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THE UNDERLYING REASONS FOR EATING DISORDERS IN ADOLESCENTS

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ABSTRACT

Eating disorders are diseases that cause severe malnutrition, including extreme thinness, as a result of abnormal eating behaviours such as intentional apocleisis, binge-eating, and self-vomiting, and they are caused by an intense fear of becoming obese. Eating disorders are classified as mental illnesses. It is a well-established fact that over the course of the last half-century, there has been a worldwide rise in the number of people diagnosed with eating disorders. It is estimated that one to two million women in the United States fit the diagnostic criteria for bulimia nervosa (BN), and it is estimated that 500,000 women in the United States satisfy the diagnostic criteria for anorexia nervosa (AN). 1) One of the causes for the growth in eating disorders seems to be connected to the increased level of interest in health that has been seen in recent years, as well as the excessive sensitivity regarding body weight and physical appearance that is mostly seen among younger people.

Keyword: anorexia nervosa, bulimia nervosa, severe malnutrition,

INTRODUCTION

Eating disorders often manifest themselves throughout the formative years of puberty, and since their development is a chronic process, their effects frequently continue into adulthood.Behaviors such as apocleisis, binge-eating, self-vomiting, and a desire to be thin

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become psychologically hazardous for family members and other persons who are in close proximity to these patients. They are at a loss as to how to deal with their conduct, which makes them feel helpless. Malnutrition may sometimes result in a tragic outcome or in suicidal conduct, which is another problem brought on by the difficulty of treating the underlying diseases. There are situations in which the family unit is destroyed. As was previously noted, eating disorders are not only illnesses involving eating behaviour such as eating or not eating, but they are also diseases that influence the patient's physical and psychological states, as well as the social environment. In this article, eating disorders are examined, and the physical, psychological, and social components, as well as the influence of the illness on these elements, are detailed. Also mentioned is the effect that the disease has on these factors.

Eating disorders in children can have a variety of causes and outcomes. They can be of an organic nature (such as the development of oromotor and orosensory functions, gastroesophageal reflux disease, and gaseous colic), or they can be of a non-organic nature and be categorised as a relationship disorder with the child's primary carer. During childhood, transient eating disorders are common at certain critical moments of development, such as during the time of weaning or between the second and third years of life with the transition to an autonomous diet; however, these disorders do not always constitute a disturbance in the child's development. These phases of growth, on the other hand, indicate moments of reconstruction of the connection with the carers and, as a result, moments of great vulnerability owing to the beginning of a feeding problem. The refusal of food is a common behaviour that occurs in the context of a maturing process in which the child's biological, cognitive, and affective capacities reorganise themselves to a more complex level of development. This requires a new interactive regulation and a new mutual adaptation of the child-caregiver couple, both of which take into account the greater sense of individual autonomy of the child. The refusal of food is a common behaviour that occurs in the context of a maturing process in which the child's biological In response to these alterations and aberrant behaviours of the child, the carers may react differently, reflecting their evolutionary experiences in the separation-individuation process. For example, while some parents may feel uncomfortable and become overprotective of their children, others may encourage their children to develop their own sense of autonomy.

The interactional experiences that parents had in the past with their own carers may thus have a considerable impact on evolutionary regulatory models; as a result, the relational history of

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parents is a crucial aspect of the diagnostic assessment of infantile eating disorders (1). Research in the field of child development has made it possible to identify the motivational forces that guide development and organise the trends that lie at the foundation of stable patterns. This research has brought to light the fact that the drive to create and maintain relationships is fundamental to human nature, and as a result, psychological experience is organised along these lines. This intrinsic drive to look for dyadic interactions and to develop a relational reciprocity reflects a motive on par with the need for food, libidinal satisfaction, or the relief of tensions in the environment (2). In this kind of relational motivation, the youngster learns to communicate his own distress to the adult who is responsible for his care and to coax harmonious reactions from that adult. When an adult responds appropriately to a hunger signal, the sense of internal tension and helplessness is transformed into contentment. These transactions make a contribution to the construction of mental representations and to the stabilisation of representations of the generalised interactions that make up the personality matrix. The personality matrix is the psychological organisation that lies beneath the specific individual patterns of perception, experimentation, adaptation, and relational style. In this regard, the research showed that by the end of the first year of life, the child has achieved some ability to regulate his own emotions and needs and to establish stable attachment bonds with the significant figures that will remain fundamentally stable throughout childhood and adolescence. (3,4). The importance of maternal deprivation and incongruent mother-child relationships in the onset of psychopathology, as well as the existence of a link between early life events and behaviour in later stages of life, has been verified. This link indicates that there is a correlation between early life events and behaviour that occurs in later stages of life. Due to the fact that children under the age of three have a reduced capacity for psychological autonomy, it is highly unlikely that a psychopathology would be focused on the child. As a result of this, it is also highly unlikely that a disorder in a child would be a pure reflection of a disorder in an adult (5). Because of this, it would seem that the behavioural disorders of childhood may be explained by the relationship dynamics of the family. Relational disorders can be categorised as follows: - relational disorders that cause worries within the family but are temporary and occur in moments of transition to new evolutionary acquisitions (weaning, autonomy in feeding, minor physical illnesses); they have a favourable outcome with satisfactory family and social support and can also be a stimulus to development. - relational disorders that cause worries within the family but occur in moments of transition to new evolutionary acquisitions (weaning, autonomy in feeding, minor physical illnesses); they occur in moments of transition to new In most cases, they

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don't endure for more than a month. - relationship disruptions that point to an evolutionary situation that is in danger, characterised by the occurrence of recurring incoherent and insensitive interactions that, should they be allowed to continue, may lead to the development of individual or relational psychopathology.

However, not all aspects of development are involved in the interactions, which are more strict. There is a range of one month all the way up to three months. Among the regulatory alterations of various functional areas (sleep, relationships with peers or parents, academic performance), which are induced by the relational disorder, there may be eating behaviour that presents itself as the child's difficulty in establishing regular feeding patterns with an Adequate intake of food, both to regulate their diet with the physiological states of hunger and satiety. This eating behaviour may present itself as the child's difficulty in establishing regular feeding patterns with an Adequate intake of food, both to regulate their diet This descriptive description makes it possible for us to incorporate the precise clinical images of the childhood nutrition and childhood disease that will be the focus of our conversation, including the non-organic failure to thrive and children obesity (6).

In this lesson, we are going to discuss the many forms of eating disorders, as well as their root causes, symptoms, and treatment options. The first thing that will be covered in this section is the definition of eating disorders as well as an explanation of the traits that are associated with them. After this, a discussion of the many forms of eating disorders, such as anorexia nervosa, bulimia nervosa, and binge eating disorders, will follow. The origins of each of these illnesses are then discussed in depth, and treatment options, including psychotherapy, cognitive therapy, and medication, are outlined thereafter."Sequential or behavioural responses related with the act of eating, way or method of eating, rhythmic patterns of feed" is how eating behaviour is characterised . This kind of behaviour is determined by social, demographic, and cultural contexts, as well as by the individual's viewpoint, the food, their prior experiences, and their nutritional state Among these elements, the socio-cultural influence on food intake and the development of eating disorders (ED) has been investigated more often.

These studies examine the family traditions as well as the information that is given by the mass media Anschutz et al. and Oliveira and Hutz(11) describe the influence of the media, which is magnified by globalisation and society. They emphasise the contradiction between the appeal for healthy lifestyle at the same time that it is praised the cult of thinness and it is

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encouraged the consumption of high-calorie foods. These inconsistencies lead to the development of eating disorders, which are defined by an excessive preoccupation with one's appearance in terms of both weight and form . In the pursuit of this archetype, weight reduction is produced by insufficient measures, such as fasting and severe physical training, and development in muscle mass is accelerated by excessive workouts, an unhealthy diet, and the use of anabolic steroids.

Eating disorders are linked to a variety of clinical complications, which can include but are not limited to the following: stunted growth cheilosis, dental erosion, periodontitis, salivary gland hypertrophy, hypovolemia, electrolyte imbalance, and weight gain. These clinical complications can vary from disorder to disorder When eating disorders manifest themselves throughout the teenage years, not only do they have a negative impact on the individual's relationships with friends and family, but they also make suicide thoughts more prevalent . In addition, teenagers who struggle with eating disorders have a higher incidence of beginning sexual engagement before the age of 16 years old. In addition, young women who have a history of ED have a greater risk of having an abortion or becoming pregnant . As a result, the purpose of this research was to address the features of eating disorders in children and adolescents as well as the risk factors connected with them.

DEFINITION OF EATING DISORDER

This Practice Parameter provides an evidence-based approach to the assessment and treatment of eating disorders in children and adolescents. These eating disorders include, but are not limited to, anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and avoidant restricted food intake disorder (ARFID) (ARFID). The conditions of pica, rumination disorder, and purging disorder, as well as eating challenges in newborns (such as failure to thrive), will not be addressed by the Parameter. Neither will the evaluation nor the treatment of obesity. Eating disorder evaluation and treatment in younger patients, particularly children and adolescents, may be challenging and often calls for specialised expertise as well as relevant professional experience. This Practice Parameter was established to aid child psychiatrists in accurately evaluating children and adolescents who have eating disorders and in delivering successful treatment for individuals who fit this patient profile. This Parameter may also give information that is relevant for other medical professionals and professionals working in the field of mental health. This is because the treatment of eating

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disorders often involves the consulting and participation of other specialists in addition to child psychiatrists.

LITERATURE REVIEW

Mr. James Lock (2015) The examination and treatment of eating disorders in children and adolescents are discussed in this Practice Parameter, which looks at procedures that are supported by evidence. To augment the findings of systematic data reviews in areas with low empirical evidence, clinical consensus opinions are used. The phenomenology of eating disorders, the comorbidity of eating disorders with other mental and medical diseases, and the management of eating disorders in children and adolescents are the primary topics covered in The Parameter. The database relating to eating disorders in younger patients is sparse, thus pertinent material collected from adult research is included in the debate. This is because the topic also includes adult patients.

The name is Jessica Robertson (2020) Adolescents, and particularly adolescent females, are more likely to develop an eating disorder if they are raised in an atmosphere that is conducive to unhealthy interactions between parents and children, as well as unhealthy parenting techniques. Authoritative parenting seems to be the most promising environment for teenage children to avoid engaging in disordered eating habits and to build robust mental and physical health. This is due to the high levels of control and warmth that are provided by authoritative parents. Authoritarian parenting and negligent parenting are two examples of parenting styles that involve activities that, in general, are not helpful and may increase the risk of their child developing an eating problem. When a girl enters her teenage years and develops an eating problem, authoritative parenting has been found to have the most ability to aid the adolescent in a manner that is both effective and suitable. This research review explores how these parenting styles impact youth in supporting or hindering an adolescent's decision to participate in disordered eating habits. Other variables are included, but this study focuses on how these parenting styles influence teens.

Diane Alix Klein (2014) Disorders of food and weight-related behaviour such as anorexia nervosa (AN) and bulimia nervosa (BN), which combined affect between 1% and 3% of women in the United States, are referred to as anorexia and bulimia, respectively. Once the disordered eating habit has started, it is quite difficult to stop doing so, which is one of the most noteworthy aspects of each of the eating disorders. Eating disorders are associated with significant psychological, social, and physiological disturbances, and it has been very

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challenging to disentangle the factors that may result from the disturbed behaviour from the factors that may have predisposed individuals to, or precipitated the development of, the disorder. Substantial psychological, social, and physiological disturbances are associated with eating disorders. In this article, a concise overview of the definitions, phenomenology, and recognised risk factors for the development of each of the main eating disorders will be provided. The pathophysiology of disordered eating will be explored, with a specific emphasis placed on possible components that could maintain disordered eating behaviour, as gleaned from studies in both clinical and fundamental scientific fields. In this section, we shall offer future paths for study.

RESEARCH MYTHOLOGY

INTRODUCTION

The Helsinki Declaration was followed in each and every one of the research procedures that were carried out for this study. The laws of Finland pertaining to data protection were adhered to throughout the process of collecting and processing the acquired information at Helsinki University Central Hospital.

Both the Institutional Review Board of Indiana University and the ethics committee of the Department of Public Health at the University of Helsinki gave their blessings for the data collection and analysis that were to take place in the FinnTwin 12 and FinnTwin 16 studies, respectively. In addition, every person who took part in the FinnTwin 12 and 16 studies gave their informed permission in writing form. Last but not least, the Helsinki and Uusimaa Hospital District (HUS) gave its stamp of approval for an ethical research to be conducted on the treatment of teenagers at the Helsinki University Central Hospital (Dnro 715/13/002012).

STUDY COHORT

The Finn Twin 12 is a population-based continuing longitudinal research that attempts to investigate genetic and environmental variables connected to health-related behaviours, with a specific emphasis on alcohol use and abuse. The project is now in its twelfth and last year of data collection. The Finnish Central Population Registry was used to determine the birth years of the twins who make up the research cohort. These twins were born in consecutive years between 1983 and 1987. In all, 5,600 sets of twins and their families were asked to take part in the research. All of these people were included in the study's epidemiological sample

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for the Fin- nTwin 12 project. In waves 1 through 4, the response rate was between 85 and 90%. (Kaprio, 2013).

An intensely examined sample was also included in the research project. This sample was derived from the epidemiological sample, and the desired total number of households to include in the intensive study was 1035. This sample was made up mostly of families who had been chosen at random from the larger epidemiological sample (72,3 percent of the total). The rest were enriched from the families who had gained high points from the Malmo-modified Michigan Alcoholism Screening Test (Mm-MAST) (Seppa, Sillanaukee, & Koivula, 1990) that has been designed to survey alcohol use and alcohol dependency. This test was developed by Seppa, Sillanaukee, and Koivula.

The first round of information collection occurred only a few days before the twins turned 12 years old. In order to collect information, questionnaires were sent out to all of the twins, as well as to their parents and instructors. The questionnaire had questions on the use of alcohol and tobacco, as well as questions about lifestyle and health status. Both the instructors and the parents of the twins were questioned on the behaviour of the children, and the parents were also questioned regarding the twins' pregnancies and early childhoods. (n = 1860) Parents from the sample that was being carefully researched were also interviewed during the first wave utilising a semi-structured psychiatric assessment interview (SSAGA) (Bucholz et al., 1994).

During the second wave of information collecting, which took place when the twins were 14 years old, information was once again acquired from the twins and teachers from the whole epidemiological sample by means of questionnaires. A semi-structured mental evaluation interview was used to conduct interviews with each of the 1,852 twins who were included in the sample that was carefully researched (SSAGA). The sample that was subjected to extensive research also took part in neuropsychological examinations as well as further saliva hormone analyses.

At the third wave of the study, when the twins were 17 years old, all of the participating twins were asked to fill out questionnaires in order to collect information.

When the twins were around 22 years old in 2006-2009 (range: 21-26 years), information was acquired from the full epidemiological sample using questionnaires for the fourth information collection wave. In addition, 1347 individuals (709 women and 638 men) from the sample that was intensively studied took part in semi-structured psychiatric interviews (a

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Structured Clinical Interview for DSM-IV, SCID (First, Spider, Gibbon & Williams, 2002)) as well as neuropsychological tests, anthropometrics, smell and taste testing, blood and/or saliva samples. The interviews were conducted using a Structured Clinical Interview for DSM-IV, SCID (First, Spider, Gib The data gathering is shown in Figure 4.

Slightly more than half of the diagnostic interviews (n = 709) were conducted in-person, while the remaining interviews were conducted over the phone. The interview team consisted entirely of Finnish women, all of whom had degrees related to the medical field. They had degrees at the master's level in health care, at the advanced graduate level in psychology, and held registered nursing licences. They had already completed extensive training on the interview instrument at the Indiana University Medical School in the United States before to performing the interviews there.

The interviewers probed the individuals with questions on symptoms of eating disorders in accordance with the DSM-IV criteria. In addition, participants were questioned on the start and duration of eating disorder symptoms, as well as the likely diagnosis of an eating disorder in health care and whether or not they got treatment. In addition, the respondents were questioned in great depth about the progression of their weight from their late teenage years into adulthood, and a weight curve was created based on the information gathered. Those participants who took part in the in-person interview had their height and weight measured as well; on the other hand, those who were questioned over the phone were responsible for providing their own height and weight information.

DATA ANALYSIS

INTRODUCTION

Within the scope of research I, we investigated the prevalence of DSM-5 eating disorders among the general population using the FinnTwin 12 sample. Out of a total of 1,347 girls and men questioned, we identified eating disorders in 142 people using the DSM-5 criteria. The male to female ratio was 8 to 1. In all, 709 females were questioned, and 127 of them were diagnosed with DSM-5 eating disorders. In comparison, just 15 of the 638 men examined had eating disorders. Three patients, two girls and one male, were each given two separate diagnoses.

Figure 6 illustrates the differences between men and females with regard to the prevalence of

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certain disorders. Anorexia nervosa was the most prevalent diagnosis among females with eating disorders. Over fifty percent of cases of eating disorders in women were restricted (anorexia nervosa, atypical anorexia nervosa, unspecified eating disorders restrictive syndrome). Unspecified eating disorders were the most frequent kind of eating disorder among boys, accounting for 63% of all eating disorders identified among males..

LIFETIME PREVALENCE

In investigations I and III, we used population samples from the FinnTwin 12 and FinnTwin 16 cohorts to conduct an analysis of the lifetime prevalence of DSM-5 eating disorders. Table 23 contains an in-depth description of the outcomes of the study.

17.9% of the female participants in research I (FinnTwin 12) had been diagnosed at some point in their history with a prevalent eating problem. Anorexia nervosa had a lifetime prevalence of 6.2%, bulimia nervosa had a prevalence of 2.4%, and binge eating disorder had a prevalence of 0.6%, bringing the overall prevalence for typical eating disorders to 9.2%. The prevalences of additional specified eating disorders were as follows: 2.1% for atypical anorexia nervosa, 1.3% for a purging condition, and 0.4% for bulimia nervosa (low frequency/lim- ited incidence).ited length), and 0.7% for binge eating disorder (low frequency/limited dura- tion), which brings the overall rate up to 4.5%. The lifetime prevalence for nonspecific eating disorders was found to be as follows: 0.4% for the restricted syndrome, 1.7% for subthreshold BN/BED, 1.1% for other, and 0.3% for inadequate information, which brought the overall prevalence up to 4.5%. Eating disorders had an incidence of 2.4% among guys across their whole lifetimes. Anorexia nervosa had a lifetime prevalence of 0.3%, whereas bulimia nervosa had a prevalence of 0.16%, and binge eating disorder had a prevalence of 0.3%. Only one guy was found to be suffering from atypical anorexia nervosa, which contributed to the overall proportion of other defined eating disorders being 0.16%. The lifetime prevalence for nonspecific eating disorders was 1.6%, with restrictive syndrome having a prevalence of 0.5%, subthreshold BN/BED having a prevalence of 0.5%, and other eating disorders having a prevalence of 0.6%, bringing the overall prevalence up to 1.6%.

The sensitivity analysis revealed that the lifetime prevalence estimates of eating disorders were not significantly different between the sample that was randomly chosen and the sample that was enriched for families with a high risk of drinking issues. This was the finding of the study. In the sample of females, the lifetime prevalence was 18.7% (95% CI 15.4-22.5) in the

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randomly chosen sample, whereas it was 15.6% (95% CI 10.8-22) in the enriched sample, with a p value of 0.37 for the difference between the two samples. Among men, the lifetime prevalence was 1.8% (95% confidence interval [CI]: 0.9-3.5) in the sample that was randomly chosen, whereas it was 3.8% (95% CI: 1.6-8.5) in the sample that was enriched; the p value for this difference was 0.16.

The criteria for diagnosing anorexia nervosa were updated from DSM-IV to DSM-5 in research III (FinnTwin 16 sample), which resulted in a rise of sixty percent in the lifetime prevalence of the condition. The lifetime prevalence of the disease was 3.6% among women, when the analysis focused just on those individuals who had actually discovered instances. In addition, we employed sample weights to compensate for false negatives that were missed by symptom screening, which resulted in an increase in the lifetime prevalence estimate to 6.3%. In addition, we used sampling weights to conduct an analysis of the lifetime prevalence of the total number of eating disorders, which included anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified and unspecified eating and feeding disorders. The total prevalence of eating disorders was found to be 14.2% among females.

Table 4. 1 The Lifetime Prevalence Of DSM-5 Eating Disorders From The Finntwin12 Sample. From The Finntwin 16 Sample, Only A Lifetime Estimate For Anorexia Nervosa Is Described With And Without Using Sampling Weights.

	FE-MALES% ⇧	**95 % CI**	**MALES %** &	**95 % CI**	**TOTAL %**	**95 % CI**
Specified Eating or Feeding Disorder						
Anorexia nervosa **FT12**	6.2	4.6–8.3	0.3	0.08-1.3	3.4	2.5–4.6
FT16 FT 16 *	3.6 6.3	2.7 - 4.2	-	-	-	-
Bulimia Nervosa	2.4	1.5-3.9	0.16	0.02-1.1	1.3	0.8-2.2

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Binge Eating Disorder	0.6	0.2-1.5	0.3	0.08-1.25	0.4	0.2-1.0
Other Specified Eating or Feeding Disorder (OSFED)						
Atypical Anorexia Nervosa	2.1	1.3-3.5	0.16	0.02-1.1	1.2	0.7-2.0
Bulimia Nervosa of low frequency and/ or limited duration	0.4	0.1–1.3	0	-	0.2	0.07-0.7
Binge Eating Disorder of low frequency and/or limited duration)	0.7	0.3–1.7	0	-	0.4	0.2–0.9
Purging Disorder	1.3	0.7-2.4	0	-	0.7	0.3–1.3
OSFED all	4.5	3.2-6.3	0.16	0.02-1.1	2.4	1.8-3.4
Unspecified Feeding or Eating Disorder (UFED)						
Restrictive syndrome	1.4	0.8-2.6	0.5	0.2-1.5	1.0	0.6-1.7
Subthreshold bulimia/BED	1.7	1.0-3.0	0.5	0.2-1.5	1.1	0.7-1.8
Other	1.1	0.6-2.2	0.6	0.2-1.7	0.9	0.5-1.6
Insufficient information	0.3	0.07-1.1	0	-	0.15	0.04-0.6
UFED all	4.5	3.2-6.3	1.6	0.8-2.9	3.1	2.3-4.2
Any Eating or Feeding Disorder						
	17.9	15.1-21.1	2.4	1.4-4.0	10.5	8.9-12.4

CONCLUSION

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Eating disorders may result in deadly effects owing to nutritional inadequacies. Patients who suffer from eating disorders may display suicidal behaviour or interfere with their own ability to function socially. In rare cases, the condition may even cause the breakdown of the family unit. It is very necessary for the patient's family and the other persons in the patient's immediate environment to be actively involved in the treatment process. In addition, it is important to emphasise that the condition does not just result in abnormalities in a patient's eating patterns, but that it also has a wide range of other effects on the patient's physical, psychological, and social aspects. Eating disorders are a severe condition that may be difficult to treat, and they need to be recognised as such.

The most important risk factors for eating disorders were found to be exposure to various forms of media, as well as the social and familial settings. While the time of meals in the household was an important factor in influencing eating behaviour and the development of eating disorders, the effect of the media and the social environment was mostly linked to the worship of thinness. The ED were linked to issues with dietary intake (including stunted development and weight gain), oral health (including cheilosis, dental erosion, periodontitis, and hypertrophy of the salivary glands), and social impact.

The results of the studies shown above suggest that there may be more than one cause of eating disorders. Personality characteristics, physiologic shifts, cognitive processes, genetic predisposition, the environment in which one is raised, and even influences from the outside world, such as those exerted by the media, may all play a significant part in the development of maladaptive eating behaviours. Readers interested in a more in-depth analysis might go to McFarlane et al. for further information (2016). According to what Foreyt and McGavin (1989) had said, "....we are unlikely that the emergence of these complex illnesses can be explained without an awareness of several pertinent aspects, including the physiological, sociological, family, psychiatric, and psychological" . First and foremost, there are cultural differences in the ways in which it manifests. Despite the fact that the DSM-5 categorization of mental illnesses, which is intended to be scientifically validated and represent consensus, there are significant debates over this topic, since many symptoms are not universal, and the criteria still remain opaque. Not only is the aetiology of eating disorders difficult to understand, but also the manifestations, which include binge eating and vomiting, regurgitation, fasting, having distorted beliefs about body image, weight gain, and even self-esteem, show a wide variety of aberrant behaviours. Some of these behaviours include avoiding food, adhering to strict dietary rules, constantly measuring the caloric intake,

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avoiding food, and constantly measuring the caloric intake. Because of this, a significant amount of research effort has been put into determining what causes eating disorders and developing effective treatments for them. This assertion has been solidly backed up by the formation of new research groups, the establishment of scientific societies, and the publishing of a significant number of research journals that are solely devoted to the investigation of eating disorders.

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