

Factors of Developing an Eating Disorder: A Critical Analysis

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ABSTRACT

The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders defines eating and feeding disorders as a persistent disturbance of eating or eating-related behavior that modifies food intake or absorption and seriously jeopardizes psychological or general health. Their consequences varying from physical and mental morbidity to death as well. Although the common mind believes that eating and feeding disorders affects mostly women, studies show that men are similarly affected. The etiology is unknown, and treatment tends to be complicated since patients deny all therapies. What is more, body image plays a key role on eating disorders, and as a result some behavioral therapists created several conceptual models such as the cognitive-behavioral theory of eating disorder. Last but not least, the risk factors vary. However, environmental, and sociocultural factors have given a great deal of explanation on developing an eating disorder while several studies have investigated and given information to scientific community.

Keywords: eating disorders, risk factors, young, environmental contributors, sociocultural contributors

INTRODUCTION

Even though eating disorders chiefly affect teenagers and young adults, much current medical and psychiatric bibliography neglects to address the single physiologic,

psychologic, and developmental challenges pertinent to younger patients, instead it's focusing on elderly patients with more severe and irreconcilable disease (Fisher et al, 1995). As cited in Yates (1989), Richard Morton (1714) reported a young girl in 1694 who had several of the basic characteristics of anorexia, such as amenorrhea, inanition, and a commitment to study. She denied all therapy and died. Morton (as cited in Yates, 1989) referred to this condition as "nervous consumption," distinguishing it from the tubercle bacillus's ravages. Although this was the first case of anorexia in medical literature, it was not in historical writing. Another case of an eating disorder as presented (as cited in Yates, 1989) from Habermas (1986) used the instance of Friderada, who lived in 895 A.D., to illustrate his point. Friderada was a very hardworking serf who gorged on food before becoming disgusted with it and fasting, though she continued eating a little, secretly. Her extreme freedom, denial of debility, refusal of assistance, piety, and great industriousness all point to anorexia. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013, p329) eating and feeding disorders are defined as a chronic disruption of eating or eating-related behavior that results in

changed food consumption or absorption and severely compromises well-being or psychosocial functioning. Eating disorders are frequent health issues that mostly affect female teenagers and women at a young age but in recent years there has been a surge in interest in males as well (Raevuori, et al., 2014). They are connected with significant physical and mental morbidity, as well as an elevated chance of mortality (Dalle Grave, 2011). Based on Polivy & Herman (2002) study anorexia and bulimia nervosa have consulted as the most common eating disorders which considered to be triggered by sociocultural effects (e.g., media and peer pressure), family influences (e.g., attachment figures and criticism), type of corrosion, low self-esteem, body dissatisfaction, cognitive and biological elements. Some contributing variables appear to be required for the emergence of eating disorders, but none appear to be sufficient (Polivy & Herman, 2002). However, as mentioned by Dalle Grave, (2011) the etiology of them is still unknown, and their treatment is complicated, with some patients refusing all current therapies. But though treatment strategies with proven effectiveness have been refined in recent years, most particularly in the fields of cognitive behavioral treatment and family counseling, a substantial proportion of patients still require long-term care (Steinhausen, et al., 2000).

As mentioned in Fisher et al. (1995), teenager eating disorders range from minor to severe. From 1955 to 1984, the frequency of anorexia nervosa increased progressively among people aged 10 to 19, but not among children aged 3-5. Anorexia nervosa has a documented incidence rate of 0.48% among girls 15-19 years old in the United States, making it the third most frequent chronic illness among teenage girls behind obesity and asthma. In studies throughout the 1980s, roughly 1%-5% of adolescent females met rigorous DSM-III-R criteria for bulimia nervosa, but as many as 10%-50% indicated occasional self-induced vomiting or binge-eating (Fisher et al., 1995). Based on Polivy

& Herman (2002), no easy therapy for any eating disorder exists. According to Fairburn et al, (2000) & Kell et al, (1999) approximately one-third of patients continue to fulfill diagnostic criteria 5 years or more after starting therapy (as cited in Polivy & Herman, 2002). Based on Herzog et al., (2000) & Steinhausen et al., (2000) the estimated death rates (including suicide) range from slightly more than 5% to slightly higher than 8%. Dozens of researches, as well as countless books and chapters, have attempted to pinpoint the specific origin of EDs. The "biopsychosocial" paradigm is a consensus-based method to integrating the several mechanisms that cause eating disorders (EDS) (Polivy & Herman, 2000). The aforementioned theory has the benefit of taking into consideration all of the components that have been demanded to make an alteration, ranging from the generally cultural to the narrowly biological, with pauses along the way for family, social, cognitive, education, personality, and other aspects (Leung et al., 1996). However, based on Polivy & Herman (2000), the model lacks precision also, every version of the biopsychosocial model changes to the next.

Over the previous 30 years, behavior therapists have created several conceptual models of eating disorders. During the 1970s, eating disorder theories highlighted dread of chubbiness and alterations in body image as main motivators for self-starvation and compensatory behaviors to compensate for the weight gain associated with binge eating based on Bruch, (1973) & Russell, (1979) (as cited in Williamson et al., 2004). The cognitive-behavioral theory of eating disorders addresses how cognition influences the emergence and maintenance of unhealthy eating and weight management behaviors. The framework of thought as ordered by schemata is a key idea in cognitive theory. A schema is regarded as a high efficiency knowledge structure in cognitive psychology; its goal is to drive attention, perception, and how data is analyzed (Vitousek, & Hollon, 1990).

Schemata are assumed to occur for any information that needs memory and cognitive processing organization; yet these cognitions might just as well serve a non-functional purpose if they influence judgment, cognition, and action in a self-destructive or maladaptive fashion (Williamson et al.,1999). According to cognitive-behavioral theory, this is exactly what happens in people with eating disorders. Individuals diagnosed with an eating disorder are thought to have formed a disorderly schema centered on excessive worry about their physique and food (Cooper & Fairburn, 1993). This schema is thought to include stereotyped, affectively laden, and overestimated data about weight and shape, particularly as it relates to oneself. Information is overrated because it is prioritized above other cognitive systems. (Williamson et al.,1999). Body form schema is regarded as a personal schema. As the schema starts to play an energetic part in data processing, ambiguous inputs are influenced by the body schema's stringent personal interpretations. This procedure is said to happen mechanically, with no mental awareness of the acts. Occurring outside of conscious awareness gives the prejudiced, schematic cognition a sense of reality; as a result, the prejudice becomes pervasive within all processes of the major schema, containing attention, judgment, memory, and body image (Williamson et al.,1999). Environmental factors relating to body form and weight are interpreted with a bias toward fatness (Williamson et al.,1999). This hypothesis implies that cognitive bias is a result of a disturbed body model rather than disordered eating behavior. (Williamson et al.,1999). Based on Williamson,1996 (as cited in Williamson et al.,1999) in nonclinical studies, cognitive-behavioral theory expects the prevalence of cognitive prejudices connected to body weight/shape and eating. People who are worried about their physical weight/shape do not fulfill eating disorder diagnosis criteria. This notion has been validated. Many studies of cognitive bias have been

tested and encourage suffering from eating disorders and body dysphoria (Williamson et al.,1999 & Williamson et al.,2004). According to cognitive-behavioral theory, cognition impacts eating and weight control habits. Dietary limit, purging (i.e., self-induced vomiting, laxative usage, diuretics, etc.), extreme training, physique evaluation, and ritualistic eating habits result from the worldwide automatic biasing of information processing relating to body shape and size. Since binges are generally a reaction to extreme dietary restriction, binge eating is thought to be an indirect outcome of cognitive bias. Eating and weight-control practices are influenced by cognitive factors (Williamson et al.,1999 & Williamson et al.,2004). Cognitive prejudices including attention, memory, and judgment, or biased interpretation of information relevant to eating fatty foods and body size and shape, are currently determined to be highly ubiquitous. According to current findings, these cognitive biases may be particular to food and body-related information. Previous studies on body image abnormalities in eating disorders, as highlighted in an earlier article (Williamson, 1996), may also be viewed within the framework of cognitive bias, which may assist in providing fresh direction to this area of research. Because these cognitive biases are so prevalent, they may impact a number of the cognitive, emotional, and behavioral responses of eating disorder sufferers (Williamson et al.,1996 & Williamson et al.,2004). Numerous areas of quantitative and qualitative research have resulted from cognitive behavioral investigations of EDs. Most of the assumptions examined until today have been confirmed, and the solid evidence favoring CBT for BN provides extra indirect support; nonetheless, a number of critical parts of the conceptual model remain unproven more than half a century since they were first proposed (Vitousek & Brown, 2015). Even with the ubiquity of weight preoccupation and dieting in the general community, research shows that patients with AN and BN differ

from ordinary people in the substance, severity, and absoluteness of their eating and weight beliefs. The findings are founded on a range of evaluation methods, such as interviews conducted, attitude surveys, self-statement inventories, and thought sampling (Vitousek & Brown, 2015). Based on Cooper, 1997, 2005; Vitousek, 1996; Williamson et al., 2004 (as cited in Vitousek & Brown, 2015) scores on eating, weight, and shape concern assessments have been demonstrated to relate with other ED symptoms and severity, to decrease with time, and to predict symptom duration, treatment response, and relapse. Weight worries (composed with negative emotionality and perfectionism) are regularly identified as important predictors of ED symptoms in risk factor research as mentioned by Keel & Forney, 2013; Stice, 2002 (as cited in Vitousek & Brown, 2015). According to Stice, et al, 2008 (as cited in Vitousek & Brown, 2015) the cognitive behavioral viewpoint is also mirrored within one of the most successful preventive programs studied to far, which is intended to create conflict between support for the slender ideal and other cherished beliefs. But based on Vitousek & Brown, 2015 concepts proposed should be devoted at investigating fundamental elements of the model that have been repeatedly and unusually overlooked, in contrast to Stice et al, 2008 (as cited in Vitousek & Brown, 2015) who state that cognitive-behavioral viewpoint is represented in one of the most successful preventive programs studied so far, which is intended to create dissonance between support for the slim ideal and other cherished beliefs. But subsequent conversations by the model's creators were more about elaborating on individual features than reformulating the core concept (Vitousek & Brown, 2015). Vitousek and Hollon (1990) (as cited in Vitousek & Brown, 2015) explored the importance of schematic processing and proposed a relationship between a certainty-oriented cognitive style and patients' engagement in symptoms. In the other hand some cognitive

behavioral theorists state that the theory was too wide, providing too much emphasis to interpersonal variables and "deep" parts of the self (Leung, Waller, & Thomas, 1999); others said it was too narrow, allocating too much attention to these issues, and urged a more concentrated approach (Vitousek & Brown, 2015).

Based on Becker et al., 2004 sociocultural contributors (e.g., social transition, media exposure and certain peer environments) seem to lead to eating disorders. EDS do not arise in all cultures and at all eras. Passion with thinness, a key trait of EDs, is more prevalent in countries where food is plentiful. The ideal body form in scarce societies is significantly expected to be rotund, indicating that ideals trend toward what is harder to accomplish, in this way, a caloric abundance culture could be viewed as a cause of EDs. (Polivy & Herman, 2000). Presently, physical attractiveness has completely changed; according to John and Harriet Worobey's (2014) research, US girls aged 3½ to 5½ years ascribed more favorable attributes to a thin or classical doll than a curvier doll, showing greater inclinations for slimness. Another research on boys done in the 1980s by Michael Maloney and his colleagues discovered that 31% of 9, 22% of 10, 44% of 11 and 41% of 12 years old aspired to be skinny. According to the data, 31% of men tried to decrease weight, 14% went on a diet, and 37% tried to lose weight, with the bulk of them being under the age of nine (Grogan, 2016). However, it is important to note that this reason is not exact; rising up in a culture of abundance, while possibly increasing one's chances of emerging an ED, does not guarantee that will grow an ED; after all, most individual's in even the most rich of cultures do not develop EDs (Polivy & Herman, 2000).

A culture of wealth should be viewed as a secondary cause at best. A slender culture could value skinniness, but whether a person takes this value to a pathological extreme depends on other factors (Polivy & Herman, 2000). Based on Stormer &

Thompson 1996, Stice 2001 (as cited in Polivy & Herman, 2000) the level to which people absorb our culture's valuing of slimness, for example, varies, and the extent of such internalization predicts body dissatisfaction, desire for thinness, and some bulimic features. On 2013 Keel & Ferney conducted a qualitative literature review concentrating on psychological and social variables that raise the risk of emerging eating disorders, with a priority on well-duplicated results in prospective longitudinal studies. Results showed that epidemiological, cross-cultural, and longitudinal research all emphasize the relevance of thinness glorification and weight worries as psychological risk factors for eating disorders. The researchers implied that both epidemiological and cross-cultural studies indicate the role of the leprosy ideal as a societal factor contributing to excessive weight behaviors and the development of an eating problem (Keel & Ferney, 2013).

Also, media is frequently blamed for the (growing) incidence of eating disorders, on the estates that media depictions of idealized (thin) physiques drive or even force individuals to strive for slimness (Polivy & Herman, 2000). The media has been accused of misrepresenting the truth by portraying models and celebrities who are either stick skinny and thus non-representative of normality, or abnormally thin Idealistic media images, like the culture of wealth, are at best a secondary cause of EDs. According to Stice et al., (1994) research who investigated the relationship between media exposure and eating disorder symptoms, as well as whether gender-role validation, internalization of ideal-body stereotypes, and body satisfaction mediated this impact. Structural equation modeling demonstrated a direct influence of media exposure on eating disorder symptoms in 238 female students' data who willingly did a 10-mile page questionnaire (media exposure scale) (in groups of 20-60) in order to be eligible for research participation credit. Additionally, mediational links for gender-role endorsement, ideal body norm

internalization, and body satisfaction were discovered. The findings support the hypothesis that internalization of societal constraints mitigates the negative consequences of the thin notion. However, the researchers state that assessment of media exposure may not have been exact enough to capture the impacts of narrow optimum exposure. Third, relying on self-report data restricts the level of trust that can be placed in the results. If behavioral observations had been employed, stronger inferences may have been reached. Finally, the model makes no differences between different forms of eating disorders, such as bulimia and anorexia. It is conceivable that these two illnesses are caused by somewhat different sources (Stice et al., 1994). As with culture, despite their ubiquity, idealized media images are just a secondary source of EDs. Media exposure is so prevalent that if it was the cause of EDs, it would be impossible to comprehend why anybody would not be eating-disordered (Polivy & Herman, 2000). Additionally, like Tiggemann & Pickering (1996, p.202) stated that while it may be tempting to conclude that watching a large dose of thin idealized images on television leads to body dissatisfaction, "a correlation cannot determine causality," said the study's lead authors, who discovered that among girls, body dissatisfaction and the drive for thinness were associated with increased exposure to certain types of TV shows. In fact, body dissatisfaction may be seen as a crucial antecedent (and ongoing companion) of EDs. The more acute the discontent, the more probable it is that one will want to reduce weight. When these attempts are coupled with other infections, they may result in AN (if the individual has extremely strong limits on eating) or BN (if the person does not) (Polivy & Herman, 2002). According to Nasser and Katzman (1999) (as cited in Nasser, M., & Katzman p.161 2003), the introduction of new social supports and the meticulous effort of offering new ways of belonging at the job

and school level will improve the prevention of eating issues.

To sum up, humanity has been dealing with eating disorders since 895 A.D even though all the incidences of them were identified later on. Despite the fact that EDs have no impact on sexes and are a controversial theme no easy therapy for any eating disorder exists (Yates, 1989 & Polivy & Herman ,2002). The causes of them vary, sociocultural factors and cognitive behavioral theory provide a great explanation to why EDs develop among people but many theorists and people on the science field doubt them or critically try to expand. Last but not least, further research should be conducted to investigate the actual causes, because the continued development of them on one's health has hazardous side effects.

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