**Topic: A study of the association between perfectionism, emotional dysregulation, cognitive distortion, and eating attitudes among Indian Young Adults.**

**Introduction**

Normal eating includes consuming nutritious foods and maintaining a well-rounded diet are essential for normal eating. A balanced diet that provides adequate nourishment and energy, and a cheerful outlook. The absence of food labelling as good or bad, healthy or fattening, can result in. The fear of being judged or rejected by others can cause feelings of guilt and anxiety. Maintaining a healthy diet is crucial for overall health and preventing and managing various health conditions. also, to acceptable social behaviour, and is both flexible and pleasurable

It is crucial to comprehend that regular eating patterns vary. Still, they shouldn't deviate so much that they result in inadequate nutrition, excessive weight loss or gain, or other health issues. Hence it is important to think about their desired foods and plan their meals, but this should not be the main focus of their daily life.

Eating attitudes is a psychological concept that examines how individuals perceive and interact with food daily. The way people feel about food can affect their overall health. It is advisable to inquire or doubt. What motivates people to consume the food they do and what are the reasons behind their decisions, obstacles, dislikes, and preferences? unmanageable actions. Eating attitudes are composed of beliefs, thoughts, feelings, and behaviours. The study examined how people’s actions and attitudes towards food are influenced by their genes.

**1. Disordered Eating Behaviours**

Disordered Eating Behaviours (DEB) are problematic eating habits, such as vomiting, overeating, starving, and other unhealthy ways to manage weight, that are not as severe or frequent as those needed to have an eating disorder (ED). The explanation for the creation of DEBs is based on biopsychosocial models that have some main symptom dimensions, such as body image concerns.

**1.1 Eating Disorders and Disordered Eating Attitudes**

Eating disorders and disordered eating are frequently mistaken for being identical. There are numerous distinctions between them. Disordered eating includes excessively working out and having an unhealthy relationship with food. not eating a diverse range of foods without a medical reason, and keeping track of the number of calories consumed. Every day, individuals consume meals and engage in activities such as exercising to offset the calories consumed.

This can result in feelings of remorse, revulsion, or sorrow following the consumption of food or contemplating the process of examining it. The amount of calories in each meal is. Harmful actions can result from distorted thoughts. like deliberately skipping meals or using laxatives or diet pills to control your weight linearly related to the amount of time spent on social media.

The degree and severity of suffering that affects what, how much, or how often someone eats, weighs, or acts is. The main distinction between disordered eating and an eating disorder that can be diagnosed is primarily what sets them apart. Individuals are more prone to being recognized with an eating disorder if they frequently engage in "unhealthy eating habits" or if they experience distress and worry when they are unable to continue these habits or when they choose not to. This implies that repetitive patterns of unhealthy eating habits can result in eating disorders.

Nevertheless, eating disorders exhibit numerous additional signs, such as difficulties in social interactions, which may manifest before the symptoms of disordered eating. When someone has trouble eating enough or too much, and this harms their body and mind, it is called an eating disorder.

A great deal of research has been done in the scientific community to understand them; nonetheless, the specific biological, behavioural, and social origins of these illnesses remain unclear. Eating disorders can arise at any stage of life, although they typically begin in late adolescence.  
  
Other symptoms of disordered eating include negative body image or disturbance in perception of the body, a rigid exercise routine coupled with extreme guilt or anxiety if the routine is not followed, and recurrent episodes of night eating (Mantilla & Bir Gegard, 2015). Body weight and shape are central to self-esteem and worth/

An additional sign of a disordered eating mindset is orthorexia. It is a fixation with healthy eating, which can lead to restrictive eating patterns and social isolation.

**1.2 Risk Factors**

As a result of disordered eating, one can even develop body dysmorphic disorder, a mental health condition in which a person is preoccupied with perceived flaws in their appearance,

leading to a disordered eating attitude.

Disordered eating has a wide range of complicated causes. The factors include Body image

distortion and unhealthy food relationships can result from culture and society, including star

culture, media, social media, and online influencers.

According to research (Forney & Ward, 2013), women's perceptions of the adjudicative norms

of peer thinness and peer, acceptability had an additive impact on moderating the link between

body dissatisfaction and disordered eating.

This is also consistent with the thin-ideal model. The degree to which a person mentally "buys into" socially constructed standards of attractiveness and behaves to approximate standards of attractiveness and behaves in line with these standards is known as thin-ideal internalisation. (Thompson et al., 1999).

Studies have shown that internalisation predicts higher levels of body dissatisfaction and predicts increased dieting. (Stice, Mazotti, Krebs & Martin, 1998).

The division of people based on their physical appearance leads to changes in eating patterns. This situation leads to the development of disordered eating patterns. This puts people at risk of developing an eating disorder.

Emotional eating has also been identified as a risk factor for developing an eating disorder. eating disorders as early as middle school (Pearson et al., 2012). Risk factors for disordered eating behaviours were categorised in a study by Salafia and colleagues (2015) as individual and sociocultural factors. Individual factors included biological predispositions, such as abnormal regulation of neurochemicals, one of which is 5-hydroxytryptamine (5-HT), a neurochemical described by Sheng and colleagues (2019, pp. 1-8) as "a major anorexigenic factor".

Furthermore, there is evidence that food and drug cravings activate the same activate the same brain regions (Schulte et al., 2016), and that the dopamine D4 receptor is involved in the modulation of reward processes associated with both food intake and drug use (Botticelli et al., 2016).

Other research suggests that there is aberrant activation in the frontal-striatal circuit, a brain region involved in self-regulation. involved in self-regulatory control (Berner & Marsh, 2014), in people with bulimia nervosa, anorexia nervosa and also in those with obsessive-compulsive disorder (OCD).

Other risk factors include personality traits such as body dissatisfaction and poor impulse which also predispose to eating disorders. Some studies have also found that body dissatisfaction predicts disordered eating (Aparicio-Martinez et al., 2019,).

Over the past three decades, these significant health concerns, along with interest in the basic science of emotions and eating behaviour, have motivated the science of emotions and eating behaviour has motivated intense research into the links between emotions and eating (Vögele et al., 2018).

The serious consequences associated with eating disorders are physical (e.g., malnutrition, heart failure and brain atrophy) and psychological complications (e.g., suicide, depression and reduced quality of life; (Smith et al., 2019). There is a need for further research is needed to improve prognosis and treatment outcomes.

**1.3 Prevalence**

According to systematically reviewed data, lifetime estimates of eating disorders range from 8.4% for women and 2.2% for men, with an overall global increase in the prevalence of 4.3% over the last 15 years (Galmiche et al., 2019).

Furthermore, research by the Multi-Service Eating Disorders Association (MEDA) found that 15% of women aged 17-24 suffer from eating disorders in India (Iyer & Shriram, 2021).

The internalisation of societal beauty standards may contribute to body dissatisfaction. Women are expected to be thin and tall, i.e. to uphold the 'thin ideal'. (Mingoia et al., 2017), while men are expected to have a muscular and lean physique. "Mesomorphic ideal" (Edwards et al., 2016).

Major pathological traits include maladaptive perfectionism (Peixoto-Plácido et al., 2015,), obsessive-compulsive personality traits and neuroticism have been recognised as predictors of disordered eating. (Lilienfeld et al., 2006). In addition, emotional, physical and sexual abuse are positively associated with disordered eating behaviours. (Salafia et al., 2015).

**1.4 Research gap**

Previous research has emphasised the tendency to eat in response to physiological cues of hunger and satiety (i.e., internally regulated eating style) along with BMI (small to medium effect size) has been correlated with better psychological outcomes (e.g. higher body self-esteem, emotional awareness, life satisfaction, psychological flexibility);

They report lower depression, anxiety, perfectionism, dichotomous thinking, preoccupation with food) and better behavioural outcomes (e.g. less restrained, emotional and external eating, unhealthy weight loss practices, eating disorder symptomatology; higher eating self-efficacy, proactive coping practices)

A systematic review by Pike and Dunne (2015) found that psychogenic vomiting, which can be anxiety- and stress-induced vomiting, was the most common diagnosis in India.

Furthermore, Riesco and colleagues (2018) found that disordered eating in India was approximately equally prevalent among men and women. In addition to the similar prevalence, the study by Nivedita and colleagues (2018) found that females have more severe disordered eating attitudes and symptoms than males.

**1.5 Impact of culture**

One of the most under-researched topics in India is eating disorders. In India, there is a lack of awareness and a poorly defined diagnostic method for identifying disordered eating patterns.

In such a situation, a large-scale screening programme is the best strategy for preventing serious complications of advanced eating disorders. While eating disorders can only be by a trained psychiatrist, regular screening with questionnaires and interviews and further referral to interviews and referral to a psychiatrist can potentially aid both early diagnosis and treatment of these conditions.

In addition, increased awareness of the symptoms and presentation among young people can help in primary and secondary prevention. (Lal et al,2015)

There are still some differences between Indian and Western experiences of eating disorders. disorders. One of these is that Indians are less aware of feelings such as "fear of losing control over food or eating" and "being afraid to eat". over food or eating" and "preoccupation with food, eating or their body" compared to Australians. (Lal et al., 2015).

This is supported by a study by Vaidyanathan and colleagues (2019), who found that. Indians present with the 'non-fat phobic' variant of anorexia nervosa, i.e. they express little concern about body fat and their body fat and shape.

This may be related to "intuitive eating", a common approach to eating in Asian countries (Hawks et al., 2004). In contrast to mindful eating, a phenomenon in which people are aware of their eating behaviour and their emotional and physical responses to it (Warren et al, 2017), intuitive eating encourages individuals to eat based on the signals their body is giving them (Healy et al., 2015).

**2. Cognitive distortion**

Current research highlights the fact that the behaviour is strongly motivated by concerns about overeating and its relationship to diseases associated with overweight and obesity.

A major assumption underlying this thought process is that eating tendencies are automatically triggered by relatively simple stimuli (e.g. amount of sugar or fat, stomach distension, portion size, appetite), and neurophysiological mechanisms, thereby producing sensations (e.g. taste, moods, hunger) and feelings of pleasure.

**2.1 Cognitive-based interventions for eating disorders**

Interventions to reduce food intake have focused on improving reasoning (emphasis on mindful eating). adopting better self-regulation strategies, and forming new eating of new eating habits through repeated instructions to the self, sometimes referred to as "implementation intentions" (Stroebe et al., 2013).

Researchers are becoming increasingly aware of the limitations and even negative effects of interventions that rely on reasoning and self-regulation to promote restrained or controlled eating and dieting.

Across diagnostic categories, the clinical presentation includes either caloric restriction alone or a (e.g. anorexia nervosa), binge eating (e.g. binge eating disorder) or purging behaviour. disorder) or purging (e.g. bulimia nervosa).

More than half of those receiving treatment fall into the diagnostic category of Eating Disorder Not Otherwise Specified (ENDOS). disorder not otherwise specified (OSFED), which has characteristic symptoms that do not meet the criteria for a that do not meet the criteria of a specific eating disorder diagnostic category (American Psychiatric Association, 2013).

**2.2 Cognitive Behavioural Therapy**

The most widely researched and accepted theoretical framework for the treatment of eating is cognitive behavioural therapy (CBT).

Early models of CBT emphasised the role that disordered eating and maladaptive attitudes to weight and shape play in maintaining eating disorder pathology (Fairburn, 1981). They subsequently proposed a transdiagnostic model and an 'enhanced' form of CBT (CBT-E), which describes four additional features of eating disorder maintenance: (1) low self-esteem, (2) perfectionism, (3) perfectionism, (3) interpersonal difficulties, and (4) mood intolerance.

The transdiagnostic model suggests that all eating disorder diagnoses share common but clinical features that tend to be sustained by similar psychopathological processes. A randomised controlled trial also reported significant effectiveness of CBT-E compared with usual care (de Jong et al., 2020).

**2.3 Schema-focused therapy**

Schema theory (Young et al., 2003) may provide a complementary framework for aetiological and maintenance factors associated with eating disorders.

Schema therapy, originally developed as an extension of traditional CBT, seeks to address developmental processes that contribute to and maintain psychopathology, such as temperament, attachment, and early adversity (Atwood & Friedman, 2020).

Despite the established efficacy of CBT and its proponents (i.e. CBT-E) for some eating disorder presentations such as presentations such as bulimia nervosa and binge eating disorder, long-term treatment outcomes have remained inconsistent (e.g. Agras et al., 2000; Poulsen et al., 2014; Waller et al., 2014).

Current evidence suggests that eating disorder psychopathology improved in the short term but was not maintained., exacerbated by significant participant attrition.

Several factors have been identified as contributing to limited treatment outcomes for certain eating disorder populations, such as entrenched cognitive schemas, problematic attachment styles and developmental trauma, and childhood experiences (Young et al., 2003).

The overlap between schema therapy and eating disorder pathology stems from evidence that individuals with eating disorders hold both disorder-specific cognitions and unconditionally negative beliefs about themselves, others and the world (Hughes et al., 2006).

Such evidence is consistent with Young and colleagues' (Young et al., 2003) description of early maladaptive schemas, which are a central tenet of schema therapy.

Schemas are defined as pervasive themes about the self and early maladaptive schemas are thought to develop in response to persistently unmet emotional needs during childhood and contribute to the etiology and maintenance of psychopathology, treatment dropout, and complex comorbidities. (e.g. personality disorders; Vall & Wade, 2015).

The findings were conclusive that the current CBT model is necessary but not sufficient to conceptualise eating disorders., and that further research is needed to clarify and extend existing conceptualisations, which may contribute to improved outcomes in the field (Klump et al., 2009).

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Studies using clinical samples have found that individuals, regardless of eating disorder diagnosis, consistently report significantly higher early maladaptive schema scores than their nonclinical counterparts (De Paoli et al., 2017).

The schema model has been used to inform eating disorder treatment. Overall, modification of schema content using group programs has been successful in reducing the severity of schemas and disordered eating pathology (Mącik &Sas, 2015)

**3. Emotional regulation**

The ability to identify and label an emotion correctly is crucial to emotional regulation. Emotional regulation (ER) is defined as the ability to manage emotions in oneself or others (Mayer, 2001).

The study by Svaldi et al. (2012) found that patients with disordered eating reported significantly higher levels of emotional intensity, less emotional awareness and clarity, more self-reported ER problems and decreased use of functional and increased use of dysfunctional emotion regulation strategies compared to healthy emotion regulation strategies compared to healthy controls.

Lavender & Anderson's (2010) study of non-treatment-seeking undergraduate men, deficits in adaptive emotion regulation correlated with a greater likelihood of engaging in disordered eating behaviours.

**3.1 Conceptualising emotion regulation**

One of the most influential conceptualisations of ER is the theoretical model proposed by Gross (1998), which differentiates regulation strategies according to their role in the emotion-generation process.

According to this model, ER can be attempted at any of the following stages of the emotion process, and ER strategies are differentiated according to 'when' they have their impact on the emotion-generating process. More specifically, antecedent-focused ER consists of modifying the situation before the emotional response is elicited; on the other hand, response-focused ER attempts to modify the emotional response after it is activated, thereby inhibiting the behavioural manifestation of the elicited negative emotions.

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The first category of ER consisted of situation selection, situation modification, attentional deployment, and cognitive modification. ER of 'situation selection' refers to limiting one's exposure to situations that could potentially produce negative emotions (e.g. avoidance).

In the next step, ER strategies of "situation modification" serve to reduce the level of negative emotions. negative emotions (e.g., assertiveness), while those that fall into the category of "attentional re-focus on distracting elements (e.g. distraction).

Finally, 'cognitive change' ER strategies consist of the selection of the personal meaning assigned to the situation (e.g. reappraisal). On the other hand, response-focused ER refers to strategies aimed at influencing the emotional response once it has already occurred, and involve mechanisms of response modulation (e.g., suppression) (Gross, 1998).



*Figure 1.* The temporal process model of emotion regulation. *Naragon- Gainey, K., McMahon, T. P., & Chacko, T. P. (2017). Individual differences in emotion regulation*

Empirical evidence supports the general distinction between adaptive and maladaptive ER strategies (Gross & John, 2003). For example, the antecedent-focused strategies of cognitive reappraisal and acceptance (i.e., accepting feelings without trying to control or judge them) are positively associated with positive psychological health outcomes (e.g., decreased negative affect, increased positive emotions) (Troy, et al,2018).

On the other hand, maladaptive strategies (e.g., rumination, suppression), which are more responsive were more strongly associated with psychopathology (e.g. depression, anxiety). (Aldao & Nolen-Hoeksema, 2010)

Research examining participants with ED diagnoses has found that participants report higher levels of negative affect and greater use of dysfunctional ER strategies compared to healthy participants (Meule et al., 2019).

Meta-analytic evidence examining associations between specific ER strategies and eating pathology suggests that maladaptive ER has a significant positive relationship with overall eating pathology, in the medium to a large range of effect sizes (Prefit, Canada, & Szentagotai-Tătar, 2019).

Researchers suggest that perfectionism as a personality trait may influence the use of certain cognitive ER strategies by triggering the emotion regulation process (Rice, Suh & Davis, 2018).

For example, perfectionistic individuals often have maladaptive schema domains that contribute to problematic emotional experiences. Striving for perfection may be an attempt to attempt to satisfy one's need for social approval and to maintain self-esteem (Blatt, 1995), but when these goals are not achieved, perfectionists are likely to experience negative effects and may exhibit poor self-regulation in the long term (Hewitt et al., 2017).

**4. Multidimensional Perfectionism**

Perfectionism has been defined as a personality trait that involves the tendency to set unrealistically high standards, despite negative consequences, combined with critical self-evaluations (Hewitt & Fletts, 1991).

Its role has been suggested to be important in the development of psychological distress and the aetiology of several psychiatric disorders. Early clinical conceptualisations of perfectionism defined it as the irrational, self-defeating belief that "one should be thoroughly competent, adequate, intelligent, and successful in every possible way" (Ellis, 1962).

Perfectionism was initially viewed as a pervasive neurotic style characterised by dichotomous thinking (i.e. rigid, "black and white" cognitive thinking) essentially a dysfunctional aspect of personality (Beck, 1976) and a sign of psychological maladjustment and disorder (e.g. Burns, 1980).

**4.1 Multidimensional model of perfectionism**

Hamachek (1978) first proposed a two-dimensional model of perfectionism, distinguishing between “normal" and "neurotic" aspects of the construct, emphasising the high levels of satisfaction associated with perfectionistic striving, and the intense need to avoid failure which motivates the pursuit of high standards.

Frost and colleagues (1990) proposed a multifactor model that assesses four aspects of perfectionism, self-directed perfectionism (i.e. personal standards, doubt about actions, concern about mistakes, organisation) and two aspects about mistakes, organisation and two aspects reflecting perceived parental demands (i.e. Parental Criticism, Parental Expectations).

In earlier times, studies using the approach of Frost's research group have included worry about making mistakes, parental criticism, and parental expectations as the most harmful aspects of perfectionism, as they reflect critical and negative self-evaluations (e.g., Magnusson, Nias, & White, 1996).

On the other hand, personal standards and organisation were generally considered to be positive components of perfectionism (e.g., Enns & Cox, 1999), as they have shown small to negative with psychopathological outcomes (e.g. depression; Magnusson et al., 1996).

**4.2 Hewitt and Flett model**

Another approach to defining perfectionism was developed by Hewitt and Flett (1991) who conceptualised a three-factor model that assesses both intrapersonal and interpersonal aspects of the trait.

According to this approach, three aspects of perfectionism can be distinguished: Self socially prescribed perfectionism, and other-oriented perfectionism.

The first dimension reflects the tendency to set excessively high personal standards and is generally considered to be an adaptive form of perfectionism (Stoeber & Otto, 2006), as it is historically been associated with positive outcomes (e.g., high appraisals of performance stress) (LaRocque, Lee, & Harkness, 2016).

Socially prescribed perfectionism, which involves the belief that others expect perfection from oneself, has been consistently recognised (Molnar, Flett, & Hewitt, 2020).

Third, Other-oriented perfectionism differs from the other two dimensions in that it focuses on excessive standards for significant others (Hewitt & Flett, 1991).

This component has been conceptualised as an aspect of 'narcissistic perfectionism', a 'dark' form of perfectionism associated with antisocial behaviour. (e.g. vindictiveness, hostility), (Nealis et al, 2013).

**4.3 Perfectionism and its role in DEBs**

Empirical evidence (Levinson et al., 2017) supports the view that perfectionism is a strong risk and maintenance factor for disordered eating.

Researchers have developed many conceptual models to explain how perfectionism may interact with other risk factors to cause and maintain disordered eating over the past 30 years. For example, the interactive three-way model (Vohs, et al 1999) theorises that perfectionism interacts with perceived weight status and self-esteem to predict the development of bulimic symptoms.

This conceptual model has been revised in some ways, for example by operationalising perceived weight status as body dissatisfaction. (Vohs, Heatherton, & Herrin, 2001). In addition, some authors have suggested that self-efficacy, rather than self-esteem, is a better predictor of body image perfectionism in predicting bulimic symptoms (Bardone et al., 2000).

**4.4 Transdiagnostic Theory of Disordered Eating**

Fairburn (1997) conceptualises the transdiagnostic theory of Disordered eating as follows "clinical perfectionism" (i.e., pathological achievement orientation despite negative consequences) (Shafran, Cooper, & Fairburn, 2002) as a dysfunctional scheme for self-evaluation that perpetuates DEB psychopathology.

This theory suggests that clinical perfectionism should be targeted in the context of DEB treatment to discourage goal-directed efforts to achieve valued goals related to eating (e.g. behavioural strategies to lose weight).

Goldner, Cockell, and Rameswaram (2002) have formulated an integrative biopsychosocial model of EDs that conceptualises a potentially necessary role for perfectionism.

They suggested that perfectionism may predispose an individual to EDs by moderating the effect of a concerted attempt at self-improvement and a need to reduce self-esteem on eating symptoms. This means that highly perfectionistic people tend to approach self-improvement unrealistically and increase their need to reduce self-awareness when experiencing self-esteem when they experience shame.

When these two mechanisms are applied to body image domains, a perfectionist may increase the frequency or intensity of disordered eating behaviours by experiencing his or her shape and weight as a significant contributor to self-esteem (Goldner et al., 2002).

Research on the relationship between perfectionism and eating disorders in different age groups and populations suggests that different models explain how perfectionism increases the risk of disordered eating for these different groups (Wade, O'Shea, & Shafran, 2016).

The role of perfectionism in predicting maladjustment differs significantly depending on across life stages (e.g., Cella, Iannaccone, Cipriano, & Cotrufo, 2020), and it is possible to hypothesise that a specific aetiological or maintenance model explaining the role of perfectionism in Disordered eating may work better in certain age groups than in others. As the age of Disordered eating onset is typically during adolescence, with increased risk occurring from mid-adolescence into young adulthood (Bulik, 2002; Hudson, Hiripi, Pope Kessler, 2007), particular attention should be paid to these two specific developmental periods.

**4.5 Impact and comorbidity**

The transdiagnostic nature of perfectionism is claimed by some authors who have reviewed evidence that individuals with many disorders report high levels of perfectionism compared to healthy controls (Shafran & Mansell, 2001).

Egan and colleagues (2011) summarise studies showing that perfectionism is a transdiagnostic process, showing that only perfectionism is a relevant dispositional factor associated with several disorders (e.g. anxiety, bipolar disorder, suicidal ideation, obsessive-compulsive personality disorder). but also, that it may be a prospective predictor of the development of certain disorders (e.g. depression, eating disorders) that are common to several disorders (Egan, Wade, & Shafran, 2012).

**4.6 Perfectionism in Young Adulthood**

Young adults who are college students face many challenges as they navigate this transitional life stage. This period, known as 'emerging adulthood', is characterised by self-focus, identity exploration, and major changes in home life and educational situations (Quick et al,2013).

Studies of perfectionism show that it has increased significantly over time, noting that recent generations of young adults have higher expectations of themselves and trying to achieve more perfection than previous generations (Curran and Hill 2019).

Young adults with high perfectionistic standards and concerns report experiencing greater psychological distress, particularly during the transition to the university environment (Levine, Milyavskaya, & Zuroff, 2020), when the likelihood of exploring career options and experiencing career decision-making difficulties is significant.

Perfectionism, emotions and cognitive distortions in young adults with eating disorders. Research suggests that young adulthood is a critical period for the development and maintenance of for the development and maintenance of eating disorders, as stressors associated with life transitions (e.g. entering college, the need for financial independence) increase vulnerability to disordered eating (Nagata, Garber, Tabler, Murray, & Bibbins-Domingo, 2018).

Research with symptomatic young adults shows that the aspects of perfectionism involving the mismatch between the discrepancy between self-prescribed high standards and perceived actual performance (i.e. a key aspect of perfectionism) are strongly associated with the severity of DEB ( Patterson, Wang, & Slaney, 2012).

These findings suggest that the internalised, culturally defined notion of the perfect body and the subsequent perceived perfectionist discrepancy may be crucial for understanding the development of Disordered Eating Patterns, particularly during young adulthood.

Perfectionism has been found to predict disordered eating attitudes in college students both cross-sectionally and longitudinally (Smith et al., 2017). Self-oriented perfectionism was found to be associated with disordered eating attitudes among women who reported high levels of socially prescribed perfectionism. It appears that individuals with elevated scores on both perfectionistic dimensions may be particularly vulnerable to ED symptoms. as suggested by recent evidence from the general population (Esposito, Stoeber, Damian, Alessandri, & Lombardo, 2019).

Findings by Cunningham and colleagues (2018) suggest that ER difficulties may be one of the potential underlying mechanisms explaining the well the well-researched relationship between perfectionism and ED-related outcomes. High difficulties with emotion regulation may lead to poorer distress management skills. maladaptive perfectionism, leading to disordered eating symptoms These findings suggest the potential protective role of adaptive ER strategies in the context of disordered eating, Thus, highlighting that future ED prevention protocols may include an increased focus on ER skills. (Donahue & colleagues, 2018).

**Conclusion**

In conclusion, disordered Eating behaviours are related to biological mental, and sociological dreariness, and critical mortality (Brilliant et al., 2003). Amid puberty, young individuals experience numerous changes as they reach physical development. Especially in young females, adolescence leads to weight pick up and amassing of body fat in particular body parts such as the midriff, hips, thighs, and buttocks. As they develop, young women move absent from the perfection of slimness, which can be related to body disappointment (Pokrajac-Bulian et al., 2004), and makes them more helpless to the advancement of disturbed eating behaviours. The special highlights and formative preparation of young people are basic contemplations in deciding the conclusion, treatment, and result of Disordered Eating behaviour at this age (Brilliant et al., 2003).

Research appears to show that perfectionism and emotional dysregulation is altogether related to Disordered Eating Behaviours (i.e. shape, weight, eating concerns, and dietary limitation) in young people (Tng & Yang, 2021).

Based on previous findings and theoretical relations between studied constructs, this study aimed to examine the relationship between difficulties in emotion regulation and perfectionism with the Eating attitudes of young adults. The hypothesis is that the relationship between emotion dysregulation and perfectionism with Disordered Eating is mediated by different cognitive eating patterns.

The major goal is to examine the possible interactions between emotion regulation difficulties, and perfectionism disordered eating behaviours and associated cognitive distortions. The Cognitive distortions might predict Disordered eating patterns s through various behaviours. By studying the interactions between specific risk factors for eating disorder symptoms, we aim to enhance the theoretical understanding and intervention strategies taking into account various psychosocial factorrs.