LITERATURE REVIEW CHICAGO STYLE SAMPLE

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Eating disorders include a wide range of relatively similar disorders whose main concern is their body shape, body dissatisfaction, focus on weight and appearance control, and inadequate patterns of food intake.[1] In the spectrum of feeding disorders, anorexia of nervous, bulimia nervosa, diarrhea and unspecific eating disorders differ. Anorexia nervousness is a psychological disorder characterized by low body weight of the diseased and specific beliefs and behavior related to the body and the food. The sufferers are overwhelmed by the desire for a slim look, their body experiences thick, and they feel intense fear of gaining weight. Bulimia nervosa is a psychiatric disorder characterized by periods of suffocation after which compensatory behaviors such as self-reported vomiting, exercise, or abuse of diuretics and laxatives occur. People who have a baby can have normal body weight, but they may be malnourished or have excessive body weight. Feeding disorders are severely subject to classification due to many cross-overlaps.[2] The basic criterion for anorexia nervousness is low body weight, and bulimia nervous overpressure and overweight compensations. What is common to these disorders is intense preoccupation with the appearance and size of the body and often dissatisfaction with them. DSM-IV in the category of eating disorder includes diarrhea, which is characterized by periods of non-compensated overgrowth and nonspecific eating disorders. Diagnosis of non-specific eating disorders is provided by people who do not meet all criteria for diagnosing anorexia or bulimia nervosa. This diagnosis is set in most cases.[3] Individuals may suffer from many different eating disorders during a lifetime, and from one disorder to another, or show insufficiently clinically relevant symptoms for diagnosing anorexia or bulimia, but still have a clinically significant eating disorder.[4] What is common to all feeding disorders is the interdependence of attitudes about body weight and feeding control with wider personal problems such as low self-esteem and poor emotional control.

Feeding disorders usually occur for the first time in the adolescent period, although they have been reported in the younger and older population. The average rate of prevalence of anorexia for adolescent and young women is 0.3%, and for bulimia anxiety 1%. The total incidence of nerve anorexia is 8 per 100,000[5] individuals per year, and bulimia 12 per 100,000. Feeding disorders are considered to be psychological disorders with the highest mortality rate. The incidence of anorexia nervosa over the past 50 years is increasing, especially in the age group of girls between 10 and 24 years. Keeping a child in a modern society is a very common occurrence, and a certain amount of concern about body weight, diet and appearance, and keeping baby are considered normative for young women.[6] Holding a child is considered to be the key and central component of a feeding disorder, and therefore such behaviors should be carefully considered and taken seriously.

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1 Hsu L.K. G. *Eating Disorders*. (New York: The Guilford Press, 1990).

2 Palmer B. Concepts of Eating Disorders. In: J. Treasure, U. Schmidt, & E. Furth, (Ed.), *Handbook of eating disorders* (1 - 11) (Chichester: John Wiley & Sons, 2003).

3 Ibid.

4 Sullivan P. F., Bulik C. M., Fear J. L. "Pickering a Outcome of anorexia nervosa: a case-control study". *Am J Psychiatry*. Jul; 155 (7) (1998)

5 Hoeken D., Seidell J., Hoek H. W. Epidemiology. In: J. Treasure, U. Schmidt, & E. Furth (|Ed.), *Handbook of eating disorders* (p. 11 - 35). (Chichester: John Wiley & Sons, 2003)

6 Bäck E. A. "Effects of parental relations and upbringing in troubled adolescent eating behaviours". *Eating Disorders*, 19, (2011).

Certain researchers find that problematic food-related behaviors can be observed on the continuum, with people diagnosed with a clinical disorder not a qualitatively different group, but are on one extremity of that continuum. This understanding points to the arbitrary difference between clinical disorders of nutrition and subclinical disorders of attitudes and behavior on food. Disturbed patterns of behavior and opinions related to food and your own body have a very negative impact on the daily lives of people who suffer from them. Understanding the etiology of these problems is key to designing appropriate approaches to treatment and prevention. Feeding disorders are related to many different psychological constructs, and many researchers emphasize the complexity of their etiology and considering the results of the research to date, it is difficult to determine the unique causative factor of their origin. Research has studied different variables, trying to find out whether they contribute to the development of eating disorder and dissatisfaction with their own body. Biological and genetic factors, personality factors, sociocultural and family factors have been recognized. The variables most frequently investigated in relation to eating disorders are the characteristics of the individual (body mass index, self-esteem, unpleasant emotion, depression, personality, perfectionism) and socio-cultural environment (family relationships and communication, exposure to media, peers). Due to multiple causes and a large number of possible variables, it is important to consider any factor that may contribute to understanding the etiology of eating disorders.

Numerous studies have shown that there are disturbed forms of attachment in the population affected by eating disorders, and the most commonly observed form of uncertain attachment.[7] In the etiology of eating disorders, among other things, the factors of self-esteem, dissatisfaction with the body and keeping of the child were shown to be prominent, and all of these factors can be related to parenting procedures, parental behavioral modeling, family interactions and childhood attachment to parents. Styles of attachment in infancy and childhood are an important factor that continues to affect developmental outcomes and adulthood by laying the foundations for safety, social acceptance and general satisfaction with life. Adolescence is a period in which styles of attachment continue to emerge despite the aspirations of adolescents to autonomy and independence from their parents. Many adolescents in the periods of stress and hardship of their parents continue to perceive themselves as sources of security and support, and styles of attachment are the basis for working models of relationships with others who make contact with peers. Research shows that there is a link between styles of adherence in adolescence and feeding problems. Uncertainly adolescent adolescents show a higher level of concern about body weight and lower self-esteem than a safe-bred peer. Unsatisfied people have a diminished feeling of their own value and a high level of rejection by others, which can lead to an increased need for acceptance by others and, consequently, to increased sensitivity to social ideals such as social stress on slimness. The quality and form of parenting plays a key role in the psychological development of children and it is considered that these variables are a predictor of quality of later interpersonal relationships and have a huge impact on personality development and psychological functioning such as self-esteem and self-respect.

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[7] Ward A., Gowers S. Attachment and Childhood Development. In: J. Treasure, U. Schmidt, E. Furth (Ed.), *Handbook of eating disorders* (p. 89 - 103). (Chichester: John Wiley & Sons, 2003).

Within the theory of attachment, parenting sensitivity to child signs and answering these signs are considered important for creating a child's sense of self-efficacy or a child's belief that it has control over events in their life. Children who have been caring and caring for a parent have usually seen others as someone who is trustworthy and caring, and loving and caring for themselves, which can later act as a protective factor. If children experience ignorance and rejection, they may experience other people unreliable and unmerciful and unworthy of acting as a risk factor for the development of various psychopathological states. Apparigliato et al. are considered parenting criticism as particularly damaging because they are a source of stress for children and are defined as a recurring and overwhelming form of communication where parents find numerous objections to the child.[8] Bruch emphasizes that parents with high expectations of children are often found in work with caregivers, while criticizing and blaming the style of communication prevails in child's attempts in building an autonomous identity.[9] According to this author, the eating disorder is an individual's response to an inflexible parenting style in which an individual becomes extremely vulnerable to the expectations and needs of his parents, but at the same time he feels lost, empty, and helpless when faced with adolescent and childhood problems. Parents constantly deprive the child of his autonomy by deciding what is good and what is bad for him not allowing him to explore his own ways of joining the world and adapting to demands for adaptation, which as a result has a child's feeling of incompetence.

Mara Selvini Palazzoliand Salvador Minuchin were concerned with the family factors involved in the feeding disorder, who thought that specific family mechanisms contributed to the development of eating disorders. They have assumed that rigidity, the loss of boundaries between family members and their interdependence, too much involvement and avoidance of conflict with the presence of the child's psychological sensitivity and personality traits are the context for the development of the disorder and have tried to change the way the family function in their therapeutic approaches.[10] If we look at the family as a system, then the behavior of a member of a feeding disorder is seen in the context of a feedback relationship with the entire family system and we study how relationships among members contribute to the survival of the disorder. The system approach examines the behavior and psychological state of an individual by emphasizing the continuous impact that family members have on each other, from the very beginning of the child's life to the present moment, and takes into account the extent to which family interactions manage the range of behavior of each family member. In the system paradigm, each part of the system organizes the whole system, but also the other parts of it are organized.

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[8] Apparigliato M., Fiore F., Ruggiero G. M., Mezzaluna C., Lamela C., Sassaroli S. Parental criticism, responsibility and humiliation in eating disorders. In: S. Sassaroli & G. M. Ruggiero (Ed.), *Cognitive therapy of eating disorders on control and worry* (p. 79 - 93). (New York: Nova Science Publishers, 2011)

[9] Bruch H. *The golden cage: the enigma of anorexia nervosa.* (Cambridge, Mass: Harvard University Press, 2001)

[10] Zubery E., Latzer Y., Stein D. Family-based program focused on parents in outpatient ED care: cognitive behavioral methods combined with a psychodynamic approach in group settings. In: S. Sassaroli & G. M. Ruggiero (Ed.), *Cognitive Therapy of Eating Disorders on Control and Worry* (p. 121- 137). (New York: Nova Science Publishers, 2011).

According to a system approach, there are certain patterns of family organization that are related to the development and maintenance of feeding disorders, and the symptoms of a family member (a diseased child) play a role in maintaining a family balance, so the disorder is not defined only through the behavior of the affected individual but through interactions of all family members. Therefore, instead of studying the behavior of the affected individual alone, behaviors and communication patterns across the family are being studied and interactions and behaviors can be associated with maintaining the eating disorders in order to change these interactions and behaviors.

During childhood adolescence, children's intimate relationships interact with their parents, especially in relation to their mother, and the importance of fathers in the field of gender identification. In parental behavioral research, the dimensions of heat (parental care, support, encouragement) and control (parental compulsion, punishment, threat, emotional neglect) have been studied most often. Rohner's theory of parental acceptance and rejection assumes that parental heat is a dimension that has two halves. One finds parenting rejection, and second acceptance, and parents can be described as accepting or rejecting their accommodation in this dimension. Accepting parents express love, give praise, compliments and reward their child, while refusing to show aggression, indifference, and neglecting the child. Acceptance refers to positive emotional aspects of relationship between parent and child, characterized by mutual intimacy, support, trust and understanding, and a certain symmetry in relationships. Refusal refers to the child's perception of different parenting procedures ranging from misunderstanding and revelation to complexity, neglect and punishment. Neglect can be defined as a child's experience that parents are uninterested in him and that they do not devote enough time and attention to him, and punish as an improper accusation, inappropriate mistakes or caused by the disapproval of parents.

Hsu L.K. G. *Eating Disorders.* New York: The Guilford Press, 1990.

Palmer B. Concepts of Eating Disorders. In: J. Treasure, U. Schmidt, & E. Furth, (Ed.), *Handbook of eating disorders* (p. 1 - 11). Chichester: John Wiley & Sons, 2003.

Sullivan P. F., Bulik C. M., Fear J. L. "Pickering a Outcome of anorexia nervosa: a case-control study". *Am J Psychiatry*. Jul; 155 (7) (1998): 939 - 6.

Hoeken D., Seidell J., Hoek H. W. Epidemiology. In: J. Treasure, U. Schmidt, & E. Furth (|Ed.), *Handbook of eating disorders* (p. 11 - 35). Chichester: John Wiley & Sons, 2003.

Bäck E. A. Effects of parental relations and upbringing in troubled adolescent eating behaviours. *Eating Disorders*, 19, (2011): 1 – 22.

Ward A., Gowers S. Attachment and Childhood Development. In: J. Treasure, U. Schmidt, E. Furth (Ed.), *Handbook of eating disorders* (p. 89 - 103). Chichester: John Wiley & Sons, 2003.

Apparigliato M., Fiore F., Ruggiero G. M., Mezzaluna C., Lamela C., Sassaroli S. Parental criticism, responsibility and humiliation in eating disorders. In: S. Sassaroli & G. M. Ruggiero (Ed.), *Cognitive therapy of eating disorders on control and worry* (p. 79 - 93). New York: Nova Science Publishers, 2011.

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