



T.C.
YEDİTEPE UNIVERSITY
INSTITUTE OF HEALTH SCIENCES

**DETERMINATION OF EATING ATTITUDES OF A
SPECIAL POLYCLINIC APPLICANTS BY EAT-40**

MASTER THESIS

MELİS DESTERECİ

Istanbul – 2019



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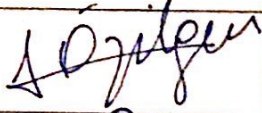
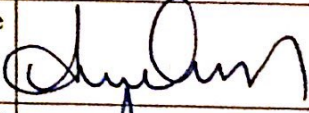

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ONAY

Bu tez Yeditepe Üniversitesi Lisansüstü Eğitim-Öğretim ve Sınav Yönetmeliğinin ilgili maddeleri uyarınca yukarıdaki jüri tarafından uygun görülmüş ve Enstitü Yönetim Kurulu'nun 20/09/2019.. tarih ve 2019/15.-29..... sayılı kararı ile onaylanmıştır.


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DECLARATION

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree except where due acknowledgment has been made in the text.

Melis Destereci

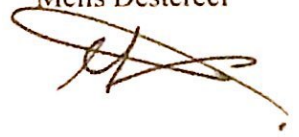
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LIST OF SYMBOLS AND ABBREVIATIONS

AN: Anorexia Nervosa

APA: American Psychiatric Association

BDD: Body Dysmorphic Disorder

BED: Binge Eating Disorder

BMI: Body Mass Index

BN: Bulimia Nervosa

DSM-5: The Diagnostic and Statistical Manual of Mental Disorders

EAT-26: Eating Attitudes Test -26

EAT-40: Eating Attitudes Test -40

EDs: Eating Disorders

ED-NOS: Eating Disorder not Otherwise Specified

OCD: Obsessive-Compulsive Disorder

OCPD: Obsessive-Compulsive Personality Disorder

SD: Standard Deviation

ABSTRACT

Destereci, M. (2019). Determination of Eating Attitudes of a Special Polyclinic Applicants by Eat-40. Yeditepe University, Institute of Health Science, Department of Nutrition and Dietetics, MSc Thesis, İstanbul.

The aim of this study was to investigate the relationship between eating attitude behaviours and Anorexia Nervosa in patients admitted to a private outpatient clinic. Eating Attitude Test-40 was used as data collection tool. A total of 100 non-pregnant, non-breastfeeding patients admitted to the outpatient clinic and agreed to participate in the study were interviewed. 69 of these patients were female and 31 were male. As a result of the study, it was observed that there was no significant difference between eating attitude behaviours of participants, age, working status, smoking, alcohol use, marital status, but there was a significant relationship between height. Finally, no significant relationship was found between healthy living and income level and regular physical activity.

Keywords: Eating Attitudes, Anorexia Nervosa, EAT-40, Esthetic.

ÖZET

Desterci, M. (2019). Özel Bir Polikliniğe Başvuranların Yeme Tutumlarının YTT-40 İle Belirlenmesi. Yeditepe Üniversitesi, Sağlık Bilimleri Enstitüsü, Beslenme ve Diyetetik Anabilim Dalı, Yüksek Lisans Tezi, İstanbul.

Bu çalışmanın amacı özel bir polikliniğe başvuran hastalarda yeme tutumu davranışları ile AnoreksiyaNervoza arasındaki ilişkiyi araştırmaktır. Araştırmada veri toplama aracı olarak Yeme Tutum Testi-40 kullanılmıştır. Polikliniğe başvuran ve çalışmaya katılmayı kabul eden hamile olmayan, emzirmeyen toplam 100 hasta ile görüşülmüştür. Bu hastaların 69'u kadın, 31'i erkektir. Araştırma sonucunda, katılımcıların yeme tutumu davranışları ile yaş, çalışma durumu, sigara içme, alkol kullanımı, medeni durum arasında anlamlı bir fark olmadığı, ancak cinsiyet arasında anlamlı bir fark olduğu görülmüştür. Yine, yeme tutumu davranışları ile vücut kitle indeksi ve kilo arasında anlamlı bir ilişki olmadığı, boy arasında anlamlı bir ilişki olduğu görülmüştür. Son olarak, sağlıklı olduğunu düşünme ve gelir düzeyi ile düzenli fiziksel aktivite arasında anlamlı bir ilişki bulunamamıştır.

Anahtar Sözcükler: Yeme Tutumu, AnoreksiyaNervoza, YTT-40, Estetik.

1. INTRODUCTION AND PURPOSE

Recently, Eating Disorders (EDs), fairly widespread, affects people from social, physical and mental aspects. Because many people consume unhealthy diets, for the sake of having a beautiful and aesthetic body, they are caught diseases that are dangerous, and the consequences are severe. As a result, individuals face problems without treatment (1).

When talking about unhealthy nutrition, the first thing that comes to our mind is the problem of gaining weight and developing obesity due to the inability to stop eating. Because many people are afraid of gaining weight, they canalize to wrong diet, develop nutrition methods in their opinion, or feeding becomes quite a problem and an obsession in their minds. As a result of this, they are confronted with the bad psychology that leads to keeping themselves away from food and starve themselves (self-starvation), the advanced stage of this, and they may catch Anorexia Nervosa (AN), one of the diseases of EDs (2).

Eating Disorders are common conditions in young generation. They cause significant morbidity and mortality. The DSM-4-TR (The Diagnostic and Statistical Manual of Mental Disorders), classification system of the American Psychiatric Association (APA), classified EDs as Anorexia Nervosa (AN), Bulimia Nervosa (BN) and the atypical forms of these two syndromes (unnamed-EDs) (3).

In recent years, the Binge Eating Disorder (BED) has also added to these. DSM-5, the latest version of this system, includes the following disorders in the title of “Nutrition and Eating Disorders” with Eating Disorders: AN, BN, BED, Pica, Ruminant Disorder, Restrictive/Limited Food Intake Disorder, Unspecified Nutrition or Eating Disorder, Other Nutrition or Eating Disorder (4).

Studies on Eating Disorders, Anorexia Nervosa and Bulimia Nervosa have accelerated in the last 20 years. Since the 1970s there has been an increase in the number of patients admitted to treatment. 5-20% of the patients who did not respond to treatment were dying in the first periods. 25% of the patients had a chronic course. In addition to metabolic complications and psychosocial sequelae, secondary affective and anxiety disorders are also high in these patients. Anorexia Nervosa is characterized by not eating, wanting to become slim, fear of gaining weight. Bulimia Nervosa is a

disorder characterized by a feeling of losing control, vomiting, or controlling weight using laxatives, with binge-style eating episodes. Bulimia may be a symptom of a medical disorder or a component of the Anorexia Nervosa. However, Bulimia Nervosa may be a separate syndrome with obesity or normal body weight. AN, which is the first defined disorder in EDs, is a psychiatric disorder which has still the highest mortality rate (5).

The real cause of AN is unknown. Many factors such as biological (genetic components etc.), sociocultural (the rates of AN are higher in societies that value thinness and among high-level athletes, models, and dancers) and spiritual are proposed in the etiology of the disease, and it is accepted that the disease is caused by the interaction of multiple causes (6). In recent years, it is emphasized that information processing processes are also important in the etiology of AN (7).

The sociocultural etiology of AN should not be ignored. We are living in a world associated with that being thin is "beautiful, strong, hard-working, and disciplined person", but being overweight is "lazy, ugly, weak, powerless, clodhopper and weak-kneed person". Self-esteem and social worth are still obstinately and inevitably connected with physical appearance, especially for women. Today, criteria for ideal beauty are youth, thinness, whiteness, and smoothness in the skin, and being glamorous. Given that less than 1% of women fit this ideal beauty, it is not surprising that most of women in our society are unpleasant with their bodies (8-9).

The media, which supports the rapid adoption of cosmetic and aesthetic practices that have not existed more than two decades ago, is effective in individuals entering into a fragile relationship with their bodies. The ideal body images, which are reflected in magazines for both men and women, cause individuals to be concerned about their bodies. This may result in fatal hunger such as AN or excessive sports such as *athletica Nervosa* (10).

Bigorexia, which implies obsessed bodybuilding and often affects men, is classified as body dysmorphic disorder, although it is not yet defined as a disease by medical authorities. Just like the anorexics, bigorexics also have a distorted body perception about their bodies. This new disorder causes individuals who see their bodies as very small to exercise continuously (11-12).

In recent years, media has offered to be slim as the ideal body image. Especially in TV programs and magazines, continuous diet types and diet products are included. Ideally, repetition of weakness in the media leads to the internalization of the ideal body image, especially in women, as being slim and thin. (13-14). Anorexia Nervosa (AN) is a disorder based on a person's refusal to maintain body weight that is considered normal and healthy in accordance with his or her age and height. Anorexics have extreme fears of gaining weight with distorted body images. In these patients, it can be seen that there are irregularities in menstrual periods or that these periods disappear. Anorexics often think that they are fat, needing to lose weight. Their assessment of anorexics is based on their body weight and control over their diet. When they completely control their eating and lose weight, they believe that they are good and valuable (14).

When reading tabloid magazines and newspapers (actually most of them are photoshopped) or watching television (TV), weak and well-groomed actresses and handsome actors seen in TV commercials and movies that can make us feel that we're not attractive or thin like them. There are, of course, so many references to thinness and fashion/style that are only designed for certain sizes in such magazines, films, and commercials. Through the instrument of these images and movies, it is easy for people to think that they are not beautiful enough (14).

In fact, it should be known; we are all different creatures, and when considered from this point of view, we can make a difference. "No-Body is Perfect" and we are all beautiful just the way we are (if we are healthy) and in this respect, individuals should know and should not forget to love themselves. In addition, the idea must be dominated that "we need to stop criticizing ourselves and start criticizing the media!". Sometimes, diets, exercises, and surgical operations starting with a simple aesthetic concern can be the beginning of an endless path. Instead of the positive thoughts mentioned above, because of "obsession with becoming a fit woman", some women go to beauty/aesthetics centers and plastic surgeons, and also improve the habit of "not eating". This habit may turn into EDs over time (8-9).

AN disorder usually starts following events that cause excessive stress or a great lifestyle change. Significantly low weight has indispensable requirement for the diagnosis. This disease is classified according to the severity of the disease. According to this classification; individuals with body mass index (BMI) greater than 17 are classified as mild type AN, those between 17 and 16 are classified as moderate type

AN, those between 16 and 15 are classified as severe type AN, and those less than 15 are classified as extreme type AN (4).

Frequently AN begins during teen years or young adulthood. According to estimates, people who are living in western of Earth have AN in their life and distributions of rate are as follows: it (AN) occurs in 0.9-4.3% of women and 0.2-0.3% of men. Although it is more frequently diagnosed in the 20th century, it is still unknown whether this is due to an increase in the better frequency of ordiohnsis. AN also increases the risk of dying for a variety of other reasons, including suicide. Almost 5% of people with AN die of difficulties over a ten-year period, which represents an approximately 6-fold increased risk. AN can lead to severe psychosocial dysfunctions such as social withdrawal, low self-esteem, problem of peer relationships, suicide attempt, and serious biological consequences like kidney failure, heart damage, osteoporosis, and infertility, among others. EDs are a group of psychiatric diseases with biological, psychological and sociocultural dimensions. This disease affects especially young women. The increase in its prevalence is closely related to health professionals working in every branch, educators and parents. Because their treatments are difficult, long and expensive, the importance of protective and preventive efforts in the social and educational manner cannot be discussed. Since early diagnosis and guidance is vital, health professionals have important responsibility in this regard. (15-17).

This study was conducted between January 1 and February 28, 2019 in a special polyclinic in Kadıköy, where an average of 200 people apply to clinic each week and often include slimming, dermal fillers, skin treatments like Botox, and laser epilation operations.

The aim of this study was to relate the eating attitudes of individuals who applied to the outpatient clinic with aesthetic anxiety with AN. To determine the extent to which people in esthetic anxiety are prone to eating disorders and which nutrition model they are feeding.

2. LITERATURE REVIEW

2.1. Anorexia Nervosa (AN)

2.1.1. Introduction

AN is a eating disorder which is psychiatric and has potential life threats and it characterized by a desire to have a weak body, an overwhelming fear of gaining weight, and various original/strange behaviors to lose weight. Usually develops during adolescence or early adulthood. It's main feature is that the individual refuses to have at least the ordinary minimum body weight and exhibits considerable distortion in the perception of the body form or size. Anorexia Nervosa is a serious life-threatening eating disorder with abnormally low body weight. People with Anorexia Nervosa disorder are extremely obsessed with staying thin and all are well below their normal weight. It is always important for people with Anorexia Nervosa to be very thin. Anorexia Nervosa is commonly seen in young girls aged 12-20 years. 90 percent of people with Anorexia are women. The overall incidence rate in societies is 1-2 percent (3).

There are many sociocultural, psychological and biological factors affecting the occurrence of Eating Disorders. Social pressures about being slim and attractive, beauty standards, socioeconomic level and ethnicity, non-adaptive cognitions about eating, use of food to cope with painful emotions, various family dynamics or structures (interfering families, perfectionist with interdependence and tension in interaction) (eg.over-demanding families), sexual abuse, traumas, and genetic predisposition to eating disorders (15).

In AN, people constantly start thinking about food, diet and weight. There are images of a distorted body. Everyone says you're too weak, but when you look in the mirror you see it fat. Patients with AN want to keep their weight as low as possible by not eating enough, exercising too much, or doing both together. It can make them very sick because they start starving. In DSM-4-TR, there are two main subtypes of AN, which are as follow(18).

Restrictive type AN: Persons suffering from this disease are often perceived by society as being overly disciplined. They use excessive exercise, fasting, limiting food

intake and/or using diet pills to lose weight. Individuals with AN consume less calories than they need to maintain a healthy weight. Some people only eat as much food as they can survive. This is a form of self-hunger that is a pathetic. While restrictive AN patterns are similar to their diet behavior, there are significant distinctions among the two disorders. Damage, to the patient due to excessive attitudes caused by AN disorder, is more and serious than the effect of any disease in the form of a diet. AN people often deny that they have a problem. They don't see or believe what they're doing (18).

Binge eating /purging type AN: The patient with this type of AN will mostly use purging after eating. This situation suppresses the individual's fear of gaining weight and relieves the guilt of consuming some prohibited or very restricted foods. Unlike Anorexia, the body weight of Bulimia Nervosa patients may be within normal limits or more (18).

During binge eating episodes, they eat foods that contain carbohydrates, which are usually high in calories. Post-attack regret / guilt feelings, self-criticism, inappropriate and harmful balancing behaviors are observed. In the absence of binge eating episodes, they limit calorie intake and take low-calorie foods. On the other hand, individuals with BN can sometimes be overweight (15-18).

Although two main classifications of AN exist, similar symptoms are shown in both types, such as an irrational fear of gaining weight and abnormal eating patterns.

Obesity, which is a medical disease, is not considered as ED in psychiatric classifications. However, considering the close connection with psychological factors and psychological consequences, obesity is a diagnostic group that deserves psychiatric evaluation. In particular, the binge eating disorder group constitutes a subset of obesity (19).

2.1.2. Signs and symptoms

The primary evidence of the patient with AN is to lose weight voluntarily or to keep weight of her/his body with lower weight. One or several signals could be observed in AN patients (18), such as:

Physical symptoms:

- Chronic limited eating or dieting, beyond the standard (too little eating, missing meals).
- Rapidly losing weight or being significantly underweight.
- Taking medication to decrease her/his appetite, such as slimming or diet pills (appetite suppressants).
- Purging (use laxatives, use medication or water to vomit).
- Extreme exercise including micro-exercising. Also, some patients with AN may sicken themselves ill because of excessive exercise and the use of purgative and diuretic drugs in order to lose weight.
- Amenorrhea: Stopping the menstrual cycle in women who have not yet entered menopause (premature menopause) or the onset of menstrual cycle early in girls (precocious puberty).
- Thinning and reduction in hair
- Dry or yellowish skin.
- Having feet discoloration causing an orange appearance.
- Growing the plumy, very thin hair on the face and body (lanugo).
- Abdominal distension (bloating), constipation and pain of abdominal.
- Headaches or sleeping problems.
- Reduced sex drive
- Chronic fatigue (feeling dizzy and tired).
- Feeling cold particularly in extremities (poor circulation in hands and feet).
- Hypothermia.
- Hypotension or orthostatic hypotension.
- Bradycardia or tachycardia.

- A distinctive bad breath (halitosis) caused by vomiting or starvation (ketosis).
- Having severe muscle tension, aches, and pains.
- Decrease in testicular rate in men
- Menstrual irregularity or menstruation
- Dizziness and fainting
- Bluish color change in nails
- Hair thinning and reduction
- Constipation
- Dry or yellowish skin
- Bone resorption
- Swelling of the arms or legs
- Kidney problems

Anorexia, like other eating disorders, is a life-long disease. People with Anorexia refuse treatment from the very beginning. In addition to physical and emotional symptoms, the patient should be referred to a doctor for suspected Anorexia if:

- Skip meals,
- Reduce food portions,
- Making excuses for not eating,
- To continuously calculate the fat and calories of foods and to be fed according to these values,
- Avoiding tasty food,
- Constantly weigh how many pounds you have,
- Refusing to eat in the community,
- Check the mirror too often,
- Complaining that he is overweight, no matter how thin,

- Storing the body by wearing plenty of clothes,
- Ignoring anyone's opinion about themselves.
- Distorted body image; Women who suffer from this disease, even though their bodies are extremely thin, still mention that they are fat and reiterates that complaining about gaining weight.
- Thick dress up; Young women with Anorexia dressed in thick usually try to hide their weight loss. Anorexia patients say they are cold even though they are wearing thick clothes.
- Withdrawal from social life; Young women with Anorexia move away from their friends and social activities; gloom
- Wacky eating habits; If Anorexia patient is more busy with the fork knife than during a meal, prolongs chewing and prefers low-calorie foods, these may be a symptom of the disease.
- Exercise obsession; Anorexia patients become obsessed with exercise to burn calories. They often move their feet when they sit down.
- Self-catering; If they prefer to eat in their private rooms or alone, that means trying to hide their eating from others.
- Withholding; It can trigger the termination of menstrual periods in women because it causes excessive weight loss.
- Pale skin; The skin color of a healthy woman is normal. A pale skin may be a symptom of the disease. In addition, hair becomes dull.
- Constipation; Some women are using over-constipation laxatives to accelerate weight loss.
- Too soft skin; According to doctors, this is defined as the body's self-protection measure against heat loss as a result of excessive attenuation.
- Severe stomach aches; Vomiting is also seen in this discomfort caused by a long empty stomach.

- Food obsession: Young women with Anorexia show extreme interest in recipes. Obsessions about food.

AN and related malnutrition can cause complications in all organ systems. Widespread muscle weakness is a known complication of the disease and may develop due to hypokalemia, myopathy or neuropathy. Hypokalemia is a decrease in the potassium level in the blood and is a sign of Anorexia Nervosa. A significant decrease in potassium can cause arrhythmia in the heart (abnormal heart rhythms), constipation, fatigue, muscle damage, and paralysis. Although hypokalemia and myopathy are well defined, peripheral neuropathy has been reported in a few cases. On the other hand, folic acid deficiency which causes axonal neuropathy is rare (2).

Psychological symptoms:

- Rapid mood swings.
- Evidence of self-harm and disfavor.
- Enthusiasm of being thinner and thinner people.
- No matter how thin the person is overweight, arguing to complain.
- To lose a lot of weight is a good case to see for them. Fear of gaining weight.
- Lying about what and when she/he's eaten, and how much weight.
- Depression, anxiety disorders and insomnia
- Lethargic stage.
- Solitude.
- Strange rituals during eating, Refuse to eat in public. To constantly calculate the fat and calories of foods and to feed according to these values. Produce excuses not to eat. Shrink portions of food.
- Interoceptive symptoms (interoception has a major role in body and motivations, emotions sides. Aside from outer appearance, AN patients also report abnormal indistinct feelings. This provides miscommunication between body and brain. In addition to this, AN patients has been noticed deficiency to discrimination of emotions from

physical sensations (alexithymia). OCD is driven to do unwanted and repeated thoughts, feelings, ideas, obsessions or behavior. Often, a person has to apply a compulsive behavior to get rid of his/her obsessive thoughts. It is another subtype. OCPT is associated attention deficit disorder, borderline and alcoholism, disorders, and body dysmorphic disorder (BDD), other personality disorders (20).

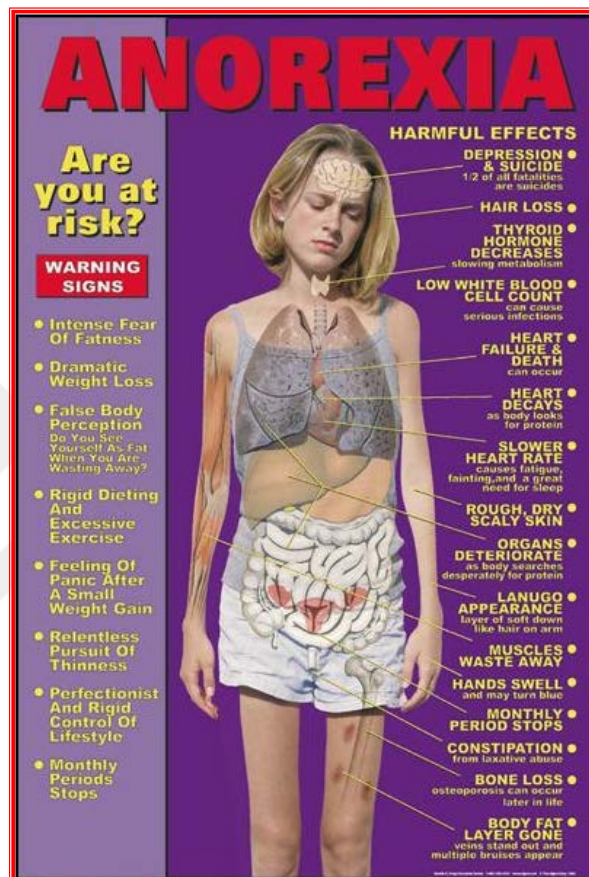


Figure 1. Signs and symptoms of Anorexia Nervosa (<https://www.weight-on.com/Anorexia-signs.html>).

2.1.3. Causes

There are many reasons in the etiology of AN. On this subject, which is still controversial; there are many types of research that query biological, socio-cultural and psychological factors, and indicate that the disease is caused by their interaction but the main and final reason of ANs is still mystery. (6). In recent years, it is also emphasized that information processing processes are important in the etiology of the disease (7,15).

Genetic causes: Patients with AN usually have a sensitive, determined and perfectionist personality. Although there are no confirmed studies of genetic predisposition, the risk of the disease may be high in patients with a family history of Anorexia. AN is a hereditary disease and is based on genetic predisposition, personality specialties, and environmental differences. The heritability rate has been shown of 28% to 58% in twin studies. First degree relative of AN patients has roughly 12 times the risk of developing AN. A total of 128 different polymorphisms related to 43 genes, including genes involved in the regulation of eating behaviors, were studied. Consistent relationships have been identified for polymorphisms related to agouti-related peptide, brain-derived neurotrophic factor, catechol-o-methyl transferase, SK3 and opioid receptor delta-1 (21-22).

Physical causes of the person:

- 1) Irregular hormone functions and neuroendocrine dysregulation.
- 2) Obstetric complications.
- 3) Gastrointestinal disorders (i.e. irritable bowel syndrome, inflammatory bowel disease and celiac disease).
- 4) Psychological causes (the fear of food (sitiophobia), anxiety lack of control, loneliness depression, and low self-esteem).

Environmental causes of AN as follows:

1) Media effects (In order to have a slim body, young people start to diet and become obsessed with looking slim (such as models, dancers). The media give people a wrong opinion of people's original view. In journals, movies, billboards; most of the stars/models undergo an artificial change in digital media in many different ways. (like photoshop In time, people try to look like these "perfect" role models and not to fall behind when they are not actually close to perfection.)

2) Dancers, ballerinas, mannequins, jockeys must keep their weight constantly due to competition and expectations in their business life. This occupational group has a high risk of eating disorders.

3) Childness sexual misuse, severe and damaging physical / mental traumas or families who do not fulfill their duty (familial and childhood traumas).

4) Pressures of peers between friends and colleagues to be thin and be sexy (23-24).

The sociocultural etiology of AN should not be ignored. We are living in a world associated with that being thin is "beautiful, strong, hard-working, and disciplined person", but being overweight is "lazy, ugly, weak, powerless, clodhopper and weak-kneed person". Self-esteem and social worth are still obstinately and inevitably connected with physical appearance, especially for women. Today, criteria for ideal beauty are youth, thinness, whiteness, and smoothness in the skin, and being glamorous. Given that less than 1% of women fit this ideal beauty, it is not surprising that most of women in our society are unpleasant with their bodies (8-9).

It is reported that the greatest impact of the media on body image and eating behavior is especially on adolescents who are overly sensitive to the views, messages and external information and stimuli of the environment to establish their own identities, who are not yet sure of their own social realities. (13). In today's world, idealized and uniformized body perception has influenced and influenced everyone, especially popular people. Slimming, diet, sports and aesthetic applications are marketed without being affected by almost any economic crisis and meet the supply demand created. The results reported in studies investigating the role of locus of control in eating disorders are contradictory. In the study in which anorectic and bulimic female patients were compared with women who applied and not applied diet and psychiatric controls, the group with eating disorder had external control focus beliefs compared to controls with and without diet, and directed the hostile feelings towards them. However, many features observed in eating disorders have also been observed in psychiatric controls (14).

It is known that peers' eating attitude affects people, especially competition and peer bullying is the basis for eating disorders. The price of this order, in which weakness is perceived as invaluable, is unfortunately much more severe for the person diagnosed with Anorexia Nervosa. The most risky age for Anorexia Nervosa is adolescence. It is generally reported that it started during adolescence, but there are some studies that report that it started very early or at an advanced age. Anorexia Nervosa seen in adulthood has characteristics similar to those in adolescence. Most cases have a history of childhood obesity or eating disorder. Relationship problems in work and private life can be added to the present table in adulthood. Avoidance of

social environments, sexual problems, not being able to conceive due to menstruation, accompanying problems of depression and anxiety; Nicotine, alcohol, substance, drug, caffeine, carbonated beverage addictions can be seen (14).

When reading tabloid magazines and newspapers (that actually most of them are photoshopped) or watching television (TV), weak and well-groomed actresses and handsome actors seen in TV commercials and movies that can make us feel that we're not attractive or thin like them. There are, of course, so many references to thinness and fashion/style that are only designed for certain sizes in such magazines, films, and commercials. Through the instrument of these images and movies, it is easy for people to think that they are not beautiful enough (14).

The existence of socio-cultural factors should be kept in mind. As mentioned above; the image of a changing beautiful woman, the fact that weakness is highlighted as an important positive feature, and reasons such as can play a role in the increase in the rate of EDs of young women (19).

Young, thin and healthy bodies are considered beautiful in postmodernity. Thin bodies are perceived as beautiful because they can have the mobility to keep up with the fluid nature of the postmodern culture. At the same time, being weak is seen as attractive and beautiful because it point out that she/he does not have modern-day diseases such as diabetes and show that the person usually has economic conditions that can provide access to rich content foods (11).

In fact, it should be known; we are all different creatures, and when considered from this point of view, we can make a difference. "No-Body is Perfect" and we are all beautiful just the way we are (if we are healthy) and in this respect, individuals should know and should not forget to love themselves. In addition, the idea must be dominated that "we need to stop criticizing ourselves and start criticizing the media!". Sometimes, diets, exercises, and surgical operations starting with a simple aesthetic concern can be the beginning of an endless path. Instead of the positive thoughts mentioned above, because of "obsession with becoming a fit woman", some women go to beauty/aesthetics centers and plastic surgeons, and also improve the habit of "not eating". This habit may turn into EDs over time (8-9).

2.1.4. Mechanisms

Evidence from studies suggests that serotonin may play an important role in Anorexia. The role of serotonin for AN is discussed. Decreased 5-hydroxyindole acetic acid in CSF, increased platelet 5-HT levels and blunted prolactin response to serotonergic changes support this linkage. The feeling of satiety against carbohydrate foods is also controlled by serotonin. 5-HT plays a role in triggering eating crises for Anorexia (25).

Differential diagnosis in Anorexia Nervosa is difficult due to the patient's denial of symptoms and resistance to search for treatment. The clinician should ensure that there is no medical illness that may cause weight loss, strange eating pattern and vomiting; other psychiatric disorders. Depressive disorder and Anorexia Nervosa have common clinical features such as depressive affect, crying, sleep disturbance, obsessive behaviors, and suicidal thoughts. However, its distinctive features are very evident. Patients with more severe Anorexia Nervosa have a metabolic disorder. Medical and psychological approach is essential in treatment. Nutritional experts may also be involved if the patient accepts after a compliant treatment process has started. The treatment of Anorexia Nervosa should be performed with the help of a team of psychologists, psychiatrists, nutritionists and other physicians, if necessary. Anorexia Nervosa can also be seen in people with intense psychological problems. Even in people who are not obsessed with dieting or losing weight, eating disorders are in question during a very problematic life. Family, school, work, or emotional issues with people who have a breakdown refuses to eat, if forced to eat. As a result, there is a lot of weight loss in the short term and all the effects of this disease are experienced. Eating problems disappear with the solution of problems; however, they may experience serious and persistent physiological problems during this stage (25).

Treatment of Anorexia is long-lasting and may last for months. It is important to continue psychotherapy with regular periodic checks. Mental diseases are among the diseases with the highest mortality rate. In untreated cases, the mortality rate is 10-15 percent. Suicidal tendencies are also serious. In the treatment of Anorexia Nervosa, it is risky to gain weight quickly without any improvement in body image during nutrition rehabilitation (26).

The effectiveness of family therapy in the treatment of eating disorders is increasingly recognized. Some researchers argue that treatment of eating disorders in which the family is not addressed will fail. It is more effective in young patients living with their families. Working with adolescents and their families on the basis of separation, individuation and autonomy, in the treatment of Anorexia Nervosa, its place seems to be more accepted than Bulimia Nervosa (26).

Eating disorders such as Anorexia and Bulimia, which are known as weakness, can cause permanent damage to the brain and may lead to a decrease in brain mass and changes in chemical reactions in the brain as well as weight loss. In AN patients, total decreases in gray and white matter areas/volumes, increase in volume of CSF (cerebrospinal fluid), zonal decreases in left inferior parietal lobe, right caudate, the left hypothalamus, and right lentiform nucleus have also been declared. These changes seem to be related to sudden malnutrition and greatly reversible with weight rehabilitation (27).

Women's relationship with their body and weight and struggle, regardless of the diagnosis of eating disorders, is the subject of various researches. In a study of more than 3400 women and more than 500 male participants between the ages of 13 and 90, weight gain is one of the most negative effects on image of body (28).

This result is the case, although the majority of respondents are in normal weight. The study said that the greatest damage to body images was caused by weight gain in one-third of the males and two-thirds of the women. Approximately half of the women surveyed expressed that they were concerned about their weight and were not satisfied about weight. The least satisfied group is women in the 30-39 and 50-59 age group. In this study; 89% of women wanted to lose weight independent of their weight and 24% wanted to reach their aimed weight (19,28).

In another comprehensive survey including women in the 75 and under age; although 70% of women aged 30-74 were in normal weight, they were not satisfied with their weight. This study indicates that, as women age, their dissatisfaction with the body increases due to fear of aging (29).

2.1.5. Diagnosis

In DSM-5, AN includes “excessive low body weight, obsessive fear anxiety of becoming obese person, strive of becoming thin person, distorted body shape perception and psychological pain and anxiety related to the alterations in body weight” (4).

In DSM-5 partial changes were made in the diagnostic criteria related to AN. In DSM-IV, the “reject” term in A criterion can imply the voluntary/intent and therefore there may be difficulties in the evaluation of patients, the criterion A is more focused on behavior in DSM-V (eg limiting calorie intake, etc.). The B criteria has been also expanded to include “the permanent behavior that prevents weight gain”. There is no change in C criteria. Since amenorrhea criterion (D criteria) could not be used in male cases, premenopausal cases in women and menstrual activity could be seen in many female cases of AN, the necessity of this criterion was abandoned. Interest in food and eating has increased considerably in recent years. Given this interest, it is inevitable that this aspect of human behavior is linked to a disorder. Although the clinical description goes backwards, these disorders first appeared in DSM in 1980 as a subcategory of childhood or adolescent disorders. Over the past two decades, due to the growing interest of clinicians and researchers, with the publication of DSM IV, eating disorders have become a distinct category of Anorexia Nervosa and Bulimia Nervosa (4,15).

In DSM-IV, diagnostic criteria for Anorexia Nervosa include persistently refusing to keep body weight at or above the expected minimum weight, or failure to obtain the expected weight over a certain period of growth. In both cases, body weight below 85% of expected weight is alarming. In post-menarche women, at least three consecutive menstrual cycles should not be seen to meet the criteria for Anorexia Nervosa (4).

The severity of the disease is graded according to BMI: Light: BMI greater than or equal to 17 kg / m²; Medium: BMI 16-16.99 kg / m²; Heavy: BMI 15-15.99 kg / m²; Advanced: BMI less than 15 kg / m². The difference among the diagnoses of AN, BN and ED-NOS is difficult (30).

2.1.6. Treatment

The treatment of AN consists of three main purposes: Redintegrate the person to a healthful weight, treat the psychological disorders connected with the AN, and decreasing attitudes or ideas that originally led to the disordered eating (31).

A team, including therapists, doctors, and nutritionists are recommended for the treatment and recovery of AN. Treatment for AN must include a combination of supervised weight gain and talking therapy. It's important to start treatment as early as possible to reduce the risk of serious complications. Effective complex treatment of an AN in an eating disorder includes three essential components (31):

Medical treatments: Untreated Anorexia can lead to starvation of death and diseases such as osteoporosis, kidney damage and heart disease. In an treatment, antidepressants should not be seen and offered as an only cure for AN. However; an antidepressant, such as fluoxetine, may be offered with treatment and the main idea of this strategy is for helping patients to control their other emotions. Especially for children, antidepressants very rarely prescribed because this issue is so sensitive and important. When the antidepressant use in Anorexia Nervosa is reviewed, it is seen that serotonergic antidepressants have occupied a great place in recent years. One of the starting points in these trials is the similarities between Anorexia Nervosa and obsessive compulsive disorder. The success of serotonergic drugs in obsessive-compulsive disorder suggested that the same drugs may be effective in Anorexia Nervosa (31).

These treatments include rehabilitation of reduced weight, administration, and surveillance of an ordered meal plan, and education regarding normal eating models. The regimen is the one of most necessary factor to cope with in people with AN and must be adapted to every individual's needs. Diversity in food is significant while determining meal programs as well as diet that are higher in energy. Patients with AN must eat up sufficient calories, starting slowly, and increasing at a measured steps (31).

Psychotherapy: The aims of psychotherapy in the treatment of AN are to recognize the underlying problems related to ED, to address and improve the traumatic events that the individual has experienced throughout his or her life, to deal with senses. For patients with AN, psychotherapy is harsh because they fear of gaining weight, they may give a meaning to their thinness and they may maintain to keeping everything

under control and resist change. Therapy for AN is slightly dissimilar for adults and teenager (32).

Treatment for adults

There are several different speech therapies for the treatment of AN. The purpose of these therapies is to help the patient figure out the causes of her/his eating problems and sense more relaxing with food. Thus, they can begin more eating and reach an ideal weight. The patient can choose from any of the following talking therapy types (15,18).

Cognitive behavioral therapy (CBT): Cognitive behavioral therapy model and exposure technique were applied in the psychotherapy process of this case by considering the evidence-based efficacy studies. To date, cognitive behavioral therapy models have been structured for the treatment of eating disorders and positive results have been reported in scientific sources. Therapist helps the patient to cope with her/his feelings, figure out nourishment and the influences of starvation, and make in good health food selections. Psychotherapy forms vary: both individual therapies and family therapies work; Cognitive therapy and drug therapy in cases of Bulimia have been successful (15,18).

Maudsley Anorexia Nervosa Treatment for Adults (MANTRA): MANTRA includes the conversation with the therapist to understand what is the underlying factor of her/his ED and what event (s) is causing AN. It focuses on what's important to patient and helps her/him to change her/his behavior when she/he are ready. Family or caretaker can be involved the therapy. 20 sessions of therapy will be offered. The first 10 should be weekly, with the next 10 scheduled to suit the patient (15,18).

Specialist supportive clinical management (SSCM): This method includes the patient's talking to a therapist, and the therapist tries to understand why the patient is caught to AN and helps the patient understand this. In this therapy, weekly 20 or more cure sessions are offered to the patient. In addition, at certain intervals, the therapist gives a destination body weight to the individual and helps the person to achieve this goal. At this time, the patient learns her/his diet and tries to understand what kinds of eating styles cause symptoms (15,18).

Focal psychodynamic therapy (FPDT): The FPDT option should be presented to the patient if she/he does not think that the above-mentioned treatments are suitable for

herself/himself or if the treatments do not work. In this therapy, the patient is given weekly sessions for 9-10 months, during in this time the individual tries to understand and adapt to the new eating habits, what she/he thinks about of the people in his life, and what they think about her/him (15,18).

Treatment for children and young people

Usually, children and teenagers are offered family therapy. They may also be offered CBT or adolescent-focused psychotherapy. CBT is very resembling to the CBT offered to adults. Generally, pediatricians first notice this situation. Weight loss, excessive exercise, repetitive vomiting, restrictive or abnormal eating behavior, over-occupation of weight gain and body-related occupation are noteworthy findings. In younger children, the cessation of weight gain and height increase should be considered as stimulating symptoms. Negative criticisms by the family or comments about weight and eating behavior are perceived as very important by adolescents (15, 18).

Family therapy: It includes patient and her/his family conversation with the therapist. In these interviews, the therapist and the patient try to find out how the AN affects her/himself and how her/his family can support her/him to be better. Sometimes FM can be proposed as a group therapy together with other families (15,18).

Adolescent-focused psychotherapy (AFP): In this method of treatment, the therapist assists the patient in defeating the fear of gaining weight, in accepting the damages of the disease if she/he will not treatment, in understanding what individual has to do in order to regain the health, and in revealing the causes of the disease and fighting with them (15, 18).

Therapy interviews are usually between 12-18 months and can be up to 40 sessions. In order to give more support to the patient, it is performed more frequently in the beginning of therapy and the interval is extended over time. (15,18).

Bone health

If you have Anorexia Nervosa, you are at risk of osteoporosis. If you want to avoid osteoporosis, you should first receive Anorexia treatment. To do this, you only need to apply to the nearest health institution. The doctors here can give you psychological support or refer you to another health care provider. Women in AN are at higher risk than men. (15,18).

Compulsory treatment

Patients with Anorexia Nervosa are hypersensitive to shaking autonomy and control emotions and are resistant to co-operation. Treatment rejection is quite common. They can't comprehend the seriousness of the disease. Their minds are conditioned to think uniformly and their flexing capacity is weakened. They oppose treatments with the concern that they will gain weight, and their insight is weak. Therefore, instead of being insistent and oppressive, it is appropriate for them to approach with compassion and judgment. Instead of making them feel problematic or guilty, they should offer to solve the problem together and act decisively and consistently. Many therapy methods have been shown to be effective in adult Anorexia Nervosa. Since the evidence value of cognitive behavioral therapy and interpersonal therapy is very high, the involvement of relatives at various stages of therapy will increase the success of treatment. Factors such as empathy, positive and supportive attitudes are the sine qua non of treatment (15).

Compulsory treatment has the same resistance as psychoses, and a long, slow and difficult process awaits the therapist and the patient. Patients who use defense mechanisms such as denial and extreme rationalization very strongly develop behavioral patterns such as indifference, neglect, negativity, distance-keeping and passive attitudes, and it takes time to overcome resistance and transfer (15,18).

The treatment of AN is still controversial. Establishing lasting and effective cooperation with young people is very important for the success and continuation of treatment. In therapy, it is worked on that establish relationship with young person's own feelings and define emotional needs. In this case, the young person should first be able to recognize and understand the emotions and therefore his own feelings. However, it is known that the group with the most difficult relationship among EDs patients is young people with AN (15,18).

2.1.7. Prognosis

The prognosis of AN is relatively poor and it has the highest mortality rate of ED among the psychiatric disorders (5,33).

Another problem in anorexic patients is perception and cognitive disorders. They make a lot of logical errors, and they show distorted attention-selectivity, abstraction and flexibility of thought. In the cognitive model of eating disorders such as Anorexia

Nervosa and Bulimia Nervosa, there are unrealistic and rigid beliefs about body shape and weight. The most preferred method of treatment is cognitive behavioral therapy and it is more effective than other treatments. Eating problems may persist after treatment (30).

Young girls who want to resemble the models, actors they see in the movies are going through hard times due to the intense weight loss. Untreated patients within five years are at risk of death. Such patients have a 50-fold higher risk of death than an individual in the same age group. The biggest cause of death is the weight loss. The person whose immune system collapses due to weakness becomes very sensitive to infections. When symptoms are detected in the first year, treatment is started and results are good. 5-6 years after the onset of symptoms, the chance of treatment is reduced by up to 30 percent (34-35).

AN leads to severe psychosocial dysfunction with serious biological complications (17,36).

When examined personality characteristics, it is reported that premorbid AN cases are generally extreme avoidant, stubborn, perfectionist, have low self-esteem and have weak social relations (15,37).

Untreated Anorexia can lead to starvation of death and diseases such as osteoporosis, kidney damage and heart disease. Some people die of these problems. Other complications below (17, 36):

- Cardiac complications: Increases the risk of sudden cardiac death, arrhythmias (irregular beat of the heart), mitral valve prolapse, abnormally slow heartbeat, orthostatic hypotension, dehydration, electrolyte imbalance, heart disease
- Urinary complications: Kidney failure.
- Neurological complications: Wernicke encephalopathy, Neurological disorders
- Endocrine complications: Growth retardation (height gain may slow and can stop completely due to severe weight loss or chronic malnutrition), pubertal delay or arrest, amenorrhea or hypomenorrhea (cessation of menstruation in women), hypogonadism (reduction of suppression of gonadotrophins), osteopenia or osteoporosis (IGF-1 is necessary for bone, AN causes bone lose).

- Gastrointestinal complications: Constipation (most common), stomach emptying, hepatic steatosis (or fatty infiltration of the liver, is an indicator of malnutrition in children, diarrhea, elevated liver function tests.

2.1.8. Epidemiology

Men and women of any age can get AN, but it's most common in young women and typically starts in the mid-teens. Although the studies differ according to the methods, the frequency of AN is generally reported to be 8-9/100.000 in women and 0.5-3/100,000 in men per year. Also, it is stated that the ratio of females to males varies between 6-10/1, and the frequency of males is gradually increasing. AN is speculated to occur in 0.9-4.3% of women and 0.2-0.3% of men in Western countries at some point in their life duration (16-17, 38-39).

It has been reported that prevalence of AN varies between 0.1-4.0% and the prevalence of BN between 18-20% in university student girls (40-42).

The epidemiological studies carried out in Turkey reported similar results (43). In our country, BN ratio was found to be 4.3% and AN ratio was 0.3% in female students (44). The emergence of AN is often triggered by a new situation in which the person has difficulty with coping. This new situation may be the initiation of puberty, new developmental difficulties related to adolescence, initiation of high school or university education, or real or psychological loss (45).

Even if the diagnosis is not reached, mental disorders related to body shape and eating behavior are common in young girls. Among young females, impaired eating behaviors are much higher than the rates of diagnosed EDs. In a study in Turkey in recent years, students in the college girls, disordered eating behavior was found to be 12% (46). These seemingly innocent behaviors may herald a future ED. Therefore, the desire of weakness, which becomes increasingly evident by the influence of the media, seen especially among young girls, to be noticed and prevented before reaching the disease size, constitutes the preventive medicine dimension of the problem (19).

Prior to psychiatry, mistakes made in AN

First of all, the symptoms of amenorrhea are referred to primarily non-psychiatric physicians, especially gynecologists, and this symptom is tried to be treated with oral contraceptives. However, the message that the patient may be AN is rarely

given. Amenorrhea is not a symptom of AN to be primarily treated. Moreover, by reaching the patient's healthy weight and improving psychological state, this symptom is often improved without the need for additional intervention. Also, early treatment of amenorrhea before fundamental problems are resolved, reduces the likelihood of patient seeking help. As a result, this intervention is faulty. The right approach is to clarify the diagnosis of the patient and to refer to psychiatry in the early stage (19).

2.1.9. History

The meaning of AN disease is the lack of appetite and the self-starvation. This term is of Greek origin and consists of the combination of the "an-" prefix that adds negativity to the word and the word "orexis", which means appetite. During this period, some young girls were self-starvation with the intention of fasting for religiosity and purity as seen in (Figure 1) (47-50).

The first record as a medical case was from London in 1689. Richard Morton published the first case called nervous consumption in the medical literature with his patient, who became ill at the age of 18 and died 3 months after he refused all food and medicine (47). It is not possible to remember that French feminist Simone De Beauvoir's words that satisfying men as the primary goal of their lives are more uncomfortable than seeing themselves deformed and distorted. Anorexia Nervosa, an illness, was first described by Sir William Gull, the physician of Queen Victoria, and entered the medical literature in 1874 (48). Anorexia Nervosa Fear of weight gain and desire to have a slim body; mental and physical health of a person, almost all his life and relationships is a mental disorder that is capable of disrupting. In 1694, Richard Morton described two cases. In 1868, William Gull began to use the term Anorexia Nervosa. In the same period, Ernest Charles Lesague described the same disorder and pointed out the patient's refusal to eat actively to lose weight and the family's involvement. In the early 20th century, when pituitary insufficiency was defined, there was confusion between these two disorders. In the 1930s, primary pituitary insufficiency and Anorexia Nervosa were distinguished (47-48).

In the 1950s, Hilde Bruch described Anorexia Nervosa as a single syndrome. B.C. In 400-500, the Babylonian Talmud spoke of a Bulimia-like disease. In the 1870s, Gull stated that Bulimia was a component of Anorexia Nervosa. Gerald Russel first

described Bulimia Nervosa as a separate eating disorder and Bulimia Nervosa was included in DSM-III as seen in (Figure 2) (47-48).

Awareness of the AN was usually limited to the medical doctors until the latter part of the 20th century. Hilde Bruch, the German-American psychoanalyst, published her book *The Golden Cage: The Enigma of AN* in 1978. With this book, awareness of AN in public increased as seen in (Figure 3 and 4) (51-52).



V.—Anorexia Nervosa (Apepsia Hysterica, Anorexia Hysterica)

William Withey Gull, M.D., Bart.
Read October 24, 1873

In an address on medicine, delivered at Oxford in the autumn of 1868,* I referred to a peculiar form of disease occurring mostly in young women, and characterised by extreme emaciation, and often referred to latent tubercle, and mesenteric disease. I remarked that at present our diagnosis of this affection is negative, so far as determining any positive cause from which it springs; that it is mostly one of inference from our clinical knowledge of the liability of the pulmonary or abdominal organs to particular lesions, and by proving the absence of these lesions in the cases in question. The subjects of this affection are mostly of the female sex, and chiefly between the ages of 16 and 23. I have occasionally seen it in males at the same age.

To illustrate the disease I may give the details of two cases, as fair examples of the whole.

Miss A., *æt.* 17, under the care of Mr. Kelson Wright, of the Clapham Road, was brought to me on Jan. 17, 1866. Her emaciation was very great. (*Vide* Woodcuts † Nos. 1 and 2.) It was stated that she had lost 33 lbs. in weight. She was then 5 st. 12 lbs. Height, 5 ft. 5 in. Amenorrhœa for nearly a year. No cough. Respirations throughout chest everywhere normal. Heart-sounds normal. Resps. 12; pulse, 56. No vomiting nor diarrhœa. Slight constipation. Complete anorexia for animal food, and almost complete anorexia for everything else. Abdomen shrunken and flat, collapsed. No abnormal pulsations of aorta. Tongue clean. Urine normal. Slight deposit of phosphates on boiling. The condition was one of simple starvation. There was but slight variation in her condition, though observed at intervals of three or four months. The pulse was noted on these several occasions as 56 and 60. Resps. 12 to 15. The urine was always normal, but varied in *sp. gr.*, and was sometimes as low as 1005. The case was regarded as one of simple anorexia.

*"Lancet," August 1868.
†The woodcuts illustrating this Paper are fac-similes of the original photographs exhibited at the time the Paper was read.
Adapted from *Transactions of the Clinical Society of London*, 7:22-28, 1874.
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Various remedies were prescribed—the preparations of cinchona, the bichloride of mercury, syrup of the iodide of iron, syrup of the phosphate of iron, citrate of quinine and iron, &c.—but no perceptible effect followed their administration. The diet also was varied, but without any effect upon the appetite. Occasionally for a day or two the appetite was voracious, but this was very rare and exceptional. The patient complained of no pain, but was restless and active. This was in fact a striking expression of the nervous state, for it seemed hardly possible that a body so wasted could undergo the exercise which seemed agreeable. There was some peevishness of temper, and a feeling of jealousy. No account could be given of the exciting cause.

Miss A. remained under my observation from Jan. 1866 to March 1868, when she had much improved, and gained in weight from 82 to 128 lbs. The improvement from this time continued, and I saw no more of her medically. The Woodcut, Miss A., No. 2, from photograph taken in 1870, shows her condition at that time. It will be noticeable that as she recovered she had a much younger look, corresponding indeed to her age. 21; whilst the photographs, taken when she was 17, give her the appearance of being near 30. Her health has continued good, and I add a fourth photograph taken in 1872.

It will be observed that all the conditions in this case were negative, and may be explained by the anorexia which led to starvation, and a depression of all the vital functions; viz., amenorrhœa, slow pulse, slow breathing. In the stage of greatest emaciation one might have been pardoned for assuming that there was some organic lesion, but from the point of view indicated such an assumption would have been unnecessary.

This view is supported by the satisfactory course of the case to entire recovery, and by the continuance of good health.

Miss B., *æt.* 18, was brought to me Oct. 8, 1868, as a case of latent tubercle. Her friends had been advised accordingly to take her for the coming winter to the South of Europe.

Figure 2. The article by William Withey Gull in 1873 (Reprinted at Obesity Research in 1997)

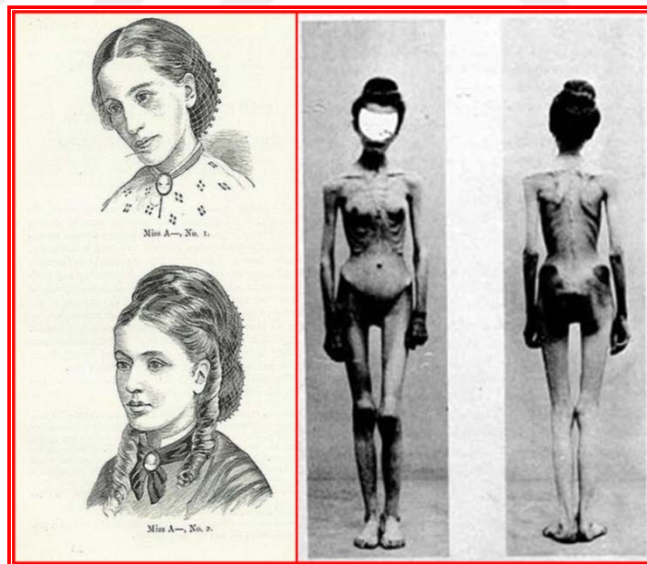


Figure 3. One of the first patients diagnosed with AN, Miss A...s picture while she was unhealthy in 1866 (up) and the picture after treatment in 1870 (below) is seen. They were taken from Gull's articles. B- Two photographs, taken from the front and back of a (https://en.wikipedia.org/wiki/Anorexia_nervosa)



Figure 4. The popular singer and drummer Karen Carpenter died due to AN complications in 1983

(<http://www.110pounds.com/?tag=karen-carpenter-Anorexia>).



Figure 5. A patient with AN (picture on the left) and patient's view of himself when he looks in the mirror (picture on the right).

(<https://nutritionlab.co/what-is-Anorexia-Nervosa/> and <https://www.dreamresearchgroup.com/2014/02/complex-eating-disorder-Anorexia-Nervosa.html>)

2.2. Eating Attitudes Tests (EATs)

2.2.1. Introduction

The Eating Attitude Test (EAT) was improved by Garner and Garfinkel in order to evaluate the behavior and attitudes of AN patients about eating habits and possible disorders in the normal eating habits of normal individuals (53). The original version of EAT, consisting of 40 items each rated on a 6-point Likert scale, was published in 1979. In 1982, after Garner and his colleagues doing a factor analysis in the original 40-item data set, they generated a new abbreviated test consisting of only 26 independent items. Since then, the EAT has been interpreted into many different languages and spread internationally as a tool to scan EDs (53-55).

These two articles, published in 1979 and 1982 by Garner et al., are the 3rd and 4th of the most cited articles in the *Psychological Medicine*, one of the leading journals in medicine, psychology and psychiatry literature as seen in (Figure 4 and 5).

The allowance to use EAT-26 and EAT-40 be able to provide from EAT-26's author David Garner via its website (<https://www.eat-26.com/>). Of course, citing to this is essential. In addition, the rules for use of tests and the information of the scoring system are available free of charge from the EAT-26 website. The EAT-40 and EAT-26 tests were not prepared to diagnose an ED. It has not been shown in studies that these tests are valid instruments for specific diagnosis. Therefore, they should be used only as a general screening methods for EDs only. EATs are used in the first step of a two-stage diagnosing process. As a result, individuals who are higher than 20 (for EAT-26) or 30 (for EAT-40) should be sent to a professional doctor to determine which ED has been diagnosed (55).

EAT is a self-assessment test that measures AN's symptoms objectively. In addition to providing more detailed information in clinical evaluation, it can determine the changes resulting from treatment. The test is also used as a screening tool to investigate undiagnosed AN cases in populations of high risk for disease (56). However, there are some limitations of EAT. As it is known, self-evaluation tests are based on the assumption that the subjects present their symptoms (their hardships) honestly. But, since AN patients are in a certain denial of their disease, they may not always fully reflect their symptoms in the test. In the test responses, it is difficult to determine the

biased effect of denial. However, studies have shown that the denial has an effect on test scores, but this effect does not constitute an obstacle in recognizing AN patients (56).

2.2.2. Eating Attitudes Test-40 (EAT-40)

In our country, no tests have been developed that can measure the AN symptoms in clinical samples objectively and determine the high-risk groups in the population. For the first time, EAT-40 was translated into our language in 1985 by Orhan Dogan and was tested in patients with AN. However, the psychometric properties of the test were not investigated. The Turkish validity and reliability study of EAT-40 was conducted by Savaşır and Erol (56). The level of total score is directly related to the level of psychopathology. EAT-40 identifies the predisposition and attitude of poor eating behavior at the clinical level. A six-digit Likert type response form contains 40 items. The breakpoint is 30 points. The increase in score is associated with an increased risk of eating behavior disorder. The Cronbach Alpha of the scale was 0.70 (57).

Garner and Garfinker identified seven factors for the EAT-40:

- 1) Struggle with food
- 2) Body image related to thinness-slimness
- 3) Vomiting and using laxatives
- 4) Diet
- 5) Slow eating pattern
- 6) Secret eating
- 7) Perception of social pressures on weight gain (56).

2.2.3. Eating Attitudes Test-26 (EAT-26)

Garner et al. (55) then formed the short form of the 26-item test. This short scale was found to be highly correlated with EAT-40 ($r = 0.98$). The cut-off score of EAT-26 was found to be 20. The short test has been proposed as a reliable, valid and economical scale and it is emphasized that it is useful to measure AN symptoms objectively (56).

The EAT-26 is a six-point measure that reflects how often a person agree with particular attitudes. The propositions are replied as never, rarely, sometimes, usually, often, and always. The finishing the EAT-26 gives the "guidance index" based upon

three standard. In generally, a guidance (or referral) is advised if a respondent points "positively" or satisfies the "cut off" points or threshold on one or more standard:

- 1) Total point according to the options given to the EAT-26 propositions,
- 2) Responses to behavioral propositions about weight loss and digestive system symptoms, and
- 3) BMI obtained by dividing the person's weight (as kg) by the square of the length (as m) $[\text{weight (kg)} / \text{height (m)}^2]$ (55).



3. MATERIALS AND METHODS

3.1. Research Model

In this study, relational survey method was used to collect data. In this relational survey method, relationship between variables are revealed according to the model seen in Figure 6. The relationship between eating attitude behaviors and Anorexia Nervosa in this study led to the relational survey method.

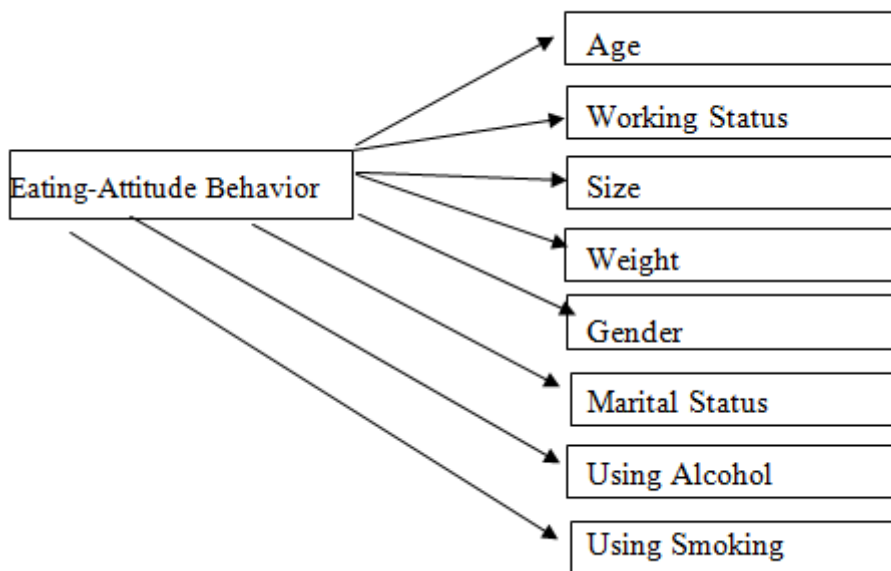


Figure-6 Model of TheStudy

3.2. Collection of Data

In this study, questionnaire method was used to obtain the data and the questionnaire questions were conveyed to the participants by using face to face survey technique. Employees' name and surname were not asked in the surveys. Therefore, objective answers to the questions in the questionnaire were supported. The questionnaire consists of 40 questions and demographic data collection form consists of 20 questions, that is total 60 questions were asked. There were four part for the participants.

In the first part, while the demographic information of the participants is included, the second part contains questions that reveal anthropometric measurements,

and in the third section, there are questions that reveal the health status of the patients. In the last section EAT-40 was used which contain statements that reveal the attitudes of patients (58-60). SPSS 24 package program was used to analyze the data obtained from the application. The data obtained is presented in results section.

Part One: Personal Information Form

In the first part, personal information includes information on the gender, age, level of education, income level, occupation, marital status, working status of the participants. This section consists of 10 questions and includes the number of participants and percentages.

Part Two: Anthropometric Measurements

In this section, anthropometric measurements reveal the height and weight status of the patients. The obesity status of the participants was determined according to the obesity classification of the World Health Organization (2006) based on the height and weight of the participants (61).

Part Three: Health Status

In the questions that reveal the health status in the third part consisting of 8 questions, thinking that it is healthy, whether it is diagnosed disease, what kind of health problem are the ones with diagnosed disease, smoking and alcohol usage status, the amount of smokers, the frequency of consumption of alcohol users and questions about whether they have regular physical activity or not.

Part Fourth: Eating Attitude Scale

There are 40 questions in this section. In the scale, I like to eat with other people, I prepare food for others, but I don't eat what I cook, I'm worried before eating, I'm afraid to be fat, and I try to eat when I'm hungry. Patients with these expressions;

- 1) Always
- 2) Very often,
- 3) Often,
- 4) Sometimes,
- 5) Rarely and
- 6) They have never chosen one of the options.

This test was developed by Garner and Garfinkel (1979) in order to evaluate the behavior and attitudes towards eating in patients with eating disorders and possible symptoms in eating habits in normal individuals. The adaptation of the test to Turkish was done by Savaşır and Erol (54,56). At this point, the test-retest reliability of the scale

was determined as $r = 0.65$ and Cronbach's alpha value was 0.70. In our study, Cronbach's alpha internal consistency coefficient was determined as 0.73. The test result is related to the psychopathology in individuals (59). The breakpoint of the test is 30 points. 1, 18, 19, 23, 27, 39 items in the test, sometimes 1 point, rarely 2 points and never 3 points and other options 0 points; In other items, it is always calculated as 3 points, very often 2 points, 1 point frequently and other options 0 points.

3.3. Universe and Sample

The population of the study consisted of patients who applied to a special clinic. A total of 100 non-pregnant, non-breastfeeding patients admitted to the outpatient clinic and agreed to participate in the study were interviewed. 69 of these patients were female and 31 were male.

3.4. Ethics of Research

This Study was reviewed by Yeditepe University Hospital – Kozyatağı Clinical Research Ethics Committee at the meeting dated 10.04.2019 and it was decided that the study was ethically and scientifically appropriate with the decision number 1008.

4. FINDINGS

4.1. Reliability Coefficient

In this study, Cronbach alpha coefficient was used. Alpha coefficient evaluation coefficients (61):

If the scale is $0.00 < 0.40$, the scale is not reliable,

If the scale is $0.40 < 0.60$, the scale is low reliability,

If the scale is $0.60 < 0.80$, the scale is highly reliable,

If the scale is $0.80 < 0.100$, the scale is highly reliable.

As can be seen from Table 1, it can be said that these scale expressions are quite reliable.

Table 1. Analysis Results of Cronbach's Alpha Technique

Reliability Statistics	
Cronbach's Alpha	N of Items
,733	40

4.2. Normality Analysis

Normality test was used for obtaining surveys. Normality test ensures normal data distribution, a fundamental condition of the availability of methods. Kolmogorov Smirnow and Shapiro-Wilk are expected to be greater than 0.05. When this condition is met, the data is assumed to have a normal distribution.

Another test technique used to analyze the data obtained from the survey method is the normality test. This is a test technique that ensures normal data distribution, a fundamental condition of the availability of parametric test methods. In the normality test, Kolmogorov Smirnow and Shapiro-Wilk are expected to be greater than 0.05. As can be seen from Table 2, the data obtained do not show a normal distribution.

Table 2. Tests of Normality

Kolmogorov-Smirnov			Shapiro-Wilk		
Statistic	Df	Sig.	Statistic	df	Sig.
,115	100	,002	,971	100	,026

4.3. Demographic, Anthropometric Measurements and Health Consequences of Participants

The majority of the age distribution of the participants was over 30 years old as seen in Table-3

Table 3. Age

	Frequency	Percent
21 years and under	17	17,0
22-25 years old	16	16,0
26-29 years old	27	27,0
Over 30 years	40	40,0
Total	100	100,0

In the study, 31% of the participants were male and 69% were female as seen in Table - 4.

Table 4. Gender

	Frequency	Percent
Male	31	31,0
Female	69	69,0
Total	100	100,0

25% of the participants were public employees, 23% were students, 6% were housewives, 5% were lawyers, 4% were insurers, 4% were economist-farmers and 33% were private sector employees as seen in Table - 5.

Table 5. Job

	Frequency	Percent
Public servant	25	25,0
Student	23	23,0
Housewife	6	6,0
Lawyer	5	5,0
Insurer	4	4,0
Economist-Farmer	4	4,0
Private sector	33	33,0
Total	100	100,0

29% of the participants were remarried, 68% were single and 3% were divorced as seen in Table - 6.

Table 6. Marital Status

	Frequency	Percent
Married	29	29,0
Single	68	68,0
Divorced	3	3,0
Total	100	100,0

14% of the participants have 1, 6% 2, 4% have 3 children. In this section, 76% of the participants did not have children as seen in Table - 7.

Table 7. Number of Children

	Frequency	Percent
1	14	14,0
2	6	6,0
3	4	4,0

I don't have children	76	76,0
Total	100	100,0

In the study, while 67% of the participants were working, 33% did not work as seen in Table - 8.

Table 8. Working Status

	Frequency	Percent
Working	67	67,0
Not working	33	33,0
Total	100	100,0

As can be seen from Table 9, it has been found that the vast majority of employees have a 3-year working period.

Table 9. Working Time (Year)

	Frequency	Percent
1	9	9,0
2	5	5,0
3	14	14,0
4	5	5,0
5	1	1,0
6	4	4,0
7	3	3,0
8	5	5,0
9	1	1,0
10	4	4,0
11	1	1,0
12	1	1,0
13	1	1,0
14	2	2,0
15	3	3,0
17	2	2,0
18	1	1,0
24	2	2,0
25	1	1,0

27	2	2,0
Total	67	67,0
Not working	33	33,0
Total	100	100,0

1% of the participants graduated from primary school, 8% from high school, 73% from university and 18% from Msc as seen in Table - 10.

Table 10. Education

	Frequency	Percent
Middle School	1	1,0
High School	8	8,0
University	73	73,0
Msc	18	18,0
Total	100	100,0

9% of the participants have a monthly income of 0-1000 TL, 9% is 1001-2000 TL, 30% is 2001-3000 TL, 17% is 3001-4000 TL and 35% is 4001 TL and above as seen in Table – 11.

Table 11. MonthlyIncome Level

	Frequency	Percent
0-1000 TL	9	9,0
1001-2000 TL	9	9,0
2001-3000 TL	30	30,0
3001-4000 TL	17	17,0
4001 TL and over	35	35,0
Total	100	100,0

The majority of the participants were found to have a size of 1.70 as seen in Table – 12.

Table 12. Size

	Frequency	Percent
150	1	1,0
155	1	1,0
156	1	1,0
157	2	2,0
158	4	4,0
159	3	3,0
160	9	9,0
162	3	3,0
163	1	1,0
164	2	2,0
165	8	8,0
166	4	4,0
167	2	2,0
168	4	4,0
169	1	1,0
170	12	12,0
171	3	3,0
172	3	3,0
173	6	6,0
175	4	4,0
176	1	1,0
177	1	1,0
178	3	3,0
179	2	2,0
180	2	2,0
181	2	2,0
182	1	1,0
184	2	2,0
185	3	3,0
186	1	1,0
187	1	1,0
188	1	1,0
190	4	4,0
193	2	2,0
Total	100	100,0

The majority of the participants were found to have a weight of 53 and 63 as seen in Table – 13.

Table 13. Weight

	Frequency	Percent
48	4	4,0
50	1	1,0
51	1	1,0
52	1	1,0
53	6	6,0
54	2	2,0
55	2	2,0
56	4	4,0
57	4	4,0
58	4	4,0
59	1	1,0
60	3	3,0
61	1	1,0
62	1	1,0
63	6	6,0
64	2	2,0
65	3	3,0
66	2	2,0
67	3	3,0
68	2	2,0
70	5	5,0
73	3	3,0
75	5	5,0
76	3	3,0
77	4	4,0
78	1	1,0
79	2	2,0
80	1	1,0
81	2	2,0
82	2	2,0
83	1	1,0
84	2	2,0
88	3	3,0
89	1	1,0
90	3	3,0

92	1	1,0
94	2	2,0
98	2	2,0
102	1	1,0
104	2	2,0
120	1	1,0
Total	100	100,0

87% of the participants feel healthy and 13% do not feel healthy as seen in Table – 14.

Table 14. Do you think you're healthy?

	Frequency	Percent
Yes	87	87,0
No	13	13,0
Total	100	100,0

While 23% of the participants had a diagnosed disease, 77% of them did not have a diagnosed disease as seen in Table – 15.

Table 15. Are you diagnosed with a health problem?

	Frequency	Percent
Yes	23	23,0
No	77	77,0
Total	100	100,0

Of the patients with health problems, 4 people had migraine, 2 had mesotherapy, 3 had PCOS, 1 had heartdisease, 2 had Multicysticovary, 3 had high bloodpressure, 3 had diabetes, 1 had anemia, 2 had Hypothyroid, 1 had sinusitis as seen in Table – 16.

Table16. If yes, what is the health problem?

	Frequency	Percent
Migraine	4	4,0
Hashimoto	2	2,0
PCOS	3	3,0

Heartdisease	1	1,0
Multicysticover	2	2,0
Hypertension	3	3,0
Diabetes	3	3,0
Digestive System	1	1,0
Anemia	1	1,0
Hypothyroid	2	2,0
Sinusitis	1	1,0
Total	23	23,0
Participants Without Health Problems	77	77,0
Total	100	100,0

31% of the participants smoked and 69% of the participants did not smoke as seen in Table – 17.

Table 17. Do you smoke?

	Frequency	Percent
Yes	31	31,0
No	69	69,0
Total	100	100,0

63% of the participants used alcohol and 37% did not use alcohol as seen in Table – 18.

Table 18. Do you drink alcohol?

	Frequency	Percent
Yes	63	63,0
No	37	37,0
Total	100	100,0

One person who used alcohol stated that he used it everyday, 23 people 2-3 times a week, 29 people used 1-2 times a month and 10 people a year as seen in Table – 19.

Table 19. If yes, your frequency of alcohol consumption?

	Frequency	Percent
Everyday	1	1,0
2-3 perweek	23	23,0
1-2 permonth	29	29,0
Yearly	10	10,0
Total	63	63,0
Participants not using alcohol	37	37,0
Total	100	100,0

While 39% of the participants do regular physical activity, 61% do not perform regular physical activity as seen in Table – 20.

Table 20. Do you regularly perform physical activity?

	Frequency	Percent
Yes	39	39,0
No	61	61,0
Total	100	100,0

17% of the participants were underweight, 25% normal weight, 14% overweight, 25% Obesityclass I, 12% Obesityclass II and 17% Obesityclass III as seen in Table – 21.

Table 21. Obesity Class

	Frequency	Percent
Underweight	17	17,0
Normal weight	25	25,0
Overweight	14	14,0
Obesityclass I	15	15,0
Obesityclass II	12	12,0

Obesityclass III	17	17,0
Total	100	100,0

The body mass index distributions according to the gender of the participants were given in the Table above. According to this, 29.4% of the males were weak, 40% of them were overweight, 7.1% were overweight, 26.7% were obesity 1. Risk group, 50% obesity 2. Risk group and 29.4% obesity 3. It was revealedt hat it is in the risk group. Again, 70.6% of women were weak, 60% were normal weight, 92.9% were overweight, 73.3% were obesity 1. Risk group, 50% obesity 2. Risk groupand 70.6% obesity 3. Risk group as seen in Table – 22.

Table 22. Body Mass Index Distribution byParticipants

BMI			Gender		Total
			Male	Female	
Underweight	n		5	12	17
	%		29,4%	70,6%	100,0%
Normal weight	n		10	15	25
	%		40,0%	60,0%	100,0%
Overweight	n		1	13	14
	%		7,1%	92,9%	100,0%
Obesity class I	n		4	11	15
	%		26,7%	73,3%	100,0%
Obesity class II	n		6	6	12
	%		50,0%	50,0%	100,0%
Obesity class III	n		5	12	17
	%		29,4%	70,6%	100,0%
Total	n		31	69	100
	%		31,0%	69,0%	100,0%

The body mass index distributions according to the ages of the participants were given in the Table above. According to this, weak, normal weight and overweight ones were more than 30 years old as seen in Table – 23.

Table 23. Body Mass Index Distribution byParticipants' Age

		Age				Total	
		Under 21	22-25 yearsold	26-29 yearsold	Over 30 years		
BMI	Underweight	n	2	0	6	9	17
		%	11,8%	0,0%	35,3%	52,9%	100,0%
	Normal weight	n	5	4	6	10	25
		%	20,0%	16,0%	24,0%	40,0%	100,0%
	Overweight	n	1	2	4	7	14
		%	7,1%	14,3%	28,6%	50,0%	100,0%
	Obesityclass I	n	4	4	3	4	15
		%	26,7%	26,7%	20,0%	26,7%	100,0%
	Obesityclass II	n	4	2	2	4	12
		%	33,3%	16,7%	16,7%	33,3%	100,0%
	Obesityclass III	n	1	4	6	6	17
		%	5,9%	23,5%	35,3%	35,3%	100,0%
Total	n	17	16	27	40	100	
	%	17,0%	16,0%	27,0%	40,0%	100,0%	

4.4. Statistics Obtained for Eating-Attitude Scale

In this part of the study, the data obtained from the responses of the participants about the expressions included in the Eating-Attitude scale were analyzed and reported in Table 24. Here, the number of participants and the percentage distributions are given for each expression.

Table 24. Frequency Distributions of Expressions in Eating Attitude Scale

	Never		Rarely		Sometimes		Often		Very Frequentl y		Alway s	
	n	%	n	%	n	%	n	%	n	%	n	%
1. I like eating with other people.	1	1	1	1	20	20	10	10	28	28	40	40
2. I prepare foods for others but do not eat what I cook.	53	53	21	21	10	10	4	4	6	6	6	6
3. I become anxious prior to eating.	63	63	12	12	18	18	5	5	1	1	1	1
4. I am terrified about being overweight.	34	34	19	19	22	22	8	8	4	4	13	13
5. I avoid eating when I am hungry.	52	52	23	23	17	17	-	-	3	3	5	5
6. I find myself preoccupied with food.	24	24	20	20	27	27	14	14	7	7	8	8
7. I have gone on eating binges where I feel that I am not being able to stop.	29	29	20	20	23	23	11	11	12	12	5	5
8. I cut my foods into small pieces.	30	30	21	21	25	25	4	4	15	15	5	5
9. I am aware of the caloric content of foods that I eat.	32	32	22	22	27	27	11	11	4	4	4	4
10. I particularly avoid foods with high carbohydrate content.	34	34	18	18	19	19	17	17	7	7	5	5

11. I feel bloated after meals.	34	34	16	16	23	23	12	12	7	7	8	8
12. I feel that others would prefer if I ate more.	63	63	7	7	11	11	9	9	4	4	6	6
13. I vomit after I have eaten.	87	87	10	10	1	1	-	-	1	1	1	1
14. I feel extremely guilty after eating.	52	52	20	20	14	14	4	4	4	4	6	6
15. I am preoccupied with a desire to be thinner.	49	49	27	27	10	10	3	3	4	4	7	7
16. I exercise strenuously to burn off calories.	61	61	25	25	8	8	2	2	1	1	3	3
17. I weigh myself several times a day.	61	61	18	18	6	6	13	13	-	-	2	2
18. I like my clothes to fit tightly.	25	25	13	13	21	21	12	12	16	16	13	13
19. I enjoy eating meat.	13	13	9	9	8	8	14	14	19	19	37	37
20. I wakeup early in the morning.	10	10	11	11	19	19	18	18	16	16	26	26
21. I eat the same food day after day.	25	25	23	23	28	28	17	17	5	5	2	2
22. I think about burning up calories when I exercise.	46	46	22	22	8	8	8	8	6	6	10	10
23. I have regular menstrual periods.	18	18	6	6	6	6	36	36	10	10	24	24
24. Other people think that I am too thin.	41	41	21	21	18	18	10	10	6	6	4	4
25. I am preoccupied with the thought of having fat	37	37	21	21	15	15	15	15	8	8	4	4

On the body.												
26. I take longer than others to eat my meals.	38	38	29	29	12	12	6	6	6	6	9	9
27. I enjoy eating at restaurants.	12	12	9	9	18	18	12	12	23	23	26	26
28. I take laxatives.	68	68	14	14	7	7	3	3	2	2	6	6
29. I avoid foods with sugar in them.	29	29	20	20	23	23	15	15	9	9	4	4
30. I eat diet foods.	29	29	19	19	20	20	21	21	7	7	4	4
31. I feel that food controls my life.	36	36	23	23	14	14	13	13	7	7	7	7
32. I display self-control around food.	14	14	15	15	13	13	16	16	28	28	14	14
33. I feel that others pressure me to eat.	59	59	18	18	9	9	4	4	4	4	6	6
34. I give too much time and thought to food.	43	43	22	22	9	9	11	11	13	13	2	2
35. I suffer from constipation.	44	44	27	27	10	10	7	7	2	2	10	10
36. I feel uncomfortable after eating sweets.	43	43	17	17	15	15	13	13	7	7	5	5
37. I engage in dieting behavior.	29	29	10	10	17	17	17	17	6	6	21	21
38. I like my stomach to be empty.	53	53	16	16	13	13	6	6	6	6	6	6
39. I enjoy trying rich new foods.	12	12	14	14	25	25	10	10	17	17	22	22
40. I have the impulse to vomit after meals.	88	88	9	9	3	3	-	-	-	-	-	-

When we look at Table 24;

40% of the respondents choose "always" for "I like eating with other people".

53% of the respondents choose "never" for "I prepare foods for others but do not eat what I cook".

63% of people stated that they always become anxious prior to eating.

88% of respondents choose "never" for "I have to vomit after meals".

12% of respondents choose "never" for "I enjoy trying rich new foods."

53% of respondents choose "never" for "I like my stomach to be empty."

43% of respondents choose "never" for "I feel uncomfortable after eating sweets."

44% of respondents choose "never" for "I suffer from constipation."

4.5. Testing Hypotheses

In this part of the study, it is stated that there is a significant difference between participants' eating attitudes and working status, sex, marital status, alcohol usage status and smoking status variables.; Kruskal Wallis H test was used for questions with more than two options.

In the study, correlation analysis of the participants' views on eating-attitudes and age, size, weight and income level were analyzed. Significance level was accepted as 0.01 in the evaluation of the results. In evaluating this analysis, the following value ranges are accepted:

0,70-1,00 high,

0,70-0,30 medium and

0,30-0,00 low level of relationship (62).

In the study, Chi-Square test results were included for relationship.

As can be seen from Table 25, there is no significant difference between age and eating attitude behaviors.

Table 25. Kruskal Wallis H Test Results of Difference Between Age and Eating Attitude Behaviors

Age	N	Mean Rank	Kruskal Wallis H	P
21 years and under	17	49,71	4.396	.22
22-25 years old	16	58,84		
26-29 years old	27	55,93		
Over 30 years	40	43,84		
Total	100			

As can be seen from Table 26, there was no significant difference between working status and eating attitude behaviors.

Table 26. Mann Whitney U Test Results of Differences Between Working Status and Eating Attitude Behaviors

Working Status	N	Mean Rank	Sum of Ranks	Mann Whitney U	P
Working	67	53,87	3609,00	880,00	.10
Not working	33	43,67	1441,00		
Total	100				

There was a significant and positive relationship between height and eating attitude behaviors.

Table 27. Results of Correlation Analysis of Relationship Between Size and Eating Attitude Behaviors

		Eating Attitude Behaviors		Size
Spearman's rho	Eating Attitude Behaviors	r	1,000	,306**
		p	.	,002
		N	100	100
Size	Size	r	,306**	1,000
		p	,002	.
		N	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

As can be seen from Table 28, there is no significant relationship between weight and eating attitude behaviors.

Table 28. Results of Correlation Analysis of Relationship Between Weight and Eating Attitude Behaviors

		EatingAttitudeBehaviors		Weight
Spearman'srho	EatingAttitudeBehaviors	R	1,000	-,003
		P	.	,976
		N	100	100
Weight	Weight	R	-,003	1,000
		P	,976	.
		N	100	100

As can be seen from Table 29, there is no significant relationship between monthly income level and healthy feeling.

Table 29. Results of Chi-Square Test of Relationship Between Monthly Income Level And Feeling Healthy

		Do you think you're healthy?		Total	X ²	p	
		Yes	No				
MonthlyIncome Level	0-1000 TL	n	8	1	9	8.765	.07
		%	88,9%	11,1%	100,0%		
	1001-2000 TL	n	5	4	9		
		%	55,6%	44,4%	100,0%		
	2001-3000 TL	n	27	3	30		
		%	90,0%	10,0%	100,0%		
	3001-4000 TL	n	15	2	17		
		%	88,2%	11,8%	100,0%		
4001 TL ve üzeri	n	32	3	35			
	%	91,4%	8,6%	100,0%			
Total	n	87	13	100			
	%	87,0%	13,0%	100,0%			

As can be seen from Table 30, there is no significant relationship between regular physical activity and healthy feeling.

Table 30. Results of Chi-Square Test of Relationship Between Making Regular Physical Activity And Feeling Healthy

		Do you think you're healthy?			Total	X ²	P
		Yes	No				
Do you regularly perform physical activity?	Yes	n	36	3	39	1.593	.21
		%	92,3%	7,7%	100,0%		
	No	n	51	10	61		
		%	83,6%	16,4%	100,0%		
Total	n	87	13	100			
	%	87,0%	13,0%	100,0%			

As can be seen from Table 31, there was significant difference between gender and eating attitude behaviors. In this section, it was found that the score of the eating attitude behavior of males was higher than females.

Table 31. Mann Whitney U Test Results of Differences Between Gender and Eating Attitude Behaviors

Gender	N	MeanRank	Sum of Ranks	Mann Whitney U	P
Male	31	62,39	1934,00	701.00	.01
Female	69	45,16	3116,00		
Total	100				

As can be seen from Table 32, there was no significant difference between marital status and eating attitude behaviors.

Table 32. Kruskal Wallis H Test Results of Differences Between Marital Status and Eating Attitude Behaviors

Marital status	N	MeanRank	Kruskal Wallis H	P
Married	29	41,17	4.649	.10
Single	68	54,78		
Divorced	3	43,67		
Total	100			

As can be seen from Table 33, there was no significant difference between alcohol use status and eating attitude behaviors.

Table 33. Mann Whitney U Test Results of Differences Between Drinking Alcohol Use Status and Eating Attitude Behaviors

Do you drink alcohol?	N	Mean Rank	Sum of Ranks	Mann Whitney U	p
Yes	63	52,56	3311,00	1036,00	.36
No	37	47,00	1739,00		
Total	100				

As can be seen from Table 34, there was no significant difference between smoking behavior of the participants and eating attitude behaviors.

Table 34. Mann Whitney U Test Results of Differences Between Smoking Status and Eating Attitude Behaviors

Do you smoke?	N	Mean Rank	Sum of Ranks	Mann Whitney U	P
Yes	31	57,69	1788,50	846,500	.10
No	69	47,27	3261,50		
Total	100				

As can be seen from Table 35, there is no significant relationship between BMI and eating attitude behaviors.

Table 35. Correlation Results Of The Relationship Between Eating Attitude Behaviors And Obesity Status Of The Participants

		Eating Attitude		BMI
Spearman's rho	Eating Attitude	Correlation Coefficient	1,000	-,104
		Sig. (2-tailed)	.	,302
		N	100	100
	BMI	Correlation Coefficient	-,104	1,000
		Sig. (2-tailed)	,302	.
		N	100	100

5. DISCUSSION

As stated in the introduction, the main purpose of this study is to investigate the relationship between eating attitudes and Anorexia Nervosa in patients presenting to a special clinic. In this part of the study, the findings obtained from the analyzes were evaluated in the context of the related literature. At the same time, recommendations are made for future research.

As a result of changing social conditions and habits, human behaviors have changed. Natural needs have been replaced by the change of consumption habits (63). Naturally, eating behavior and habits have also become out of the norm over time, and at certain periods the ideal self-perception has been shaped on weight and in certain periods it has been shaped on the weakness. Nowadays, eating behavior has led to extreme weakness, excessive weight gain and inappropriate compensation. Therefore, it was revealed that eating attitude behaviors should be examined. Especially because of the physical symptoms, physical and vital health threatening dimensions and the possibility of recurrence, eating attitude behaviors have been the subject of many studies (64).

Eating disorders, especially in adolescence and young adulthood, are grouped according to the DSM - 4 diagnostic criteria, mainly in the form of Anorexia Nervosa (AN) and Bulimia Nervosa (BN). The first one, the Anorexia Nervosa, is described as low body weight. Here, there is a physiological, psychological and behavioral change in the fear of a pathological fatality and a constant desire to lose weight. The frequency of reading fashion magazines in adolescent girls is related to the degree of disturbing their own body. The desire to have a body similar to the people they see in the media causes frequent diet and bulimic attacks. The incidence of eating disorders has been shown to increase after the start of television broadcasts in Fiji and the spread of Western series. The media affects both the person directly and indirectly through the group of friends. However, socioeconomic variables do not only affect Western civilization; The prevalence of eating disorders is increasing in all societies in transition, where the capitalist mode of consumption is dominant and identity confusion is experienced.

In this study, the relationship between eating attitude behaviors and Anorexia Nervosa in patients admitted to a private clinic was examined. Results were reached:

- It was found that there was no significant relationship between the attitude of the participants and their eating attitudes.

- It was revealed that there was no significant relationship between the study status of the participants and their eating attitudes.
- It was revealed that there was no significant relationship between the participants' feeling healthy and regular physical activity.
- Participants' gender and eating attitudes include significant difference.
- It was determined that there was no significant difference between marital status and eating attitude behavior of the participants.
- It was determined that there was no significant difference between alcohol use status and eating attitude behavior of the participants.
- It was found that there was no significant difference between smoking behavior and eating attitude behavior of the participants.
- It was found that there was no significant relationship between obesity status and eating attitude behaviors of the participants.

When we look at the studies, it has been observed that eating disorders are observed in more women and 15-24 age groups in general population. In a study conducted by Bulik et al. (2006), the prevalence of AN was found to be 1.2% for women and 0.3% for men. In a study conducted by Yeşilbursa (1990) on 1022 female and 956 male participants in our country, the prevalence of AN was found to be 0.2% for women and 0.1% for men; BN was 4.31% in females and 0.63% in males (44). Uzun et al. (2006) in their research in female university students, 17.1% of the eating attitudes were found to be. In our study, it was found that there was a significant difference between the gender of the participants and their eating attitude behaviors. However, in our study, it was revealed that the total score of the eating attitude behavior of males was higher than that of females. Batur et al. (2005) Arslan and Alparslan (1998) in their study of males in females has been shown to be more distorted in the proportioning attitude. This is due to the fact that males are also affected by their eating habits by using the media effectively in a similar way to women. Since being handsome and well-groomed in the media is also associated with poor appearances, eating habits of men have recently changed. The desire to keep the body fat as low as possible for a healthy life has led to eating disorders in men. In a study conducted by Polivy and Herman (2002), women between 15-29 years of age reported eating disorders ranging from 3% to 10%. In this study, BN was twice as high as AN. In this context, no significant relationship was found between

age and eating attitude behaviors. The reason for this is thought that tall people will have a larger appearance as their weight increases and that they will affect the eating attitudes of the people because the large image is not desired. In addition, being tall is similar to the model body in the media and in our study, a significant relationship between eating attitude and height. In the study, there was no significant relationship between eating attitude behavior and weight of the participants; however, there was a significant relationship between the participants' height. In addition, it was found that there was no significant difference between the study status, marital status, alcohol usage, smoking status and eating attitudes of the participants. Finally, the study revealed that there was no significant relationship between the participants' feeling healthy and their income level and regular physical activity.

Obesity has a decisive role in the development of eating disorders. In a study conducted by Leonard et al. (2005), 10% of the obese subjects had eating attitude disorder. In our study, there was no significant relationship between BMI values and eating attitude behaviors of the participants.

According to Michale Friedman et al., marital status was not associated with increased body dissatisfaction. In this study no significant relationship was found between marital status and eating attitude (58).

6. CONCLUSION AND RECOMMENDATIONS

Anorexia Nervosa is an eating disorder characterized by an inability to eat and to lose weight, which is often associated with body perception disorder and threatens the physical integrity of the person. Refusal to have the lowest number of body weight, fear of gaining weight, and weight loss leading to a body weight below 85% of the expected are the main symptoms of the disease. This behavior, which was loaded with mystical meanings centuries ago, is now considered a psychiatric disorder, including physical symptoms such as amenorrhea, hormonal disorders and constipation. In patients with eating disorders, prolactin, thyroid hormones, gonadal hormones, and changes in testosterone levels in men, as well as metabolic disorders due to the degree of nutritional disorder occur. Eating disorders are generally chronic. Permanent problems can arise in many systems over the years. Catecholaminergic systems in the brain, especially dopaminergic and noradrenergic systems, are affected, resulting in permanent impairment of cognitive functions. Information on the effect of gender on the course of the disease is controversial.

As a result of the data obtained from the study and the related literature review, the following suggestions are given:

- Based on the realization of the research on patients who apply only to a special clinic, research on different samples can be carried out.
- In the study, eating attitude behaviors and age, marital status and gender were compared with the variables and the relationship status was revealed. In future research, comparisons can be made according to the different characteristics of the participants.
- Based on the effect of the family on eating attitude behaviors, researches can be carried out to determine the effect of parental attitudes on eating attitude behaviors.
- Finally, with providing focus group discussions on the participants' views on eating attitude behaviors qualitative research was carried out.

Limitations and Assumptions of the Research

This study included patients admitted to a private clinic.

The study is thought to be sufficient to gather reliable and sufficient information about eating attitude and Anorexia Nervosa. In this study participants would sincerely answer the questions in the assessment tool.



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Education

Degree	Department	The name of the Institution Graduated From	Graduation year
Master	Nutrition and Dietetic	YeditepeUnivrsiy	2019
University	Nutrition and Dietetic	Yeditepe University	2016
High school	-	Tekirdağ Anatolian High School	2011

Languages	Grades (#)
English	
Turkish	

#All the grades must be listed if there is more than one (KPDS, ÜDS, TOEFL; EELTS vs),

Work Experience (Sort from present to past)

Position	Institute	Duration (Year - Year)
Dietitian	Melis Destereci Nutrition and Diet Consultants	2019-
Dietitian	Dermatec Polyclinic	2016-2019

Computer Skills

Program	Level
Microsoft Office Excel	Good
Microsoft Office Word	Good

* Excellent, good, average or basic

8. APPENDIXES

8.1. Ethical Approval



T.C. YEDİTEPE ÜNİVERSİTESİ

Sayı : 37068608-6100-15- 1658

11/04/2019

Konu: Klinik Araştırmalar
Etik kurul Başvurusu hk.

İlgili Makama (Melis Destereci)

Yeditepe Üniversitesi Sağlık Bilimleri Fakültesi Beslenme ve Diyetetik Bölümü Dr. Öğr. Üyesi Arzu Durukan'ın sorumlu araştırmacı olduğu "Özel Bir Polikliniğe Başvuranların Yeme Tutumlarının EAT-40 Ölçeği ile Belirlenmesi" isimli araştırma projesine ait Klinik Araştırmalar Etik Kurulu (KAEK) Başvuru Dosyası (1628 kayıt Numaralı KAEK Başvuru Dosyası), Yeditepe Üniversitesi Klinik Araştırmalar Etik Kurulu tarafından 10.04.2019 tarihli toplantıda incelenmiştir.

Kurul tarafından yapılan inceleme sonucu, yukarıdaki isimi belirtilen çalışmanın yapılmasının etik ve bilimsel açıdan uygun olduğuna karar verilmiştir (KAEK Karar No: 1008).

Prof. Dr. Turgay ÇELİK

Yeditepe Üniversitesi
Klinik Araştırmalar Etik Kurulu Başkanı

8.2. Sample of Eating Attitudes Test-40

YEME TUTUM TESTİ

Bu anket sizin yeme alışkanlıklarınızla ilgilidir. Lütfen her bir soruyu dikkatlice okuyunuz ve size uygun gelen kutunun içine **X** işareti koyunuz. Örneğin; "**Çikolata yemek hoşuma gider**" cümlesini okudunuz. Çikolata yemek hiç hoşunuza gitmiyorsa "**hiçbir zaman**" yazılı kutunun içine **X** işareti koyunuz, her zaman hoşunuza gidiyorsa "**daima**"nın altını **X** işaretleyiniz.

SORULAR	Daima	Çok sık	Sık sık	Bazen	Nadiren	Hiçbir zaman
1. Başkaları ile birlikte yemek yemekten hoşlanırım.						
2. Başkaları için yemek pişiririm, fakat pişirdiğim yemeği yemem.						
3. Yemekten önce sıkıntılı olurum.						
4. Şişmanlamaktan ödüm kopar.						
5. Acıktığımda yemek yememeye çalışırım.						
6. Aklım fikrim yemektedir.						
7. Yemek yemeyi durduramadığım zamanlar oldu.						
8. Yiyeceğimi küçük küçük parçalara bölerim.						
9. Yediğim yiyeceğin kalorisini bilirim.						
10. Ekmek, patates, pirinç gibi yüksek kalorili yiyeceklerden kaçınırım.						
11. Yemeklerden sonra şişkinlik hissedirim.						
12. Ailem fazla yememi bekler.						
13. Yemek yedikten sonra kusarım.						
14. Yemek yedikten sonra aşırı suçluluk duyarım.						
15. Tek düşüncem daha zayıf olmaktır.						
16. Aldığım kalorileri yakmak için yorulana kadar egzersiz yaparım.						
17. Günde birkaç kere tartılırım.						
18. Vücudumu saran dar elbiselerden hoşlanırım.						
19. Et yemekten hoşlanırım.						
20. Sabahları erken uyanırım.						
21. Günlerce aynı yemeği yerim.						
22. Egzersiz yaptığımda harcadığım kalorileri hesaplarım.						
23. Adetlerim düzenlidir. (Yalnızca kızlar cevaplandırarak)						
24. Başkaları çok zayıf olduğumu düşünür.						
25. Şişmanlayacağım (vücudumun yağ toplayacağı) düşüncesi zihnimi meşgul eder.						
26. Yemeklerimi yemek, başkalarınınkinden daha uzun sürer.						
27. Lokantada yemek yemeyi severim.						
28. Müshil kullanırım						
29. Şekerli yiyeceklerden kaçınırım.						
30. Diyet (perhiz) yemekleri yerim.						
31. Yaşamımı yiyeceğin kontrol ettiğini düşünürüm.						
32. Yiyecek konusunda kendimi denetleyebilirim.						
33. Yemek konusunda başkalarının bana baskı yaptığını düşünürüm.						
34. Yiyeceklerle ilgili düşünceler çok zamanımı alır.						
35. Kabızlıktan yakınırım.						
36. Tatlı yedikten sonra rahatsız olurum.						
37. Diyet (perhiz) yaparım.						
38. Midemin boş olmasından hoşlanırım.						
39. Şekerli, yağlı yiyecekleri denemekten hoşlanırım.						
40. Yemeklerden sonra içimden kusmak gelir.						