https://doi.org/10.55843/ivisum241027sh

ANOREXIA NERVOSA AND BULIMIA NERVOSA

Havva Şaban, Esra Baki, page 27-46

ABSTRACT

Eating disorders are a serious psychopathology type based on the mutual interaction of biological, environmental, psychological, and socio-cultural factors. Individuals are indicated to be at risk for eating disorders from adolescence onwards. The most common eating disorders worldwide are anorexia nervosa and bulimia nervosa; approximately 1% of the general population exhibits symptoms of anorexia nervosa, while 4% shows symptoms of bulimia nervosa. These disorders, which negatively impact an individual's physiological health, mental health, and life for various reasons, are generally perceived by others in the environment after the illness has become chronic.

Anorexia nervosa is characterized by very low body weight, distorted perception of body weight, and intense fear of gaining weight. Bulimia nervosa, on the other hand, is a disorder where individuals secretly consume large portions of food and then try to expel these foods in an unhealthy manner due to subsequent remorse. A multidisciplinary approach is necessary for diagnosing, treating, and monitoring the disease. Screening tests recommended for schools can detect anorexia nervosa and bulimia nervosa patients at an early stage before the disorders become chronic. Patients diagnosed with anorexia nervosa and bulimia nervosa tend to deny their illnesses. During the treatment, CBT, Family therapy, and Cognitive Behavioral Therapy are preferred depending on the patient's clinical findings to normalize eating behavior and regulate emotions and thoughts.

Key Words: Eating Disorders, Anorexia Nervosa, Blumia Nervosa.

Asst. Prof. Dr. Havva Şaban
International Vision University, Gostivar, N.Macedonia

e-mail: havva.saban@vision.edu.mk

Research Assistant Mr. Esra Baki
International Vision University, Gostivar, N.Macedonia

e-mail: esra.baki@vision.edu.mk

UDK: 616.89-008.441.42

Declaration of interest: The authors reported no conflict of interest related to this article.

INTRODUCTION

Eating behaviors have a content that meets the psychological needs of individuals as well as their biological needs. When individuals make food choices without confusing factors such as emotional reasons, they can intuitively create hunger, satiety, and fullness signals that naturally emerge in their bodies. However, in situations where negative emotions such as anger, pressure, excessive excitement, stress, and body-related concerns increase, individuals can also form eating behaviors associated with these emotions (AKAY, 2016 , 2018).

With its current definition, *healthy nutrition* is defined as the consumption of certain nutrients in appropriate amounts and times in a way that is beneficial to the body to protect health, grow and develop the body, and improve the quality of life (OGDEN, 2010). Therefore, healthy, and proper nutrition is very important for individuals to continue their healthy lives.

Healthy eating can be defined as the process where an individual who feels physically hungry starts eating and continues until they feel satisfied, stopping when they feel full or believe they have consumed enough. Individuals with healthy eating habits can identify their nutritional needs, avoid excessively fatty and sugary foods, refrain from overindulging even in their favorite foods, and adjust their eating behavior when feeling sadness, happiness, or boredom. They can occasionally consume unhealthy foods without strict adherence to rules, compensate for them afterward, and return to a healthy eating pattern (SATTER, 2011).

Individuals' eating patterns and behaviors may undergo temporary changes and deteriorations in the face of a stressful event, a physical or mental illness, or due to various personal reasons such as losing weight and looking thinner (GITIMU, ve diğerleri, 2016).

The observed changes and disruptions can manifest as excessive eating behaviors, also known as emotional eating, which occurs solely under the influence of emotions without a physical or social need and is often used to cope with negative emotions. Additionally, these behaviors can be seen as restricting eating, skipping meals, and avoiding certain food groups (EATON, ve diğerleri, 2010).

This situation is not only a bad eating habit inherited from family and culture or a bad eating pattern due to the person's living conditions, but sometimes it can be a sign of a pathological disease related to eating. Therefore, if irregular eating continues for a long time, functional losses occur, individuals' physical and mental well-being are negatively affected, and cognitive difficulties begin to occur; this may indicate the presence of an eating disorder. The concept of "impaired eating attitude" is often used to describe the process leading to disorder in eating behaviors (Attie, L.; Brooks- Gunn, L., 1989).

Eating disorders are psychiatric disorders that are characterized by changes in eating or absorption due to permanent damage to eating or eating-related behaviors, significantly affecting physical-psychological functions, and have a wide range, starting with mild abnormal changes in eating habits and causing life-threatening chronic diseases (Arıca, S.G.; Arıca, V.; Arı, M.; Özer, C., 2011).

Although defining the exact cause of eating disorders is challenging, it is believed that social, biological, and psychological factors all play a significant role. The World Health Organization's classification system, the ICD-10 (International Classification of Diseases), includes eating disorders under the category of 'Behavioral syndromes associated with physiological disturbances and physical factors (Öztürk, ve diğerleri, 1993).

According to the DSM-IV diagnostic criteria, eating disorders are examined under three main headings: 1. Anorexia Nervosa (AN), 2. Blumiya Nervosa (BN) and 3. Atypical eating disorders (AYB). (Köroğlu, E., 2015).

According to DSM-5 diagnostic criteria (2013), eating disorders are classified as pica, rumination disorder, restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge eating disorder (Köroğlu, E., 2014).

According to DSM-5 estimates, the prevalence of eating disorders in adolescents is between 5.7-15.2% in girls and 2.9-1.2% in boys. Fairburn et al. (2013) emphasize that ED is among the most difficult psychiatric diseases to treat. Eating Disorders have become increasingly

important over the years because they can be fatal diseases. According to Maner's (2001) research findings, within the last thirty years, 25% of anorexia nervosa (AN) patients have lost their lives, 25% have continued living with low weight, 40% have recovered, and the remaining have been able to continue a healthy life.

Etiology and Risk Factors of Eating Disorders:

The emergence of Eating Disorders has a complex structure that a single factor or perspective cannot explain. Various factors, such as developmental, genetic, sociocultural, familial, cognitive, and psychodynamic influence the process (Yücel, B., 2009).

Patients with eating disorders have a broad range of demographic characteristics. The primary features of eating disorders include a distorted body image where individuals see themselves as fat (despite having a normal or low weight), an intense fear of gaining weight and becoming fat, and obsessive thoughts related to thinness (Kreipe & Brindorf, 2001).

In line with the research conducted on eating disorders, it has been observed that there are many factors. Therefore, to conceptualize the etiology of eating disorders, they have been divided into three groups, examined and explained by experts.

Biological and Developmental Factors: Epigenetic studies aimed at demonstrating the genetic effect in eating disorders focus on DNA structures and the effects of genes. Biological and developmental factors such as hereditary and genetic predisposition, puberty, early puberty, and premature birth, which make the person vulnerable to the development of Eating Disorders, are discussed under this heading. Recently, the number of studies pointing to the genetic aspect of the disease has been increasing. It has been determined that the incidence of this disorder is higher in individuals with a family history of eating disorders.

A study has shown that the frequency of both disorders in the first-degree relatives of people with anorexia and bulimia nervosa is high. It has been observed that the rate of comorbidity in twins varies between 10-66% in monozygotic twins and 0-10% in fraternal twins. For AN and BN, the monozygote/dizygote ratio is approximately 3/1, and the monozygote ratio is above 50%. These rates show that the contribution of genetic factors is more than expected, at a rate of 50% (Fairburn & Brownell, 2002). In this context, it has been observed that more specific results regarding eating disorders have been obtained in studies conducted on twins to measure the biological and genetic context.

Psychological Factors: The first psychological theories regarding the etiology of Anorexia Nervosa were based on phobic mechanisms and psychodynamic formulations. AN creates a phobic avoidance response to food because of sexual and social development in puberty. Psychodynamic theories focus on guilt arising from fantasies of oral conception, passive and warm fathers, and aggression towards the dependent mother. In this context, cognitive and perceptual developmental disorders cause AN. These are feelings of inefficacy resulting from disorders in body image (denial of weakness), perception disorders (fatigue, weakness, denial, or non-recognition of hunger), and inappropriate learning experiences. High rates of major depression (68%), anxiety disorders (65%), obsessive-compulsive disorder (OCD) (26%), and social phobia (34%) were detected in AN patients (Maner, 2001).

Sociocultural Factors: Cultural pressures that being thin represents thinness, beauty, success, and attractiveness lead to dieting, and it has been noted that it may play a role in the development of eating disorders. The incidence of eating disorders is higher in some professional groups where body shape and weight are important, such as ballerinas, models, and athletes. Even though the change in the perception of beauty, social and media pressure to have a thin body, and diet and weight issues have turned into social obsessions, the incidence of AN is low. The vast majority of the cultural factors in question do not make AN. Only a small proportion of people more susceptible to the disease are at risk of developing AN. These factors are considered insufficient to explain AN, but these sociocultural factors may be more effective in Bulimia Nervosa than AN (Fairburn & Brownell, 2002).

Anorexia Nervosa (AN):

Anorexia Nervosa is characterized by weight loss that causes body weight to fall below 85% of healthy norms, refusal to reach the appropriate weight as growth continues, intense fear of gaining weight and becoming fat despite being thin, and disturbance in body image and perception of body shape. Anorexia Nervosa, which entered the medical literature in 1874, is an eating disorder disease in which the desire to have a thin body and excessive fear of obesity leads the patient to various specific behaviors (such as excessive restriction of food intake, excessive exercise, use of laxatives and diuretics) in order to lose weight (Köroğlu, E., 2014).

Research shows that the frequency of occurrence in adolescents and young adults is 4%. The most common age of onset is between 15 and 19 years of age. However, in approximately 5% of cases, it starts after age 20 (5). It is 20 times more common in girls than boys. Its incidence in adolescent girls is between 0.5-1%. The most distinctive feature of Anorexia Nervosa is the extreme fear of obesity. The patient thinks that his body is too large and constantly tries to lose weight, even though he is extremely thin.

Diagnostic Criteria for Anorexia Nervosa DSM-V

1. The attitude of restricting energy intake according to requirements leads to a significantly lower body weight in the context of the person's age, gender, developmental path, and physical health. *Significantly low body weight* is below the lowest normal or, for children and adolescents, the lowest expected weight.
2. Being very afraid of gaining weight, becoming fat, or constantly engaging in behaviors that make it difficult to gain weight despite having a significantly low body weight.
3. How the person perceives body weight or shape is a disturbance. When evaluating oneself, the person attaches undue importance to body weight and shape or may need to realize the importance of the current low body weight. AN can transform from one of these types to another at different stages of the disease (Köroğlu, E., 2014).

Types of Anorexia Nervosa:

Restrictive Type: It describes a situation in which people lose weight by dieting, eating almost nothing, or exercising excessively.

Binge Eating/Purging Type: It consists of periods in which the person exhibits recurring binge eating or purging behaviors (e.g., self-induced vomiting or misuse of laxatives, diuretics, or enemas) within the last three months.

Differential Diagnosis: Depression, social phobia, anxiety disorders, and obsessive-compulsive disorder are often seen together with eating disorder behaviors.

Clinical Features: Anorexia Nervosa (AN) is characterized by very limited food intake, refusal to eat, and resulting weight loss. There are three main criteria. Firstly, there is severe self-induced starvation to a significant degree. Secondly, there is an intense fear of gaining weight and/or an illness-level fear of being fat. Thirdly, there is the presence of medical symptoms and signs resulting from severe starvation (Öyekçin & Şahin, 2011).

Intense fears of gaining weight led to attitudes towards maintaining or even reducing weight, reaching the minimum weight they set for themselves, and plans to prevent weight gain again. Most of them are overly preoccupied with food on a mental level. It is noteworthy that the patients had detailed knowledge of nutrition (Yücel, B., 2009). Although most AN patients are severely underweight, they are excessively active in order to burn calories and increase weight loss. The state of excessive activity appears to be beyond voluntary control. Mobility continues until their physical condition worsens, and they become very weak and bedridden (Öztürk O. , 1994).

The patient with AN has a distorted body perception. For this reason, he sees himself as heavier than he is and weighs himself frequently during the day. While some people perceive themselves as completely fat, others claim that they are thin, but some areas, such as the abdomen, thighs, and hips, are fat. He looks in the mirror for a long time to believe he has not gained weight. He does not even realize that his weight loss has

reached a dangerous level and believes that he needs to lose more weight (Koptagel, G. İlal, 2000). Research has shown that perfectionism and the perception of personal inadequacy can cause a person to become obsessed with their appearance, thus making dieting a potential reinforcer. Similarly, seeing portrayals of ideal thinness in the media, being overweight, and comparing oneself with particularly attractive people causes one to feel dissatisfied with one's body.

Prognosis (Prognosis and Outcome): The course and outcome of eating disorders, which are important and chronic diseases, vary greatly. Among all deaths occurring naturally or unnaturally in people with mental illness, the highest risk is seen in eating and substance use disorders. The diagnosis with the highest mortality rate among psychiatric diseases is AN. The mortality rate in AN is approximately 10%, with 2-5% being complicated by comorbid internal diseases and suicide (Maner, F., 2001). AN can occur as a single episode, as recurring episodes, or continuously. Approximately 40-50% of patients recover completely, 30-40% recover moderately, and 20% show continuity (Hekimsoy, 2009).

Treatment: AN treatment is a long and difficult process. The disease has life-threatening features, and the basic principle of treatment is to consider it as a serious mental disorder that can become aggravated and complicated. It requires a multidisciplinary team effort to address various aspects of the disease. This team should include a family physician, psychiatrist, psychologist, psychiatric nurse, and dietitian. Multidimensional treatment approaches that consider the disease's multiple causes and unpredictable course are applied. Treatment strategies are determined according to the severity of the disease. Basic approaches applied in treatment medical management, nutritional rehabilitation, cognitive behavioral therapy, family therapy, and other spiritual treatments (V.Sadock, 2007).

Cognitive therapy is based on two basic assumptions. The first is food avoidance behavior due to the necessity of maintaining a low weight. Second, the positive function of AN is that it allows the individual to avoid distressing, often interpersonal, life events. In the cognitive restructuring approach, the patient is asked to identify specific negative thoughts, list

the evidence that supports and does not support these thoughts, draw a logical conclusion, and use this conclusion to guide his or her behavior.

In family therapy, by clarifying the boundaries between family members and addressing the power relations within the family, the treatment specialist tries to reveal what kind of rebellion the difficulties of the anorexic patient mean (Öztürk M. O., 2020). A previous study of 50 girls who received this type of family therapy to treat anorexia found that as many as 86% were still functioning well when evaluated three months to 4 years after treatment (Kring, Johnson, Davinson, & Neale, 2017).

Bulimia Nervosa (BN):

Bulimia Nervosa is a disease characterized by binge eating attacks and behaviors developed to maintain weight, such as frequent vomiting or the use of laxatives/diuretics. In 1979, Russell defined bulimia nervosa as a separate condition. Russell mentioned three main characteristics of BN patients. These:

1. A strong and irresistible desire to eat,
2. Avoiding the weight-gaining effects of foods by vomiting and using laxatives
3. It is an extreme fear of getting fat.

DSM-V Diagnostic Criteria for Bulimia Nervosa:

A. Recurrent episodes of binge eating. Both of the following mark a binge-eating episode:

1. Eating in a discrete period (e.g., any two hours) more food than most people would eat in a similar period under similar circumstances.

2. During this period, there is a feeling of loss of control overeating (e.g., the feeling that the person cannot stop eating or control what or how much she eats).

B. Engaging in recurrent, inappropriate compensatory behaviors to avoid weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, hardly eating at all, or excessive exercise.

C. Both binge eating behaviors and inappropriate compensatory behaviors have occurred, on average, at least once a week for three months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. This disorder does not occur exclusively during periods of AN. (Köroğlu, E., 2014)

Types:

Purging type: During the current episode of bulimia nervosa, the person regularly self-induced vomiting or abusing laxatives, diuretics, or enemas. **Non-purging type:** During the current episode of bulimia nervosa, the person engaged in behaviors such as not eating at all or exercising excessively but did not induce vomiting or use laxatives, diuretics, and enemas (Morrison, James, 2017). **Clinical Symptoms:** BN is characterized by cycles in which binge eating attacks are followed by feelings of guilt and behaviors aimed at preventing weight gain.

The individual seeks refuge in eating to find relief from one side, to escape from anger and loneliness, to overcome perceptions of failure and inadequacy, and to gain control over life. However, on the other hand, as the deceptive period of relief ends, a vicious cycle begins with the emergence of new problems and emotions. During binging episodes, they consume large amounts of food, opting for fatty, sugary, high-calorie foods. The consumption of food often occurs rapidly and excessively. A typical bulimic episode lasts for 30 minutes to 1 hour in most cases. They may go without eating for 24 hours before a binge-eating episode. Initially, there is a sense of relief in response to tension, but this relief is quickly followed by guilt, self-hatred, and regret (Morrison, 2017).

After a binge period, to compensate for binge eating, exercise or excessive food restriction is followed. The use of emetics for weight control and fluid loss, the use of excessive amounts of laxative diuretics, and frequent vomiting behavior are observed. Despite overeating, the weight of bulimic patients generally fluctuates within normal limits. Although most of them are at the upper limit of the normal or slightly

overweight, they prefer the lower limit of the normal range as their ideal weight. Approximately 10% of patients are significantly obese (Fairburn, C.G.; Brownell, K.D., 2002).

Prognosis (Course and Outcome): BN has a more variable structure than AN regarding prognosis, that is, the course of the disease. Complete recovery rates are higher, and mortality rates are lower in BN than in AN. In a review study conducted in 2009, the average crude death rate of BN was reported as 0.32% (Steinhausen & Weber, 2009). It has been determined that factors such as onset at an early age, frequent binge eating and vomiting, impulse control problems, borderline features, excessive preoccupation with body weight, and a tendency to anorexia, comorbidity, and low self-esteem make recovery difficult. The presence of personality disorders in bulimia makes treatment very difficult. (Hales & Yudofsky, 2004)

When we look at the studies, it has been observed that after a two-year treatment period of the disease, there is a 50% improvement, bulimic behaviors improve over time, and there is a 20% probability of the behavior recurring.

Treatment: Bulimia nervosa patients usually seek treatment years after the disease begins. They often seem eager for treatment and have expectations because they want to get better quickly. In treating BN, each patient's condition should be evaluated individually and in detail, and treatment should be planned according to the patient's problems. As a result of meta-analysis research, It shows that cognitive behavioral therapy, other psychotherapies, antidepressant medications, and a combination of these treatments are useful in patients with B.N. (Örsel & Erol, 2014).

Cognitive-behavioral therapy (CBT) is the most effective and specialized psychotherapy for individuals with this disorder. It has been observed as the most effective treatment method in 35 controlled psychosocial studies. Approximately 40-50% of patients cease binge eating and purging after 16-12 weeks of treatment. Generally, there is a 70-95% reduction in binge-eating and purging. For the 30% of patients who do not show immediate improvement after treatment, they tend to achieve complete recovery one year later.

If there is also a depressive disorder present, depression tends to lighten. In this psychotherapeutic approach, individuals begin to understand the relationship between thoughts and feelings that lead to bulimic behaviors, recognizing the thoughts and feelings that contribute to their eating disorder. The person becomes able to cope with food-related anxiety and begins to get rid of negative thoughts in her perception of her body structure (Whittal, Agras, & Gould, 1999).

In this respect, cognitive behavioral treatment is more effective in bulimia nervosa than simple behavioral treatment and interpersonal psychotherapy. In uncomplicated BN cases, it has been recommended to start treatment with cognitive behavioral therapy and add pharmacotherapy when necessary (Fairburn, C.G.; Norman, P.A.; Welch, S.L., 1995).

In patients who do not respond to behavioral, cognitive therapy, interpersonal therapy, drug therapy, or family and group therapies can be applied. Combining behavioral cognitive therapy with interpersonal therapy and other therapy methods is common in clinical practice (Chair, ve diğerleri, 2006).

If bulimia nervosa is observed in adolescents, it is thought that family therapies would be more effective. The primary goal of treating bulimia nervosa is to develop normal eating patterns. Bulimic individuals need to learn to eat snacks between meals before moving on to three meals a day, bingeing, and purging. Regular meals help control the urge to eat excessively and follow irregular eating patterns (Ann M. Kring, Anormal Psikopatolojisi, 2017).

Cognitive behavioral treatment of bulimia focuses on challenging social standards regarding physical attractiveness, changing beliefs that encourage severe dietary restrictions, and promoting normal eating patterns. Short and long-term results are good.

Epidemiology of Eating Disorders:

Research findings indicate that the prevalence of eating disorders during adolescence varies. According to DSM-5 estimates, the prevalence of eating disorders in adolescent girls is reported to be between 5.7% and 15.2%, while in boys, it is between 2.9% and 1.2%. It is emphasized that adolescents diagnosed with eating disorders, based on these estimates, later receive treatment for eating disorders (Eddy, 2007).

The American Psychiatric Association reports that the incidence of Anorexia Nervosa (AN) increases between the ages of 15-19, and 40% of AN cases are in this age group. The majority of Bulimia Nervosa (BN) cases occur in university youth, including adolescents, and before the age of 25. When the effect of gender is evaluated, it is seen that especially young girls attach more importance to body image and aesthetics and are more prone to eating disorders than boys (Tam C, Cherry FN, Chak MY., 2007).

In a study conducted on adolescent girls, it has been found that the attitudes of family, friends, and the media regarding body image are highly influential and lead to misguided practices due to body dissatisfaction. In line with this, in a study by Dunkley and colleagues (2001), the rate of influence from media and magazines on the decision to start a diet was found to be 63.8%, while the influence of friends was determined to be 44.8%. In the same study, the influence rate from family on the decision to start a diet was found to be 32.1% (Dunkley TL, 2001).

Epidemiological studies conducted in Europe also indicate similar lifetime prevalence rates for eating disorders. As part of the project, in a study conducted by Preti and colleagues (2009) in 6 European countries (Belgium, France, Germany, Italy, the Netherlands, and Spain), the prevalence of eating disorders in individuals aged 18 and older was examined. The lifetime prevalence of eating disorders was found to be higher in females than males, with rates for anorexia nervosa (AN) at 0.48%, bulimia nervosa (BN) at 0.51%, binge eating disorder (BED) at 1.12%, and subthreshold BED at 0.72% (PRETI, 2009).

In the review study conducted by Mitchison and Mond (2015), the lifetime prevalence of ED for adult men according to DSM-5 criteria was examined, and found that BED varied between 0.78% and 2%, AN (0-0.53%) and The prevalence of BN (0.13-1.34%) was found to be lower than that of BED. When the findings for adolescent males were examined in the same review, it was determined that the lifetime or current prevalence of AN (0 - 0.2%), BN (0 - 0.7%), and BED (0 - 0.8%) was lower than in adult males (MITCHISON, 2015).

In epidemiological studies conducted in South Asia, In a study conducted on the epidemiology of ED in India; As a result of a study involving 66 psychiatrists, it was reported that 32 (43.2%) of 74 ICU patients who applied to the clinic in Bangalore had AN, 12 (16.2%) had BN, and 30 (40.6%) had BTAYD. The general opinion among experts in this region is that the number of ICU patients applying to the clinic is increasing (CHANDRA, 2012).

One of Turkey's most comprehensive epidemiological studies is the study of Vardar and Erzengin (2011). One of Turkey's most comprehensive epidemiological studies is the study of Vardar and Erzengin (2011). This study covers 10th and 11th-grade high school students in Edirne. In the study, 2,907 students were evaluated, and the prevalence of ED was found to be 2.33% (68 people). 86.8% of the people diagnosed with ED are girls (59 people), and 13.2% (9 people) are boys. The point prevalence for AN is 0.034% (1 person), and for BN, it is 0.79% (23 people). None of the men were diagnosed with AN or BN. Among girls, the prevalence of AN is 0.068%, and the prevalence of BN is 1.57% (VARDAR, 2011).

Another important epidemiological data about Turkey comes from the research conducted by Semiz, Kavakcı, Yağız, Yontar, and Kuğu (2013) with 1122 people between the ages of 18-44 in Sivas province. 2.8% of the 544 women (15 people) in the sample and only 0.35% (2 people) of the 578 men were diagnosed with ED. No one was diagnosed with AN. The prevalence of women diagnosed with BN is 0.63% (7 people), and 0.89% of those diagnosed with BED (SEMIZ, 2013).

CONCLUSION AND RECOMMENDATIONS

Eating disorders have physical and psychosocial dimensions. These disorders manifest themselves with disruptions in a person's thoughts and eating behaviors regarding food, body weight, and physical appearance. Research on the prevalence of diseases is of great importance. Therefore, it provides a basis for understanding the effects of diseases on society, conducting prevention studies, determining treatment needs, and revealing differences between demographic groups. Many patients with eating disorders do not seek treatment for their illness because they do not believe anything is wrong. Others do not go to therapy because they are ashamed of their situation or feel hopeless about it.

No one treatment method is consistently more effective than other treatment methods in treating anorexia nervosa. Various forms of psychotherapy have been practiced by clinicians, most often using CBT or a combination of Cognitive-Behavioral and psychodynamic techniques. However, none of these treatments have been conclusively shown to work. For adolescents with a short-term history of illness, the most effective treatment method is family therapy. When patients with bulimia go to therapy, they are treated with both biological and psychological treatment methods. The treatment represents a combination of cognitive processes used to treat depression and behavioral approaches used to treat eating disorders. As a result of the research, only half of the patients with bulimia show a significant improvement during the treatment period. One year after completion of treatment, only one-third maintain their treatment gains.

When we look at research on eating disorders shows that behavioral disturbances can occur for various reasons and that eating disorders may not immediately manifest when eating behavior is disrupted. The prevalence of eating disorders during adolescence is often associated with the influence of family and personality traits, as well as the impact of the social environment and media on the development of self-esteem and body dissatisfaction, contributing to the emergence of eating problems.

It should not be forgotten that one of the most important life crises that individuals who are in the period of emerging adulthood, especially those who have reached the stage of completing adolescence but cannot yet fulfill all the responsibilities of being an adult, is identity conflict.

For this reason, individuals' identity formation efforts should be carefully examined in protective/preventive studies. On the other hand, it is recommended that protective/preventive programs include psychoeducation in which accurate information about nutrition and eating behaviors is given, as well as techniques that will enable individuals to move away from the desire to have a slim body, especially idealized by the media.

It is thought that strengthening social relations in individuals in this age group, improving their communication skills, and enabling them to express themselves in different fields such as sports and arts are of great importance to protect their physical and psychiatric health and to create a healthy society.

Therefore, in order to minimize the risk of eating disorders, especially in adolescents, it is recommended that seminars be given by psychological counselors and psychologists at school for students and their families, as this will be effective in reducing the risk of eating disorders.

REFERENCES

AKAY, G. G. (2016 , 2018). "Yeme Bozukluklarında Fiziksel Açlığı Duygusal Açlıktan Ayırt Edebilme" & "Duygusal Yeme", . *Türkiye Klinikleri Psychology-Special Topics,Arşiv Kaynak Tarama Dergisi*, 1/2, 17-22, 27/1, 70-82.

Attie, L., & Brooks-Gunn, J. (1989). Development of eating problems in adolescent girls: Alongitudinal study. *Developmental Psychology*(25), 70-79.

Arıca, S., Arıca, V., Arı, M., & Özer, C. (2011). Adolesanda Yeme Bozuklukları. *Mustafa Kemal Dergisi, 2*(5), 1-10.

Ann M. Kring, S. L. (2017). *Anormal Psikolojisi.* (M. Şahin, Çev.) Nobel Yayıncılık.

Ann M. Kring, S. L. (2017). *Anormal Psikopatolojisi* (Cilt 12. Basım). (M. Şahin, Çev.) Nobel Yayınevi.

Chair, J. Y., Devlin, M. J., Halmi, K. A., Herzog, D. B., III, J. E., Powers, P., & Zerbe, K. J. (2006). *PRACTICE GUIDELINE FOR THE Treatment of Patients With Eating Disorders Third Edition.* U.S.: Act. For permission for reuse.

CHANDRA, P. S. (2012). "Are Eating Disorders A Significant Clinical Issue in Urban India? A Survey Among Psychiatrists in Bangalore". *International Journal of Eating Disorders, 3*(45), 443-446.

Dunkley TL, W. E. (2001). Examination of a model of multiple sociocultural influences on adolescent girls' body dissatisfaction and dietary restraunt. *Adolescence Publishing, 26*(36), 52-79.

Dünya Sağlık Örgütü, Ruhsal ve Davranış Bozukluklarının Sınıflandırılması (ICD-10). (1993). (Ç. M. Öztürk, Çev.) Ankara: Türkiye Sinir ve Ruh Sağlığı Derneği Yayını.

Eddy, K. T.-K.-B. (2007). Eating disorder pathology among overweight treatment-seeking youth: Clinical correlates and cross-sectional risk modeling. *Behaviour research and therapy, 10*(45), 60-71.

EATON, D. K., KANN, L., KINCHEN, S.SHANKLIN, ROSS, S., HAWKINS, J., & LIM., J. C. (2010). "Youth Risk Behavior Surveillance-United States". *59*(5), 1-142.

Fairburn, C., & Brownell, K. (2002). *Eating Disorders and Obesity a Comprehensive Handbook.* New York: The Guildford Press.

Fairburn, C.G.; Norman, P.A.; Welch, S.L. (1995). A prospective stydy of out come in blumia nevrosa and the long term effects of three psychological treatments. *Arch Gen Psychiaty, 4*(52), 4-12.

GITIMU, P. N., JAMESON, M. M., T.TUREL, KRAUZA, R. P., MINCHER, J., ROWLANDS, Z., & ELIAS, J. (2016). Appearance Issues, Depression, and Disordered Eating Among College Females". *Cogent Psychology, 3*(1).

Hales, R., & Yudofsky, S. (2004). Essential of Clinical Psychiatry . *American Psychiatric Publishing*, 759-781.

Hekimsoy, Z. (2009). Anoreksiya Nevroza Epidemiyolojisi Klinik Özellikler ve Tanı. *Türkiye Klinikleri J. Endocrin Special Topics, 3*(2), 7-13.

Köroğlu, E. (2015). *Klinik Psikiyatri Yeme Bozuklukları* (Cilt 2. Basım). Ankara : HYB Yayın.

Köroğlu, E. (2014). *Amerikan Psikiyatri Birliği (DSM-5), Ruhsal Bozuklukların Tanısal ve Sayımsal Elkitabı, 5. Baskı*, 5. Baskı. Ankara: Hekimler Yayın Birliği.

Kring, A. M., Johnson, L. S., Davinson, G., & Neale, J. (2017). *Anormal Psikopatolojisi,* (Cilt 12. Basım). (M. Şahin, Çev.) Ankara: Nobel Yayınevi.

Köroğlu, E. (2014). *Amerikan Psikiyatri Birliği (DSM-5) Ruhsal Bozuklukların Tanısal ve Sayımsal Elkitabı.* (E. Köroğlu, Çev.) Ankara: Hekimler Yayın Birliği.

Kreipe, R., & Brindorf, D. (2001). Eating disorders in adolescents and young adults. *Medical clinics of North America, 4*(84), 102-104.

Koptagel, G. İlal. (2000). *Yeme Bozukluklarında Psikonevroz Psikosomatik Psikoterapi.* İstanbul: AB Ofiset Basın Yayını Matbaacılık.

MITCHISON, D. M. (2015). "Epidemiology of Eating Disorders, Eating Disordered Behaviour, and Body Image Disturbance in Males: A Narrative Review". *Journal of Eating Disorders, 1*(3), 20.

Maner, F. (2001). *Yeme Bozuklukları* (Cilt 5). Psikiyatri Dünyası.

Morrison, J. (2017). *DSM_5'i Kolaylaştıran Klinisyenler İçin Tanı Rehberi.* (H.Uğur Kural, Çev.) Ankara, Nobel Yayınevi

OGDEN, J. (2010). *"Treating Eating Disorders", The Psychology of Eating from Healthy to Disordered Behavior, (2nd Edition).* Wiley-Blackwel.

Öztürk, M. O. (1993). *Dünya Sağlık Örgütü Ruhsal ve Davranış Bozukluklarının Sınıflandırılması (ICD-10).* Ankara: Türkiye Sinir ve Ruh Sağlığı Derneği Yayını.

Öztürk, M. O., Çuhadaroğlu, F., Kaplan, İ., Özgen, G., Rezaki, M., & Uluğ, B. (1993). *Dünya Sağlık Örgütü Ruhsal ve Davranış Bozukluklarının Sınıflandırılması (ICD-10).* (M. O. Öztürk, F. Çuhadaroğlu, İ. Kaplan, G. Özgen, M. Rezaki, & B. Uluğ, Çev.) Ankara.

Öyekçin, D. G., & Şahin, M. (2011). Yeme Bozukluklarına yaklaşım. *1*(15), 29-35.

Öztürk, O. (1994). *Ruhsal Etkenlere Bağlı Olan Fizyolojik İşlev veya Yapı Bozuklukları II. Ruhsal Sağlığı ve Bozuklukları.* Ankara: Hekimler Yayın Birliği.

Öztürk, M. O. (2020). *Ruhsal Etkene Bağlı olan Fizyolojik İşlev yada Yapı Bozuklukları* (Cilt 1. cilt). Ankara.

Örsel, S., & Erol, A. (2014). *Yeme Bozukluklarında Klinik Seyir ve Sonlanım, Yeme Bozuklukları ve Obezite Tanı ve Tedavi Kitabı.*

PRETI, A. D. (2009). THE ESEMED-WMH INVESTIGATORS:"The Epidemiology of Eating Disorders in Six European Countries: Results of the ESEMed- WMH Project". *Journal of Psychiatric Research*(43), 1125-1132.

SEMIZ, M. K. (2013). "Sivas İl Merkezinde Yeme Bozukluklarının Yaygınlığı ve Eşlik Eden Psikiyatrik Tanılar". *Türk Psikiyatri Dergisi, 3*(24), 149-157.

SATTER, E. (2011). *"What is Normal Eating?", Eating Disorders Sourcebook* (Cilt (3rd Edition)). ((. b. Judd., Dü.) US: Omnigraphics.

Steinhausen, H., & Weber, S. (2009). The outcome of blumia nevrosa: finding from one quater century of research. *13*(166), 31-41.

Tam C, Cherry FN, Chak MY. (2007). Disordered eating attitudes and behaviours among adolescent in Hong Kong: prevalence and correlates. *J Paediatr Child Health, 43*(81), 17-18.

Tam C, C. F. (2007). Disordered eating attitudes and behaviours among adolescent in Hong Kong: prevalence and correlates. *J Paediatr Child Health, 43*(81), 17-18.

V.Sadock, B. S. (2007). *Comprohensive Textbook of Psychiatry, 8. Basım* (Cilt 2. Cilt). (H. Aydın, & A. Bozkurt, Çev.) Ankara: Güneş Kitabevi.

VARDAR, E. E. (2011). "Ergenlerde Yeme Bozukluklarının Yaygınlığı ve Psikiyatrik Eş Tanıları İki Aşamalı Toplum Merkezli Bir Çalışma". *Türk Psikiyatri Dergisi, 4*(22), 205-212.

Whittal, M., Agras, W., & Gould, R. (1999). Blumia Nevrosa: a meta analysis of psychosocial and pharmacological treatments. *1*(30), 17-35.

Yücel, B. (2009). Estetik bir kaygıdan hastalığa uzanan yol: Yeme bozuklukları. *Klinik Gelişim Dergisi, 4*(22), 39-44.