

# The Impact of Eating Disorders and Self-Disorders on Women's Behavior in Kuwait

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## Abstract

The purpose of this study is to examine the impact of eating disorders and self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) on women's behavior in Kuwait. This study used a quantitative approach based on a survey questionnaire by the online survey has been used as the main technique for data collection. The survey was sent to a group of 500 women in Kuwait. The survey was administrated through an online survey tool. 212 women completed the full questionnaire, resulting in a response rate of 42.2 percent. The results indicated that eating disorders have a direct effect on women's behavior in Kuwait. Moreover, self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) have a direct effect on women's behavior in Kuwait.

## Keywords

Eating Disorders, Self-Disorders, Women's Behavior, Kuwait

## 1. Introduction

Many popular eating disorder theories touch on the behavior directly and indirectly. Thin ideal internalization has a key role in the development of eating pathology, according to the dual pathway model [1], and the tripartite influence model [2], the degree to which one buys into and connects with the value of being thin, and so presents thinness and its pursuit as important to one's sense of self, is referred to as thin-ideal internalization. The importance of overvaluation of shape and weight (physical features of the self-determining self-worth) and low self-esteem is highlighted in the transdiagnostic cognitive-behavioral model of eating disorder maintenance [3]. Finally, escape theory supports eating as a behavioral effort to avoid uncomfortable self-awareness in bulimia nervosa and

other eating disorders [4].

Anorexia nervosa is defined by a fear of gaining weight and the maintenance of extremely low weight, most typically by dietary restriction and exercise. Bulimia nervosa is characterized by a pattern of binge eating (consumption of enormous amounts of food in a short period of time, followed by a feeling of loss of control) and improper compensatory behaviors (e.g., vomiting). Both anorexia nervosa and bulimia nervosa use self-evaluation as a diagnostic criterion, which is heavily impacted by body weight and shape. Binge eating disorder is similar to bulimia nervosa in that it requires recurrent binge eating, but it does it without any regular compensatory behaviors. Subthreshold cases of anorexia nervosa (e.g., subthreshold on a weight-related criterion), as well as bulimia nervosa and binge eating disorder, are included in other specific eating disorders (e.g., subthreshold in terms of frequency of binge eating).

Of 306 physical and mental disorders, anorexia nervosa and bulimia nervosa combined ranked as the 12<sup>th</sup> leading cause of disability-adjusted life years in females aged 15 - 19 years in high-income countries. Despite evidence that eating disorders have a global distribution and are linked to rising health costs in Asia, epidemiology data from Asia and Pacific Island countries is limited. Furthermore, epidemiological data in Latin America is limited, and epidemiological data in Africa is even scarcer.

Self-disorders have been described as a core feature of schizophrenia both in classical and recent psychopathological literature. The notion of self-disorders in schizophrenia as its core phenotypic feature was articulated, in various terms and clarity in all classic texts on schizophrenia. These disorders affect the behavior of women. These disturbances refer to the first subjective expression of all experiences (thoughts, images, perceptions). For example, patients describe those thoughts appear to be of unknown origin or lacking in form, or that the body or some of its parts are experienced as strange, strange, or lifeless, perhaps with a sense of distance or separation between mind and body, or their sense of self is ephemeral” as If only it was something and a refrigerator and not something human.” Patients may have an incomplete sense of the privacy of the inner world and various selfish experiences, such as a fleeting feeling of being at the center of the world or that the individual’s experiential field is the only reality that exists.

Therefore, the purpose of this study is to examine the impact of eating disorders and self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) on women’s behavior in Kuwait.

## **2. Literature Review**

### **2.1. Eating Disorders**

Eating disorders are described as a change in eating habits that leads to altered food consumption and has a negative impact on physical and psychological health [5]. The most common eating disorders are anorexia nervosa, bulimia nervosa, and binge eating disorder [6]. Eating disorders are on the rise all across

the world, with prevalence rates in western countries particularly high [7]. For example, eating disorders affect 0.3 percent of women and 1.0 percent of teenage women, respectively [8]. That is why preventative and intervention programs are so vital. However, developing these programs necessitates the precise identification of people who are at risk of developing eating disorders [9].

According to some writers, young women from industrialized countries are at the highest risk of having eating disorders [10]. Moreover, millions of women may be affected by disordered eating if they are not appropriately treated [11]. To strengthen these prevention and intervention programs for this especially vulnerable demographic, it's important to recognize that eating disorders are multifaceted, with biological, familial, psychological, and societal risk factors all playing a role. The effect of mass media, social attitudes toward thinness, and social anxiety are major risk factors to consider among the sociocultural variables [12].

Early reports of eating disorders in Asian countries often surfaced at a period when the country's growth and development were rising, thereby speeding up the industrialization, urbanization, and modernization processes. Eating disorders first surfaced in Japan in the 1970s, and they were quickly followed by Hong Kong (China) [13], Malaysia [14], and South Korea [15]. Meanwhile, eating disorders were not reported in less economically developed Asian countries such as Chinese Mainland, Chinese Taipei, Thailand, and other parts of Southeast Asia until the late 1990s and early 2000s, as their societies began to industrialize and globalize [16].

Recent research in Asia shows that factors linked to a higher risk of developing eating disorders, such as body dissatisfaction and dieting, as well as a negative weight perception, have become increasingly common [17]. Indeed, some data suggest that levels of physical dissatisfaction and disordered eating habits among some Asian groups, such as Singaporean and South Korean women, may not only rival but surpass those recorded in the West [18]. An increasing body of research suggests that eating disorders and antecedent risk factors are still prevalent in Asian males and that Asian men may be more susceptible to eating and weight disorders than Western men [19]. However, eating disorders and the conditions that contribute to them are still prevalent, just as they are in the West.

The data is restricted and not evenly dispersed throughout the several countries that make up the Arab region, as is true with many mental health studies from this region of the world [20]. Furthermore, in contrast to larger population surveys or epidemiological data, current research on eating disorders has primarily comprised of case reports and examinations of past causes of eating disorders such as body dissatisfaction and dieting behaviors. According to recent publications, interest in and study on this area is quickly growing [20]. Since the 1980s, eating disorders have been observed in Egypt [21]. Saudi Arabia was one of the first countries in the region to report data on eating disorders, along with

Egypt. Case documentation began in Saudi Arabia in the mid-1980s [22].

In Saudi Arabia, studies show that the slim model is very common and that rates of body dissatisfaction, poor weight perception, and slimming practices, as well as subclinical and clinical eating disorder incidences, have grown [23]. In research on Egyptian secondary school females, a greater prevalence of disordered eating habits and behaviors was discovered [24].

In general, studies from a variety of Arab Middle Eastern nations concur with those from Saudi Arabia and Egypt, which show the prevalence of “slim ideal” internalization as well as increasing rates of physical dissatisfaction and dieting behaviors [25]. Recent studies in the United Arab Emirates [26], Oman [27], Lebanon [28], Kuwait [29], and Iran [30] show an increase in subthreshold and clinical eating disorders. Eating disorders are on the rise among Jordanian adolescent females, according to evidence. Moses *et al.* [31] found that one-third of girls aged 10 to 16 had a significant eating disorder, with prevalence estimates of 0.6 percent for bulimia nervosa, 1.8 percent for binge eating disorder, and 31% for nonbinary eating disorder-specific. It’s worth mentioning that no cases of anorexia nervosa were discovered during the research. Meanwhile, research from Oman shows that phobias and phobias regarding the excessive dieting are on the rise among Omani adolescents [32].

In short, behaviors that predispose both males and females to develop eating disorder, such as unhealthy dieting, restricted eating, body preferences based on a “skinny model,” dissatisfaction with body weight and shape, and misunderstanding of weight, is on the rise in many parts of the Arab world. Furthermore, data from several nations suggests both preclinical and clinical eating disorders are on the rise, albeit larger research with more diverse populations is needed. Adolescent girls and young women in Asia and Arab countries, like those in the West, are more likely to acquire an eating problem, especially as the “slim model” has grown more widespread in culture and body ideals have evolved to mirror this trend. Preliminary evidence suggests that teenage and young males in these locations are more susceptible to eating disorders than their Western counterparts, but further research is needed.

## 2.2. Self-Disorders

Self-disorders have been described as a core feature of schizophrenia both in classical and recent psychopathological literature. The notion of self-disorders in schizophrenia as its core phenotypic feature was articulated, in various terms and clarity in all classic texts on schizophrenia. Here we highlight the five dimensions of self-disorders namely self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion.

Self-esteem is an emotional and cognitive construct that focuses on an individual’s feelings and thoughts about themselves. It is usually divided into a global self-esteem dimension (overall sentiments/beliefs about oneself) and domain-specific dimensions. Women with anorexia nervosa and bulimia nervosa

express poorer global self-esteem than controls [33]. As a result, it appears that low global self-esteem pre-cedes and contributes to the onset of eating disorder symptoms. Low self-esteem is a maintenance factor for eating disorders, according to both theoretical and empirical studies in populations of mixed eating disorder diagnoses [34]. Moreover, self-esteem can wreak havoc on the course of an eating disorder, where increases in self-esteem have been associated with weight gain as well as reductions in eating disorder symptomatology in people with anorexia nervosa [34]. On the other hand, self-esteem functions in more complicated moderation and mediation models in relation to eating pathology, in addition to being connected with eating disorders as a probable cause and maintenance component.

Selflessness is defined as disregarding one's own needs in favor of those of others, and it is assumed to be founded on a widespread sense of low self-esteem and self-worth [35]. Weight restored women with a history of Anorexia nervosa exhibited greater selflessness scores than recovered women, who, in turn, did not differ in selflessness from controls [36]. Anorexia nervosa has been linked to selflessness, with patients with the disorder reporting higher levels of selflessness than controls and a psychiatric comparison group [37]. Individuals with anorexia nervosa who prefer to "mute the self" by repressing demands in the service of interpersonal connections can also get help [38]. Keel and Brown [39] discovered that patients with anorexia nervosa suppressed themselves more than controls and psychiatric groups, similar to the idea of selflessness. There is some evidence that selflessness may play a role in the development of an eating disorder. Even after correcting for baseline eating pathology levels, selflessness at baseline predicted greater levels of eating pathology four years later in a teenage female sample [35].

Self-efficacy is a self-concept component that connects the self to agency; a person with high self-efficacy is confident in their capacity to take the actions necessary to attain their objectives [40]. Self-efficacy can be thought of from both broad and narrow perspectives. Women with eating disorders had lower general self-efficacy than healthy controls [41]. Moreover, prospective research has identified ineffectiveness (low self-efficacy) as a predisposition factor for eating disorders [42]. In the arena of eating disorders, more attention has been paid to domain-specific self-efficacy. In studies of preadolescent girls [43], as well as adult men and women, eating self-efficacy, or the idea that one can resist overeating habits has been found to be inversely associated with binge eating [44]. In women with anorexia nervosa, eating disorder recovery self-efficacy, or the idea that they can recover from their eating disorder predicts a shorter stay in an inpatient treatment facility, as well as less eating pathology and more weight gain after treatment [45].

The degree to which an individual has a securely held well-defined, stable, and definite idea of self is referred to as self-concept clarity. [46]. It's worth noting that the content of the self-concept isn't the main focus of this construct, which distinguishes it from comparable measures like self-esteem, which refers to the

actual substance of one's self-belief. In theory, having a hazy sense of one's own identity makes people more sensitive to other sources of identity formation, and women with vague self-concepts may be more prone to internalization of the slender ideal and the value of seeking an identity based on looks [47]. Self-concept clarity plays a role in disordered eating attitudes and actions, according to mediation models in a sample of college women [48]. For example, the relationship between self-concept clarity and body dissatisfaction appears to occur via thin-ideal internalization, and evidence suggests a pathway of early childhood adversity leading to poor self-concept clarity, which is associated with thin-ideal internalization and, in turn, body dissatisfaction in early adulthood [49].

Self-compassion entails taking a compassionate and sympathetic approach to one's distress rather than a judgemental one, and accepting failure and hardships as part of the universal human experience rather than as unique experiences [50]. Ferreira *et al.* [51] indicated that in a sample of eating disorder patients, there is tentative support for self-compassion as a mediator, with body dissatisfaction linked to lower levels of self-compassion and, as a result, a greater drive for thinness. Self-compassion has also been shown to be a protective factor against eating disorders. Importantly, self-compassion appears to be linked to the rehabilitation process [52]. In a sample of patients with eating disorders, Kelly *et al.* [53] discovered that being more self-compassionate early in treatment resulted in faster declines in shame. Moreover, group-based compassion-focused therapy combined with treatment as usual performed better than treatment as usual alone in a transdiagnostic, outpatient eating disorder population for decreased eating disorder pathology and shame and increased self-compassion [54] [55].

According to the above discussion, this study suggests the following hypotheses:

- H1: Eating disorders have an effect on women's behavior in Kuwait.
- H2: Self-esteem has an effect on women's behavior in Kuwait.
- H3: Self-lessness has an effect on women's behavior in Kuwait.
- H4: Self-efficacy has an effect on women's behavior in Kuwait.
- H5: Self-concept clarity has an effect on women's behavior in Kuwait.
- H6: Self-compassion has an effect on women's behavior in Kuwait.

### 3. Methodology

This study used a quantitative approach based on a survey questionnaire. As a result of the Kuwaiti government's measures to limit the spread of the Covid-19 virus, an online survey has been used as the main technique for data collection. The survey was sent to a group of 500 women in Kuwait. The survey was administered through an online survey tool. 212 women completed the full questionnaire, resulting in a response rate of 42.2 percent. The survey instrument included four sections. The first section included the demographic information of women including age, status, education, and work. The second section included seven items to measure eating disorders (e.g., "Only if I have my weight under

control does being looked at by the others make me feel alright”). The third section included twenty-five items to measure self-disorders (e.g., “I spend a lot of time wondering about what kind of person I really am” or “My beliefs about myself seem to change very frequently”). The fourth section included seven items to measure women’s behavior (e.g., “I always feel that my behavior is positive, and it fits very well with my family”). All items of these variables were measured using a 5-point Likert-type scale namely “1: Strongly Disagree”, “2: Disagree”, “3: Neutral”, “4: Agree” and “5: Strongly Agree”.

#### 4. Data Analysis and Results

This study uses statistical software of SPSS (version 25) in order to test the demographic information and descriptive analysis, as well as this study uses SmartPLS (version 3.3.7) in order to hypotheses testing. As shown in **Table 1**, the results of demographic information analysis clarified that the largest group of women was between 31 - 40 years of age (30.2%), followed by (28.8%) between 21 - 30 years, (25.5%) between 41 - 50 years, (9.4%) between 51 - 60 years,

**Table 1.** Demographic information analysis (n = 212).

Demographic Variable	Category	Frequency	Percent (%)
Age	Less than 20 years	10	4.7
	21 - 30	61	28.8
	31 - 40	64	30.2
	41 - 50	54	25.5
	51 - 60	20	9.4
	More than 61 years	3	1.4
	Total	212	100.0
Status	Single	49	23.1
	Married	133	62.7
	Divorce	24	11.3
	Widow	6	2.8
	Total	212	100.0
Education	Diploma or less	31	14.6
	Undergraduate	119	56.1
	Postgraduate	62	29.2
	Total	212	100.0
Work	Public sector	112	52.8
	Private sector	59	27.8
	Without work	41	19.3
	Total	212	100.0

(4.7%) less than 20 years, and (1.4%) were more than 61 years. In terms of status, (62.7%) of women were married, (23.1%) of women were single, (11.3%) of women were divorced, and (2.8%) of women were widows. Regarding education, most of the women has an undergraduate degree (56.1%), (29.2%) of women had a postgraduate, and (14.6%) of women had a diploma degree or less. In terms of work, (52.8%) of women work in the public sector, (27.8%) of women work in the private sector, and (19.3%) of women are without work.

**Table 2** shows descriptive analysis, where eating disorders achieved a value of 3.94 for mean, 1.01 for standard deviation, and 1.24 for variance. Self-esteem achieved a value of 3.67 for mean, 1.05 for standard deviation, and 1.18 for variance. Selflessness achieved a value of 3.45 for mean, 0.95 for standard deviation, and 0.98 for variance. Self-efficacy achieved a value of 3.82 for mean, 0.81 for standard deviation, and 1.11 for variance. Self-concept clarity achieved a value of 3.91 for mean, 1.95 for standard deviation, and 0.81 for variance. Self-compassion achieved a value of 3.99 for mean, 1.01 for standard deviation, and 1.04 for variance. Women's behavior achieved a value of 4.02 for mean, 1.12 for standard deviation, and 1.42 for variance.

As shown in **Table 3**, eating disorders have a direct effect on women's behavior in Kuwait (Path Coefficient = 0.136 and P-Value = 0.000), therefore H1 was

**Table 2.** Descriptive analysis (n = 212).

Variable	Mean	Standard Deviation	Variance
Eating disorders	3.94	1.01	1.24
Self-esteem	3.67	1.05	1.18
Selflessness	3.45	0.95	0.98
Self-efficacy	3.82	0.81	1.11
Self-concept clarity	3.91	1.95	0.81
Self-compassion	3.99	1.01	1.04
Women's behavior	4.02	1.12	1.42

**Table 3.** Hypotheses testing.

H	Independent variable	Dependent variable	Path coefficient	P-values	Result
H1	Eating disorders	Women's behavior	0.136	0.000***	Supported
H2	Self-esteem	Women's behavior	0.125	0.002**	Supported
H3	Self-lessness	Women's behavior	0.274	0.000***	Supported
H4	Self-efficacy	Women's behavior	0.067	0.019*	Supported
H5	Self-concept clarity	Women's behavior	0.083	0.004**	Supported
H6	Self-compassion	Women's behavior	0.267	0.000***	Supported

Note: \*: P < 0.05, \*\*: P < 0.01, \*\*\*: P < 0.001.



supported. The results of this study support the assumption that women with eating disorders are at risk for negative behavior. Also, women with eating disorders mainly cause superficial disturbances and moderately severe injury to themselves and their behavior. Moreover, the results indicated that self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) have a direct effect on women's behavior in Kuwait. Self-esteem has a direct effect on women's behavior in Kuwait (Path Coefficient = 0.125 and P-Value = 0.002), therefore H2 was supported. Selflessness has a direct effect on women's behavior in Kuwait (Path Coefficient = 0.274 and P-Value = 0.000), therefore H3 was supported. Self-efficacy has a direct effect on women's behavior in Kuwait (Path Coefficient = 0.067 and P-Value = 0.019), therefore H4 was supported. Self-concept clarity has a direct effect on women's behavior in Kuwait (Path Coefficient = 0.083 and P-Value = 0.004), therefore H5 was supported. Self-compassion has a direct effect on women's behavior in Kuwait (Path Coefficient = 0.267 and P-Value = 0.000), therefore H6 was supported.

## 5. Conclusion

This study aimed to examine the impact of eating disorders and self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) on women's behavior in Kuwait. The results indicated that eating disorders have a direct effect on women's behavior in Kuwait. Moreover, self-disorders (self-esteem, selflessness, self-efficacy, self-concept clarity, and self-compassion) have a direct effect on women's behavior in Kuwait.

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## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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