

This essay is an examination of eating disorders and body image dissatisfaction in the UK, these will include Anorexia Nervosa, Bulimia Nervosa, Binge eating and Body Image Dissatisfaction. It will look at the pressures of modern-day life and the influences they have on a person's self-image. It will examine the physical and psychological issues of individuals with eating disorders, treatments on offer, waiting times and the importance of partnership working within health and social care. Aspects of theory will be applied with reference to eating disorders, behaviour and life-style choices within health and social care. According to the World Health Organization (2016) an eating disorder is a form of mental health. An eating disorder is a diagnosis given to a person with unhealthy thoughts, feelings and behaviours about food and their self- image (time to change.org 2019). According to Patel et al (2016), an individual with an eating disorder often lack the skills needed to cope with negative experiences. Latzer et al (2016) agree that eating disorders are becoming a major problem due to a world of social media increasing the pressure to have an ideal body type.

The National Institute of Mental Health (2019) recognises that an eating disorder can affect all ages of people, racial and ethnic backgrounds, body weights and the sex of the individual. It also recognises that the causes of eating disorders are not known fully, it could be numerous factors such as behaviour, stress, pressures, lifestyle and could be genetic that can heighten the chances of a person developing an eating disorder. Exworthy (2008) identifies that the Dahlgren-Whitehead rainbow theory 1991 is used to identify the different paths that can lead to impacts on health which can be determined by social factors. The theory consists of layers of influences surrounding an individual that could affect a person's health. The first layer is lifestyle factors, this could be how a person behaves and the way they live, the second layer is social and community network these include family and friends, and the third layer includes factors such as education, work environment and conditions, living conditions and health care services. Strober et al (2000) also recognise that the cause of eating disorders is unknown but can be due to a combination of issues which can include puberty, stress, overcoming pressures, family, lifestyle choices and the growing life of social media pressures.

According to Beat Eating Disorders (2015) in the UK there is an estimated 1.25 million people with a form an eating disorder with young women under 20 years of age making up the vast majority. Beat also identifies that an estimated 4 million people do not seek help for any form of eating disorder. Hoek and van Hoeken (2007) identify that Anorexia Nervosa most commonly begins in adolescent girls. Beat also recognises that the two most common models of eating disorders are Anorexia Nervosa, Bulimia Nervosa with Binge eating only recently became an eating disorder. The WHO (2010) acknowledges that Anorexia Nervosa involves an individual wants to deliberately lose weight due to excessive thoughts and perceive themselves being overweight. Living in fear of gaining any weight can lead to a restricted diet with insufficient essential nutrients, lead to over exercising and use

of laxatives. The WHO acknowledges that Bulimia Nervosa is where an individual will eat excessively followed by making themselves vomit and take laxatives to ensure the control of not becoming overweight. According to the American Psychiatric Association (2013), binge eating has only recently been recognised as a serious mental illness, until 2013 it came under the eating disorder not otherwise specified category. It acknowledges that binge eating is where an individual will experience lack of control and will eat copious amounts of food on a regular basis as well as having their regular meals. It can affect anyone of any age but normally is more common in adults. It is different from Bulimia Nervosa as the individual to not feel the need to vomit or dispose of the food consumed, they just experience feelings of guilt and disgust at the lack of control during and after binge eating. Javaras et al (2008) recognise that binge eating can lead to weight gain and obesity, it can also lead to high blood pressure, high cholesterol, type 2 diabetes and heart disease. Hudson et al (2007) identify that issues with most eating disorders are likely to lead to changes in behaviour, thoughts and feelings, have low self-esteem, depression and anxiety. Kimberly et al (2007) identify that an effective form of treatment for binge eating is cognitive behavioural therapy, this is a talking therapy that aims to change the way of thinking more positively by changing negative thoughts and behaviours into positive ones by breaking them down into smaller parts. Most treatments for binge eating will take part in outpatient services, inpatient treatment is used when a person is at risk of severe self-harm or suicide.

According to Beat Eating Disorder (2010) eating disorders have both psychological and physical symptoms. Physical symptoms can pose long-term health implications and long-term side effects. Physical impacts include difficulty swallowing due to the size of a shrunken stomach, an individual can feel cold, weak and tired due to the metabolism slowing down, suffer with constipation and can lead to brittle bones. Psychological symptoms can lead to sleeping problems, suffer from anxiety and depression, not being able to focus on anything other than food and calories and become obsessed by this.

O'Brien et al (2017) identify that an individual can experience many long-term side effects even after recovery, with Anorexia Nervosa the brain, heart liver and kidneys, can all function poorly, it can lead to infertility, osteoporosis and can stunt a person's growth. Bulimia Nervosa can experience painful swallowing, low levels or an imbalance of vital minerals, increase heart problems, cause severe problems to the oesophagus due to vomiting, stomach and bowel. Mitchison et al (2013) suggests that an individual who suffers from a form of eating disorder long-term may struggle with an active social life, family life, continuing education or work due to associated impairment in these areas.

According to the National Eating Disorder Association (2019) recovery from an eating disorder requires professional help and when detected during the early stages and early treatment given, the chances of recovery are improved. Many sufferers wait for several months before seeking help or

become aware they are experiencing eating disorder symptoms. This delay can impact recovery and is more likely to lead to multiple episodes of treatment, it can also have an impact on long-term health issues. Eating disorders are diagnosed once a person seeks medical help, this is often from their GP who will carry out an assessment and refer them to a consultant and psychiatrist for further assessments and treatments. NHS England (2013) identify that most patients are treated locally by the outpatient eating disorder services, only a small number of severe cases need to be treated as inpatients. For a young child or adolescent there are 4 main settings that provide eating disorder treatments these are the Child and Adolescent Mental Health Service, eating disorder mini teams, child and adolescent eating disorder services and inpatient treatment in a hospital or clinic for severe cases. According to the Nuffield Trust (2019), it is vitally important that families or persons caring for young children and adolescences that are suffering with an eating disorder are able to seek medical help as soon as possible, this can reduce further complications and enhance their recovery process and reduce hospital admissions. It identifies that urgent cases for treatment of a child with an eating disorder is approximately one week and non-urgent issues are seen within four weeks. NHS England (2015) recognises that there is a delay in seeking help and diagnosing eating disorders before treatment can start, this can be more than 6 months and up to a year's waiting time. Furukawa et al (2014) recognises that waiting for treatment is harmful to the sufferer and can impose long-term health complications, The NHS England (2019) identifies that it was working with the Department of Health in 2014 to improve the access to therapy treatments and waiting times to access mental health services by 2020 with the UK Government announcing extra funding to be spent on mental health services. Schmidt et al (2016) recognises that First Episode Rapid Early Intervention for Eating Disorders has been developed by South London and Maudsley NHS Foundation Trust, this service is aimed at young adults aged between 18-25 offering rapid screening, assessments and self-help advice on eating disorders. This early intervention can cut waiting times and reduce further health issues by starting treatment immediately. Brown et al (2018) and McClelland et al (2018) identify this service has been piloted and proven successful and has now been scaled up in England. Gardner and Wilkinson (2011) identify that there are many therapies on offer that can be used to treat an eating disorder, these include cognitive behavioural therapy, psychotherapy which includes family therapy and self-help therapy. The National Institute for Clinical Excellence (2004) suggest that children and adolescents who suffer from an eating disorder should be recommended family intervention as family plays an important role on a child's treatment and their recovery. Cooper et al (1996) have identified that cognitive behavioural therapy and self-help therapy to be an effective treatment for bulimia nervosa sufferers. Sanchez-Ortiz et al (2011) identify that by accessing immediate online cognitive behavioural therapy guidance had started to improve conditions than those on a waiting list. Carter et al (2012) recognise that those waiting a long time to start treatment were more likely to give up and not seek any treatment. The American Psychiatric Association (2006) recognises that treatment and behaviour goals are used across the range of therapies, to allow the person to focus more positively on

improving their lifestyle and things which they have an interest in rather than focusing on how much they weigh. According to Graham and Stevens (2013) partnership working within health and social care is a key element that bring together different organisations who specialise in a specific area, offering a wide range of services that meet the demands and needs of individuals and reduce waiting time for treatments. Petch et al (2013) recognise the importance of partnership working to deliver high quality services and products to clients. Balloch and Taylor (2014) suggest that partnership working creates strong inter-organisational relationships and is essential for effective practice. Glasby and Dickenson (2016) identify that partnership working is needed for early intervention and if it is delayed can lead to a person's needs not being met and their condition deteriorating resulting in inpatient treatment.

Deans (2011) recognises that Anorexia Nervosa dates back as far as the 12th century but was rare until the later 20th century. There was a rise in this eating disorder in the 1960's due to the ideal body shape being thinner, this was due to super skinny models such as Twiggy being recognised as the epitome of beauty. The Marilyn Monroe curvy, hour-glass figure was no longer the ideal body shape. Female models and celebrities in the 1990's strived to become a size zero. According to Helfert and Warschburger (2013) social pressure has an impact on an individual's appearance and enhances the negativity thoughts and feelings around their body image, it can lead to low self-esteem along with other severe mental disorders such as depression and eating disorders in adolescence. Morris and Katzman (2003) suggest that young people are struggling with pressures of modern life, social media, thin celebrities, bullying, family arguments or pressure to do well in school or work. They recognise that social media has created new pressures on today's adolescents as their lives are focused around social media, television, movies, fashion designer labels, billboards and music with them all portraying the beautiful thin ideal body image for girls and the muscular six pack lean male ideal body image. Field et al (1999) identify that models are filtered and digitally enhanced to portray the ideal body image which promotes fake body images that are almost impossible to achieve. They suggest that beauty and fashion magazines can increase levels of concerns regarding a person's weight and lead to an eating disorder. Brechan and Kvalem (2015) recognise that body image dissatisfaction can lead to a lack of confidence and self-esteem, perfectionism, problems with bullying about their self-image. Eriksson et al (2018) recognise that Bronfenbrenner's ecological model identifies how the different types of environmental systems have a great influence on a child's development and growth through social and cultural values. Crompton (2018) recognises that Maslow's hierarchy of needs identifies that esteem is the fourth layer before being able to gain self-actualization, lack of self-esteem can lead to negativity, lack of self-confidence and not feel loved or belong in society. Jones (2004) recognises that in western society body dissatisfaction is very popular among adolescence individuals, with low self-esteem, depression and eating disorders are main issues. Mc Guinness and Taylor (2016) also recognise that body image dissatisfaction has increased

amongst western men and women and is considered a public health issue that is linked with psychological problems. Philips and de Man (2010) define body image dissatisfaction as feeling negative and think negatively about their body shape, size, appearance and attitude to weight gain in relation with achieving to have an ideal body. According to Harrison (1997) dissatisfaction with body image and attitudes to eating are very important factors for adolescent girls, many perceive themselves as being overweight and strive to become thinner. According to Van den Berg et al (2002) and Stice (1994), Thompson's Tripartite Influence Model of body dissatisfaction and Stice's Sociocultural Model of Disordered Eating have identified that appearance pressures from friends, family and the media can contribute to the development of body image dissatisfaction and eating disorders. Parents and peers are closest to the individual and can also have a negative effect on a child's body image without realising by teasing them and commenting on their weight and image.

In conclusion an eating disorder is a mental health issue with symptoms of both physical and psychological issues, which can affect all ages, racial and ethnic backgrounds, any sex of individuals, although it is most common in young adolescent girls. An estimated 1.25 million people in the UK are suffering with an eating disorder and an estimated 4 million people have a form of eating disorder but not seeking any help. The exact cause of an eating disorder is not known but suggests that numerous factors can increase a person's risk of developing one. The two main eating disorders are anorexia nervosa and bulimia nervosa, with binge eating recently been recognised as an eating disorder. Treatment commonly used for eating disorders are enhanced therapies, these can be talking, self, family and cognitive behavioural therapy. Eating disorders among young persons are usually diagnosed and treatment is started within seven days for urgent cases and can take up to a month for non-urgent cases. For adults, treatment can take from six months to eighteen months, this can have an impact on recovery time and long-term health issues. Lack of funding in mental health and increased pressure on the NHS is to blame for the lengthy waiting times, early intervention can lower the cost as inpatient treatment would not be needed and the patient would attend out-patients appointments.

Young girls are struggling with the pressures of modern life, with thin celebrities modelling clothing brands on billboards, fashion and beauty magazines and fear of being bullied for not having the right size body or looks, this leads to body image dissatisfaction are at more risk of developing an eating disorder. Social media has created new pressures to look good in self-images, photos on dating apps also emphasis the increased pressure to look right. These pressures around body image dissatisfaction can cause anxiety and depression as many adolescent girls feel shame and lack self-esteem by not feeling like they belong in society due to their body weight and image. Dissatisfaction with body image and healthy eating are important aspects for young girls, many young girls see themselves as being overweight and strive to be thinner. They become vulnerable to messages on social media and cannot discriminate between what are real or fake images, models are digitally enhanced and therefore their image is impossible to achieve. Parents and peers play a vital role in educating their children on

healthy eating and fitness to gain a positive body image of themselves. Parents can also have a negative effect on a child's body image by teasing them or mentioning their child's body weight. The Dahlgren and Whitehead rainbow theory and the Bronfenbrenner ecological model systems theory was applied to identify the importance of immediate environment and layers of influence of health on a child's life. Maslow's hierarchy of needs theory was applied to recognise the importance of self-esteem for a person to feel like they belong, feel self-worth to reach self-actualisation. Thompson's Tripartite Influence Model of body dissatisfaction and Stice's Sociocultural Model of Disordered Eating were applied to identify that sociocultural influences are media, parents and peers contribute to the development of body image and eating disorders.

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