DOWNLOAD PDF SELF-PRESENTATIONAL MOTIVES IN EATING DISORDERS

Chapter 1 : Self-Mutilation: The Truth Behind the Shame | HealthyPlace

Awareness of self-presentational motives may aid in early detection and treatment of those at-risk, thereby potentially reducing the incidence of eating disorders. Treatment of self-presentational concerns should be tailored to those characteristics that contribute to how the individual is regarded by others (Leary,).

Eating disorders are complex illnesses with a genetic component that can be affected by a wide variety of biological and environmental variables. Eating disorders include a range of conditions that involve an obsession with food, weight and appearance. It is estimated that over 10 million people in the United States suffer from eating disorders such as anorexia, bulimia, and binge eating disorder, and the statistics are growing. Research on the causes of eating disorders is constantly evolving, and we continue to gain increased insight into risk factors that may contribute to the illness. However, the answers remain multi-factorial, and they reflect a complex combination of biopsychosocial factors that may intersect differently for each person. Several major risk factors for eating disorders are outlined below. Genetics Increasing numbers of family, twin, and adoption research studies have provided compelling evidence to show that genetic factors contribute to a predisposition for eating disorders. This also means that eating disorders are heritable. Individuals who have had a family member with an eating disorder are times more likely to develop one themselves. Newer research is exploring a possible epigenetic influence on eating disorder development. Epigenetics is a process by which environmental effects alter the way genes are expressed. Temperament Some of the genes that have been identified to contribute to eating disorders are associated with specific personality traits. These aspects of personality are thought to be highly heritable and often exist before the eating disorder and can persist after recovery. Additionally, brain imaging studies have shown that people with eating disorders may have altered brain circuitry that contributes to eating disorders. Problems with the serotonin pathway have also been discovered. Trauma Traumatic events such as physical or sexual abuse sometimes precipitate the development of an eating disorder. In some cases, the eating disorder is an expression of self-harm or misdirected self-punishment for the trauma. Coping Skill Deficits Individuals with eating disorders are often lacking the skills to tolerate negative experiences. Behaviors such as restricting, purging, bingeing and excessive exercise often develop in response to emotional pain, conflict, low self-esteem, anxiety, depression, stress or trauma. In the absence of more positive coping skills, the eating disorder behaviors may provide acute relief from distress but quickly lead to more physical and psychological harm. Instead of helping, the eating disorder behaviors only serve to maintain a dangerous cycle of emotional dysregulation and numbing feelings. Effective treatment for the eating disorder involves education about and practice of alternative coping mechanisms and self-soothing techniques such as in Dialectic Behavior Therapy. In , a researcher documented the response of adolescents in rural Fiji to the introduction of western television. This landmark study illustrated a vulnerability to the images and values imported with media. Dieting Dieting is the most common precipitating factor in the development of an eating disorder. Restrictive dieting is not effective for weight loss and is an unhealthy behavior for anyone, especially children and adolescents. For individuals who are genetically predisposed to eating disorders, dieting can be the catalyst for heightened obsessions about weight and food. Dieting also intensifies feelings of guilt and shame around food which may ultimately contribute to a cycle of restricting, purging, bingeing or excessive exercise. More worrisome though is that dieting is associated with higher rates of depression and eating disorders and increased health problems related to weight cycling. Intuitive eating and the health-at-every size paradigms are recommended as alternatives to diets for people looking to improve their health and overall well-being. As more research is done on the diverse contributing factors discussed above, it becomes more and more clear that this is not the case. While stressful or chaotic family situations may intersect with other triggers to exacerbate or maintain the illness, they do not cause eating disorders. The Academy of Eating Disorders AED released a position paper that clarifies the role of the family in the acquisition of eating disorders. The paper points out that there is no data to support the idea that

eating disorders are caused by a certain type of family dynamic or parenting style. Alternatively, there is strong evidence families play an integral role in the recovery process. In particular, family-based treatment for younger patients, implemented early on in their illness, leads to positive results and improvements in conjunction with professionally guided family interventions. The family is an integral system in the healthy development of a child. While parents and families are not to blame for eating disorders, they can play a role in helping kids establish a positive body image, healthy coping skills and eating competence which are all important protective factors against eating disorders. The heritability of eating disorders: Curr Top Behav Neurosci. Shared genetic and environmental risk factors between undue influence of body shape and weight on self-evaluation and dimensions of perfectionism. An investigation of temperament endophenotype candidates for early emergence of the core cognitive component of eating disorders. Prospective predictors of the onset of anorexic and bulimic syndromes. Int J Eat Disord. Personality characteristics of women before and after recovery from an eating disorder. Neuroticism and low self-esteem as risk factors for incident eating disorders in a prospective cohort study. The biology of human starvation. Neurocircuity of eating disorders. Neurobiology of anorexia and bulimia nervosa. Lee Y, Lin PY. Association between serotonin transporter gene polymorphism and eating disorders: Threshold and subthreshold post-traumatic stress disorder in bulimic patients: Prevalences and clinical correlates. Posttraumatic stress disorder in anorexia nervosa. Body image, eating disorders, and the media. Adolesc Med State Art Rev. Spettigue W, Henderson KA. Eating disorders and the role of the media. Can Child Adolesc Psychiatr Rev. Television, disordered eating, and young women in Fiji: Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. This group is FREE and facilitated by a licensed clinician.

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Chapter 2 : Underlying Causes | The Center for Eating Disorders | Baltimore, Maryland

Self-presentation reflects the processes by which individuals attempt to monitor and control the impressions others form of them (Schlenker & Leary,). Concerns over impressions conveyed have.

This article explores the claims made by researchers about the relationship between OCD and eating disorders, particularly anorexia nervosa. Is there a Link Between the Two? Albert Rothenberg, a clinical professor of psychiatry at Harvard University, was one of the biggest proponents of the theory that anorexia nervosa is a manifestation of OCD. The foundations of his claims of how OCD and eating disorders are linked were his observations of the similarities in symptoms and traits of patients suffering from those illnesses. Among the similarities are the following: The obsessions, fears, and concerns of people suffering from anorexia nervosa have similarities with those who have OCD. Obsessive-compulsive symptoms are among the most recurrent and persistent symptoms of anorexia nervosa. The need for control allows them to develop and follow certain food rituals, such as chewing food longer than usual and cutting food in tiny pieces. An obsession on an ideal bodily shape and perfect appearance serve as motivating factors in adhering to a strict diet. In the same way, people with OCD have the intense desire to be in control of their thoughts, wishes, and motives. In fact, control is a core element of OCD. People who are OCD create rules for themselves that allow them to feel that everything in their life is in order. He believed that there are similarities in personalities of those who suffer from OCD and eating disorders. He described some of the traits evident in both illnesses such as rigidity, perfectionism, stubbornness, negativism, and excessive dedication to physical activity. Rigidity and Perfectionism Those who suffer from OCD and eating disorders follow rituals and self-imposed rules that allow them to achieve their goals. In the case of anorexics, their strict diet, obsession in counting calories and consuming only the total number of calories that they set for themselves is evidence of this. Adhering to these rituals enable them to achieve their ideal weight and gaunt appearance that they perceive as perfect. OCD patients are rigid about being in control of their impulses and actions; thus their compulsive rituals keep things in perfect order. Stubbornness and Negativism People with eating disorders have a negative attitude toward food; this is particularly true of anorexics. In addition, they are stubborn about keeping to the kind of diet that they impose on themselves. They tend to resist any interventions by concerned family members and friends. OCD patients display stubbornness as they cling to their compulsions, no matter how irrational they might seem to others. They become pessimistic or negative about being unable to take full control of themselves. Excessive dedication for physical activity Those with eating disorders have a strong desire to burn off calories by exercising excessively or by engaging themselves in a number of physical activities. In the same manner, OCD patients have several compulsions that require them to perform frequent and repetitive tasks, such as keeping things in order, repeated checking of doors and locks, and frequent cleaning of body parts, to name a few.

Chapter 3 : Self-Esteem and Eating Disorders

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Just like with eating disorders, self-injury is used as a coping mechanism in life. The prevalence of self-injury is unknown because many cases go unseen and untreated, but it has been estimated that about per , persons per year have problems with self-injury. Self-injury usually begins in late childhood and early adolescence, and although for some it becomes a chronic problem, most self-mutilators do not continue the behavior after years. However, self-injury can be a chronic problem if the situation that triggers the victim to cut or hurt themselves continues to stay in their lives. Sometimes there is the loss of a parent through death or divorce, or parental depression or alcoholism. Often the person who hurts themselves has rapid mood swings and suffers from some sort of depression, possibly even Bipolar Disorder. When it appears that the family is in good shape but yet a child still self-injures, perfectionism and the feelings of low or non-existent self-worth are the next possible explanations as to what triggers it. They then re-enact their abuse and lack of protection through a variety of self-harming behaviors and this is how self-mutilation can begin. The person who self-injures experiences an inability to tolerate intense feelings and often has trouble expressing emotional needs or experiences, which is where the injury comes in to help "end" or lessen the stress. A self-injurer may injure themselves as a way of empowering themselves, as well. The person feels strong and in control by enduring the pain that they inflict on themselves. This frequently is the motive with victims of eating disorders, as in both cases the feelings of unworthiness are there. Another theory is that the victim is constantly told that they are beautiful and that they will attract a lot of boys girls if it is a male and the person becomes afraid of being raped possibly again or victimized, so they create scars to hopefully scare away anyone who tries to come in contact with them. Just like with someone binging but not purging, prolonging a self-injurer from hurting themselves can cause them to experience symptoms such as agitation, paranoia, and irritability. Because of this, it is too hard in the beginning for any self-injurer to stop, at least immediately. Within those years the emotions causing you or someone you know to injure themselves could get even more severe and frequent and lead to suicide attempts and cause other disorders, like an eating disorder, to get worse. You can also cause yourself more harm than intended from infection. For someone with bulimia or anorexia this can easily cause their immune system to weaken even more and have the inability to fight off bacteria and viruses as fast as before the onset of their problem s , leaving the victim to be open to the problem of getting sick and not recovering for practically months! There are self-help techniques and centers out there for sufferers of this demon, although it is always up to you to WANT to stop and to learn different ways of dealing with your emotions. You must find out, in treatment and on your own, why you hurt yourself and then what triggers you to hurt yourself. Stay away from the triggers as much as you can, and also be prepared to distance yourself with healthy activities when the temptation to harm comes. Realize that replacing pain with another form of pain is not recovery, nor does it help you! You will always have the same empty and alone feeling the more and more you do this, and you DESERVE to not have to put up with any more abuse.

Chapter 4 : OCD and Eating Disorders: Exploring the Relationship Between Eating Disorders and OCD

The aim of this research was to examine the effect of eating habits and family flexibility on the body mass index in gifted students of the eighth and ninth grade of high school.

This is an Open Access article which permits unrestricted noncommercial use, provided the original work is properly cited. This article has been cited by other articles in PMC. Abstract Adolescent girls with eating disorders experience unattainable and contradictory expectations in daily life, which create stress and negatively affect their self-evaluation. Disordered eating may function as a way of seeking control and consistency. In order to make progress in the understanding of eating disorders, the aim of this study was to describe how adolescent girls with eating disorders reflect upon ways of dealing with sociocultural pressures in daily life. Eighteen interviews with girls aged 15â€”19 years were analyzed using a phenomenographic approach. The results were summarized into three conceptions: Within these conceptions, the participants described various strategies that could be used more or less effectively depending on the circumstances. A common theme was their difficulties in finding a balance between trying harder to live up to perceived expectations from others on one hand, and trying to accept the situation as it was, without trying to change themselves or the situation, on the other hand. The participants believed that their eating disorder was partly a result of being unable to deal with sociocultural pressures in an effective way, and they experienced a conflict between societal values of being assertive and values of being interpersonally oriented. Implications for treatment are discussed. Some of them also described their eating disorder as a means of communicating difficulties and eliciting care from other people. Adolescence is a time characterized by added preoccupation with image and concern with social acceptance. For adolescents whose self-evaluation is closely related to success and achievement instead of inner qualities, a fear of negative evaluation may prohibit discussing their problems with others and constrain effective and flexible coping. Social pressures from mass media, family, and peers have been shown to encourage social comparisons, internalization of a thinness ideal, over-emphasis on the importance of appearance, and body dissatisfaction in adolescent girls. It has been shown that recurring distressing experiences and conditions in daily life affect psychological health more negatively than isolated adverse life events. These perceived expectations were often contradictory, and the participants experienced considerable stress about how to balance between them. Consequently, sociocultural pressures concerning appearance, behavior, and performance are likely to be daily influences that impact powerfully on adolescent girls. However, empirical studies on how patients with eating disorders deal with sociocultural pressures in daily life are scarce. Thus, the aim of this study was to describe how adolescent girls with eating disorders reflect upon ways of dealing with sociocultural pressures in daily life. Methods Participants and procedure Data for this study were obtained from interviews with girls who had been accepted for treatment at an out-patient unit at a specialized eating disorder service in Sweden. A total of 31 girls were asked to participate in the study, and 18 of them accepted. Participants were between the ages of 15 and 19 years, and all of them were diagnosed with an eating disorder according to the Diagnostic and Statistic Manual of Mental Disorders DSM-IV. Six participants reported binge eating. The remaining four participants were girls of normal weight who frequently purged after eating normal amounts of food as a means of weight control EDNOS type 4. Ten of the girls were living with both parents, five alternated between living with their mother and their father, one was living with an older sister, and two were living with their boyfriends. Nine of the girls were living in a Swedish middle-sized city population , , and the remaining girls were living in smaller towns or in the countryside. Four of the girls were still in high school, and the remaining girls represented a broad range of higher education. One girl had immigrated to Sweden and another had parents who had immigrated to Sweden. A purposeful selection was made to ensure a variety of diagnoses, ages, living conditions, school backgrounds, and interests. The girls were given verbal and written information about the study. The first author contacted the girls who agreed to take part in the study, and an appointment was made at a time and

place that suited the girl. The first author conducted all the interviews, each lasting 35â€”65 minutes. Each interview was tape-recorded and transcribed verbatim. The inclusion period was between November and March A checklist was used to ensure that important topics were covered, and the participants were encouraged to speak freely about each topic. In doing so the girls spontaneously began to reflect upon various ways of dealing with sociocultural pressures. Therefore this study was divided into two. Data analysis A phenomenographic research approach was used. Focus is then upon the way in which the studied phenomenon is perceived ie, second order perspective. According to phenomenography, every phenomenon or situation that a person encounters may be understood in a limited number of qualitatively distinct ways. These are represented by different conceptions of the phenomenon. The results of a phenomenographic study consists of the various conceptions and the relations between them. This is known as the outcome space. In the third step, these preliminary groups were discussed and compared in a process of negotiated consensus. In the final step, each statement was discussed and grouped in relation to the outcome space. This process resulted in descriptions of the unique character of each conception and the relations between them. The results are presented with citations that clarify the specific character of each conception. Brackets enclosing three dots ie, [The names of the participants have been changed to protect their privacy. Findings All of the participants experienced difficulties in dealing with sociocultural pressures effectively, and nearly all of them believed that their eating disorder was at least partly a result of these difficulties. Several described how, once their eating disorder had become established, they used it to reduce anxiety and create a feeling of control. It kind of evened things out in a way Tina, 16 years. The participants described three qualitatively different conceptions of dealing with everyday expectations. Conception A regarded striving to be oneself, conception B had to do with adapting to various situations, and conception C involved presenting oneself in a positive light. Most of the participants made use of all three strategies, but in varying degrees and with variable success. Conception A was described by the participants as the most desirable, but also the hardest. Conception B was not given a positive or negative evaluation as long as it worked, but when it did not work the participants described this way of relating negatively. Conception C was described in a negative way, as being weak, false, or immature and not daring to be oneself. This meant standing for who they were without pretence, setting themselves realistic goals, daring to say what they felt, and marking boundaries towards others if they felt that their own needs or wishes were in conflict with those of others. This was described to require a concerted and conscious effort. Feel secure in yourself and trust yourself, then I think you manage most things and it feels good. The participants tried to find a way of relating in which they would not rub others up the wrong way but in which they could still stand up for their own behavior. They tried to consider how their behavior affected other people. One way of doing this was to put aside their own needs, if they felt that this would give the best outcome for someone else or several of those in the group, even if this cost a lot of energy. Maybe something will happen that everyone will talk about and yeah. This meant largely being happy, making an effort to look good, and giving the impression that one succeeded with things. The participants evaluated these strategies negatively. Yet all of the participants described several situations in which they used strategies in conception C, and many described how these strategies worked well in certain situations. It was for my own sake or because I wanted to feel I looked good when I saw myself in the mirror and yeah, feel that I This often resulted in a situation where they struggled really hard to achieve something, and although they initially succeeded, instead of feeling satisfied with themselves they felt that this only increased the expectations and they had to try even harder to reach an even higher level in the future. It gets more and more intense. Like it never ends. Everything is about climbing higher and higher: Eventually the standards were set so high that the participants inevitably failed to live up to these perceived expectations, and then they were afraid to try again because they were afraid of failing again. When they reached a point where they could no longer change themselves or the situation to fulfill these high expectations, they described that they gave up and felt like failures. Either I fight really hard to get it just perfect or I give up Linda, 18 years. In some situations, the participants felt discouraged from some options, based on their gender: Thus, regardless of whether they used

strategies from conception A striving to be oneself , conception B adapting to various situations , or conception C presenting oneself in a positive light , they appeared to struggle with these contradicting sociocultural pressures and with finding the right balance between different strategies to deal with them. Discussion The participants described three qualitatively different conceptions of dealing with sociocultural pressures in daily life. These three conceptions can be hierarchically ordered according to how desirable the participants felt that they were. Conception A striving to be oneself was described by the participants as the most desirable, but also the hardest. Adapting to various situations conception B was regarded as obvious when it worked. However, none of the participants described an interpersonal orientation as being a resource. Instead, they noted when it did not work and they then viewed their consideration for others negatively. Trying to deal with perceived expectations by presenting oneself in a positive light conception C was described in negative terms. However, all of the participants described situations in which this strategy was successful. They tended to initially struggle really hard to live up to perceived expectations from others, and they described that even if they succeeded, the pressure they felt did not diminish because the expectations upon them were then raised for the next time. When the standards eventually became too high, they described a fear of failing, which resulted in a tendency to avoid trying at all next time. This way of dealing with the situation was not interpreted as a plausible way of dealing with the situation, by accepting the situation and themselves as they were; instead they interpreted it as giving up, and they evaluated themselves negatively and as a failure. Most participants described that their eating disorder contributed in the short term to reducing anxiety and giving a feeling of control. The participants struggled with balancing the three conceptions of dealing with sociocultural pressures described in this study. Many of the participants said they felt they should set firmer limits for those around them, lower their high demands, and accept themselves as they were. The feeling they had of being unable to do this contributed to feelings of guilt and negative self-evaluation, since their wish to be themselves conflicted with values of being interpersonally oriented and showing consideration of others. For example when Tina explains that not eating can even things out when she feels that she has failed in something, we suggest that the treatment needs to address contradictions and pressures in her daily life, and explore and discuss what functions the eating disorder fulfils and how to find other, less harmful ways to reduce stress. It may then be clear that interpersonal skills, such as readiness to adapt in order to find solutions that suit everyone, or choosing to show positive sides of oneself are also important resources, and they are necessary in both working relations and personal relationships. She lowers her expectations and thereby reduces the pressure upon herself; she is less at risk of disappointment than if she was to invest fully and fail. But this is also an illustration of how gender stereotypical expectations influence people and make choices more or less functional. We mean that this situation should not be interpreted as an individual dysfunctional coping strategy, but should rather be addressed on a societal level.

Chapter 5 : Self-presentation can be hazardous to your health: impression management and health risk.

Thus self-presentation motivation appears to have an influence on females who have an eating disorder and those at risk for an eating disorder. Potential applications of the influence of self-presentational motives on eating disorders and future research directions are discussed.

Abstract The objective of this experiment was to determine if gender or self-esteem contributed to the development of eating disorders. The study involved a total of students who participated by completing a survey used to examine self-esteem, dietary habits, and experience with eating disorders. Results found that participants who reported higher self-esteem also reported less experience with eating disorders. Additionally, it was found that females rated themselves lower for self-esteem and were more likely to report experience with an eating disorder than did males. These results indicated a significant correlation between self-worth and eating disorders, as well as a significant correlation between gender and self-esteem, and gender and eating disorders. Therefore, it can be said that both hypotheses were supported within this sample, suggesting that students with high self-esteem are less likely to have an eating disorder, and that women are more likely than men to suffer from eating disorders. It has been known that gender, self-esteem, body image, and perceived self-worth seems to be related to dietary habits and eating disorders; but researchers have wanted to understand the relationship more clearly, comprehending the degrees to which they interact with each other. Many research studies have presented the idea that those who suffer from an eating disorder are more likely to have lower self-esteem than those who do not have an eating disorder e. These studies and others have shown that eating disorders are associated with lower levels of self-esteem and perception of self-concept. Additionally, research regarding the impact of gender on self-esteem has continually supported the idea that women are more likely than men to report lower levels of self-esteem and endorse eating disorders e. Although much research has been conducted to show the degrees of relation between self-esteem, gender, and eating disorders among various populations, few studies have attempted to find these correlations among college students. The motivation that prompted this research study was to determine if students with higher self-esteem were less likely to develop eating disorders and to understand the impact of gender on self-esteem and eating pathology. For example, de la Rie, Noordenbos, and Furth sought to measure the quality of life of eating disorder patients and former eating disorder patients. The purpose of this study was to investigate whether the quality of life differs between four diagnostic groups: To do this, the experimenters administered a generic health-related quality of life questionnaire, the Short Form, and the Eating Disorder Examination-Questionnaire to eating disorder patients 44 anorexia nervosa patients, 43 bulimia nervosa patients, 69 eating disorder not otherwise specified patients and former eating disorder patients, all recruited from different parts of the Netherlands by various means. A limitation of this study was that participants were not asked to report on whether or not they had comorbid disorders. Another limitation was that the advertisements to participate in this study may have appealed especially to those who have received treatment for eating disorders. The results of the de la Rie, Noordenbos, and Furth study indicated that eating disorder patients had significantly poorer quality of life measures than the former eating disorder patients on the Short Form subscales of Physical Role Functioning, Emotional Role Functioning, Vitality, General Health Perception, Social Functioning and Mental Health. Additionally, no significant differences were revealed between eating disorder diagnostic groups with regard to the quality of life, except on General Health Perception. Anorexia nervosa and eating disorder not otherwise specified patients reported poorer quality of life than former eating disorder patients on General Health Perception, but not bulimia nervosa patients. Higher self-esteem was associated with a higher score on General Health Perception and with a higher score on vitality. These findings presented that self-esteem showed the highest association with the quality of life of both eating disorder patients and former eating disorder patients. Previous studies have sought to observe to correlations of self-worth and eating disorders. On the contrary though, not many have researched these in

regard to college students. Hesse-Biber, Marino and Watts-Roy conducted a longitudinal study to determine whether women in the college population who suffered from eating disorders during their college years would recover during their post-college years. The participants, who included women in the original population, were asked to answer questionnaires during their sophomore and senior years of college. Later, the twenty-one participants that continued for the duration of the six-year study were engaged in in-depth interviews that covered a wide range of psychological, environmental, developmental, and sociocultural factors. A limitation of this study was that the researchers relied on qualitative data rather than hypothesis testing and replication of past studies. After the interview, participants answered a short questionnaire, which dictated demographic information and used continuum scales to measure eating patterns. The Eating Habits Scale consists of five categories: Women in the study were placed in these categories during three different points in time: The Changes in Eating Habits Scale measured changes in individual eating patterns from the sophomore year to the senior year and from the senior year to two years post-graduation. It was designed to capture the ways in which eating patterns could change. The researchers Hesse-Biber, et al. For those that remain at risk, their relationships are described as tense, dissatisfaction was reported in the autonomous realm, and the women expressed self-doubt and a diminished self-esteem. The participants were a volunteer sample with a total of participants, with ages ranged from seventeen to thirty-two years and body weights ranged from ninety to pounds. The results indicated that undergraduate women were more likely to endorse eating disorder pathology. Additionally, the hypothesis was supported, that minimal unique variance was found in eating disorder behaviors explained by depression after controlling for maladaptive social comparison, body satisfaction, and low self-esteem. A limitation of this study was its exclusive reliance on self-report measures and failure to incorporate biological and sociocultural predictors. There are many steps in recovery from an eating disorder, including biological, psychological, social, behavioral, and emotional aspects. Additionally, research by Bardone,-Cone, Schaefer, Maldonado, Fitzsimmons, Hamby, Lawson, Robinson, Tosh, and Smith provides support that an improved self-concept may be an integral part of full eating disorder recovery. In an experiment that focused on measures of self-esteem, self-efficacy and self-directedness, these researchers hypothesized that individuals fully recovered from an eating disorder would have higher self-esteem, self-efficacy and self-directedness than individuals partially recovered from an eating disorder or those currently meeting criteria for an eating disorder. Participants included ninety-six current and former female eating disorder patients from the University of Missouri Pediatric and Adolescent Specialty Clinic and sixty-seven healthy control participants who were aged sixteen and older with no current or past eating disorder symptoms. Results indicated that the healthy controls and fully recovered group did not differ significantly in global self-esteem, self-efficacy, or self-directedness. The nature of this study made the experimenters able to examine self-concept variables across various stages of an eating disorder: Ross and Wade presented a study in which they investigated mediational processes by which variables may work together to increase the likelihood of dietary restraint and uncontrolled eating, directed by the framework suggested by the cognitive model. A self-image questionnaire was distributed to participants, who were asked to indicate the answer which was true for them at that particular moment in time. Their individual Body Mass Index was also calculated. Concerns about weight and shape, dietary restraint, and uncontrolled eating were measured using the Eating Disorders Examination-Questionnaire, where higher scores are indicative of higher degree of restrained eating behavior, and the Eating Disorders Inventory-2, where higher scores are indicative of a higher degree of uncontrolled eating behavior. Results of this study indicated that BMI, externalized self-perception and self-esteem together accounted for Self-esteem and weight shape concern together accounted for Dietary restraint did not mediate the relationship between weight and shape concern and uncontrolled eating. In a study conducted by Tchanturia, Troop and Katzman , women from Georgia completed a number of questionnaires to determine whether weight and shape affect self-esteem and self-worth for women of non-Western countries as much as it affects those of Western countries. The questionnaires, measuring eating pathology, anxiety and depression, as well as two measures concerning their

evaluation of weight and shape in relation to self-esteem, were distributed to the participants. Both overvaluation of weight and shape and shape- and weight-based self-esteem were significantly correlated with measures of eating deviations. In addition, the of the women desired a smaller body shape. However, despite these associations, the overall degree to which women based their self-esteem on weight and shape was less than that reported in Western-based studies. Katsounari conducted a cross-cultural study to examine two psychological variables â€" self-esteem and depression â€" and their relationship with eating disturbance in two different cultural contexts, Cyprus and Great Britain. Participants consisted of randomly selected women, seventy from Great Britain and seventy from Cyprus, who ranged from nineteen to twenty-five in age and who were born and raised in Great Britain and Cyprus, respectively. Selection criteria required the Cyprus females to be able to read English. It was hypothesized that the women participants of Cyprus would have lower scores in the self-esteem scale and higher scores in the depression scale, suggesting higher disturbed eating attitudes than the British sample. Variables were operationalized using the EAT Eating Attitudes Test , wherein participants respond to forty questions on a six-point frequency scale support to this measure of assessment is present in both Western and non-Western populations , the Beck Depression Inventory, which serves as the most prominent and frequently cited self-report of depression, and the Battle Culture-Free Self-Esteem Inventory for Adults, which measures perceived self-worth in three subscales: For both samples, a positive relationship was found between depression and eating disordered attitudes, which was found to be significant. On a more specific note, not many studies have focused on male participation in studies measuring eating disorders and self-esteem. Even further, a rare amount has included transsexual subjects, as most of the studies seem to involve women only. Participants consisted of participants in total, including eighty-eight self-identified male-to-female MtF transsexuals, forty-three female-to-male FtM transsexuals, sixty-two females with an eating disorder, fifty-six male controls, and female controls. Results of the study conducted by Vocks et al. Additionally, FtM displayed a higher degree of restrained eating, weight concerns, body dissatisfaction and body checking compared to male controls. Even more, participants with GID showed higher depression scores than did the controls, though no differences concerning drive for muscularity and self-esteem were found. One implication of this study was that the participants were self-identified transsexuals, not diagnosed by the researchers, so therefore it cannot be known for certainty that each participant fully met the criteria for GID according to the DSM-IV-TR. This study is important because it speculates that people with GID might be at a higher risk of eating disorders, therefore prevention programs should be implemented to help people with GID to avoid developing an eating disorder. Another study, conducted by Roberto, Grilo, Masheb, and White , aimed to compare bulimia nervosa, binge eating, and purging disorder on clinically significant variables and examine the utility of once versus twice-weekly diagnostic thresholds for disturbed eating behaviors. Participants in the study consisted of female community volunteers chosen from a total of respondents who discovered the study through various websites. Participants were asked to self-report on questionnaires including the Eating Disorder Examination Questionnaire, the Three Factor Eating Questionnaire, which looks at cognitive restraining, disinhibition of control over eating, and perceived hunger, the Questionnaire for Eating and Weight Pattern-Revised, the Beck Depression Inventory, The Rosenberg Self-Esteem Scale, and self-reported demographic information, height and current weight were also collected. The results of this study indicated that bulimia nervosa was a more severe disorder than binge eating disorder and purging disorder. Additionally, the three disorders differed significantly in self-reported restraint and disinhibition; the bulimia nervosa and binge eating disorder groups reported higher levels of depression than those of the purging disorder. Also, for bulimia nervosa, participants that engaged in behaviors twice-weekly rather than once-weekly were more symptomatic in their responses. In trying to examine the effects of anger, perfectionism, and exercise on eating pathology among college women, Aruguete, Edman, and Yates conducted a study involving students of a California community college who varied in ethnicity and were unaware of the purpose of the study. The procedure involved a series of survey questions that measured trait anger and suppressed anger, eating pathology, exercise commitment, and

perfectionism. Lastly, perfectionism was assessed using two subscales from the Multidimensional Perfectionism scale: After performing bivariate correlations to test whether anger, perfectionism, and exercise commitment would be correlated with eating pathology, Aruguete et al. The results indicated that exercise and perfectionism but not anger showed significant associations with eating pathology. Additionally, they found that anger did not independently predict eating pathology, but that trait anger was negatively associated with exercise commitment and that anger would independently predict perfectionism. Each group included male and female participants, and the mean age was Though the Eating Disorder Examination has been supported in prior research to be valid and reliable among Asian cultures, the researchers sought to examine its reliability in a specific population of central China after having it translated to Mandarin. The researchers distributed the CEDE to all participants to evaluate the reliability and validity in the study population. The reliability indicators were internal consistency, inter-examiner reliability and test-retest reliability. The validity indicators were content validity, criterion validity and discrimination validity. The researchers found the internal consistency, test-retest reliability, and inter-examiner reliability of the CEDE to be quite high, indicating that the CEDE has high validity and reliability for the study of eating disorders in Mainland China. Additionally, they found that the clinical features of eating disorders among this population are essentially similar to those of other cultures. They wanted to analyze the riding style of the athlete and academic status, along with perceived body image disturbances. The study was cross-sectional and included volunteer participants of seven universities throughout the United States. A questionnaire was used to acquire basic and demographic data, such as academic status and equestrian background, and participants also self-reported their height, current weight, lowest weight, and ideal weight. Following, the researchers administered two surveys via email to the participants. The first was the Eating Attitudes Test, which was used to screen for eating disorder characteristics and behaviors; the test includes three subscales: The second, the Figural Stimuli Survey, was used to asses body disturbance based on perceived and desired body images; the survey is a scale involving sex-specific body mass index figural stimuli silhouettes associated with Likert-type ratings of oneself against nine silhouettes. Chi-square analyses and multivariate analyses of varies were run to examine the data. Based on the Eating Attitudes Test, estimated eating disorder prevalence among the participants was The experimenters found that no body mass index or silhouette differences were found across academic status or riding style in eating disorder risk.

Chapter 6 : Four Types Of Borderline Personality Disorder (Video) | Therapy Soup

Title / Author Type Language Date / Edition Publication; 1. Self-presentational motives in eating disorders: a known groups difference approach. 1.

Chapter 7 : Self-presentational motives in eating disorders : a known groups difference approach - CORE

Trait and self-presentational dimensions of perfectionism were examined in women with anorexia nervosa (AN), a psychiatric control group of women with mood disorders, and a normal control group of women without mental disorders. With one exception, self-report measures and interview measures.