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Eating disorders are classified as developmental crises. According to Kanel (2015), a developmental crisis is a "period of psychological upset" which is "induced by special tasks and role changes required by each new stage in the sequence of psychosocial maturation" (p. 110). Inabilities to adapt to new family situations and role changes, and lack of support through social, physical, and cognitive stages of development may result in a developmental crisis (Kanel, 2015).

Anorexia nervosa and bulimia nervosa are eating disorders that typically develop during the adolescent years (Kanel, 2015). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), people with anorexia nervosa are tremendously fearful of gaining any amount of weight and believe they are fat. They refuse to maintain a sufficient diet for their stature, and may engage in excessive exercise in attempt to achieve the slender body image they are striving for. Although their emaciation is real, some gaze in the mirror and a large figure is all they can see. Others take note that their emaciation is real, but have identified the look as appealing (Herpertz-Dahlmann, 2015). The *DSM-5* additionally states an individual must have missed at least three menstrual periods and lose "original body weight at least to a level 85 percent of that expected on the basis of height and weight norms" to be categorized as anorexic (American Psychiatric Association, 2013). This obsession with losing weight is dangerous. In fact, anorexia nervosa has the highest mortality of all mental disorders (Herpertz-Dahlmann, 2015).

Similarly, individuals with bulimia nervosa are unhappy with their body shape and size. However, their disorder may be harder to distinguish. Gabbard (2000) emphasizes that they tend to maintain a typical body weight although they participate in binge eating and purging (as cited

in Kanel, 2015, p. 125). Their normal body weight can mask their underlying illness. Bulimics binge at least once a week for three months, and then purge as a compensatory behavior for their overindulgence (Herpertz-Dahlmann, 2015). Purging includes self-induced vomiting, intentional overuse of laxatives, extreme exercise, and abstaining from food (Herpertz-Dahlmann, 2015).

Kanel (2015) states that those with anorexia nervosa and those with bulimia nervosa share the following characteristics:

> (1) Are highly emotionally reserved and cognitively inhibited; (2) prefer routine, orderly, predictable environments and adapt poorly to change; (3) show heightened conformity and deference to others; (4) avoid risk and react to appetitive or affectively stressful events with strong feelings of distress; and (5) focus on perfectionism, negative self evaluation, and fears of becoming an adult. (p. 125)

A struggle with anorexia nervosa or bulimia nervosa is similar to that of a drug addiction (Herpertz-Dahlmann, 2015). The persistent and vicious cycle of dieting or binging and purging takes over, and the individual has a hard time breaking free.

Understanding Eating Disorders Within Context

Eating disorders often arise during adolescence, an age period proposed by Erik Erikson that occurs within in the normal "sequence of psychosocial maturation" and confronts an adolescent with the identity versus role confusion crisis (Kanel, 2015, p. 110). During this stage, teenagers search for a sense identity and autonomy while also relying on their family to provide basic needs, guidance, and emotional encouragement. This "critical transition point" places them in a vulnerable position in regards to psychological distress and confusion (Kanel, 2015, p. 110). Emergence from this state of dependence into a state of independence is a particular challenge, especially for adolescents who face the constant demands of culture and family.

Culture

Contemporary society acknowledges slimness as an attractive female feature. Movie producers cast beautiful, slender women in their main roles, models "weigh 25 percent less than the average woman," and advertisements utilize camera tricks and airbrush techniques to portray an unrealistic, flawless body image (Kanel, 2015, p. 124). It is easy for females to compare their own bodies to the ones the media chooses to broadcast and idolize and then feel poorly about the way they look. In addition, peers and friends may have an effect on an adolescent's body image satisfaction. Hamel, Zaitsoff, Taylor, Menna, and LeGrange (2012) found that "adolescent girls were more likely to report weight loss behaviors if the proportion of underweight females in their school was relatively high" (p. 1261).

Social comparison theory is demonstrated in these body comparison habits. This theory claims that individuals evaluate their personal features and capabilities, and then assess whether these features and capabilities are suitable by comparing themselves to others (Hamel et al., 2012). If they are not satisfied with their assessment because they find they are different than others, they may adjust their behaviors or attitudes in order to fit in and reduce their cognitive dissonance (Hamel et al., 2012). A study conducted by Hamel et al. (2012) took 75 females between the ages of 12 and 18 and sought to investigate whether body-related social comparison (BRSC) and eating disorders were correlated. Their study revealed that they were strongly related. The researchers also implicated that "because BRSC is so strongly related to eating disorder symptoms, especially cognitive aspects of the disorder, treatment and prevention programs for adolescents with an eating disorder may benefit from a focus on reducing BRSC" (p. 1270).

Family

The family plays an important role in eating disorder development. According to Leonidas and Santos (2015), anorexia nervosa is most prevalent in families where strict parameters are established, intrusive behaviors are exhibited, and avoidance of conflicts is common. On the other hand, the researchers state that bulimia nervosa occurs in families that are disorganized and those diagnosed often claim they experience lack of affection and care within the family as well as a close relationship with their fathers.

When family dynamics are dysfunctional and cannot cultivate healthy development, it is difficult to strike a balance between individuality and reliance on family for nurture and direction. Consequently, eating disorders develop in attempt to manage the crisis. However, this delicate balance between individuality and reliance on family is crucial. The adolescent stage of development sets the foundation for young adulthood, where those entering into the beginning of adulthood strive to take responsibility for their own lives by fulfilling their emotional needs through intimate relationships and undertaking personal finances (Kanel, 2015). Eating disorders "during adolescence may represent a turning point that sets individuals on a different trajectory whereby they do not have the same life chances or opportunities for achievement and success throughout their adult life" such as "lower levels of educational attainment, personal income, and lower odds of owning a home" (Tabler & Utz, 2015, p. 629). If adolescents do not resolve the identity versus role confusion conflict, they will be ill equipped to step into the next phase of their lives.

Prevalence of Eating Disorders in Society

When examining the research conducted regarding eating disorders, the findings can be staggering. These disorders typically affect females. Radcliffe (1999) states:

> Approximately seven million females and one million males are afflicted with an eating disorder. Of the females, 86 percent developed it before the age of 20; 10 percent before the age of 10; and 33 percent between the ages of 11 and 15. Girls at highest risk for developing an eating disorder are white and middle or upper class. Unfortunately, these disorders are now becoming more prevalent among less-privileged girls of minority status as they assimilate into Anglo American culture. (as cited in Kanel, 2015, p. 124)

Also, current research conducted by Herpertz-Dahlmann (2015) shows that "eating disorders are the third most common chronic illness among adolescents, after obesity and asthma" and the "peak age of onset occurs between 14 and 19 years" (p. 177). In addition to the fact that these disorders significantly affect young people, the very numbers of those affected are stunning as well as the numbers of those affected who do not seek support. Ten percent of the general population has some form of an eating disorder, but only a small sum of these people seeks help (Herpertz-Dahlmann, 2015). When treatment is not pursued, "adolescents often become adults in whom these disorders persist: the chronic and disabling courses of these conditions generate high somatic and psychiatric comorbidity rates, along with substantial personal and societal costs" (Herpertz-Dahlmann, 2015, p. 178).

Furthermore, eating disorders go beyond a single psychological health issue. For example, anorexia nervosa has the greatest mortality rate of all mental disorders, and about one-fifth of those who die from anorexia nervosa commit suicide (Herpertz-Dahlmann, 2015). These disorders present physical as well as psychological problems and further study must be done to discover the best prevention methods.

Intervention

Prior to engaging in psychological intervention, crisis workers must make sure the

suffering individual is physically stable. Malnutrition, dehydration, or seizures caused by electrolyte imbalance may need to be treated in a hospital, and medications such as antidepressants or mood stabilizers may need to be prescribed (Kanel, 2015). Once medical care is taken care of, the crisis worker must assess whether the individual is suicidal since many will feel empty, depressed, and helpless (Kanel, 2015).

Whether eating disorders develop due to lack of self-esteem or as a result of unhealthy family situations, getting the family involved in the intervention process is most beneficial for the diagnosed individual, particularly for adolescents and children (Robinson, Dolhanty, & Greenberg, 2013). Anorexia nervosa and bulimia nervosa affect the entire household. If the eating disorder is mainly due to lack of self-esteem or identity, Kanel (2013) suggests that the family members should learn about eating disorders, inquire about what they can do to encourage the suffering individual, and tend to emotional needs. However, if the eating disorder is a result of unhealthy family situations, new boundaries should be established and healthier roles should be discussed. Many people develop anorexia nervosa in response to a rigid family structure (Kanel, 2015). They feel trapped and believe this is the only aspect of their lives they can control so independence as well as emotional and psychological needs must be acknowledged (Robinson et al., 2013). On the other hand, those who suffer with bulimia nervosa may come from a disengaged family background, where they feel unloved or unsupported and resort to binging and purging to soothe their pain (Kanel, 2015). Nonetheless, in both disorders the families may be keeping their family member in a crisis state without realizing it; they are not allowing their family member to healthily work through their developmental phase, which is typically adolescence when dealing with an eating disorder patient (Kanel, 2015). Robinson et al. (2013) "believe that parents—with supportive guidance from therapists—can also support

their child in the processing of emotions, increasing their emotional self-efficacy, deepening the parent-child relationships and thereby making ED symptoms unnecessary to cope with painful emotional experiences" (p. 77). When structural family therapy is employed, the whole family can recalibrate and learn how to healthily move through stages of development together by supporting each other's emotional needs (Kanel, 2015).

Analysis

With the click of a button on their iPhone or laptop, teenage girls are able to see what media and culture depict as an ideal woman's body. Researchers propose "that when women make comparisons of their bodies to other women's bodies, more negative, or self-defeating, conclusions are likely to predict engagement in compensatory behaviors, as manifested in the presence of ED symptoms" (Corning, Krumm, & Smitham, 2006, p. 339). It is heartbreaking that they accept the idea that one must embrace a slender and fit stature to be considered beautiful, and then take drastic measures, such as fasting or binging and purging, in attempt to achieve this unrealistic image. However, it is also understandable. The "thin body has become a revered symbol or emblem and the fat body a devalued one in contemporary society" (Kadish, 2012, p. 437). It is nearly impossible to flip through a magazine or go on social media without coming across diet and exercise tips or a picture of a skinny model. The prevalence of eating disorders within society is overwhelmingly sad. The homework load, shifts in interests and hobbies, questions regarding purpose and existence, desire to find a close-knit group of friends, and longing to be socially accepted by peers during adolescence are hard and confusing enough without the burden of a negative body image and an eating disorder.

It is interesting to note that anorexia nervosa and bulimia nervosa do not simply occur due to the pressure of culture. They tend to occur in combination with other emotional issues that

the suffering individual does not know how to cope with properly. Dolhanty and Greenberg (2007) underscore that, “symptoms may regulate or soothe an emotional sense of some combination of feeling insecure and unloved, or humiliated, trapped and powerless. Starving numbs, binging soothes and vomiting provides relief” (as cited in Robinson et al., p. 77). Clearly, the effects of anorexia nervosa and bulimia nervosa are harsh and terrible, and the causes of the disorder cannot be boiled down to a single source.

Conclusion

Given these points, eating disorders are more complex than one might assume. The effects are detrimental, and even deadly, if one does not seek therapy or hospitalization. Intervention is most beneficial when the family is involved, since eating disorders are a developmental crisis tending to emerge during the identity versus role confusion psychosocial stage of development. During this time of life, the balance between independence and family dependence is the key to success. Improper capability to strike this balance and resolve the crisis may result in anorexia nervosa, bulimia nervosa, or another psychological disorder or issue.

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