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Psychosocial Determinants of Eating Disorders and Challenges Encountered in Treatment Processes

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ABSTRACT: This study aims to investigate the psychosocial effects arising from eating disorders, the underlying causes of the difficulties encountered in treatment processes, how social functioning affects individuals' lives, and the importance of social functioning. Eating disorders are a significant category of conditions that have become increasingly prevalent in recent years, rapidly increasing the incidence of chronic illness, and significantly affecting individuals' physical and psychosocial functioning whilst substantially reducing their quality of life. Eating disorders, which encompass a wide range of conditions, are primarily classified as 'Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED)'. Numerous clinical studies have been conducted on eating disorders, and by detailing the underlying causes, insights into emerging psychopathologies have been gained.

KEYWORDS: Eating disorders, common conditions associated with eating disorders, psychosocial determinants, functioning, treatment processes.

INTRODUCTION

Nutrition, a fundamental requirement for human survival, has in recent years gone beyond mere necessity and given way to eating disorders. This distorted attitude generally has a negative impact on individuals' health, reaching the level of a disorder. As research conducted by the World Health Organisation indicates, many countries are facing this problem, which poses a threat to public health in general. It has been observed that eating disorders, which serve as a precursor to many illnesses and manifest in vastly different ways in people, have numerous effects on individuals. Numerous studies and investigations have identified various forms of eating disorders in individuals. Whether it involves binge eating, deliberate vomiting out of fear of weight gain, intense exercise regimes, or the emergence of forms characterised by loss of appetite, these manifestations are clear indicators that eating disorders have now reached the level of a disease. In recent years, the widespread use of 'slimming pills' and the reckless use of 'slimming injections' and diuretic drugs have caused serious harm to human health. Research has classified eating disorders into distinct categories, and it has been observed that patients exhibiting certain characteristics align with these categories. These classifications have served as a guide to the diagnoses outlined in the World Health Organisation's "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)" published by the American Psychiatric Association. According to data from the field of psychiatry, eating disorders are among the conditions with the highest mortality rates, and it has been observed that they significantly impact an individual's future quality of life. It is known that eating disorders, which are influenced by many different factors, negatively impact individuals' social relationships and family life. Findings related to eating disorders are particularly common in young adults and early adolescence. This situation affects not only individuals' family and social relationships but also their academic lives and potential professional careers in a negative way.

It is known that numerous factors play a role in the onset and development of eating disorders. Both psychological and biological factors contribute to the causes of this condition. The primary factors include family-related factors, environmental factors, obsessive preoccupations with body image and weight, social media and visual media, and in some cases, genetic and hormonal factors. Although an eating disorder is a psychiatric condition, it is also a condition with a very high likelihood of relapse. Psychiatrists argue that individuals who have undergone treatment are likely to experience a recurrence of the eating disorder later in life; they also state that individuals experiencing this condition have typically suffered from at least one other psychiatric disorder.

What is the Definition of Eating Disorders?

Eating disorders are psychiatric conditions that can lead to serious physical health risks and endanger a person's life. Characterised by an individual's constant efforts to control their weight or by eating patterns that exceed normal levels, these conditions—which can develop alongside such emotions—have become one of the most significant areas of focus within the field of psychiatry.

Alongside these clinical features, it is observed that patients have experienced severe traumatic events in their lives and, due to body dissatisfaction, are constantly preoccupied with the need to control their body weight. These psychiatric disorders, which target a specific age group, are particularly common among adolescents and young adults. Whilst it is known that they are more frequently observed in women from an epidemiological perspective, it has been noted in recent years that they are also beginning to appear in men. (Zilifli, Karaaziz, 2024) Eating disorders, which come in various forms, vary from person to person. The attitudes a person may develop, sometimes influenced by depression, along with various unusual behaviours, cognitive awareness, changes in eating behaviour and physical changes, are the most fundamental symptoms observed in eating disorders. Whilst the behaviours of patients with eating disorders develop in various ways, frequently stepping on the scales, becoming obsessed with weight, becoming dependent on carbohydrates and following a carbohydrate-heavy diet (such as a monotonous diet), frequent dieting or the urge to binge eat, night-time snacking, and waking up from sleep to eat—all of which cause serious disruptions to the eating system whilst also paving the way for the individual to develop the condition.

In addition to these, it has been observed that patients with eating disorders develop other unusual behaviours. In recent years, these include the use of weight-loss injections and medications, diuretic drugs, self-induced vomiting after meals, excessive exercise and dependence on it, frequent consumption of appetite-suppressing foods or herbal tea derivatives, waking from sleep due to sudden night-time eating binges, cravings for sweets or carbohydrate cravings, or a restricted diet are cited as examples of such unusual behaviours. It has also been observed that these abnormal behaviours create certain negative consequences for individuals. Calculating the calories of every food item, frequently thinking about eating, preparing high-calorie foods that one will not eat, and frequently thinking about food on a cognitive level are among the primary factors driving an individual towards a state of illness. The fact that patients with eating disorders frequently think about food and eating can reduce their concentration on their work or other activities, damage their social life, affect their family life, create weaknesses in family bonds, and make it easier for the individual to become psychologically worn down over time. For example, family dinners eaten together in the evenings may be replaced by the individual's own scheduled meals, and they may stop sitting down to eat with their family; this situation also negatively affects the individual's family life. Another example is that when an individual is intensely preoccupied with dieting, they may eventually lose interest in their hobbies entirely. In such cases, the individual, whose mental health has been eroded, may begin to exhibit changes in behaviour and display a more depressive attitude. They may respond harshly to any criticism directed at them and may succumb to a binge-eating episode in that moment. On the other hand, a behavioural pattern that dominates the individual's thoughts is observed. These changes also include denying hunger to appear more attractive and slimmer in their social circle and to avoid negative criticism, disliking their own appearance , and statements such as: "If I could just lose a bit of weight around my stomach, I don't like the sagging on my arms, I have cellulite on my legs'—are among the most accurate examples of cognitive distortions regarding body and weight control. Dietary control alone may not be sufficient for individuals. The individual may not merely fixate on physical changes; poorly executed diets can cause deep-seated damage to the body, and associated misconceptions about food can lead to muscle loss. Consequently, due to potential complications, the individual may also refuse medical intervention. They may become fixated on a single way of thinking and, in this sense, remain closed to any form of assistance; they are also resistant to healthy eating. Individuals with other types of eating disorders, on the other hand, may engage in the act of consuming uncontrolled portions by refusing the help offered to them. The development of numerous illnesses associated with eating disorders is a common occurrence. The World Health Organisation (WHO) defines 'obesity' in the context of binge-eating disorders as 'abnormal or excessive fat accumulation that poses a health risk'. (Demirci and Özkan, 2025) Obesity is a significant risk factor for numerous non-communicable diseases. These include cardiovascular diseases, diabetes, musculoskeletal disorders, metabolic syndrome, and certain types of cancer (endometrial, breast, ovarian, prostate, liver, gallbladder, kidney and colorectal cancers). (Demirci and Özkan, 2025) Furthermore, in cases of severe malnutrition, physiological losses resulting from the loss of muscle and abnormal fat mass may lead to conditions such as amenorrhoea, hypothermia and bradycardia, as well as associated cardiac disorders. It is known that these conditions are often preceded by behaviours such as self-induced vomiting.

Developmental Stages of the Psychopathology of Eating Disorders

The stages of an eating disorder, which arise from a combination of many factors, typically begin with recurring cycles. It is understood that these evolve into a multi-layered process involving genetic predispositions, psychological processes, and environmental and social pressures. The first stage of this process, which often begins with dissatisfaction with one's body image, is the point at which one starts dieting. Over time, the inability to sustain the diet, coupled with efforts to control changes in body perception, creates a vicious cycle, leading the individual to become obsessed with repeatedly starting and restarting the diet. Chronicity facilitates the individual's psychological breakdown and serves as an indicator that the condition has progressed to advanced stages. In this sense, early intervention for the individual facilitates protection against potential relapses and helps prevent this situation from becoming a festering wound. It is known that, globally, the mortality rate associated with this mental disorder is very high, and it has become a trigger for many other conditions that may develop as a result. The most important and primary factor in the developmental stages is known as 'predisposition'. Rather than stating that this genetic predisposition is entirely decisive, we

can say that it carries a risk. In particular, a predisposition inherited from the first generation may be a factor in eating disorders. In another possible scenario, it is known that hormonal changes during adolescence—particularly in the release of 'happiness hormones' such as serotonin, dopamine, oxytocin and endorphins—can cause significant alterations. A constant need for body control, an 'all-or-nothing' mindset (such as binge eating or starving oneself completely), a loss of self-identity (often prioritising others' opinions over one's own), and a desire for perfection.

Authoritarian attitudes and critical behaviour originating within the family, the 'perfectionism' label imposed by parents from childhood (regarding success and physical appearance), peer bullying as a sociocultural factor, and traumatic events experienced during puberty emerge as behavioural patterns that lead to eating disorders in an individual's life.

Another developmental stage is the "onset of triggering". During adolescence, the intensification of stress factors experienced by the individual alongside hormonal changes, coupled with the diverse body images seen on social media and the internalisation of these, weight gain that cannot be accepted alongside physical growth, the end of a romantic relationship, social pressure and peer bullying are the most significant triggering factors. There is also a tendency to attribute the consequences of academic failure to one's own body. As these triggering factors converge, the individual begins to feel dissatisfaction with their body, and it is known that the first inclination towards dieting, self-loathing, and harsh treatment of one's body begins precisely at this point.

Another factor is 'cognitive distortions'. This refers to the situation where an individual limits their self-worth to their weight. The constant connection with mirrors, feelings of dissatisfaction with one's body, and thoughts such as 'I must not gain weight', 'I won't be liked if I gain weight', and 'I am only valuable if I have a perfect body' all contribute to these cognitive distortions. In this process, which begins with dieting, body image is progressively triggered, transforming into a perception of life itself.

Once this stage is reached, it is very clear that psychopathological issues begin to emerge. These psychopathological factors are known as established behavioural patterns and 'patterned cycles'. Repetitive behavioural patterns create behavioural patterns and cognitive distortions within a specific cycle. Dieting often begins; the individual, who is constantly preoccupied with the mirror and scales, resorts to constantly starving themselves. Strict diets are followed, leading to binge-eating episodes at the end of the diet, feelings of guilt, and the individual attempts to compensate for this guilt through excessive exercise, laxative use, or vomiting. The individual believes that they have achieved mental peace and happiness during the periods when they lose weight within this vicious cycle.

With the development of psychopathologies, the individual has now entered a chronic phase, and *the 'chronic process'* has become a defining factor. The psychological and physiological conditions the individual experiences have begun to become chronic, and their effects on the body have started to increase to a noticeable degree. The individual exhibiting depressive symptoms, entering a process of social isolation, becoming withdrawn, experiencing cardiac and heart-related problems, anxiety disorders, obsessive-compulsive disorders, the occurrence of secondary amenorrhoea, and the inability to perform daily life functions are all causes of the development of chronic conditions.

Psychopathological conditions have begun to become increasingly apparent during this process, and the individual is making steady progress in maintaining their behaviour. *'Behavioural continuity'* is another psychopathological condition. By adopting the behaviour of starvation, the individual establishes this as a routine, making them feel more successful and self-assured. The individual's withdrawal reaches an advanced stage in this context, further increasing social isolation. This situation, which is not limited to the social environment, intensifies by avoiding contact with family members, leading to conflicts. Believing that self-confidence and success are inseparable, the individual does not wish to relinquish the control they have gained. The individual believes they have found themselves and seeks to create their identity by clinging tightly to the body they imagine.

Psychiatrically, the likelihood of comorbidity increases significantly, and various mental health conditions may begin to emerge in the individual. *'Psychiatric comorbidity'* represents the final stage of the psychopathology that can develop in this eating disorder. The individual fails to recognise the harm they are inflicting upon themselves, focusing solely on their body image. As this condition becomes chronic, depression, major depression, obsessions, the transformation of obsessions into anxiety, and obsessive-compulsive disorders may begin to appear, sometimes in isolation and sometimes as comorbidities. At this stage, the time has come for psychiatric intervention, and not only the individual but also the family with whom they live must accompany them through the therapeutic process.

Fairburn has commented on this issue as follows: "It is difficult to assess the personalities of patients with eating disorders because many relevant traits are directly influenced by the presence of the eating disorder. In particular, it is thought that certain personality traits (perfectionism and low self-esteem) are common and are generally clearly evident before the onset of the eating disorder". (Fairburn, 2008)

Types of Eating Disorders

Eating disorders are categorised into three main groups. These are classified as "Anorexia Nervosa", "Bulimia Nervosa", and "Eating Disorders Not Otherwise Specified". Alongside these, "Pica" and "Rumination Disorder" are eating disorders that, although rare, can occur. In a psychological context, eating disorder subtypes that emerge alongside personality disorder diagnoses are particularly characterised by the individual's body weight and body image obsessions.

Psychosocial Determinants of Eating Disorders and Challenges Encountered in Treatment Processes

Anorexia Nervosa

Anorexia Nervosa (AN) is a serious psychiatric disorder characterised by individuals resisting the act of eating and placing excessive importance on their body weight and body shape. For patients with this condition, the desire to control their weight takes precedence over their appetite. The individual's healthy and regular appetite is replaced by thoughts of resisting food, aiming to reach a specific weight, and living in constant preoccupation with scales. Whilst completely refusing to eat is a common behavioural pattern for those with anorexia nervosa, it is a disorder characterised by an unhealthy body image. Whilst attempting to maintain weight control, individuals resort to any method they believe might compensate for this, thereby employing all manner of unhealthy practices. For example, engaging in excessive exercise. To diagnose this condition, the individual must not fall below a certain body weight threshold.

According to the DSM-5 (the Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychiatric Association), weight is classified as:

- Underweight: BMI > 17 kg/m²
- Moderate: BMI 16–16.99 kg/m²
- Severe: BMI 15–15.99 kg/m²
- Extremely severe: BMI < 15 kg/m²

The onset of this condition can be traced back to adolescence (ages 12–18). It is observed that dietary restrictions and the body image formed in the brain begin during these years. Particularly in young people who are slightly overweight or have a history of obesity during this period, it is observed that behaviours and thoughts such as low self-esteem are prevalent, often stemming from experiences of being mocked, looked down upon, humiliated and excluded by their social circle. Anorexia nervosa is characterised by a strong association with these forms of treatment or the emergence of mental health disorders during adolescence. It is known that adolescents diagnosed with anorexia nervosa are unable to complete their development in a healthy manner, and that growth in height and weight does not occur. Whilst it is known that adolescents begin to restrict their food intake during this period, it is also observed that they exhibit behaviours that suggest they are punishing themselves. It is understood that these young people's desire to be liked, accepted within their social circles, and to seek approval leads them to place even greater importance on their physical appearance. The primary causes include pressure from the family, particularly the creation and emphasis of gender roles and the highlighting of what it means to be a woman, as well as the presence of familial pressure on male adolescents; the creation of perceptions of thinness in visual and social media; and environmental pressures and factors, all of which contribute to adolescents being more heavily influenced. They adopt and develop a perspective that beauty is achievable only through thinness and that this will lead to greater acceptance from their peers. Often rejecting social interaction, these individuals may adopt an antisocial attitude to avoid facing negative comments or behaviour from their surroundings. This situation creates social, psychological and physical problems in adolescents, serving as a precursor to mental disorders. When traumatic events experienced from childhood onwards are not overcome, it is frequently observed in adolescents and individuals with this condition that thoughts such as becoming fixated on an unhealthy body image, failing to derive pleasure from life, and even choosing not to live—as seen at —become dominant. It is observed that the most prominent of these traumatic events is a loss of self-confidence. An individual who has lost their self-confidence may punish themselves in various ways and drift away from healthy thinking. Refusing even to taste a high-calorie food can be one of the greatest causes of unhappiness for the individual. Individuals who are not confined to this line of thinking adopt behavioural patterns aimed at self-punishment. They possess an 'all-or-nothing' mindset. To protect themselves against this situation, the individual may resort to vomiting after eating.

According to Fairburn (2008), the three characteristics she identifies for diagnosing anorexia nervosa (AN) are as follows:

1. "Excessive preoccupation with body shape, weight and control. That is, evaluating one's self-worth predominantly or exclusively in terms of body shape, weight and the ability to control them
2. Actively maintaining an abnormally low body weight (typically defined as maintaining a weight below 85% of the expected body weight or having a body mass index of 17.5 or below).
3. (In post-pubertal women) amenorrhoea. The validity of this criterion is questioned and it may be removed from the DSM-5 because most women who meet the other two diagnostic criteria experience amenorrhoea, and those who do not exhibit similarities to those who do." (p.24)

Alongside these three criteria, Fairburn argues that the fundamental issue underlying eating disorders is that the individual's psychopathology is of a cognitive nature; the individual defines their self-worth through their body weight and body shape, and in this context, makes sacrifices regarding their body. (Fairburn, 2008) In particular, eating and sleep disturbances beginning in childhood, perfectionism and obsessive-compulsive thoughts, parents who impose anxious and perfectionist thoughts on their child, and obstetric issues ( ) – that is, complications experienced by the mother during childbirth or pregnancy – can serve as starting points for this process.

One of the fundamental causes of anorexia lies in psychodynamic factors; issues in personality development arising from a lack of self-confidence in the individual's earlier life have become a significant factor, and it has been observed that the bonds the individual

forms with family members are problematic in nature. (Karaaziz, 2024) Studies have concluded that group psychotherapy yields positive outcomes for individuals, with participants experiencing an enrichment of their personalities and making progress in terms of self-confidence. It has been suggested that treatment processes conducted within a social framework, such as group-based interventions, may also lead to collective success.

This disorder, which typically begins in early adolescence, is particularly prevalent among young women; however, in recent years, it has also begun to manifest in young men. Individuals frequently attempt to maintain control over their weight and, in an effort to avoid potential weight gain, voluntarily subject themselves to prolonged periods of hunger, exhibiting a high degree of anxiety in this regard.

In this context, Anorexia Nervosa is a mental health condition characterised by an eating disorder, particularly prevalent among young girls aged 12–18. In recent years, factors such as the internet, social media and visual media have emerged as significant psychosocial contributors worldwide. This group, which is particularly self-conscious about their appearance, becomes demoralised at the slightest weight gain, leading to complex emotional states. It has been observed that they experience anxiety, worry and panic at the slightest weight gain, and for this reason, the individual voluntarily remains constantly hungry. These individuals, who have a profound fear of becoming overweight, are extremely anxious about 'becoming obese'. This mindset becomes a hindrance, leading them to refuse food. Health problems arising from the body's struggle against starvation eventually become apparent. The main ones include anaemia and atrophy (muscle loss due to lack of food), as well as sarcopenia (muscle wasting), arrhythmia (irregular heartbeat), and sudden deaths resulting from these conditions.

Bulimia Nervosa

Bulimia Nervosa is one of the types of eating disorder that exhibits symptoms similar to those of Anorexia Nervosa. It is a common variant of eating disorders characterised by recurrent episodes of binge eating, alongside the individual's attempts to maintain weight control. A key aspect of this type of eating disorder is that the individual's psychopathology is of a cognitive nature, with their lifestyle observed to be entirely shaped by their body type and weight. By shaping their lifestyle standards around their body weight, they tend to weigh themselves frequently and strive to maintain control over their weight; they may attempt to compensate for any weight gain through vomiting, laxative use, continuous fasting, or excessive exercise. Due to these compensatory behaviours, they are generally underweight. (Karaaziz & Zilifli 2024)

Research findings indicate that the use of laxatives is more prevalent among young people diagnosed with bulimia nervosa. The underlying cause of their behavioural disorders is a fear of gaining weight; consequently, they are constantly preoccupied with the scales. They cannot conceive of a life without scales or of having no control over their weight. From time to time, as a result of prolonged fasting, they may experience binge-eating episodes, characterised by consuming every food in sight in a ravenous manner despite feeling full. An individual experiencing a binge-eating episode may feel guilty, become angry with themselves, and choose to punish themselves. It has been observed that this condition, which generally begins in adolescence, is more common in female adolescents than in male adolescents. In particular, being ignored by parents during childhood, being frequently punished or blamed, can lead to a lack of self-confidence in individuals; similarly, suffering bullying from social circles and relatives—including blood relatives and in-laws—can result in individuals facing severe traumatic situations later in life and potentially developing this type of eating disorder. Behaviours such as humiliation, contempt and mockery, which begin in childhood within social environments, can be considered the starting point of this illness. In a child who feels ashamed of their body, a severe traumatic situation has already begun to form, serving as a precursor to the cognitive impairments they will carry into their future life. Among the aetiological factors, issues in the individual's attachment patterns with their parents, unhealthy eating patterns within the family, genetic factors, the importance and role of weight within the family, alongside the significance of the traumatic experiences the individual has endured, as well as their personality and temperament, are all stages of this process. A family history of eating disorders, alongside the unhealthy eating patterns established within the family, plays a crucial role in the emergence of these factors, which have a profound psychological impact. Research has shown that severe psychopathological causes stemming from the past encompass numerous factors, whilst it has also been observed that they contribute to the identity search of young individuals during puberty. It is also known that bulimia nervosa is associated with depressive symptoms. In addition to the influence of genetic factors, structural factors and acquired mental illnesses may also be present. Epidemiological studies reveal that, alongside depressive symptoms, anxiety disorders, obsessive-compulsive disorder (OCD), mood disorders and personality disorders, the individual's tendency to self-harm is frequently accompanied by active suicidal thoughts in young people. Furthermore, aversion to sexuality and menstruation is characteristic of this disorder.

In this context, Bulimia Nervosa is a condition frequently encountered today, rooted in the presence of obesity within the family, childhood-onset obesity, a search for identity, aversion to sexuality or menstruation, family discord and conflict with family members, particularly affecting young adults aged 14–18, and is a serious mental health disorder associated with an eating disorder that can even result in death.

Psychosocial Determinants of Eating Disorders and Challenges Encountered in Treatment Processes

Binge Eating Disorder

In the United States, it has emerged as a topic in the context of the rise in obesity. It differs from Anorexia Nervosa in that there is no weight loss, and from Bulimia Nervosa in that the individual does not exhibit behaviours such as self-induced vomiting, laxative use or excessive exercise. While research indicates that individuals with a Body Mass Index (BMI) exceeding 30 are diagnosed with obesity, it is not the case that every obese individual has binge eating disorder, nor do they all meet all the criteria. According to the DSM-5, the root cause of binge eating disorder is obesity and dieting. This condition, which eventually enters a vicious cycle, is characterised by the individual abandoning their diet and eating frequently, consuming far more than the required amount. In this type of eating disorder, which lacks a regular eating pattern, as the name suggests, the individual swallows food in one go, chewing very little. In this action, the person is unable to exercise self-control. The individual may eat without feeling hungry and, as they are often ashamed of the amount of food they consume, they prefer to eat alone. Frequently suppressed urges to eat transform into a hunger caused by this suppression, leading to binge-eating episodes. After consuming food in the desired quantity without pausing to breathe, the individual begins to feel remorse and blame themselves. Unlike in anorexia nervosa, compensatory behaviours (excessive exercise, self-induced vomiting, laxative use) are not present. Fairburn and colleagues (1998) identified that obesity in childhood and among family members, exposure to negative evaluations regarding the body and appearance, and low self-esteem are significant factors in the development of binge eating disorder. (Fairburn et al., 1998) An individual's negative beliefs about themselves may manifest when comments are made regarding their weight, body shape or eating behaviour, and may lead to the formation of negative automatic thoughts (such as 'I am a failure') and associated emotional responses (such as feeling distressed) . (Turan, Poyraz, Özdemir, 2015) Many traumatic situations, particularly those involving a lack of self-confidence acquired during childhood within the family and behaviours such as being mocked due to social pressure, intensify the individual's connection to eating disorders. At the same time, mood disorders, personality disorders, anxiety, obsessive-compulsive disorders and, most importantly, major depression are conditions that accompany binge eating disorder. As a result of distressing emotional responses, both positive thoughts regarding eating behaviour (such as "if I eat, my distress will lessen" or "eating brings pleasure") and negative thoughts (such as "if I eat, I will gain weight") may arise. If a person eats to alleviate emotional distress, they may subsequently develop new thoughts suggesting that eating is uncontrollable, such as "I can't stop myself" (Turan, Poyraz, Özdemir, 2015). An individual who processes food through emotional thoughts is, after a certain time, at risk of becoming dependent on eating, which they associate with happiness. The person seeks happiness in foods that do not conflict with their thoughts, whilst experiencing serotonin release when they imagine eating.

Clinical findings indicate that numerous complications associated with obesity also occur in patients with binge eating disorder. These include Type 2 diabetes, high blood pressure, diabetes, high cholesterol, cardiovascular diseases, and sudden heart attacks, all of which constitute critical risk factors. It is classified as 'Eating Disorders Not Otherwise Specified' (EDNOS) in the DSM-IV.

Pica Eating Disorder

This involves consuming non-food items as if they were food, constituting a specific dietary pattern. To diagnose this condition, the individual must have been engaging in this behaviour for at least one month. This dietary pattern, which has no developmental or cultural basis, is a difficult-to-accept form of eating. If this eating disorder arises following another mental health condition, a thorough clinical assessment is required.

Rumination Disorder

This condition, which is distinct from other eating disorders (anorexia nervosa, bulimia nervosa, and binge-eating disorder), may present with symptoms such as regurgitation alongside eating, or re-chewing or swallowing the regurgitated material. If it stems from other types of neurological disorders, such as pica, a thorough clinical assessment is required.

What is Psychosocial Determinism?

Psychosocial determinism refers to the phenomenon whereby an individual's behaviour is shaped by the internal interaction of their emotions, thoughts, and personality traits—along with their psychological and cognitive processes—and the interaction with external factors such as family and social environment, work life, and cultural contexts. Psychosocial determinism also holds significant importance for an individual's mental health within their social environment. The individual and their social environment are engaged in a reciprocal interaction. This interaction plays a crucial role in the formation of the individual's social personality and behavioural patterns. The emotions that shape their inner world and the social environment that shapes their outer world form a unified whole for the individual. Throughout their lives, individuals are exposed to psychosocial conflicts due to external factors, and this situation affects their mental health, leading to various illnesses. In particular, social norms, the environment in which they live and the geography that shapes their cultural values, as well as working life and economic status, are very important factors affecting psychosocial health. An assessment of psychosocial determinants is also carried out. The assessment process aims to evaluate, in a holistic manner, the extent to which an individual's mental health functions effectively within society, how well they can maintain healthy socialisation within their social environment, and how the problems they face affect their mental health, taking into account both the social and psychological causes. Individuals are shaped by the social environment in which they find

themselves. The effective assessment and implementation of treatment processes are facilitated through psychosocial determinants. In this context, both internal and external factors hold critical importance in terms of individuals' psychosocial determinants.

The Application of Cognitive Behavioural Therapy to Eating Disorders

Cognitive Behavioural Therapy (CBT) is the psychotherapeutic approach to eating disorders. It is recognised as a method used to improve an individual's emotional and cognitive state, as well as their behaviour. It is a highly effective form of therapy for young people diagnosed with anorexia nervosa, helping them to alter their obsessive preoccupations with body image and weight, as well as their unchangeable thought patterns and body perceptions. The core strategy underpinning Cognitive Behavioural Therapy involves formulating a description (or a set of hypotheses) of the processes contributing to the persistence of the patient's psychopathology, and using this to identify the specific features that should be targeted in treatment. (Fairburn, 2008) Through the use of self-monitoring, psychoeducation, emotion regulation skills, cognitive restructuring strategies, problem-solving skills and behavioural intervention techniques, the aim is to regulate the individual's eating habits. The core treatment approach involves collaborating with patients throughout the illness process, changing distorted thought patterns regarding weight and food, establishing control over behaviour and thoughts, restructuring relationships with family and the social environment, and identifying and managing behavioural and emotional factors that may contribute to the illness. The aim is not only to address cognitive distortions regarding the social environment and body image but also to help the individual overcome feelings of self-worthlessness and come to terms with their physical appearance. Alongside this, behavioural patterns that shape cognitive thought structures are identified, as are factors that may hinder weight loss and the maintenance of lost weight. The aim is to replace maladaptive and dysfunctional cognitions with healthy and functional ones (Özdamar-Ünal, 2018). CBT also aims to identify where functional thoughts originate, facilitate their transformation into functional thought patterns, and address the individual's perception of their social environment and the structure of their relationships with their family. In this context, cognitive behavioural therapy is a highly effective set of techniques used in all eating disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder ( ).

Challenges Encountered During Treatment

Many individuals diagnosed with an eating disorder refuse treatment, fearing they will lose their body image. Often, perfectionism, a fear of losing control, and a fear of stepping on the scales, as well as resistance to change, lead them to refuse treatment. Furthermore, relapse following the course of the illness and the recovery process is also among the challenges encountered. It is also necessary to mention the medical difficulties that can vary depending on the course of the illness. For individuals resistant to treatment, the likelihood of experiencing extreme weight loss, hormonal imbalances, muscle wasting, and heart attacks is high; these psychiatric processes significantly complicate the treatment journey for such individuals. Traumas carried over from the past (such as feelings of shame, stigmatisation, being the subject of ridicule, etc.), the reluctance to seek help from others and the fear of appearing weak, an inability to recognise the physical severity of the condition, and the refusal to accept the cost of treatment are all factors that complicate the treatment process. For this reason, programmes aimed at prevention and early intervention for eating disorders should focus on reducing stigma and shame, educating individuals about the seriousness of eating disorders, and increasing knowledge about ways to seek help for eating disorders (Frank, 2024). It is ensured that action is taken based on the principle that "attempting to instil and cultivate self-worth through CBT should be the starting point for treating a treatment-resistant individual". In this sense, whilst the individual is better understood in their social relationships, they accept that their sense of self must be receptive to improvement and that their perception of self-identity must be restructured.

CONCLUSİON

Eating disorders, which have become increasingly widespread worldwide in recent years, are one of the most significant factors affecting human health that can lead to death. Whilst conditions such as obesity and binge eating disorder ( ) sometimes present themselves, other conditions such as bulimia nervosa create a control mechanism over individuals; they become obsessed with scales, refuse to eat continuously, focus solely on their body image and feel dissatisfied with it (body dysmorphic disorder), experiencing binge-eating episodes, and in the case of anorexia nervosa, resorting to excessive compensatory behaviours such as vomiting, using laxatives, or engaging in excessive exercise—these are common characteristics of individuals diagnosed with or undiagnosed with eating disorders, and they constitute very serious mental illnesses that can even result in death. Anorexia nervosa, bulimia nervosa and binge eating disorder share a distinctive underlying psychopathology of a cognitive nature; therefore, eating disorders are essentially 'cognitive disorders'. This form of psychopathology involves an excessive preoccupation with weight and the control of weight. (Fairburn, 2008) Genetic predisposition to mental illness and the co-occurrence of two mental illnesses (comorbidity) are conditions frequently observed in eating disorders. What is most striking about anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified is not so much how they differ, but how similar they are. The same psychopathology is observed to a greater or lesser extent in the diagnoses of eating disorders, and the severity is also quite similar. There is a degree of arbitrariness in the way this psychopathology is divided to form the three diagnostic categories. (Fairburn, 2008) The development

of anorexia typically begins during adolescence. In young women, amenorrhoea (cessation of menstruation) due to food restriction may be observed. The individual usually has no physical appearance issues but becomes obsessed with their weight and develops an intense fear of gaining weight. Patients may also engage in excessive compensatory behaviours. Bulimia nervosa also emerges during adolescence, and the individual's history of the onset and course of the illness spans many years. In binge-eating disorder, the individual continues to eat even after feeling full and prefers to use food to regulate their emotions. In eating disorders, where psychosocial factors play a crucial role, the importance of the individual's emotions, thoughts, and cognitive-behavioural patterns is significant. This involves investigating the impact and causes of the family and social environment on the formation of the individual's personality and their effects on mental health. The most important technique used in psychotherapy is drawn from cognitive-behavioural therapy. The aim is to work primarily on the individual's self-confidence and to move them away from distorted thought patterns. Techniques such as cognitive restructuring are seen as the healing power of cognitive behavioural therapy. However, certain difficulties encountered during treatment can be challenging. Patients who resist treatment may be unable to let go of their outward appearance, which can pave the way for various illnesses such as muscle wasting and heart attacks, and lead to very serious consequences. Providing the patient with psychoeducation, attempting to rebuild their self-worth, and strengthening their relationships with their social environment should be considered before treatment for eating disorders.

During the developmental stage of puberty, the growth, functioning, long-term health and productivity of young individuals are of paramount importance. Eating disorders play a crucial role in the development of human health and the prevention of potential diseases (particularly cardiovascular conditions), necessitating treatment at an early age.

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