



EATING DISORDERS IN ACCORDANCE WITH THE INTERNATIONAL CLASSIFICATION OF DISEASES

Imani Hamzatovna Salgirieva^{1*}, Tamara Olegovna Stepanyan², Rassita Hiziroyva Voitleva³, Vladislav Ikromzhonovich Achilov³, Mikail Alihanovich Albakov³, Aminat Aslanovna Ahmarova⁴

1. *Department of Pediatrics, Medical Institute of the Chechen State University, Grozny, Republic of Chechnya, Russia.*
2. *Department of Therapy, Faculty of Medicine of Stavropol State Medical University, Stavropol, Russia.*
3. *Department of Therapy, Medical Faculty of Rostov State Medical University, Rostov-on-Don, Russia.*
4. *Department of Therapy, Medical Institute of the Chechen State University, Grozny, Republic of Chechnya, Russia.*

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ABSTRACT

In recent years, there have been more and more cases of eating disorders in the world. Such cases are especially common among teenagers and young people. The fashion for slender bodies and attempts to be like their idol often force teenage girls around the world to go on strict diets, exhaust themselves with heavy workouts, and use medicines for weight loss. On the other hand, constant stress and bullying, misunderstandings in the family - these factors lead to uncontrolled appetite and attempts to "jam" stress, which subsequently exerts even greater psychological pressure on a person. The International Classification of Diseases of the 10th revision identifies the following types of eating disorders: anorexia nervosa, bulimia nervosa, compulsive overeating, vomiting associated with various psychological disorders, etc. Eating disorders affect at least 9% of the world's population and often end in death. Unfortunately, people rarely turn to specialists at the first symptoms that allow them to diagnose eating disorders, so most often correction requires a whole range of measures. Several specialists are necessarily involved in the process, including a psychiatrist. The article presents a description and symptoms of the main types of eating disorders describes in detail the principles of psychotherapy for these diseases and also presents some methods of psychotherapeutic assistance for eating disorders.

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Introduction

In modern literature, eating behavior is understood as a stereotype of eating under normal conditions and stress, attitude to food in general and meals in particular, as well as attitude to one's own body. Thus, eating behavior is an individual attitude of a person to eating, which determines the amount and composition of what is eaten under various conditions [1].

There is adequate and deviant (deviant) eating behavior. Moreover, the concept of "norms" of eating behavior is significantly influenced by many parameters: the place of residence, gender, age of a person, type of activity, position in society, and belonging to any ethnic group and culture.

Eating disorders are a group of behavioral psychogenic syndromes that are characterized by deviations in food intake and processing. The general characteristic of this group of disorders is the contradiction between the physiological needs for food and the desires of the patient [2, 3].

Figure 1 shows the age statistics of people who first encountered eating disorders.

Corresponding Author: Imani Hamzatovna Salgirieva; Department of Pediatrics, Medical Institute of the Chechen State University, Grozny, Republic of Chechnya, Russia. E-mail: ruslankalmykov777@yandex.ru.

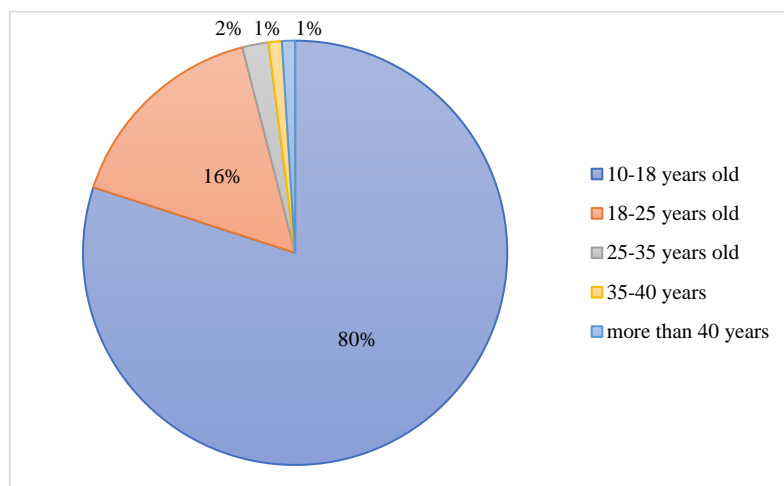


Figure 1. Age groups of people who have experienced eating disorders for the first time.

Some scientists identify two main causes of eating disorders:

- preoccupation with body shape and weight;
- increased anxiety, especially with orthorexia Nervosa and with some restrictive types of eating behavior.

All causes of eating behavior are purely individual, however, some groups with characteristic features can be distinguished:

1. Genetic predisposition. Some experts point out that anorexia nervosa and bulimia nervosa are inherited in 40-60% of cases, and paroxysmal overeating in 48%.
2. Biological factors. For example, intestinal microflora can cause obesity, anxiety disorder, and clinical depression. In addition, eating behavior depends on the regulation of serotonin, type II diabetes, food intolerance, and other factors.
3. Social factors. Bullying, the ideal of thinness in the family or society in 60-80% leads to eating disorders. Some statistical facts characterizing the eating behavior of modern people are shown in **Figure 2**.
4. Psychological factors. Negative self-esteem, perfectionism, achievement, increased anxiety, depression, attachment disorder, and so on.
5. Alcohol and drug addiction in the family.
6. Affective disorder in family members, for example, depression or anxiety disorder [4-7].

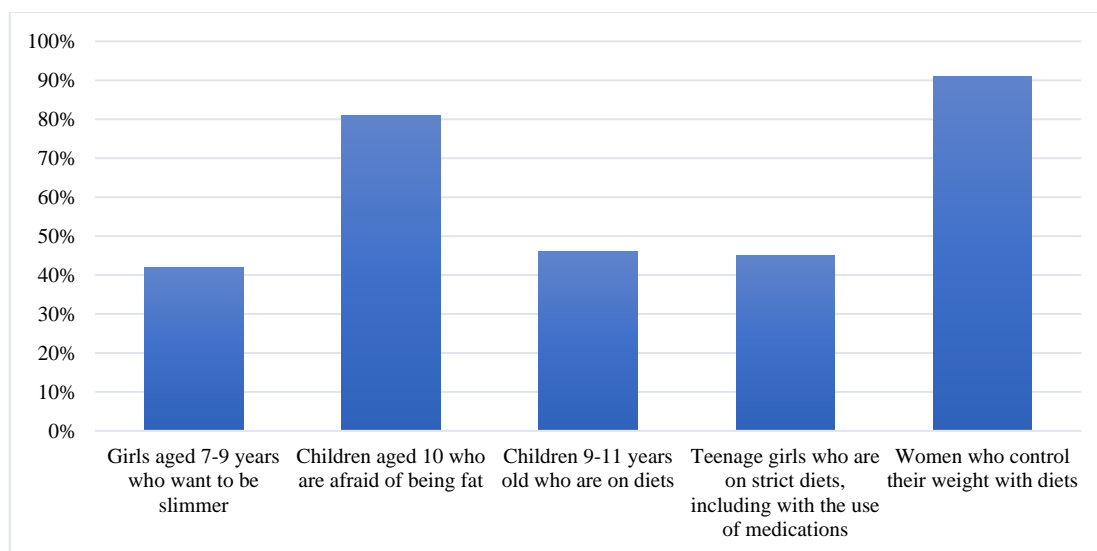


Figure 2. Statistics of eating behavior of modern people

International Classifier of Diseases

In accordance with the international Classification of diseases of the 10th revision (ICD 10), adopted in Europe and Russia, the category of eating disorders includes:

1. Anorexia nervosa is a mental disorder characterized by unintentional loss of body weight caused and maintained by the patient. It is most often found in young girls and women. The disorder is associated with a specific psychopathological

fear of obesity and flabbiness of the figure, which becomes an annoying idea, and patients set a low body weight limit for themselves. Signs of anorexia nervosa:

- restriction in the consumption of necessary energy leading to a significantly low weight, for a certain age, gender, and level of development of physical health;
 - a strong fear of weight gain or obesity, obsessive behavior that prevents weight gain, despite its significantly low level;
 - distorted perception of one's weight or figure, excessive influence of weight, figure on self-esteem, and misunderstanding of the seriousness of the problem of such a low weight.
2. Atypical anorexia nervosa is a disorder that corresponds to some features of anorexia nervosa, but the full clinical picture of which does not allow this diagnosis.
 3. Bulimia nervosa is a syndrome characterized by repeated bouts of overeating and expressed anxiety about weight control. This leads to the development of a style of overeating, accompanied by vomiting and the use of laxatives. Repeated vomiting is fraught with electrolyte imbalance and somatic complications. The prevalence of behavioral criteria in bulimia nervosa is shown in **Figure 3**. Signs of bulimia nervosa:
 - repeated bouts of gluttony. That is, the amount of food in a certain period of time (no more than 2 hours) is significantly higher than what other people could eat in the same period, under the same conditions. During this state, a person cannot stop eating and cannot control it.
 - periodically unacceptable compensatory behavior. It is aimed at preventing weight gain, that is, it causes vomiting, laxatives, diuretics, some medications, fasting, dieting, and excessive physical exertion.

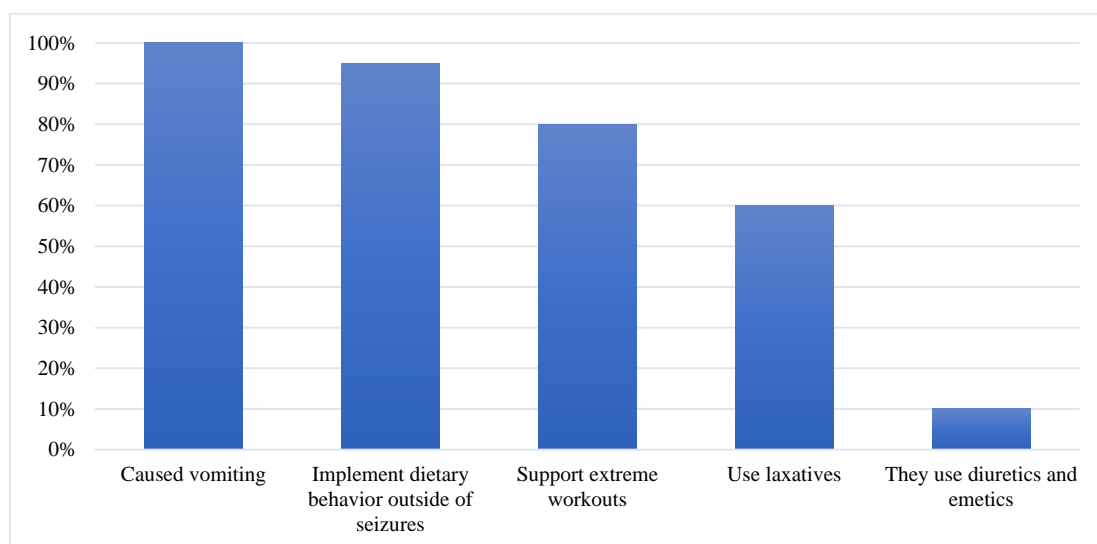


Figure 3. Statistics of behavioral criteria of bulimia patients

4. Atypical nervous bulimia is a disorder that has some signs of nervous bulimia, but the full clinical picture does not allow this diagnosis.
5. Paroxysmal (compulsive) overeating is associated with other psychological disorders, for example, due to stressful events, such as bereavement, accident, the birth of a child, etc. The diagnosis is made if three or more criteria of behavior are confirmed:
 - episodes of loss of control over the process of absorbing food;
 - episodes of gluttony during severe stress;
 - eating an abnormally large amount of food in a short time;
 - eating large amounts of food in the absence of hunger, eating to excess;
 - eating in a state of depression, sadness, and boredom;
 - eating alone out of a sense of shame associated with the process of eating or with one's abnormality;
 - feeling disgusted, depressed, or guilty after such an attack of overeating.
6. Vomiting is associated with other psychological disorders. It includes repeated vomiting, which occurs with dissociative disorders and hypochondriacal disorder and which is not solely a consequence of conditions not included in the list of this class.
7. Other eating disorders include inedible eating (perverted appetite) in adults or psychogenic loss of appetite.

In addition, orthorexia is supposed to be introduced into ICD 10. Orthorexia is a disordered eating, which is characterized by an obsessive desire for healthy and proper nutrition, which leads to significant restrictions in the choice of food [8-11].

At the moment, there are no strict criteria for orthorexia, however, the following are indicative criteria:

- healthy nutrition for a person becomes so important that concern with this issue leaves no room for any other hobbies, or interests in life and interferes with a person's social life;
- the food ration is determined solely by the criterion of the usefulness or non-usefulness of food;
- anxiety and guilt when eating "wrong" foods.

General Principles of Treatment of Eating Disorders

Unfortunately, people rarely turn to specialists for the first symptoms that make it possible to diagnose eating disorders, so most often correction requires a whole set of measures [12].

Several specialists are required to participate in the process: a psychiatrist, a nutritionist, a psychologist, a gastroenterologist, and other specialists if necessary.

Complex treatment of eating disorders is carried out in several stages:

- restoration of the central nervous system;
- weight recovery;
- restoring power;
- rehabilitation psychotherapy.

It should be noted that the study of only one criterion, as a rule, does not end in victory.

For example, in the case of obesity, weight loss courses are used, however, they turn out to be ineffective if it is impossible to induce the client to change instinctive and emotional behavior, within which overweight and hyperphagia lose their need for him.

With dietary treatment, more than half of the clients demonstrate irritability, nervousness, increased fatigue, and various depressive manifestations, which can also manifest as diffuse fear.

In the case of obesity, behavioral psychotherapy aimed at changing inappropriate behavior patterns in the client demonstrates high efficiency [13].

For any type of eating disorder, it is necessary to consult a psychiatrist for qualified support and supervision.

Psychotherapy for Eating Disorders

Psychotherapy is purposeful verbal or non-verbal communication with a patient to influence his painful somatic and mental state.

In psychology, there are several main sources of emotionally conditioned (i.e. psychosomatic) diseases.

The first source is an internal conflict, i.e. a conflict between the conscious and the unconscious in a person. The task of psychotherapy in this case is to reconcile these parts. Suppressing one of the parts will not help eliminate excess weight. Neuro-linguistic programming and gestalt therapy offer effective techniques for dealing with the conflict of opposite parts of the personality.

The second reason is motivation or secondary benefit. This is a very significant reason because the symptom is often beneficial for the patient. When studying the well-known phenomena of the relationship between being overweight and a person's lifestyle from the point of view of obtaining stable existential, biological, psychological, and social benefits, specific motivational advantages that fix excess weight were found [14].

The motivational advantages of excess weight act as additional means of effective adaptation to the conditions of existence, as a means to achieve meaningful goals. At the same time, therapy becomes more difficult and the pathological process is stabilized. It is impossible to ignore motivational advantages.

There are several main motivational benefits to maintaining a psychosomatic illness. Any disease:

1. allows you to get away from an unpleasant situation or from solving a difficult problem;
2. gives the right to care, love, attention to others;
3. eliminates the need to meet the requirements of others and yourself.

For example, the secondary benefit of obesity is that overweight people have fewer demands, and overweight people themselves blame their appearance for all their failures. Being overweight protects a woman from exhibitionistic tendencies and excessive male attention, and can also protest against a male-dominated society. Obese husbands avoid housework and sex. In addition, being overweight in some cases gives a more authoritative, solid, assertive (or, conversely, kinder and harmless) appearance, serves as an excuse for life's failures and helps to evoke sympathy, helps to realize the need for love and care [15, 16].

In order to understand the problem of motivational benefits in relation to the problem of excess weight, it is necessary to solve two main tasks:

1. identify the needs that are met due to excess weight;
2. find alternative (without the participation of excess weight) ways to meet these needs.

The next source of psychosomatic disorders is identification, the desire to become like someone, an ideal. Unconscious imitation of parents is especially dangerous. The implementation of the parental scenario may be one of the causes of diseases

that are considered hereditary. Perhaps the parental scenario is the background on which hereditary pathology begins to develop.

The following sources of psychosomatic disorders are also distinguished: the effect of suggestion, self-punishment, "speech of organs", and painful, traumatic experiences from the past. Since the psychological factor in eating disorders and the occurrence of overweight acts as one of the etiological factors, psychotherapy as one of the components of the therapeutic and rehabilitation process should play an important role in its correction. Correctional programs for the treatment of eating disorders and alimentary obesity mainly solve the following tasks:

1. Correction of eating disorders and inadequate lifestyle.
2. Correction of the Self-image.
3. Achieving the objectivity of self-assessment.
4. Rehabilitation of the Self in their own eyes and gaining self-confidence.
5. Correction of the system of values, needs, and hierarchy, bringing claims in line with psychophysical capabilities.
6. Correction of attitudes towards others, increasing the ability to empathize and understand the experiences of others.
7. Acquisition of skills of equal communication, the ability to prevent and resolve interpersonal conflicts.

When working with psychosomatic patients, all known psychotherapeutic approaches are used. However, the choice of a specific method and tactics of therapy depends on several factors: the clinical picture of the disease, the characteristics of the patient's personality, the established terms of therapy, and the experience of the psychotherapist. The methods of psychotherapy used in psychosomatic medicine can be divided into two groups: depth-psychological methods and methods focused on symptom and behavior modification. In practice, they can be combined.

Deep psychological methods aim to uncover the psychological conflict that is behind the psychosomatic symptoms, the restructuring of the personality as a whole, and its relations with the outside world. An important point in therapy, especially when working with psychosomatic diseases and addictions, is the conclusion of a therapeutic contract. A therapeutic contract is a working agreement between a patient and a specialist on the goals of therapy and the means to achieve them [17].

The initial consultative reception has a certain logic. First, the patient tells the specialist about the reasons for his request for help and answers his questions. Gradually, the therapist begins to understand the essence of the problem that led the client to him. At the same time, he also finds out what changes the client would like to achieve. Listening to the client, the therapist correlates what has been said:

- with their observations of the client;
- with their professional installations;
- with potentially possible methods of assistance to this client, taking into account the specifics of his problem.

Taking all this into account, the professional begins to formulate appropriate goals and outline certain priorities. When working with overweight and eating disorders, the following issues and topics should be discussed during the first consultation:

1. Concepts of the patient's excess weight and his ideas about how he can influence this symptom.
2. Psychological factors of the appearance of excess weight and the essence of therapy: the therapist is accessible, using metaphors, explaining the pathogenesis of excess weight and the influence of the mental state on the occurrence of symptoms.
3. Therapeutic contract: clarification of the patient's goals and, if the patient is ready, discussion of the problem of excess weight in the ideological aspect [18].

Psychotherapy Approaches in the Treatment of Eating Disorders

Cognitive Behavioral Therapy

First, the connection of emotions, automatic thoughts, and behavior is explained, and a vicious circle is described when irrational automatic thoughts trigger negative emotional experiences that lead to overeating. They are taught to conduct a description of behavior during meals, control stimuli preceding the act of eating, slow down the eating process, and strengthen concomitant activity. The immediate goal of this psychotherapy is to teach patients "proper eating behavior" through positive reinforcement and negative reinforcement of pathological eating behavior. As goals and standards govern behavior, the patient and therapist can jointly set the level of daily calorie intake. Achievement of specific goals leads to self-reinforcement, which, in turn, increases the likelihood of maintaining self-regulation in the future. In this model, the patient is invited to learn to be more aware of his body: to recognize his internal sensations, such as hunger, thirst, psychological discomfort, anxiety, etc.; to feel how the body reacts to certain changes in the psychological and physical environment and not to mix these sensations [15, 19, 20].

Suggestive Psychotherapy

It has a direct and indirect suggestive effect, accompanied by point-pressor irritation of sensitive zones in the projection area of the stomach, eyeballs, and places of exit of the trigeminal nerve; moreover, the suggestive effect is carried out against the background of breathing exercises. To block pathological hunger, autosuggestion sessions with elements of larvated psychotherapy are conducted daily. The method allows you to rebuild the value system of an obese person in such a way that

the motivation to eat delicious food is subordinated to more significant attitudes toward health, life expectancy, career, personal life, and creativity [16].

Gestalt Therapy

The specifics of working in the gestalt approach are to pay attention to the emotions that were the basis of overeating attacks and to try to understand the experiences that were realized in this behavior. The gestalt approach also consists in facilitating the reaction of one's feelings. They teach you to talk about your experiences and connect them with events. In addition, you can use the method of art therapy - a drawing in which feelings and events are symbolically depicted [21].

Body-Oriented Therapy

This therapy works great with body image disorders. People with eating disorders will have a distorted perception of their bodies. There are many techniques for perceiving the human body which explains to us how to feel and understand and perceive the body image correctly. Mandatory conditions for psychotherapeutic effects on eating disorders include: developing the client's motivations for healthy eating, setting and forming a weight loss program, visualizing the goal and its concretization, drawing up a nutrition plan, keeping a food diary, changing unhealthy eating habits, forming the client's faith in success and developing self-confidence, formation of psychological protection in the event of situations of possible violations of the diet [22].

Behavioral Psychotherapy

In behavioral psychotherapy, weight loss is carried out as a result of calorie restriction in accordance with modern dietary concepts [20]. The program of behavioral psychotherapy includes the following five elements:

A written description of eating behavior. The client needs to record in detail the time of meals, the amount eaten, where and in whose company the meals took place, and the client's feelings when eating. Control of the stimuli preceding the meal. It is necessary to identify and eliminate food-provoking stimuli: easily accessible stocks of sweets, and high-calorie food. It is necessary to limit the number of such products in free access for the client [21, 22].

Slowing down the eating process. The client is taught the skill of self-control in the process of eating. To do this, you need to count every bite and sip during a meal. After each third piece was eaten, cutlery should be set aside until this piece is completely chewed and swallowed. Over time, the pauses in the process of eating lengthen. Increased concomitant activity. It is proposed to form a system of client incentives for changing eating behavior and weight loss. Each achievement in the field of changing and controlling eating behavior – counting bites and sips, keeping a diary, pauses when eating – is awarded a certain number of points [22].

Cognitive Therapy

The client is invited to argue with himself. At the same time, the therapist helps to find suitable counterarguments that convince the client of the possibility and expediency of losing weight. Suggestive psychotherapy reinforces the clients' attitude to observing proper eating behavior. This type of therapy is most effective in clients who have psychological protection by the type of regression, and who have hysteroid personality traits.

Such methods as gestalt therapy, transactional analysis, art therapy, psychodrama, body-oriented therapy, dance therapy, and family psychotherapy are successfully used in obesity. For anorexia, it is usually recommended to carry out the treatment in specialized centers, where a combination of various therapeutic measures is used, with well-interacting staff with clients. The most pronounced effect of anorexia is characterized by family therapy.

Specialists in behavioral therapy in the treatment of anorexia use the method of integrated exposure. The method at the first stage includes the use of behavioral and training techniques, and in the second stage — treatment, which is aimed at the psychosocial problems of the client. In the hospital, it is important to pay attention and effort not only to the client himself but also to the difficulties he has in dealing with staff and other clients. Together with behavioral concepts, body-oriented treatment methods are used in the treatment of anorexia, allowing the correction of the client's distorted ideas about his appearance, diet, optimal weight, and physical activity [15-17]. Also, such methods as gestalt therapy, transactional analysis, art therapy, psychodrama, and dance therapy are successfully used in the treatment of anorexia.

In the treatment of bulimia, outpatient treatment is quite adequate, in which the client lives in normal conditions. Inpatient treatment for clients suffering from bulimia is used in cases when abnormal personality traits expressed in the client, alcohol abuse, suicidal tendencies, etc. come to the fore in the picture of the disease. In the treatment of bulimia, system-centered structured and confrontational interventions and active treatment are used, which are aimed at overcoming the symptoms of bulimia, mainly in forms limited in time. The result of the treatment is stabilized due to subsequent protective, accompanying, and, if necessary, revealing forms of treatment [15-17].

Family therapy in the treatment of bulimia gives, as a rule, positive results. Trial therapy in the treatment of bulimia assumes that the client is placed in conditions of shock or temptation: they are sent to an expensive restaurant or a candy store, forced to try on swimwear in stores, and actively perform other actions that usually cause him bouts of gluttony, without succumbing to temptation.

Psychotherapy of interpersonal relationships is aimed at treating the causes of bulimia that lie in the field of interpersonal relationships. The therapist explores how the client's eating habits help him cope with stress, replacing other feelings and

actions. Such methods as gestalt therapy, transactional analysis, art therapy, psychodrama, body-oriented therapy, and dance therapy are successfully used in the treatment of bulimia [19-23].

Conclusion

For any type of eating disorder, psychotherapeutic help is needed. Attempts to return to normal weight and normal eating behavior only with the help of diets and sports cannot end with a positive result. Any eating disorder is based on any psychological trauma (from childhood or the present), even if they are justified by a genetic predisposition. Therefore, working with a psychotherapist and using various psychotherapeutic techniques in practice (in combination with adequate diets and physical activity) can defeat the disease. In behavioral psychotherapy, weight loss is carried out as a result of calorie restriction in accordance with modern dietary concepts. The immediate goal of this psychotherapy is to teach patients "proper eating behavior" through positive reinforcement and negative reinforcement of pathological eating behavior. As goals and standards govern behavior, the patient and therapist can jointly set the level of daily calorie intake. Achievement of specific goals leads to self-reinforcement, which, in turn, increases the likelihood of maintaining self-regulation in the future.

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