than what most individuals would eat in a similar period of time under similar circumstances
    b. Feeling out of control
2. Recurrent inappropriate compensatory behaviors in order to prevent weight gain
3. Binge-purge cycle occurs at least once a week for 3 months
    a. DSM IV: twice a week
4. Severity is based on number of inappropriate compensatory behaviors/week

c. Binge Eating disorder (BED):

i. Characterized by:

1. Cycles of binge eating not accompanied by regular compensatory behaviors

ii. <u>Diagnosis:</u>

1. Recurrent episodes of binge eating
2. Binge-eating episodes associated with:
    a. Eating:
        i. Faster than normal
        ii. Until uncomfortably full
        iii. Large amounts when not hungry
        iv. Alone because of embarrassment
    b. Feeling disgusted, depressed, or guilty after overeating
3. Marked distress
4. 1 day a week for 3 months
    a. DSM IV - 2 days/wk for 6 months
5. Severity based on the number of episodes

d. Other Specified Feeding or Eating Disorder (OSFED):

i. DSM IV: Eating Disorder Not Otherwise Specified (EDNOS)

ii. <u>Characterized by:</u>

1. Symptoms characteristic of an ED but do not meet the full criteria for other eating disorders
2. Significant distress, impairment in functioning
3. Can progress to other ED's if disordered behaviors continue

iii. <u>Diagnosis:</u>

1. Generally up to the discretion of the professional

2. EX:
    a. Atypical anorexia - No significant weight loss, or weight is within the normal range
    b. Bulimia nervosa - low frequency and/or limited duration
    c. BED - low frequency and/or limited duration
    d. Night eating syndrome - recurrent episodes of eating while sleeping or between dinner and bed

C. Misconception #2: People who have an eating disorder look a certain way such as being in a smaller body for AN, or bigger body for BED

a. Emphasis on how the body looks rather than behavior

i. DSM-V just dropped specific restrictions on weight diagnostic criteria, frequency, and duration

1. EX: 1 day a week for 3 months compared to 2 days a week for 6 months

2. The number of EDNOS diagnoses dropped and AN and BN increased = more people getting treatment for behavior

ii. DSM-V still has criteria that emphasize weight
   1. Examples:
      a. Atypical anorexia
      b. Nonpurging BN vs restricting AN - same behaviors of restricting, only difference is weight
      c. Purging BN vs Purging AN - same behaviors of purging, only difference is weight

b. The use of the BMI scale as a diagnostic tool

i. History:
   1. Academic exercise in 1830s
      a. Lambert Adolphe Jacques Quetelet - Belgian mathematician NOT doctor or health practicioner
      b. Find 'average man' not measure health
      c. Participants - white, western european men
   2. Ancel Keys (1970s) - physiologist and dietician promoted the BMI index to quickly screen for obesity
      a. Participants - 'healthy men' as samples

ii. Problems:
   1. Athletes - does not account for the differences between muscle mass, bone density, and body fat
   2. Women
   3. Racial and ethnic minorities - research has shown that healthy weight is different for different ethnicities

c. Impact/Significance:

i. Failure to seek/find treatment
   1. 20% or less report receiving treatment
   2. > 30% of college students with ED report receiving treatment

ii. Underdiagnosis
   1. 92% of frontline medical providers believed they had missed an eating disorder diagnosis - could be the result of the lack of training to identify eating disorders

iii. Lack of awareness
   1. Almost 1/2 wait over a year after recognizing symptoms before seeking treatment - longer for BED (general lack of awareness)
   2. There is a lag time of 15 months between identifying symptoms and starting treatment

iv. Lack of validity (since it is based on weight not behavior)

1. AN and BN as 'officially recognized' diagnoses despite EDNOS being 50% of diagnoses
2. Incentive to reach "validated" diagnosis? - lack of motivation to change

D. Misconception #3: Only adolescent, white, female-presenting people get EDs
   a. ANYONE!!! can have an ED - no matter age, cultural background, economic status, or gender
   b. Certain populations have higher rates than others
      i. Is this a result of a stereotype leading to underdiagnosis and lack of awareness
   c. Age
      i. 1/3 of patients are diagnosed as preteens and adolescents up to age 15 and 86% of patients are diagnosed before age 20
   d. Cultural background
      i. No difference between Asian, Latino, and white adolescent girls and boys in dieting and restriction
      ii. Overall, African-American women are less likely than white to have an eating disorder
      iii. Native American women have higher rates of restriction and purging behaviors
   e. Gender
      i. The majority of diagnosis for bulima, BED and anorexia are female
   f. Impact of Misconception:
      i. Underdiagnosis
         1. Individuals from racial/ethnic minority backgrounds are significantly less likely than their white counterparts to be diagnosed with an eating disorder, receive care or a referral for further evaluation, or even be asked by a doctor about eating disorder symptoms
         2. The majority of mental health professionals do not provide care to populations/ clinical problems for which there is especially great demand in this field, such as with children and adolescents, which is when the majority of individuals with ED have onset.
      ii. Bias in the medical field and therapists
         1. Providers may believe eating disorders are uncommon in ethnic minority groups and therefore fail to detect this disorder in a minority client

E. Conclusion