

The Relationship Between Eating Disorders and Emotional Inhibition Among Females

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ABSTRACT

Anorexia nervosa (AN) is a complex psychiatric disorder characterized by the restriction of dietary intake, resulting in significantly low body weight. Individuals with AN often experience an intense fear of weight gain and hold a distorted perception of body image. Emotional inhibition, defined as the suppression or restraint of emotional responses, is considered a maladaptive coping strategy frequently observed in patients with AN. Increasing research has examined psychological factors that contribute to the development and maintenance of AN, with emotional inhibition emerging as a significant correlate. This study focuses on the relationship between anorexia nervosa and emotional inhibition in young female adults aged 18 to 25. Relevant literature and empirical research were reviewed to establish a foundation for this work, including an exploration of the causes of eating disorders and evidence-based treatment interventions and therapies.

Keywords: *Anorexia Nervosa, Emotional Inhibition, Eating Disorders, Body Image, Young Adults, Treatment Interventions*

Eating Disorders

Eating problems are serious psychological circumstances or issues that influence both food and eating ways of behaving. These conditions affect how an individual thinks about food, eating habits, shape, and weight. These thoughts are not a lifestyle choice but something much more serious that is often associated with severe disturbances. Although eating disorders are treatable, many times, if left untreated or undiagnosed, they can lead to many health issues or even lead to fatality.

Although eating disorders do not discriminate and are seen in people of all races, genders, ethnicities, body weights, etc., they usually appear in adolescence or young adulthood. In a study conducted by the Youth Risk Behaviour Surveillance System (YRBSS), “6.2% of girls and 2.8% of boys detailed spewing or taking purgatives in the past month to lose or maintain weight. An individual’s obsession with self, comparison among peer groups, and outbursts of thoughts lead to conditions where they become obsessed with their perception of ‘perfect’ about their bodies and appearances- to either love them intensely or hate them till they find it perfect.

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There are 6 common types of eating disorders: Bulimia nervosa, Anorexia nervosa, Binge eating disorder, Pica, Rumination Disorder, and ARFID (Avoidant/restrictive food intake disorder).

Anorexia nervosa is considered to be one of the most common eating disorders among young females. Even though later research has shown that the predominance in males was already belittled, these disorders do have a clear female dominance. People with this disorder avoid food, severely restrict food to the point of starvation, or may eat minimal quantities of food. This eating disorder is characterized by a never-ending drive for thinness and a need to reduce their weight, even if they are dangerously underweight. Cachexia resulting from self-induced malnutrition is a direct output of anorexia nervosa and the most common symptom. Ordinarily, symptoms of anorexia nervosa are related to starvation, while behavioral signs involve a strong fear of gaining weight and unrealistic perceptions of a 'perfect' self.

Physical symptoms that may develop over time include:

- Extreme thinness
- Thinning of bones (osteopenia or osteoporosis)
- Mild anemia and muscle weakness
- Dry, blotchy, and yellowish skin
- Brittle nails and hair
- Growth of fine hair all over the body
- Low blood pressure
- Severe constipation
- Feeling cold due to a drop in internal body temperature
- Dizziness
- Slowed pulse
- Damage to the structure and function of the heart
- Brain damage
- Multiorgan failure
- Lethargy or fatigue
- Absence of menstruation
- Disintegrated teeth and calluses on knuckles from normal vomiting

Individuals with Anorexia who attempt to lose weight by various means also show behavioral symptoms such as:

- Visit skipping dinners or denying eating
- Denial of hunger
- Eating certain foods that are 'safe' for their weight stability
- Preoccupation with food
- Adopting unhealthy eating habits or rituals, such as spitting food out after chewing.
- Resist eating in public
- Dishonesty about food intake
- Fear of gaining weight and an obsessive act of measuring the body
- Lack of emotion
- Irritability
- Social withdrawal
- Insomnia
- Reduced interest in sex

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Even though the elemental causes of anorexia nervosa remain tricky, there's developing evidence that sociocultural and natural components contribute to its causation, as do less specific mental components and a vulnerability of identity.

1. Biological causes

- a) 10 times increase in risk if a first-degree relative is diagnosed with anorexia
- b) GWAS (Genome-wide association studies) identified specific risk loci and metabolic traits like insulin resistance and lipid profile associated with anorexia nervosa
- c) Monozygotic (identical) twins have shown higher concordance for anorexia nervosa than dizygotic (non-identical) twins

2. Environmental causes

- a. Occupational demand- professions that emphasize certain physical appearances
- b. Dieting and weight loss -
 - Restricted dieting under the influence of society
 - Initial weight loss gives rise to certain compliments/admirations that may motivate further restriction and unhealthy eating disorders.
- c. Sociocultural influences -
 - Exposure to media glorifying thinness and creating a standard of beauty
- d. Trauma and abuse
 - Physical, sexual, and emotional abuse
 - Bullying and teasing
- e. Peer pressure - Adolescents often compare themselves to others

3. Psychological causes

- a) Low self-esteem
- b) Chronic stress
- c) Dysfunctional relationships
- d) Fixation of certain actions/thoughts (obsessions) or compulsiveness

According to DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders), for an individual to be diagnosed with Anorexia nervosa, the following criteria should be met:

- A. Restriction of energy intake leads to a significantly low body weight
- B. Intense and persistent fear of gaining weight despite having a low body weight
- C. Disturbing influence in a way that one's body weight or shape is experienced, the undue impact of body weight or shape on self-evaluation, or the determined need for acknowledgment of the reality of current low body weight.

The most prominent test in treating anorexia is making a difference in the person seeing and recognizing that they have an affliction. Individuals suffering from anorexia often deny having an eating disorder or, in most cases, find it unbelievable. When their condition is genuine or life-threatening, they ordinarily look for restorative care. Due to this, early conclusions and treatment of anorexia are basic. Treatment strategies are different for every person due to individual needs. Observing their current mental state, either residential care or hospitalization is granted to the personnel. Treatment includes a combination of the following:

- Acceptance and commitment therapy
- Maudsley method (family-based therapy)
- Cognitive behavioral therapy (CBT)

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- Psychodynamic psychotherapy
- Dialectical behavioral therapy (DBT)
- Hospitalization (if needed, in serious circumstances)

For most eating disorders, like anorexia nervosa, food is the primary medicine. When medications are provided to an individual with an eating disorder, the use of the same is very restricted to the treatment of medical complications and also the comorbid psychiatric conditions, often anxiety and depression, that may hinder the psychosocial treatments. As compared to medicines, many evidences support psychotherapy that has been proven to be far more effective.

- Antipsychotics- atypical antipsychotics (second-generation antipsychotic medications) like olanzapine may help lead to slow weight gain. Generally, they are recommended to help the patient maintain a healthy body weight.
- Antidepressants- although not used mainly for eating disorders, they are used to treat comorbid psychiatric conditions.

Emotional Inhibition

According to the American Psychological Association, inhibition is defined as ‘the method of constraining or limiting an individual’s emotions, impulses, or behavior, either deliberately or unintentionally’. People going through the emotional inhibition schema often find it difficult to open up to others, feel uncomfortable when others share their emotions, or even tend to see themselves as rational rather than emotional. Out of 18 early maladaptive schemas, one of them is the emotional inhibition schema. Individuals not only suppress their negative emotions and behaviours but also positive ones due to lack of confidence, fear of judgment, low self-esteem, and more. When others around these individuals try to express their emotions, people with emotional inhibition schema try to inhibit others from doing so and usually monitor their behavior and communicate in a particular way since it causes them discomfort.

Usually, when in childhood, the caregiver is not capable of handling the emotions and impulses of their child, this schema develops; that is, when a primary caregiver is not adjusted to the child’s needs. According to the child, expressing emotions or displaying them might result in mockery, being shamed, or even being rejected by any individual. Moreover, certain caregivers may use overprotective and inflexible parenting styles by debilitating lively and unconstrained behavior. Schema development involves many factors, such as:

Early experiences

a. Interactions between a child's early environment and natural disposition can frustrate their central emotional needs, driving EMS development.

b. Young and colleagues (2003) recognize 4 encounters of childhood that contribute to the schema -

- Traumatization: parental abuse (emotional, physical, or sexual), humiliation or bullying, etc.
- Toxic withholding: careless primary caregivers, insufficient attention or affection
- Toxic excess: granted everything and excessive freedom, overprotectiveness, and over-indulgence.
- Selective internalization: internalizing maladaptive demeanors that are modeled by a caregiver or family member

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2. Core emotional needs

a. There are 5 core emotional needs based on Bowlby's attachment theory (1977) and clinical observation, according to Young and colleagues (2003):

- Self-control and limits
- Spontaneity and play
- Freedom to express needs and emotions
- Autonomy, competence, and sense of identity
- Secure attachment

b. Attachment needs were of essential significance for the developing child, laying the foundation for the fulfillment of other needs.

3. Emotional temperament

a. Temperament refers to persistent differences in children's behavioral style and reactivity. It can influence parenting styles and contribute to EMS, such as:

- Impulsive children tend to bring out controlling parents, increasing impulsivity
- Fearful children tend to bring out protective parents- leading to more fearful activity and anxiety.
- Irritable children tend to bring out punitive parenting, leading to increased anger

In general, those with the emotional inhibition schema may need help in expressing their emotions and being open and vulnerable with other individuals. In such cases, Schema therapy arises where the focus is to change and challenge the maladaptive schemas and/or experiences of early childhood, and maintain therapeutic relationships. This therapy includes the following adaptive strategies:

A. Challenging your rationale

- Rationalizing between the positive and negative consequences of expressing your emotions.
- Make a list of positive consequences and remind yourself whenever the schema is triggered.

B. Increasing self-awareness

- Being aware of when the schema usually arises and triggers
- Knowing when one is triggered and practicing techniques will make it easier

C. Vulnerability, along with boundaries

- Being vulnerable to certain people who are also capable of expressing the same emotion.
- Being clear about what your expressions are and with whom you might share them will help you feel safe.

D. Seek therapy

- If the mind needs a push to help change the mindset and be vulnerable to others, then treatment can give the important tools one needs to manage the feelings better.

REVIEW OF LITERATURE

Zsigo, C., Lingl, C., & et. al. (2022) conducted a study that inspected contrasts in emotion regulation (ER) between youthful girls with major depression (MD) and anorexia nervosa (AN). The data was divided into three clinical groups, in which deficits of emotion regulation were highlighted by females in all groups, wherein the use of adaptive regulation

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strategies was less than maladaptive strategies. All clinical groups revealed more successive utilization of techniques like surrendering, withdrawal, and self-devaluation, and less of the versatile or adaptive procedures like mental critical thinking, problem-oriented activity, neglecting, and interruption. They studied that when contrasted with just anorexia nervosa, an extra finding of major depression is connected with a more sustained utilization of maladaptive emotion regulation. The outcomes recommend that the connection between psychopathology and emotion regulation is, by all accounts, stronger for maladaptive than for versatile/adaptive emotion regulation.

Testa, G., Sanchez, I., et. al. (2020) led a review with a sum of 17 patients with anorexia nervosa, 16 patients with bulimic-range eating disorders, and 20 healthy control members who finished an impulsivity scale (UPPS-P) before playing out a close-to-home inhibitory control task during electroencephalography (EEG) recording. According to the research conducted, hardships in controlling feelings are viewed as transdiagnostic qualities of patients with dietary issues. The results showed an impulsive trait and behavior that is a common quality of anorexia nervosa.

Meule, A., Richard, A., et. al. (2019) aimed to prove that individuals with anorexia nervosa show deficits in emotion regulation. The ongoing review inspected the feeling administrative capability of over-and undereating because of various emotional states in ladies with prohibitive AN (n = 54), BN (n = 47), and ladies without dietary issues (n = 68). The results showed that in response to positive emotions, the AN group reported eating more than usual and less following negative emotions. In the AN group, eating less in response to negative emotions is associated with dysfunctional emotion regulation.

Damiano, S.R., Reece, J., et. al. (2015) compared the Early Maladaptive Schemas that female adolescents with Anorexia Nervosa reported to a group from the community. In this research, emotional isolation appeared to be one of the most well-known qualities and characteristics of anorexia nervosa. As per the discoveries, different anorexia subtypes may require individualized treatment techniques, and maladaptive schemas might require consideration in the treatment of AN in young females.

Wildes, J. E., & Racine, S.E. (2013) aim to discuss the clear relationship between anorexia nervosa and emotional inhibition, under the expression of emotions, behavior, and impulses in a variety of fields. 1192 participants who were diagnosed with anorexia nervosa were presented with intensive therapy. This study proved that dietary issue perceptions were altogether connected with various types of feeling dysregulation, notwithstanding the fact that the absence of profound mindfulness was autonomously related to these effects.

Oldershaw, A., DeJong, H., et. al. (2012) proved that poor profound handling propagates anorexia nervosa. To preserve relationships in recovered patients of anorexia nervosa, this study looked at beliefs about emotions, emotional tolerance and avoidance, and emotion suppression. According to the results of this study, the healthy and recovered groups were comparable and had better processing of emotions than current patients of anorexia nervosa.

Espeset, E. M. S., Gulliksen, K. S., et. al. (2012) investigated how patients with an eating disorder deal with negative emotions like sadness, rage, fear, and disgust, as well as how these emotions are linked to their eating disorder behaviors. Subjective information was gathered through semi-organized interviews with 14 females, 19-39 years, determined to have Anorexia Nervosa. Interviews were investigated utilizing Grounded Hypothesis

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techniques. The members detailed elevated degrees of outrage toward themselves, self-question, and the feeling of dread toward becoming fat, as well as a propensity to smother sensations of trouble and outrage in relational settings. Dietary problems and ways of behaving were utilized to get a handle on various feelings.

Hambrook, D., Oldershaw, A., et. al. (2011) looked to research people with anorexia nervosa and Chronic fatigue syndrome's pain resistance, self-quieting, and convictions regarding the experience and articulation of feelings. Notwithstanding the way that mental conduct models propose that challenges with profound handling contribute to the etiology and maintenance of both, these circumstances were selected for this study in light of the fact that their clinical presentation is portrayed by actual side effects. For the method, there were 40 individuals with anorexia nervosa, 45 with chronic fatigue syndrome, and 48 healthy controls, all of whom finished measures of clinical symptomatology, BES Scale (beliefs about emotions scale), DTS Scale (distress tolerance scale), and Silencing the Self Scale (STSS). On a subscale that measures hardship in trouble resilience, AN and CFS members scored higher than HCs in the underlying gathering examinations. Members with AN and CFS were additionally bound to pass judgment on themselves according to external norms and to extend a picture of themselves that is socially adequate outwardly while feeling unfriendly inside.

Forbush, K. & Watson, D. (2011) recommended that ladies with dietary issues (Eating Disorders) are bound to extend their negative self-discernment onto their bodies. Emotional inhibition and character attributes in ladies with ED were analyzed in this review to survey these clinical perceptions. The study found that participants with ED had difficulty expressing both positive and negative emotions, even after controlling for neuroticism. Additionally, ED-afflicted women were reported to be more hostile and irrational.

Harrison, A., Sullivan, S., & et. al. (2009) proposed a study that aimed to examine emotion regulation using the Difficulties in Emotion Regulation Scale (DERS) and emotion recognition using the Reading the Mind in the Eyes (RME) task in 20 women who had anorexia nervosa (AN) and 20 women who were healthy controls (HCs). Women with AN had significantly more issues with emotion regulation and scored significantly lower on RME than HCs. These outcomes recommend that ladies with AN experience issues with profound acknowledgment and guideline.

Wildes, J. E., Ringham, R. E., & Marcus, M. D. (2009) examined whether emotion avoidance helps to explain the relationship between depressive and anxiety symptoms and eating disorder (ED) psychopathology in patients with anorexia nervosa (AN). Disclosures certify that feeling avoidance is accessible in patients with AN and offer starting assistance for the likelihood that anorexic aftereffects capacity, somewhat, to help individuals with avoiding aversive significant states.

METHODOLOGY

Aim

To understand the correlation between eating disorders, specifically Anorexia Nervosa, and Emotional Inhibition.

Objective

To research the relationship between anorexia nervosa and emotional inhibition, and successfully write a research paper with the help of relevant literature. Additionally, this

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research aims to examine the relationship between eating disorders and emotional inhibition in young female adults aged 18 to 25 years.

It takes a gander at the inescapability of frustrated sentiments among females with anorexia nervosa, as well as looks at the factors through which limitation adds to the progression of anorexia nervosa. This objective entails looking into a variety of mental factors, such as a person's maladaptive approaches to coping with stress, early hardship or injury, or feeling challenges that moderate the connection between the two.

Inclusion Criteria

1. Usage of pertinent and authentic literature to examine the relation between anorexia nervosa and emotional inhibition.
2. Research papers/kinds of literature before 2005 were not included to ensure that the research is based on current methodologies and data.

Exclusion Criteria

1. Studies that focused on all eating disorders.
2. Studies that were uncertain about the conclusion.
3. Studies published before 2005.
4. Studies solely focused on small sample sizes or restricted their research to one geographical location.
5. Studies where anorexia nervosa is not the primary diagnosis.

DISCUSSION

Numerous eating disorders, such as anorexia nervosa, bulimia nervosa, and binge eating disorder, are closely related to enthusiastic dysregulation. It has been observed that numerous disposition disorders have been associated with eating disorders. Amid starvation, individuals with Anorexia Nervosa have poor consideration for their own sentiments, difficulty understanding others' mental states, and sad personal sentiments.

According to the study conducted by Testa, G., Sanchez, I., et. al., the current discoveries recognized cynicism as a normal highlight of anorexia nervosa. Negativity is a private characteristic related to feelings. They conducted a study in which 17 patients with anorexia nervosa, along with 16 people diagnosed with bulimic range eating disorders, and 20 healthy control members were asked to complete an impulsivity scale before completing an enthusiastic inhibitory control task during the procurement of electroencephalography (EEG).

Feeling concealment shows up to be not solely to bring about extended rumination around nourishment and eating-related substance, but also is associated with gluttony and nourishment wants among restricted eaters and individuals tall in both restriction and disinhibition. In clinical populations, it has been noted that thought concealment was related to bulimic side effects. Other than, studies and clinical discernments suggest that A patients are depicted by an overall strategy of avoidance toward genuine significant states, indeed beyond any doubt ones, which may moreover require unflinching checking and concealment of approaching feelings.

CONCLUSION

This paper included investigations, explorations, and ideas that were expected to analyze the connection between emotion dysregulation/restraint and anorexia nervosa.

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Throughout the study, there were many limitations to face, such as much of the literature being uncertain about the outcomes of their research, and many studies being conducted in a specific geographical location and not for the sample size needed for this research.

Despite many discrepancies, there was a variety of literature and articles to help support the aim of proving the correlation between emotional inhibition and anorexia nervosa.

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Conflict of Interest

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