



Psychological Impact of Eating Disorders- A Comprehensive Review

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Abstract

Eating disorders (EDs) are severe mental health conditions characterized by dysfunctional eating behaviors and cognitions, significantly impacting psychological well-being. This comprehensive review explores the psychological impact of eating disorders, focusing on anorexia nervosa, bulimia nervosa, and binge-eating disorder. The review synthesizes current literature on the prevalence, risk factors, comorbidities, and psychological consequences of EDs. Key psychological impacts discussed include anxiety, depression, obsessive-compulsive behaviors, body dysmorphia, and impaired social functioning. The review also examines therapeutic interventions and their efficacy in addressing these psychological issues. By highlighting the complex interplay between EDs and psychological health, this paper aims to inform clinical practice and future research directions.

Introduction:

Eating disorders represent a significant public health concern, characterized by disturbances in eating behaviors, body image, and psychological well-being. These disorders, which include anorexia nervosa, bulimia nervosa, and binge eating disorder, affect individuals across diverse demographic groups and have profound implications for physical health, mental health, and quality of life. While the physical consequences of eating disorders are well-documented, their psychological impact is equally profound and warrants careful examination.

The purpose of this research paper is to provide a comprehensive review of the psychological impact of eating disorders, synthesizing existing literature and research findings to enhance understanding of the cognitive, emotional, and behavioral dimensions of these conditions. By exploring the psychological symptoms, risk factors, etiological models, and treatment approaches associated with eating disorders, this paper aims to shed light on the complex interplay between psychological factors and eating disorder pathology.

Eating disorders are characterized by a range of psychological symptoms, including cognitive distortions related to body image dissatisfaction, perfectionism, and distorted beliefs about food, weight, and shape. Individuals with eating disorders often experience intense emotional distress, including anxiety, depression, guilt, and shame, which may exacerbate disordered eating behaviors and contribute to the maintenance of the disorder. Furthermore, eating disorders frequently co-occur with other psychiatric conditions, such as substance abuse, self-harm behaviors, and personality disorders, further complicating diagnosis and treatment.

Understanding the psychological impact of eating disorders requires a comprehensive examination of the underlying risk factors and etiological models that contribute to their development and maintenance. While





genetic, biological, psychological, and sociocultural factors all play a role, current research suggests that a complex interplay of these factors contributes to the onset and progression of eating disorders. By exploring these factors and theoretical frameworks, researchers and clinicians can gain insights into the multifaceted nature of eating disorder pathology and inform more targeted interventions.

Effective treatment of eating disorders requires a multidisciplinary approach that addresses both the physical and psychological aspects of the disorder. Evidence-based treatment approaches, such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and family-based treatment (FBT), have demonstrated efficacy in reducing eating disorder symptoms and improving psychological well-being. However, challenges remain in accessing appropriate care, overcoming treatment resistance, and addressing the complex psychosocial implications of these disorders.

In conclusion, understanding the psychological impact of eating disorders is essential for informing assessment, treatment, and prevention efforts. By elucidating the cognitive, emotional, and behavioral dimensions of these conditions, this research paper aims to contribute to a deeper understanding of eating disorder pathology and enhance efforts to support individuals affected by these complex mental health conditions. Through continued research, collaboration, and advocacy, we can work towards reducing the burden of eating disorders and promoting psychological well-being for all individuals.

Prevalence and Diagnostic Criteria:

Prevalence:

Eating disorders are prevalent worldwide and affect individuals across diverse demographic groups, including age, gender, socioeconomic status, and cultural background. While accurate prevalence estimates can be challenging due to underreporting, stigma, and cultural variations in symptom presentation, epidemiological studies provide valuable insights into the scope and impact of eating disorders.

Research indicates that eating disorders disproportionately affect adolescent and young adult populations, with peak onset typically occurring during adolescence or early adulthood. However, eating disorders can also develop in childhood or later in life, underscoring the importance of early detection and intervention across the lifespan.

Prevalence rates vary by specific disorder, with anorexia nervosa, bulimia nervosa, and binge eating disorder representing the most commonly diagnosed conditions. Additionally, subthreshold and atypical presentations of eating disorders may occur, further complicating prevalence estimates and diagnostic classification.

According to epidemiological studies, the lifetime prevalence of anorexia nervosa is estimated to range from 0.3% to 1.0% among females and 0.1% among males, with higher rates reported in clinical samples. Bulimia nervosa has a lifetime prevalence ranging from 1.0% to 1.5% among females and lower rates among males. Binge eating disorder, characterized by recurrent episodes of binge eating without compensatory behaviors, has a higher prevalence, estimated at 1.6% among females and 0.8% among males.

While eating disorders are more commonly diagnosed in females, males are also affected, and recent research suggests increasing recognition of eating disorders in male populations. Additionally, eating disorders are increasingly recognized as a global health issue, with variations in prevalence rates observed across different countries and cultural contexts.



Diagnostic Criteria:

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, provides standardized diagnostic criteria for eating disorders, facilitating accurate diagnosis and treatment planning. The DSM-5 outlines specific criteria for anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding and eating disorders (OSFED).

Anorexia Nervosa:

- Criterion A: Restriction of energy intake relative to requirements, leading to significantly low body weight.
- Criterion B: Intense fear of gaining weight or becoming fat, despite being underweight.
- Criterion C: Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of low body weight.

Bulimia Nervosa:

- Criterion A: Recurrent episodes of binge eating, characterized by eating an unusually large amount of food in a discrete period and feeling a lack of control over eating during the episode.
- Criterion B: Recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- Criterion C: Binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for three months.



Fig.1 Types of eating disorders, Source- Mind Journal



Binge Eating Disorder:

- Criterion A: Recurrent episodes of binge eating, characterized by eating an unusually large amount of food in a discrete period and feeling a lack of control over eating during the episode.
- Criterion B: Binge eating episodes are associated with three or more of the following: eating more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone due to embarrassment, or feeling disgusted with oneself, depressed, or very guilty afterward.
- Criterion C: Marked distress regarding binge eating is present.

Other Specified Feeding and Eating Disorders (OSFED):

- OSFED encompasses eating disorder presentations that do not meet the full criteria for specific disorders but still cause clinically significant distress or impairment. Examples include atypical anorexia nervosa, purging disorder, and night eating syndrome.

Accurate diagnosis of eating disorders requires careful assessment of symptoms, clinical presentation, and functional impairment, often involving a multidisciplinary team approach that includes mental health professionals, physicians, dietitians, and other healthcare providers. Diagnostic criteria provide a standardized framework for identifying and classifying eating disorders, facilitating appropriate treatment planning, and ensuring consistency in research and clinical practice.

Psychological Symptoms and Comorbidities

Eating disorders are complex mental health conditions characterized by a range of psychological symptoms and frequently co-occurring psychiatric disorders. Understanding the psychological manifestations of eating disorders is essential for accurate diagnosis, effective treatment planning, and addressing the underlying factors contributing to disordered eating behaviors. Additionally, recognizing and addressing comorbidities is crucial for providing comprehensive care and improving long-term outcomes for individuals with eating disorders.

Psychological Symptoms

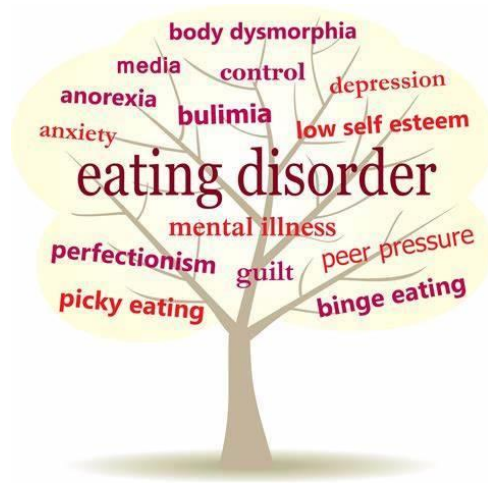


Fig 2. Symptoms and comorbidities of eating disorders Image source: blogs.missouristate.edu, by- [Jerilyn Reed](#)



- **Distorted Body Image:** Individuals with eating disorders often experience a distorted perception of their body size, shape, and weight. They may perceive themselves as overweight or unattractive, despite being underweight or within a healthy weight range. This distorted body image contributes to body dissatisfaction and drives disordered eating behaviors.
- **Perfectionism:** Many individuals with eating disorders exhibit perfectionistic tendencies, characterized by rigid standards for achievement, excessive self-criticism, and fear of failure. Perfectionism may manifest in obsessive-compulsive behaviors related to food intake, exercise, and body weight control.
- **Low Self-Esteem:** Eating disorders are often associated with low self-esteem and feelings of inadequacy. Individuals may base their self-worth on their appearance or ability to control their eating habits, leading to self-critical thoughts and diminished self-worth.
- **Anxiety and Depression:** Anxiety and depression are common psychological comorbidities of eating disorders, contributing to emotional distress and impairing daily functioning. Anxiety symptoms may include excessive worry, social anxiety, and panic attacks, while depression symptoms may include sadness, loss of interest or pleasure, and feelings of hopelessness.
- **Obsessive-Compulsive Behaviors:** Some individuals with eating disorders engage in obsessive-compulsive behaviors related to food, weight, and body image. These behaviors may include ritualistic eating patterns, compulsive exercise, and preoccupation with calorie counting or food labels.
- **Emotional Dysregulation:** Difficulty regulating emotions is common among individuals with eating disorders, leading to mood swings, impulsivity, and emotional outbursts. Emotional dysregulation may contribute to binge eating episodes, purging behaviors, and self-harm.

Comorbidities:

- **Substance Use Disorders:** Eating disorders frequently co-occur with substance use disorders, including alcohol abuse, illicit drug use, and misuse of prescription medications. Substance use may serve as a maladaptive coping mechanism for managing emotional distress or controlling appetite.
- **Self-Harm and Suicidality:** Individuals with eating disorders are at increased risk of self-harm behaviors, such as cutting, burning, or scratching, as well as suicidal ideation and suicide attempts. Co-occurring depression, anxiety, and low self-esteem contribute to heightened suicide risk.
- **Personality Disorders:** Certain personality traits and disorders, such as borderline personality disorder (BPD) and avoidant personality disorder, are commonly associated with eating disorders. These disorders may exacerbate difficulties in interpersonal relationships and contribute to emotional instability.





- Trauma and Post-Traumatic Stress Disorder (PTSD): Traumatic experiences, such as physical or sexual abuse, neglect, or interpersonal violence, are risk factors for developing eating disorders. Individuals with a history of trauma may experience symptoms of PTSD, including intrusive memories, hyperarousal, and avoidance behaviors.
- Psychiatric Comorbidities: In addition to anxiety and depression, eating disorders frequently co-occur with other psychiatric conditions, such as obsessive-compulsive disorder (OCD), bipolar disorder, and substance use disorders. Addressing these comorbidities is essential for providing comprehensive care and improving treatment outcomes.

Risk Factors and Etiological Models:

Understanding the risk factors and etiological models of eating disorders is essential for identifying individuals at heightened risk, informing prevention efforts, and guiding treatment interventions. Eating disorders are multifactorial in nature, involving a complex interplay of genetic, biological, psychological, and sociocultural factors. By examining these risk factors and theoretical frameworks, researchers and clinicians can gain insights into the underlying mechanisms contributing to the onset and maintenance of eating disorders.

1. Biological Factors:

- Genetic Predisposition: Family and twin studies suggest a genetic component to eating disorders, with heritability estimates ranging from 40% to 60%. Certain genes and genetic variations may confer susceptibility to eating disorders, although specific genes implicated in these disorders remain to be identified.
- Neurobiological Factors: Dysfunction in brain regions involved in appetite regulation, reward processing, and emotional regulation has been implicated in eating disorders. Alterations in neurotransmitter systems, including serotonin, dopamine, and norepinephrine, may contribute to disordered eating behaviors and body image disturbances.

2. Psychological Factors:

- Cognitive Distortions: Maladaptive beliefs and cognitive distortions related to body image, weight, and food are central to the development and maintenance of eating disorders. These distortions may include overvaluation of weight and shape, dichotomous thinking (e.g., "good" foods vs. "bad" foods), and cognitive biases toward appearance-related stimuli.
- Personality Traits: Certain personality traits, such as perfectionism, neuroticism, and impulsivity, are associated with increased vulnerability to eating disorders. Perfectionistic tendencies may contribute to rigid dietary rules and excessive exercise, while neuroticism and impulsivity may drive emotional dysregulation and impulsive eating behaviors.

3. Sociocultural Factors:

- Media Influence: Sociocultural ideals of thinness and beauty perpetuated by mass media, advertising, and social media contribute to body dissatisfaction and disordered eating behaviors, particularly among adolescents and young adults. Exposure to thin-ideal media images is associated with increased body dissatisfaction and drive for thinness.





- **Family Dynamics:** Family factors, including parental modeling of dieting behaviors, criticism of weight and shape, and dysfunctional family dynamics, may contribute to the development of eating disorders. Negative family interactions, such as conflict, enmeshment, and invalidation, may exacerbate emotional distress and perpetuate disordered eating patterns.

4. Interpersonal Factors:

- **Peer Influences:** Peer relationships and social dynamics play a significant role in the development of eating disorders, particularly during adolescence and young adulthood. Peer pressure to conform to thin-ideal standards, social comparison, and weight-related teasing or bullying contribute to body dissatisfaction and disordered eating behaviors.
- **Interpersonal Trauma:** Experiences of interpersonal trauma, such as physical or sexual abuse, neglect, or bullying, are risk factors for developing eating disorders. Trauma-related symptoms, including post-traumatic stress, dissociation, and emotion dysregulation, may contribute to maladaptive coping strategies, such as disordered eating.

5. Developmental and Environmental Factors:

- **Developmental Transitions:** Developmental transitions, such as puberty, adolescence, and young adulthood, represent critical periods of vulnerability for the onset of eating disorders. Biological changes, identity development, and social pressures during these transitions may increase susceptibility to body dissatisfaction and disordered eating.
- **Life Stressors:** Life stressors, such as academic pressure, interpersonal conflicts, and life transitions, may precipitate or exacerbate eating disorder symptoms. Stress-related coping strategies, such as restrictive eating or binge eating, may serve as maladaptive attempts to regulate emotions and cope with stressors.

Etiological Models:

- **Biopsychosocial Model:** The biopsychosocial model posits that eating disorders result from the interaction of biological, psychological, and sociocultural factors. This integrative model emphasizes the complex interplay between genetic predisposition, neurobiological vulnerabilities, cognitive-behavioral processes, interpersonal dynamics, and sociocultural influences in the development of eating disorders.
- **Sociocultural Model:** The sociocultural model emphasizes the role of sociocultural ideals of thinness and beauty in the development of eating disorders. Sociocultural factors, including media exposure, peer influences, and cultural norms, shape body image ideals and contribute to body dissatisfaction and disordered eating behaviors, particularly among vulnerable individuals.
- **Cognitive-Behavioral Model:** The cognitive-behavioral model highlights the central role of cognitive distortions, maladaptive beliefs, and behavioral patterns in the maintenance of eating disorders. This model emphasizes the importance of identifying and challenging distorted thoughts and beliefs related to body image, weight, and food, as well as addressing dysfunctional behaviors through cognitive restructuring and behavior modification techniques.
- **Interpersonal Model:** The interpersonal model focuses on the impact of interpersonal relationships and social dynamics on the development and maintenance of eating disorders. Interpersonal factors, including family dynamics, peer relationships, and interpersonal trauma, shape individuals' self-





concept, social identity, and emotional regulation strategies, influencing vulnerability to disordered eating behaviors.

By integrating biological, psychological, sociocultural, and interpersonal perspectives, these etiological models provide comprehensive frameworks for understanding the multifactorial nature of eating disorders and guiding research, assessment, and treatment efforts. Recognizing the complex interplay of risk factors and etiological mechanisms is essential for addressing the underlying factors contributing to eating disorder pathology and developing effective prevention and intervention strategies.

Psychological Assessment

Psychological assessment plays a critical role in the evaluation, diagnosis, and treatment planning for individuals with eating disorders. A comprehensive assessment encompasses a range of psychological, behavioral, and psychosocial factors to inform personalized treatment interventions. Key components of psychological assessment for eating disorders include:

- **Clinical Interview:** A structured or semi-structured clinical interview is conducted to gather detailed information about the individual's eating behaviors, body image concerns, weight history, medical history, psychiatric symptoms, and psychosocial functioning. The interview may also explore family dynamics, interpersonal relationships, trauma history, and treatment history.
- **Standardized Measures:** Various self-report questionnaires, rating scales, and standardized assessment tools are utilized to assess specific aspects of eating disorder pathology, including eating attitudes and behaviors, body image dissatisfaction, mood symptoms, anxiety, depression, and quality of life. Examples of commonly used measures include the Eating Disorder Examination (EDE), Eating Attitudes Test (EAT-26), Body Shape Questionnaire (BSQ), and Beck Depression Inventory (BDI).
- **Behavioral Observations:** Observational assessment techniques involve direct observation of the individual's eating behaviors, meal patterns, exercise habits, and body language during clinical interviews or structured meal assessments. Behavioral observations provide valuable insights into the severity of eating disorder symptoms, including dietary restriction, binge eating, purging behaviors, and avoidance of specific foods or social situations.
- **Cognitive Assessment:** Cognitive assessment tools may be used to evaluate cognitive functioning, cognitive distortions, and maladaptive beliefs related to body image, weight, and food. Cognitive tasks, such as attentional bias paradigms or implicit association tests, can assess automatic thoughts and cognitive biases associated with eating disorder pathology.
- **Psychosocial Assessment:** A psychosocial assessment examines various psychosocial factors that may contribute to the development or maintenance of eating disorders, including family dynamics, peer relationships, academic or occupational stressors, trauma history, substance use, and coping strategies. The assessment aims to identify psychosocial stressors and strengths that may impact treatment engagement and outcomes.

Treatment Approaches

Effective treatment of eating disorders requires a multidisciplinary approach that addresses the complex biopsychosocial factors contributing to the disorder. Psychological interventions play a central role in





treatment, focusing on cognitive restructuring, emotion regulation, behavior modification, and interpersonal skills development. Common psychological treatment approaches for eating disorders include:

1. **Cognitive-Behavioral Therapy (CBT):** CBT is an evidence-based treatment approach that targets maladaptive thoughts, beliefs, and behaviors associated with eating disorders. CBT aims to challenge cognitive distortions related to body image and weight, modify dysfunctional eating behaviors, develop coping skills for managing urges and emotions, and address underlying psychological factors contributing to the disorder.
2. **Dialectical Behavior Therapy (DBT):** DBT is a skills-based therapy originally developed for borderline personality disorder (BPD) but adapted for individuals with eating disorders. DBT combines cognitive-behavioral techniques with mindfulness-based strategies to enhance emotion regulation, distress tolerance, interpersonal effectiveness, and self-acceptance.
3. **Interpersonal Psychotherapy (IPT):** IPT focuses on resolving interpersonal difficulties and addressing interpersonal triggers associated with eating disorder symptoms. IPT aims to improve communication skills, enhance social support networks, address interpersonal conflicts, and promote healthier relationships with others.
4. **Family-Based Treatment (FBT):** FBT, also known as the Maudsley approach, is a family-centered treatment approach for adolescents with eating disorders, particularly anorexia nervosa. FBT involves empowering parents to take an active role in supporting their child's recovery, restoring healthy eating patterns, and addressing family dynamics that may contribute to the disorder.
5. **Acceptance and Commitment Therapy (ACT):** ACT is a mindfulness-based therapy that focuses on promoting psychological flexibility and values-based living. ACT helps individuals develop acceptance and mindfulness skills to cope with distressing thoughts and emotions, clarify personal values, and engage in committed actions aligned with their values.
6. **Nutritional Counseling:** Nutritional counseling is an integral component of eating disorder treatment, providing education about balanced nutrition, meal planning, portion sizes, and mindful eating practices. Registered dietitians work collaboratively with individuals to establish regular eating patterns, challenge food-related fears and beliefs, and restore nutritional health.
7. **Supportive Therapy:** Supportive therapy provides emotional support, validation, and encouragement for individuals with eating disorders, particularly during early stages of treatment or during periods of crisis. Supportive therapists offer a nonjudgmental space for individuals to explore their thoughts and feelings, express concerns, and develop coping strategies.
8. **Group Therapy:** Group therapy offers opportunities for individuals with eating disorders to connect with others who share similar experiences, receive peer support, and practice social skills in a supportive environment. Group therapy may focus on specific themes, such as body image, emotion regulation, or relapse prevention.

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