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PSYCHOLOGICAL CHARACTERISTICS OF BODY WEIGHT ISSUES IN WOMEN WITH DISORDERED EATING BEHAVIOR

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ABSTRACT

This article examines the psychological characteristics of body weight issues in women with disordered eating behavior. It analyzes the influence of emotional, cognitive, and behavioral factors on body image perception and eating attitudes. The study highlights the role of body dissatisfaction, perfectionism, and emotional dysregulation in the development of anorexia, bulimia, and binge-eating tendencies. The findings support the need for targeted psycho-correctional programs to improve self-image and regulate maladaptive eating behavior.

I. Introduction

Obesity has become a global health epidemic, affecting individuals across all age groups and socioeconomic backgrounds. According to the World Health Organization (WHO, 2024), more than 1.9 billion adults were overweight in 2022, and of these, over 650 million were classified as obese. The causes of obesity are multifactorial, with eating behavior playing a central role. This article investigates how psychological variables—particularly emotional regulation, self-esteem, and cognitive distortions—contribute to the development and maintenance of obesity.

In recent decades, body image dissatisfaction and disordered eating behavior (DEB) have become pressing psychological concerns, especially among women. Cultural norms that idealize thinness contribute to distorted body perceptions and unhealthy dietary restrictions. Disordered eating encompasses a spectrum of behaviors including chronic dieting, compulsive overeating, bulimia nervosa, and anorexia nervosa. These behaviors are not only physical but reflect deeper emotional and

cognitive dysfunctions. Research shows that **1 in 10 women** worldwide suffer from clinically significant eating disorders, and even more engage in subclinical patterns of disordered eating. These behaviors often emerge during adolescence and persist into adulthood, interfering with psychosocial functioning, emotional wellbeing, and physical health. Therefore, identifying the psychological underpinnings of DEB is essential for early diagnosis, treatment, and prevention.

II. Theoretical Significance of the Topic

Eating behavior is a complex psychological construct influenced by physiological, social, and emotional factors. It is shaped during early childhood through parental modeling, cultural norms, and individual personality traits. Among the various types of disordered eating behaviors, emotional eating, external eating, and restrained eating are most strongly linked to obesity.

Psychological Constructs Associated with Disordered Eating

Disordered eating behavior (DEB) is not merely a problem of nutritional imbalance or lifestyle; it is deeply rooted in complex psychological processes that shape an individual's perception of self, body, and emotional world. While disordered eating can present in various forms—ranging from restrictive eating to binge-purge cycles—the underlying psychological constructs tend to show remarkable consistency, particularly among women. These constructs include low self-esteem, perfectionism, emotional dysregulation, cognitive distortions, and the lasting impact of early trauma and attachment issues. Understanding these components is vital for both diagnosis and treatment planning.

1.Low Self-Esteem and Body Dissatisfaction. One of the most consistent psychological characteristics of individuals with disordered eating is **low self-esteem**, especially when it comes to appearance and body image. In women, this is often exacerbated by **sociocultural pressures** and pervasive media portrayals of thinness as the ideal standard of beauty. From a young age, women are socialized to equate their value with their physical appearance. As a result, they may engage in chronic self-comparison with unattainable beauty ideals presented in advertisements, films, and social media. This leads to **body dissatisfaction**, a persistent negative evaluation of one's body shape, size, or weight. Body dissatisfaction is not simply about aesthetics; it is intrinsically tied to feelings of self-worth. In many cases, women begin to believe that being thinner will lead to greater acceptance, love, and success. This distorted belief system fuels a cycle of restrictive eating, compulsive exercising, and, in more extreme cases, purging or starvation. Notably, body dissatisfaction is often **resistant to change**, even after significant weight loss, indicating that the problem lies in psychological perception rather than physical reality.

2.Perfectionism and the Need for Control. **Perfectionism** is another major psychological trait found among individuals with disordered eating. It involves setting unrealistically high standards for oneself and being excessively self-critical when those standards are not met. In the context of DEB, perfectionism often manifests in the form of rigid dietary rules, obsessive calorie counting, or compulsive exercise. For these individuals, “success” is often defined by strict control over food intake and body appearance, and “failure” is equated with even minor deviations from their dietary regime.This need for control frequently extends beyond eating habits. In many cases, individuals with DEB feel a lack of control in other areas of their lives—such as family dynamics, personal relationships, or academic/work performance—and food becomes the one domain where they can exert authority. **Restrictive eating** may serve as a coping mechanism for managing anxiety, uncertainty, or chaos in one’s emotional world. Paradoxically, the more they strive for

control through perfectionistic behaviors, the more out of control their psychological well-being becomes.

3.Emotional Dysregulation and Coping Deficits. **Emotional dysregulation**, or the inability to effectively manage emotional responses, plays a crucial role in the maintenance of disordered eating behaviors. Individuals with DEB often experience intense emotions—such as shame, guilt, sadness, or anger—but lack the skills to cope with them in adaptive ways. Instead, they turn to food-related behaviors as maladaptive coping mechanisms. For example, **binge eating** is commonly used to numb or distract from distressing emotions, providing temporary relief but often followed by feelings of guilt and self-loathing. In contrast, **purging behaviors** (e.g., self-induced vomiting or misuse of laxatives) may serve as a form of self-punishment or an attempt to undo perceived mistakes. Restrictive eating can be seen as a way to achieve a sense of control and calm amid emotional chaos. Many individuals with DEB report difficulties in **identifying and labeling their emotions** (a phenomenon known as alexithymia), which further complicates emotional regulation. Without the ability to recognize or verbalize their emotional states, they are more likely to act out their distress through disordered eating patterns.

4.Cognitive Distortions and Maladaptive Thinking. Cognitive distortions—systematic errors in thinking—are highly prevalent in individuals with disordered eating. These distorted thoughts often reinforce negative self-beliefs and irrational fears, particularly regarding food, weight, and self-worth. Common cognitive distortions seen in DEB include:

- **All-or-nothing thinking**: Viewing eating behavior in black-and-white terms (e.g., "If I eat one piece of chocolate, I've failed entirely.").
- **Catastrophizing**: Exaggerating the negative consequences of minor dietary deviations (e.g., "If I eat carbs, I will gain weight instantly and be unlovable.").
- **Overgeneralization**: Applying one negative experience broadly across situations (e.g., "I couldn't stick to my diet yesterday, so I'll never be successful.").
- **Personalization**: Assuming that others are judging them harshly based on their appearance (e.g., "Everyone is staring at my stomach.").

These maladaptive thought patterns reinforce disordered behavior and often persist even in the face of contradictory evidence. Cognitive Behavioral Therapy (CBT) for eating disorders typically focuses on identifying and restructuring these thoughts to promote healthier beliefs and behaviors.

5. Early Trauma and Attachment Insecurity. There is increasing evidence that **early life trauma**—such as physical, emotional, or sexual abuse—can contribute to the development of disordered eating. Trauma disrupts an individual's sense of safety and self-worth, often leading to chronic feelings of shame, distrust, and emotional numbness. Eating disorder behaviors may emerge as attempts to regain a sense of control, soothe emotional pain, or express unmet emotional needs.

In addition, **insecure attachment patterns**—often resulting from emotionally unavailable or inconsistent caregivers—can result in difficulties with emotional regulation and self-concept. Children who grow up without reliable emotional support may internalize beliefs of being "unworthy" or "unlovable," and these feelings can manifest in adulthood through self-destructive behaviors such as starvation, binging, or purging.

Disordered eating, in this context, becomes not only a symptom but a language of emotional expression—a way to

communicate unmet needs, unresolved trauma, or unprocessed grief.

The psychological constructs associated with disordered eating are multifaceted and deeply embedded in an individual's emotional and cognitive framework. Low self-esteem, perfectionism, emotional dysregulation, cognitive distortions, and trauma histories collectively shape the disordered relationship with food and body image seen in many women. Effective treatment must therefore address not only the behavioral symptoms but also the underlying psychological issues. Therapeutic approaches that incorporate cognitive restructuring, emotion-focused strategies, and trauma-informed care hold the most promise for sustainable recovery. By acknowledging and targeting these core psychological factors, clinicians can provide more compassionate, comprehensive, and effective care for individuals struggling with disordered eating.

III. Psychological Features of Body Weight Problems in Disordered Eating Behavior (DEB)

Body weight concerns are among the most visible symptoms of disordered eating behavior (DEB); however, these concerns are more than just physical or medical issues—they are rooted in complex psychological processes. Importantly, **disordered eating is not necessarily linked to a high body mass index (BMI)**. Many women suffering from DEB may fall within the medically defined "normal" weight range or even below it, yet they still perceive themselves as overweight or unattractive. This **distorted body image**—commonly known as body image distortion or body dysmorphia—is not just a symptom but a central psychological feature that fuels and sustains disordered eating patterns.

The psychological features tied to body weight concerns in DEB are varied but interrelated. Below are the most prominent constructs observed in clinical and empirical settings:

1. Distorted Body Image and Negative Self-Concept. One of the hallmarks of DEB is a **negative self-concept**, in which individuals measure their self-worth predominantly—if not exclusively—based on their body size, shape, or ability to control their eating. Women with DEB frequently hold rigid and unrealistic standards of beauty and may internalize harmful societal messages that equate thinness with success, discipline, attractiveness, or moral virtue. In this context, gaining weight—even in small increments—can be perceived as a catastrophic personal failure. This **cognitive distortion** leads to the development of extreme weight control strategies such as starvation, overexercising, or purging, all in an effort to maintain a fragile sense of self-worth. Over time, the individual's entire identity may become wrapped up in their ability to meet self-imposed (and often unattainable) aesthetic standards. Furthermore, these individuals often experience **body-checking behaviors**—such as frequently weighing themselves, pinching fat, or compulsively looking in the mirror—despite evidence that their body is objectively healthy or even underweight. This confirms that their distress is psychological rather than based in physical reality.

2.Social Comparison and Social Withdrawal. Another core psychological feature is a heightened tendency toward **social comparison**, especially concerning physical appearance. Women with DEB often compare their bodies to those of peers, celebrities, or social media influencers, typically concluding that they fall short. This constant comparison not only reinforces body dissatisfaction but also fosters **feelings of inadequacy, shame, and low social self-esteem**. These internalized beliefs can lead to **social withdrawal** and avoidance behaviors. Many women with DEB report feelings of embarrassment around eating in front of others, leading them to avoid social events, family meals, or public settings where food is present. They may eat in secrecy, avoid discussing their struggles, and isolate

themselves from support networks. This **cycle of secrecy and isolation** can intensify feelings of loneliness and further entrench maladaptive behaviors. In some cases, this social withdrawal is motivated by the **fear of judgment**—whether it's being judged for their appearance, what they eat, or how much control they exert over their diet. These social anxieties perpetuate disordered patterns and reduce opportunities for social and emotional support, which are critical for recovery.

3. Anxiety and Depressive Symptoms. Psychological distress in DEB is rarely confined to issues with body weight or eating habits alone. A large body of research has documented the **strong co-occurrence of anxiety and depression** in individuals with disordered eating. These symptoms can exist as **precursors**, **consequences**, or **maintaining factors** of the eating disorder.**Anxiety**: Many women with DEB report **chronic anxiety** about food, weight gain, social evaluation, and loss of control. Anticipating a meal, eating in front of others, or even the thought of deviating from a strict eating routine can provoke panic and distress. This anxiety can lead to compulsive behaviors and rituals designed to reduce perceived threats.

Depression: Similarly, **depressive symptoms**—such as persistent sadness, low energy, hopelessness, and guilt—are common. Individuals may feel trapped in their behaviors, ashamed of their inability to "just eat normally," and emotionally exhausted by the internal battles they face daily. These emotional states not only hinder treatment engagement but also fuel further disordered behaviors as methods of coping or self-punishment. Moreover, the **cyclical nature** of anxiety and depression in DEB cannot be ignored. Restriction and purging may momentarily reduce distress but eventually exacerbate mood symptoms due to physiological imbalances, shame, and emotional numbness.

4. Obsessive-Compulsive Traits and Ritualized Eating Behavior. Many individuals with DEB demonstrate **obsessive-compulsive traits**, which include rigidity, perfectionism, and the need for control. These traits are most commonly observed in **ritualized eating behaviors** that serve as coping mechanisms to manage inner chaos or anxiety. Common examples include:

- Eating only at specific times or under specific conditions
- Cutting food into small pieces or eating in a particular order
- Counting calories with extreme precision
- Weighing food portions obsessively
- Checking one's weight multiple times per day

These **rituals provide a temporary sense of order and predictability** in what may otherwise feel like an emotionally overwhelming world. However, the rigidity of these behaviors also leads to **inflexibility** and distress when routines are disrupted, such as during travel, holidays, or spontaneous meals.Obsessive behaviors also **extend beyond food**. Some individuals become preoccupied with exercise routines, constantly thinking about their body's shape or weight, or meticulously planning meals in advance to avoid perceived dietary errors. Over time, these behaviors become compulsive and **interfere with daily functioning**, reducing the quality of life.

IV. Methods and Correctional Strategies

Addressing DEB in women requires a **multimodal psycho-correctional approach**. Therapeutic interventions should be adapted to address the emotional, cognitive, and behavioral dimensions of the disorder.

1. Cognitive-Behavioral Therapy (CBT).CBT targets dysfunctional thoughts about food and body image, helping clients develop healthier beliefs and coping mechanisms.

2. Mindfulness-Based Approaches. Mindfulness helps clients become aware of emotional triggers without resorting to disordered behavior, promoting acceptance and body neutrality.
3. Emotion Regulation Training. These sessions help women identify, understand, and manage their emotions, reducing the need for maladaptive coping such as bingeing or restriction.
4. Group Therapy and Support. Interpersonal processing groups provide shared experiences and promote recovery through collective insight and mutual support.
5. Psychoeducation. Educational modules about nutrition, health consequences of DEB, and the psychology of body image help demystify the disorder.

V. Findings from Empirical Research.

To better understand the psychological underpinnings of body weight issues in women with disordered eating behavior (DEB), a **quasi-experimental pre-post design** study was conducted. The sample comprised **40 women aged 18 to 35** who reported varying degrees of DEB symptoms, ranging from mild dietary restriction to clinically significant binge-purge behaviors.
Methodology and Instruments
Each participant underwent psychological assessments **before and after a 12-week psycho-correctional intervention program**, which combined elements of **Cognitive Behavioral Therapy (CBT)**, **body image restructuring**, and **emotional regulation training**. The following standardized psychometric tools were employed:

- **Eating Attitudes Test (EAT-26)**: A screening tool used to assess symptoms and concerns characteristic of eating disorders.
- **Body Image Avoidance Questionnaire (BIAQ)**: Measures behavioral indicators of body image dissatisfaction.
- **Beck Depression Inventory-II (BDI-II)**: Assesses the severity of depressive symptoms.
- **Rosenberg Self-Esteem Scale (RSES)**: Measures global self-esteem.

Summary of Statistical Findings

N	Variable	Pre-Intervention	Post-Intervention	t-value	Significance
1	Body dissatisfaction	32.5	24.1	4.52	$p < 0.001$
2	Disordered eating score	28.7	20.4	4.13	$p < 0.001$
3	Self-esteem (RSES)	17.2	22.3	-3.89	$p < 0.01$
4	Depression (BDI-II)	21.6	14.8	3.71	$p < 0.01$

Interpretation of Results

1. **Significant reduction in body dissatisfaction**: Post-intervention BIAQ scores decreased by approximately **25.8%**, indicating that participants experienced a more positive perception of their body image after the intervention. This supports the effectiveness of cognitive restructuring exercises and body image exposure techniques in mitigating body image avoidance behaviors.
2. **Improvement in disordered eating patterns**: The EAT-26 score showed a **28.9% decline**, reflecting reduced preoccupation with dieting, food-related anxiety, and compensatory behaviors. This suggests that

addressing cognitive distortions and emotional coping strategies directly impacts eating behavior.

3. **Increased self-esteem**: The RSES scores rose significantly, from **17.2 to 22.3**, showing an increase in participants' global self-worth. This highlights the intervention's success in helping participants shift their identity from being body-focused to more self-compassionate and holistic.
4. **Decrease in depressive symptoms**: Depression scores (BDI-II) dropped by **over 30%**, which is a clinically meaningful change. This reduction may be attributed to the combined effect of emotional regulation strategies and improved body acceptance, which alleviate persistent negative emotions.

Taken together, these findings confirm that a well-structured, psychologically grounded intervention can produce measurable improvements across several key domains: body image, eating behavior, mood, and self-concept.

VI. Conclusion and Recommendations

This research demonstrates that **body weight concerns in women with disordered eating behavior are primarily psychological in origin**, rather than purely based on physical or medical factors such as BMI. Many participants, despite being of normal or low weight, displayed profound dissatisfaction with their appearance, pointing to a **distorted internal self-image** as the central issue.The following psychological dysfunctions were identified as primary contributors:

- Over-identification with physical appearance as the core of self-worth
- Maladaptive perfectionism and cognitive rigidity
- Emotional dysregulation and poor coping strategies
- High levels of social comparison and fear of negative evaluation

The intervention program effectively targeted these dysfunctional patterns and yielded **statistically and clinically significant improvements** across all measured variables.Therefore, **treatment approaches must shift from solely nutritional correction to include psychological restructuring** as a primary focus. Ignoring the psychological dimensions not only limits recovery but may also lead to relapse.

Recommendations.

1.Integrative Clinical Intervention

- **Holistic treatment teams** comprising **psychologists, dietitians, and medical doctors** should collaborate to address both the psychological and physiological dimensions of DEB.
- Emphasis should be placed on **CBT, body image therapy, and trauma-informed care** as core psychological modalities.

2. Early Screening and School-Based Interventions

- Implement **regular screening programs** in schools and universities to detect early signs of body dissatisfaction, low self-esteem, and perfectionism in adolescents and young adults.
- School psychologists should be trained to identify disordered eating risk factors and refer students to appropriate care.

3. Parent and Caregiver Education

- Launch **parental education programs** to promote understanding of **healthy emotional development, communication, and body positivity** in children and adolescents.
- Encourage **non-appearance-based praise** and model body-accepting attitudes at home.

4. Societal Awareness and Media Literacy

- Conduct **national awareness campaigns** that challenge harmful beauty standards perpetuated by social media and popular culture.
- Promote **diverse body representations** in media to reduce unrealistic expectations and normalize natural variations in body shape and size.

5. Policy Development and National Mental Health Initiatives

- Advocate for national mental health policies that **recognize DEB as a serious public health concern**, not merely a lifestyle issue.
- Support funding for **community-based body image programs, youth counseling services**, and research initiatives aimed at understanding cultural factors influencing body image in specific regions (e.g., Central Asia, Uzbekistan).

The psychological complexity of disordered eating requires nuanced, compassionate, and evidence-based approaches. Addressing only the physical symptoms without treating the psychological roots—such as low self-worth, perfectionism, and distorted self-perception—risks incomplete recovery. By promoting integrative interventions and societal shifts in body norms, it is possible to foster healthier relationships with food, self, and body, particularly among young women who are most at risk.

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