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Editorial

Eating Disorders in Developing Countries

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Editorial

Eating disorders, once thought to be a set of rare diseases, found predominantly in females, are being increasingly seen in both males and females. They include binge eating disorder (BED), anorexia nervosa (AN), bulimia nervosa (BN), pica, rumination disorder, avoidant/restrictive food intake disorder, and a group of other specified feeding or eating disorders [1]. Eating disorders occur predominantly in females and the onset often follows puberty [2].

The number of people coming to psychiatrists with problems of anorexia and bulimia has shown a steady rise. It has been estimated that the lifetime prevalence of DSM-IV anorexia nervosa, bulimia nervosa, and binge eating disorder are 0.9%, 1.5%, and 3.5% among women, and 0.3% 0.5%, and 2.0% among men in USA [3]. In Ontario prevalence rates of of BN was 1.1% in women and 0.1% in men [4]. The prevalence rates for AN and BN in Zurich was 0.7% and 0.5% respectively [5]. In South Australia the prevalence of BN and BED was 0.3% and 1% respectively [6]. Across six European countries the prevalence rates for AN, BN, and BED were 0.48%, 0.51%, and 1.12% respectively [7]. Eating disorders as a group are psychiatric disorders with the highest mortality rate, resulting in about 7,000 deaths a year in 2010 [8]. What was earlier thought as a disease pertaining to a few developed countries is now being increasingly seen in developing countries. Moreover, patients of all ages and sexes are coming with these problems.

This has been attributed to acculturation and exposure through the media to Western standards of attractiveness and body size [2,9]. Increasingly, the population of developing countries is adopting Western views on thinness and the dietary habits associated with that state [9]. The point prevalence of AN, BN and BED in China and Japan is 1.05 and 0.43; 2.98 and 2.32; and 3.58 and 3.32 respectively [10]. The prevalence of eating disorder is believed to have increased in India over the past three decades as indicated by sporadic case reports. [11-12]. Though no epidemiological studies have been carried out using the Global Burden of Disease Study 2016 approach it was estimated that the prevalence rate of AN for males was 10/100,000, whereas for females, it was 37.2 and combined prevalence was 22.3/100,000[13].

The cause of eating disorders is not very clear as it is seen that biological and environmental factors appear to play a role. Many studies have shown a possible genetic predisposition causing eating disorders due to Mendelian inheritance [14]. A role for serotonin 4 receptors has been proposed [15]. Some studies suggest that both early pubertal timing and advanced pubertal development in girls are associated with increased rates of eating disorders. On the other hand, findings in boys suggest a smaller role for puberty in the development of eating disorders. Results from twin and animal studies suggest that the female-specific risk is due, at least partly, to genetic factors associated with puberty related estrogen activation [16]. People having previous disorders like anxiety, obsessive compulsive disorder etc have increased vulnerability to developing an eating disorder [17-18]. Cultural idealization that beauty is the same as thinness is also believed to contribute to the etiology [19]. Self-respect is being linked to the body shape and size. Social change and globalization are causing the shift in the thinking of the people in urban cities.

The children are being exposed to social media these days. A significant link has been shown between self-objectification, body dissatisfaction, and disordered eating, as the beauty ideal is altered through social media [20]. Organic cause and other psychiatric disorders must be ruled out before diagnosing eating disorder. The test to be done should include neuroimaging [21]. Beck Depression Inventory [22] just to name a few. Treatment differs according to type and severity of eating disorder, and more than one treatment option is used [23]. Treatment includes pharmacotherapy and psychotherapy. Medicines which can be given are cyproheptidine, [24] pimozide [25] and zinc supplementation [26] for anorexia nervosa, naltrexone for binge eating [27]. Cognitive behavioral therapy, [28] Dialectical behavior therapy [29] family therapy [30] are some of the therapies which show promising results. Most of the patients and their families do not know that they are

suffering from a psychiatric disorder and may go to physicians for physical complaints. They are very reluctant and rarely come to psychiatrists. Patients should be encouraged to seek psychiatric treatment through media and other social awareness programmes.

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