Differences In Eating Disorders Depending On The Race Of Individuals

Anorexia Nervosa (AN) and Binge Eating Disorder (BED) have become increasingly popular in the United States, specifically among young women. In 2011, Dr. Luana Marques and six other experts decided to conduct a study in order to find out if there were any differences in eating disorders depending on the race of individuals. They were specifically interested in the differences between Americans who are Asian, African Americans, Latino, and non-Latino whites (Marques et al., 2011). The overall aim of the study was not to show a race disparity, but instead, it aimed to prove how to help Americans who struggle with eating disorders (Marques et al., 2011).

They begin their article by discussing the statistics around health care and how very few people actually receive help for their disorders. Near the beginning of the article, they point out that, “a substantial percentage of individuals with an eating disorder do not receive care for this problem (Marques et al., 2011, p. 412).” The reason the researchers were interested in this topic was that they believed that there had never been a study on eating disorders with a multi-ethnic perspective. The researchers in this article also point out that there had yet to be a study done on the proper care for people struggling with an eating disorder (Marques et al., 2011). Instead of simply concluding that there is disparity, these seven experts also researched some of the best ways to help people, especially low-income members of society. Many studies have been published about one particular race compared only to white Americans, but there were no studies that compared multiple races in the United States with each other.

The issue at hand can be summed up as an eating disorder, but it is more complex than that. The researchers divided the issue into four distinct categories: “(1) anorexia nervosa (AN); (2) bulimia nervosa (BN); and (3) binge-eating disorder (BED); as well as a fourth category termed, any binge eating (ABE) (Marques et al., 2011, p. 413).” The specifics surrounding the fourth category, ABE, we're dependent on if the participant in the study reported that they were overeating and felt out of control at least twice a week and for a period that lasted at least 3 months (Marques et al., 2011). They also note that Any Eating Disorder (AED) and Any Binge Eating (ABE) can “co-occur” with one or more of the other categories (Marques et al., 2011, p. 414). The surveys were questioners that had two areas of interest. The first area was the eating habits of individuals and the second area was information on their access to health care assistance (Marques et al., 2011). The surveys also had questions about gender, race, and age so that the researchers could properly indicate if these factors would be variables. There were also questions about the level of education that the participants had. The researchers were curious to see if there were correlations between eating disorders and someone with a high school education compared to a college education. Ultimately, these numbers were so insignificant that they did not use them for the final results of the study (Marques et al., 2011).

Throughout the article, they used the data from those previous studies. For example, they used statistics provided by the World Health Organization and research that corresponded with the Diagnostic and Statistical Manual of Mental Disorders (Marques et al., 2011). Their own research was a written survey that was originally done by the University of Michigan Survey Research Center. Once the research was completed, the researchers combined the previous

numbers with the surveys. They used software called STATA 8.0 to determine the statistics surrounding the issue (Marques et al., 2011).

The overall conclusion of the study was that every person who is struggling with any type of eating disorder in America should be properly diagnosed and should receive proper mental and physical health assistance, despite race, gender, or age (Marques et al., 2011). There were no numbers found that suggested that minority groups in America had a higher chance of having eating disorders (Marques et al., 2011). The best the numbers could state was that the number of minority groups who struggle with an eating disorder is at least equivalent to White Americans (Marques et al., 2011). The one disparity between races, however, was the accessibility of health care. According to the surveys, those who belong to ethnic minority groups in the United States use health services less than non-Latino Whites (Marques et al., 2011). The researchers conclude that there is an “unmet need” in this area (Marques et al., 2011, p. 419). These findings correspond with several other findings both in the United States and the United Kingdom. The reason for this unequal use of health care is still not agreed upon and is clearly complex and multifaceted.

Beyond the conclusion, the statistical results showed a similarity between different ethnicities. For example, across all ethnic groups, AN turned out to be the least common eating disorder (Marques et al., 2011). In fact, the numbers for this category were very low for women, ranging from 0.01% for African Americans to 0.04% for Asian Americans. The researchers concluded that in this area there was no “statistical significance” (Marques et al., 2011, p. 414).

Even the most common eating disorder determined by this study, BED, did not reach a substantial margin (Marques et al., 2011). Lifetime BED was shown to affect Asian Americans the least (1.24%) and affect Latino Americans the most (2.11%) (Marques et al., 2011). However, even comparing the most affected racial group with the least affected, the researchers determined that there is, in fact, no statistical significance to support the notion that race and eating disorders are correlated (Marques et al., 2011). There is evidence that shows that there is significance between genders, but not ethnic groups. There were also numbers that found that the time that an individual suffers from an eating disorder did vary depending on race. Asians and Latinos, for example, are more likely than non-white Latinos to suffer from a lifetime eating disorder (Marques et al., 2011).

The results of the first study show that there is no evidence that says that anorexia is related to race. If the culture was the same and the ethnicity was different in the first study then it seems reasonable to look at a study where the ethnicity is the same, but the culture is different. In 2004, Maria Makino, Koji Tsuboi, and Lorraine Dennerstein set out to research the differences in eating disorders in different cultures. They specifically wanted to analyze the difference between Western culture and non-Western cultures (Makino et al., 2004). The methodology that they used for this research was the combination of three different research projects that they tied together and analyzed the average outcome of different cultures to compare them (Makino et al., 2004). In a study done between 1935 and 1989, it was discovered that the most popular sect of people that anorexia nervosa (AN) affects are young women between the ages of 15 and 24 (Makino et al., 2004). In other Western countries like Italy, Norway, and the United Kingdom, the 55-year study found similar numbers for girls between the ages of 15 and 19. One of the reasons the study hypothesized that anorexia nervosa decreased at the same time that age increased is because college students tend to be affected less (Makino et al., 2004). One other interesting note from this study is that bulimia is more of a problem than anorexia nervosa.

The researchers then compared the numbers above with numbers from Non-Western countries. The conclusions were as they hypothesized; anorexia nervosa and bulimia are more prevalent issues from people in Western societies. In Malaysia, for example, only 0.05% of the population struggles with anorexia and the numbers are not increasing like they are in the West (Makino et al., 2004). The highest numbers for non-Western cultures were Japan and Iran. The article says that the Iran surveys, “indicate that the prevalence of anorexia nervosa is 0.9% among school girls (Makino et al., 2004).” 0.9% is small compared to the highest rates among Western countries which are 22.3% (Makino et al., 2004).

It is difficult to answer why this is the case because anorexia nervosa is a personal struggle and there are many causes of the disease. However, the researchers point to two socio-cultural reasons that may cause an increase in this eating disorder. The first cause is westernization or modernization where societies move away from survival and begin to place more value in material things and outside appearances (Makino et al., 2004). The second cause that is pointed to in the article is urbanization. They summarize this by saying, “The higher prevalence is also associated with urbanization or population density” and then the authors give Japan as an example: “In Japan, Nagaoka reported that most eating disorder patients came from medium-sized cities (population: 60,000 to 250,000) compared with small and rural districts (Makino et al., 2004).” And they concluded that “more anorexia nervosa sufferers were found in urban areas (Makino et al., 2004).”

The conclusions of this research are twofold. First, out of all the countries that were examined, women tended to suffer more from eating disorders than men and as their age increased, the prevalence of anorexia nervosa or bulimia decreased. The reason for this is unknown, but an educated guess is that because students suffer less from eating disorders, this may be the correlating factor between eating disorders and age. Secondly, non-Western countries have significantly lower rates of eating disorders than Western countries. The reasons for this are both westernization and urbanization.

As far as the research shows anorexia is psychological and sociocultural. However, there is an argument for a third perspective: the biopsychosocial perspective. This perspective combines three different ideas: biological, psychological, and sociocultural, and claims that all three play unique roles in how people behave. It is difficult to make an argument for the biological factor in anorexia nervosa; however, the psychological and sociocultural factors are clearly evident in the very definition of the disease. However, Dr. Wade Berrettini attempts to make the argument that eating disorders may be associated with the biological aspect. In his article titled The Genetics of Eating Disorders, he says, “The eating disorders anorexia nervosa and bulimia nervosa traditionally have been viewed as sociocultural in origin. However, recent behavioral genetic findings suggest a substantial genetic influence on these disorders (Berrettini, 2004 p. 18).” The research that Dr. Berrettini based his article on were families who struggled with eating disorders, twin studies, and molecular genetic studies (Berrettini 2004 p. 18). Berrettini suggests that the level at which individuals who struggle with eating disorders are affected by those who come from families who also struggle with eating disorders is, “a 7 to 12-fold increase in the prevalence of AN and BN (Berrettini 2004, p. 18).”. He ties the biological argument with the fact that the majority of patients struggle with being overly self-conscious of their bodies when he says, “Common to individuals with AN and BN are pathological concern with weight and shape, depression, and anxiety (Berrettini 2004 p. 18).” This further proves the evidence that anorexia nervosa is affected by the biopsychosocial aspect in psychology because it is not solely a biological disease, but the phycological factors and sociocultural factors play an equal if not

bigger roles in anorexia nervosa and bulimia nervosa.

My opinion on this topic was pretty closely matched with what I researched. It is not a surprise that citizens of America struggle with body consciousness more than other citizens in other countries. It is not an ethnic or race-based issue, but instead, it is the difference in cultures in America and non-Western countries. It is also not surprising that body consciousness shows itself through various eating disorders, especially anorexia nervosa and bulimia nervosa. Starving oneself is almost a complete unheard-of subject in other countries, whereas in America many of us know someone who struggles with excessive weight loss or weight gain. One aspect that did surprise me when researching this topic was the genetic argument that came from Dr. Wade Berrettini. The findings amongst families were very interesting and raise a lot of unanswered questions. With family studies, however, it can still be argued that the reasons for eating disorders are environmental, not genetic—or the results are because of nurture, not nature. The second part of his study takes this argument on with twin studies. If twins are separated at birth and still have common characteristics in this area, that helps remove the environmental or the nurture argument. By looking at the unique genetics of twins and then studying their behavior in regards to dieting and exercising, the research shows that these behaviors are “roughly 46 to 72 percent heritable (Berrettini, 2004).” Beyond that, the numbers show that attitudes towards body satisfaction are 32 to 72 percent heritable as well (Berrettini, 2004). I had not considered this perspective before reading his article and the findings are significant. Although the culture and environmental factors have more to do with eating disorders than genes, it is certainly evidence to take into consideration.

What is to be done about this research? And can it be used to help people? One thing I can do to increase the level of understanding of the subject is to promote in-depth studies like the ones above. Having body insecurities or being afraid of being overweight is a very personal problem and cannot be understood with psychological terms or concrete numbers. Psychological terms can help us realize the level at which the problem is affecting people. Numbers and statistics can also help determine where people are affected and who is affected. Similar to depression, there are many root causes of anorexia. Some people struggle with body dysmorphia, some have phobias of being overweight, others strive for unrealistic body types and still, others attempt to satisfy a need for control by being very strict with the way they eat. Thus, like any mental disease, it is a personal struggle and can only be understood by understanding individuals.