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Eating disorders and dysfunctional attitudes in women working for public vs. private organizations

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Abstract. There is a common view that eating disorders are a lifestyle choice. Eating disorders are a serious and often fatal disease. Food obsessions, body weight and fitness can also signal an eating disorder. Common eating disorders include anorexia nervosa, bulimia nervosa, nocturnal eating syndrome, otherwise unspecified eating disorders, and overeating disorders. Eating disorders occur in men and women, young and old, rich and poor, and from all cultural backgrounds; they have resulted in about 7,000 deaths a year since 2010, making them the mental illness with the highest mortality rate. The chances of recovery increase as they are detected earlier, so it is important to be aware of some of the warning signs of an eating disorder. More than seven million girls and women and one million boys and men will suffer from an eating disorder during their lifetime. Up to 3.7% of women will be diagnosed with anorexia nervosa and it is estimated that 4.2% will have bulimia nervosa. Anorexia is often associated with denial of disease and resistance to treatment.

Keywords. attitudes, dysfunctional, women, work, organizations

1. Types of eating disorders

1.1. Anorexia

Anorexia is a very serious mental disorder. It can affect individuals of all ages, genders, sexual orientations, races, and ethnicities; however, adolescent girls and young adult women are especially at risk. The disorder involves the fear of gaining weight, having a distorted body image, a refusal to maintain a normal weight and the use of extreme measures to maintain weight. Anorexia is usually diagnosed after a person is 25-30% under normal weight for three months or more. In addition, cognitive and emotional functioning is significantly disrupted in people with this disorder.

Usually, two subtypes of anorexia are identified. First of all, anorexia nervosa Restrictive type (R-AN) I lose weight only through diet and exercise, without overeating or purging. Second, binge-eating / purging-type anorexics (BP-AN) also limit their dietary intake and exercise to lose weight, but regularly engage in binge-eating and / or purging.

1.2. Bulimia

Bulimia nervosa is a serious, life-threatening eating disorder. It is characterized by a cycle of exacerbation and compensatory behaviors, such as self-induced vomiting, designed to nullify or compensate for the effects of excessive food consumption. Patients diagnosed with bulimia nervosa closely follow the patients diagnosed with binge purge anorexia. Bulimia is diagnosed if the binge-purge cycle occurs at least twice a week.

The act of purging can cause severe damage to the esophagus and teeth and also it may make the gag reflex less sensitive.

The type of non-purging bulimia is also diagnosed and is characterized by the use of other inappropriate methods to compensate for binge episodes, such as excessive exercise or fasting. In these cases, typical forms of purge, such as self-induced vomiting, are not regularly used.

1.3. Excessive eating disorder

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), the 5th edition, the overeating disorder is defined by several criteria. People need to report that they are consuming more food than is likely to be eaten by most people in a similar period of time under similar circumstances, in addition to losing control of their eating behavior during this time. In addition, at least three of the following characteristics must be present: summing food much faster than normal; eating to the point of uncomfortable satiety; consuming large amounts of food when you are not physically fit; eating food alone to avoid embarrassment; or feeling disgusted, depressed, or guilty after the meal event. The diagnosis also requires that binge episodes be associated with a significant amount of distress, which should occur at least once a week for 3 months or more.

Finally, the disorder should not be accompanied by any regular compensatory behavior, nor should binge-eating occur only during an episode of bulimia nervosa or anorexia nervosa.

1.4. Nocturnal feeding syndrome

The other prominent form of disordered eating related to overweight and obesity is NES. NES was first described by Stunkard et al. in a group of obese people seeking treatment for weight loss. They reported that those with the syndrome consumed a large majority of their caloric intake (25% or more) at a time when non-obese people would not eat. In addition, patients experienced insomnia and anorexia nervosa. The focus on NES was neglected until the late 1990s, when the focus of nutrition research shifted in response to the growing prevalence of obesity in the United States. Since then, the definition of NES has varied. For example, in the following years, Stunkard's definition was expanded to include night intakes. NES is characterized by recurrent episodes of nocturnal feeding, which is described as excessive consumption of food in the evening (after dinner, ie evening hyperphagia) or food after waking from sleep (ie night intakes). NES is also characterized by at least three of the following symptoms: morning anorexia, the presence of a strong urge to eat between dinner and sleep. Signs and physical effects of excessive eating disorder: insomnia at the beginning of sleep and / or maintenance of insomnia, frequent depressive mood or worsening mood in the evening and the belief that you can not fall asleep without eating. To be diagnosed with NES, individuals need to be aware and able to remember their eating episodes. These symptoms should also cause significant distress and / or impairment of functioning and should not be better explained by external factors or another disorder, such as sleep disturbance or other disorderly eating. NES

is classified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) as "another eating disorder or specific eating disorder."

1.5. Side effects of eating disorders

Anorexics have an increased risk of osteoporosis due to low intake, underweight and decreased estrogen related to amenorrhea. Calcium supplementation may increase the beneficial effects of physical activity on the bones. Vitamin D deficiency in young people can affect their ability to reach maximum bone mass.

The association between oral pathology and eating disorders is most clearly established in cases with frequent self-induced vomiting, regardless of whether the diagnosis is anorexia or bulimia, and is characterized by tooth erosion on the palatal surfaces. Dental caries, dry mouth, dysfunction of the salivary glands also occur. Inflammatory changes in the gums due to vitamin C deficiency are also observed.

•Treatment

Medication is generally useful for patients with bulimia nervosa. Common forms of pharmacotherapy include antidepressants, antiepileptic drugs, anti-obesity drugs and stimulants. For bulimia nervosa, antidepressants are the primary pharmacological treatment. Evidence for the use of fluoxetine in the treatment of bulimia nervosa comes in the form of various case reports, systematic studies, and randomized, double-blind, placebo-controlled studies.

2. Organizations

2.1. Private vs. Public organizations

Every organization has a system in place to achieve certain goals. Organizational goals are what an organization seeks to achieve and function.

Researchers suggest that private and public organizations differ significantly in terms of goals or achievement of goals. It is argued that public agencies have distinct objectives, such as equity and accountability, which are absent in the private sector. Public sector organizations are predominantly controlled by political forces, not by market forces, the differences in objectives between these two organizations being an obvious phenomenon. . It is perhaps a little difficult to find similarities in this regard, as both organizations have two different ideologies and are controlled by those ideologies. The objectives of public organization are controlled by political factors, and the objectives of private organizations are dominated by market forces. One of the interesting anomalies in the comparison between public and private organizations is the complexity and ambiguity of the purpose. Private organizations pursue a single purpose for profit.

Public organizations, on the other hand, have relatively vague, intangible, and multiple goals. Public organizations are exposed to external control and greater responsibility, and their goals are often conflicting or confrontational.

2.2. Dysfunctional attitudes in organizations

The term dysfunctional is defined as "abnormal or affected functioning" by a person, between persons in any form of relationship or between members of a family. Defective functioning refers to both behavior and relationships that do not work and have one or more negative, unhealthy aspects, such as poor communication or frequent conflicts.

This is a term often used by mental health professionals for human interactions and is often used to describe any relationship in which there are significant problems or conflicts. Relationships or dysfunctional situations are often the impetus for help in psychotherapy.

Dysfunctional behavior refers to discretionary behavior that tends to harm the organization as a whole as well as its members. Peterson (2002) defines dysfunctional behavior as behavior that is intended to violate appropriate rules and policies in the workplace, which in turn may affect overall organizational performance.

Unfortunately, several studies show that there is a marked increase in dysfunctional behavior in the workplace, such as sexual harassment, lying, and harassment. There are other forms of dysfunctional behavior, such as theft, arrogance, alcohol consumption, extended breaks, and many other forms as well. Dysfunctional workplace behavior negatively affects the overall performance of the organization, leading to decreased productivity, increased job dissatisfaction, increased business numbers, and higher levels of work-related stress. In turn, it can affect the overall organizational performance. Consequently, dysfunctional behavior at work can adversely affect the personal and professional well-being of employees, as well as a significant cost to the organization.

3. Applied Research

3.1. Research objectives and hypotheses

This research has taken into account the following objectives:

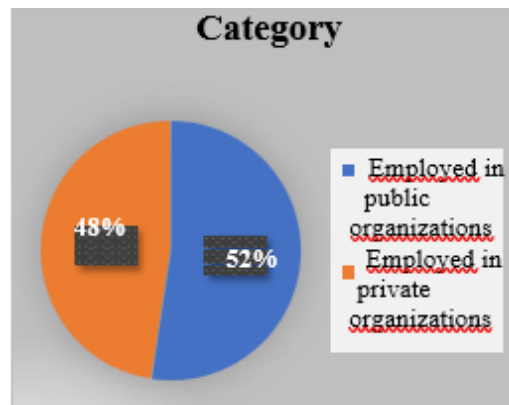
1. Highlighting significant differences between women working in public organizations and women working in private organizations in terms of eating disorders and dysfunctional attitudes.
2. Highlighting the correlation between eating disorders and dysfunctional attitudes in women in private organizations and women in public organizations.

Following the objectives, the research hypotheses are:

1. It is presumed that there is a significant difference between women working in private organizations and women working in public organizations in terms of eating disorders.
2. It is presumed that there is a significant difference between women working in private organizations and women working in public organizations in terms of dysfunctional attitudes.
3. It is assumed that there is a positive correlation between behavioral disorders and dysfunctional attitudes among women in private organizations and women in public organizations.

3.2. Description of the investigated sample

To conduct the research, we selected a representative sample of 42 female subjects employed in public and private organizations. Of the 42 women evaluated, 22 work in public organizations and 20 in private organizations. Subjects range in age from 25 to 48 years. Regarding the environment of origin, 14 are part of the rural environment and 28 of the urban environment.



3.3. Tools used in research

For the collection of data related to our paper, we applied two evaluation tools:

- Endler Scales Handbook for Multidimensional Anxiety Assessment (EMAS)
- Inventory of Eating Disorders - 3 (EDI-3)

4. Analysis and interpretation of results

Hypothesis 1. *It is presumed that there is a significant difference between women working in private organizations and women working in public organizations in terms of eating disorders.*

The first step in the statistical processing of the obtained data is the calculation of the statistical indices of start, visible in the table below.

Tabel 1 - Start indicators

Descriptives				
	Job type		Statistics	Std
Bulimia Scale	Private	Mean	22,201 22.20	,851
		Median	22,00 22.00	
		Strd. deviation	3,806 3.806	
	Public	Mean	8,14 8.14	,851
		Median	7,50 7.50	
		Variance	15,933 15.933	
		Std. deviation	3,992 3.992	

This table contains the starting points of the hypothesis, for each type of organization. Therefore, we have: for private organizations the average = 22.20, the median = 22.00 and the standard deviation = 3,806, and for public organizations average = 8.14, median = 7.50 and standard deviation = 3,992.

In order to identify what type of statistical coefficient we will use, we calculated the indicators normal distribution of scores. The following results:

Table 2 -Test of Normality

Tests of Normality							
	Job Type	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Bulimia scale	Private	.150	20	.200*	.957	20	.482
	Public	.142	22	.200*	.919	22	.071

For a better visibility of the distribution of scores, the histograms related to the scores obtained by the two categories of subjects are presented:

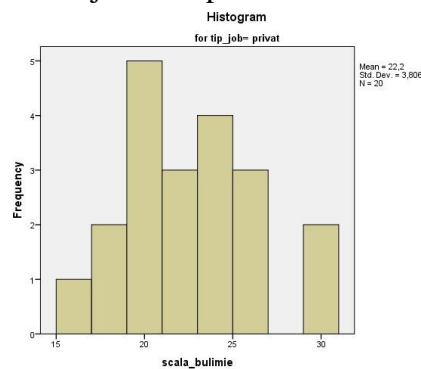


FIG. 1 - Results for women working in the private sector

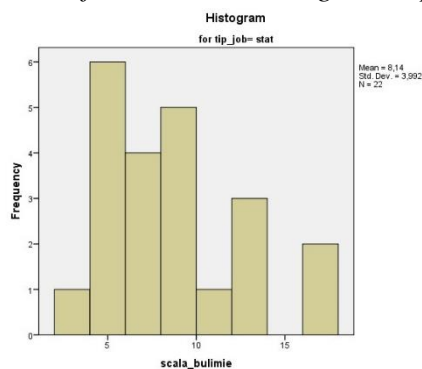


FIG. 2 - Results for women working in the public sector

After testing the normality, we obtained in the Kolmogorov -Smirnov test the value of Sig. of 0.200 both for women working in the private sector and for women working in public organizations. Given the fact that both significance thresholds are greater than 0.05, we obtained a normal distribution, and we will continue to use it to perform the comparison of the parametric calculation method, namely the T test for independent samples.

Table 3 - Mean and standard deviation for the bulimia variable, by type of organization they belong to.

	Job type	N	Mean	Std. Deviation	Std. Error Mean
Bulimia scale	Private	20	22,20	3,806	,851
	Public	22	8,14	3,992	,851

Table 4 - Independent T Sample Test

		Independent Samples Test								
		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
scala_bulmie	Equal variances assumed	,004	,952	11,658	40	,000	14,064	1,206	11,626	16,502
	Equal variances not assumed			11,686	39,900	,000	14,064	1,204	11,631	16,496

Following the use of the T test for independent samples, we obtained Sig. (2-tailed) with a value of 0.000. This shows that there is a statistically significant difference in terms of eating disorders between women working in the private sector and women working in public organizations. Analyzing Table 3, the average rank is 22 , 20 for women working in private organizations, and 8.14 for those in public organizations, in terms of bulimia scale. Thus, the hypothesis is confirmed.

Tension and stress are ubiquitous in the workplace due to workload, lack of support, and many other workplace-specific factors, but feelings of stress at work can be particularly problematic for women with disabilities. you eating disorders. Specifically, stress at work has been linked to work-related problems, such as declining job satisfaction, absenteeism, burnout, and business-changing intentions. Experiencing stress at work is also associated with reduced psychological well-being and has been shown to predict clinical depression and anxiety. Harmful stressors in the workplace can be particularly problematic for women's occupational well-being in areas such as organizational commitment, negative emotions, and job, supervisor, and job satisfaction.

The link between workplace stress and adverse psychological outcomes is of unique importance to those with ADD, as ADD is both a cause and a consequence of psychological distress. Participation in stressful pregnancies has been shown to increase cognition and TCA (Sassaroli, Fiore, Mezzaluna, and Ruggiero, 2015), and stressful life events, especially work-specific ones, have been shown to predict TCA recurrence (Grilo et al. , 2012). Also, perfectionist tendencies can be triggered by stressful situations, which can increase TCA symptoms in women with and without clinical TCA (Sherry & Hall, 2009; Smith et al., 2017). Thus, while preliminary research suggests that work-related stress may exacerbate the symptoms of TCA, the intersection between work and TCA remains poorly studied.

Eating disorders, especially anorexia nervosa and bulimia nervosa, have been classically described as occurring in young women. Although recent research has shown that male prevalence has previously been underestimated, these disorders have a clear predominance of females. Various reasons have been given for this finding, most of them psychosocial. Overestimation of weight loss, which is common in our society, is considered to be an important factor contributing to the pathogenesis of eating disorders. These disorders have been shown to

be more common in private organizations and have been shown to spread more slowly in public organizations.

Hypothesis 2. *It is presumed that there is a significant difference between women working in private organizations and women working in public organizations in terms of dysfunctional attitudes.*

The first step in the statistical processing of the obtained data is the calculation of the starting statistical indices, visible in the table below. The results obtained were:

Table 5 - Start indicators for the hypothesis

Descriptives				
	Job type		Statistic	Std. Error
Anxiety scale	Private	Mean	76,15	2,216
		Median	75,50	
		Std. Deviation	9,912	
	Public	Mean	47,27	2,856
		Median	44,00	
		Std. Deviation	13,396	

The table shows the starting points for the two groups in which the study participants were assigned. Thus, for the first average category it is 76.15, the median is equal to 75.50 and the standard deviation is 9.912 while for the other average category it is 47.27, the median is 44.00 and the standard deviation is 13.396.

Subsequently, in order to identify what type of statistical coefficient we will use, we calculated the indicators of the normality of the distribution of scores. The following results:

Table 6 - Test of Normality

Tests of Normality							
	Job type	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Anxiety scale	rivat	,070	20	,200 [*]	,978	20	,909
	tat	,153	22	,197	,940	22	,196

For a better visibility of the distribution of scores, the histograms related to the scores obtained by the two categories of subjects are presented:

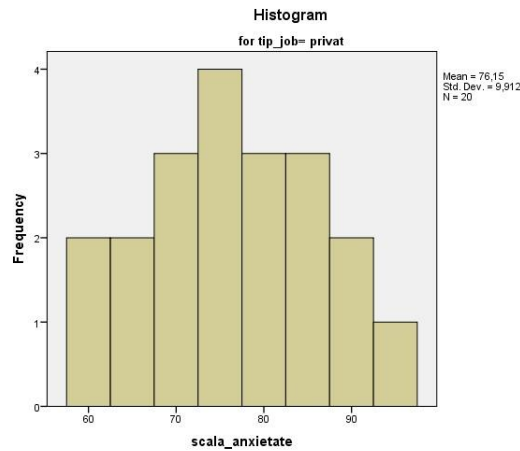


FIG. 3 - Histogram for women in private organizations

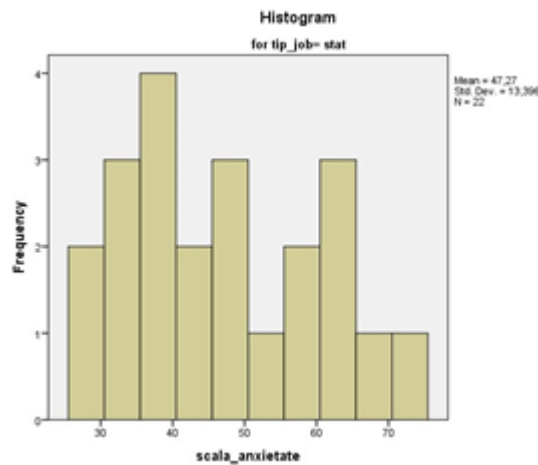


FIG. 4 - Histogram for women in public organizations

After testing the normality, we obtained in the Kolmogorov -Smirnov test the value of Sig. of 0.200 and 0.197 respectively. Given that both significance thresholds are greater than 0.05, we obtained a normal distribution, and we will continue to use it to perform the comparison, the parametric calculation method, namely the T test for independent samples.

Table 7 - Mean and standard deviation for the anxiety variable, by type of organization they belong to

Group Statistics					
	Job type	N	Mean	Std. Deviation	Std. Error Mean
Anxiety scale	Private	20	76,15	9,912	2,216
	Public	22	47,27	13,396	2,856

Table 8 - Independent T Sample Test

		Independent Samples Test									
		Levene's Test for Equality of Variances		t-Test for Equality of Means						95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper	
scala_anxietate	Equal variances assumed	3,246	,079	7,875	40	,000	28,877	3,667	21,466	36,289	
	Equal variances not assumed			7,988	38,483	,000	28,877	3,615	21,562	36,193	

Following the use of the T test for independent samples, we obtained Sig. (2 -tailed) with a value of 0.000 in both cases. Analyzing table 6, the average rank is 76.15 for women working in private organizations, and 42.27 for those in public organizations, in terms of anxiety scale. Because the values are less than 0.05 and the second hypothesis is confirmed.

Anxiety disorder can have a major impact on the workplace. People may refuse a promotion or other opportunity because it involves travel or public speaking.

Wood (2008) examines the influence of job characteristics, including job control and job requirements, and employees' voice on well-being using measures of job satisfaction and anxiety at work. Consistent with the Karasek (1979) model developed in the psychology literature, he finds evidence of higher anxiety in more demanding jobs, with lower levels of employee control. He also finds evidence that levels of perceived support from management and consulting with him reduce the level of anxiety. In contrast, Bryson et al. (2010) focuses on the influence of employee earnings on job satisfaction and professional anxiety in the private sector. They find evidence of a positive relationship between earnings and anxiety at work, which is robust for detailed controls on the nature of work, effort and job characteristics. Instead, they find no influence on the salaries of colleagues on occupational anxiety.

Cottini and Lucif Ora (2010) focus instead on work-related mental health, as measured using self-reported answers to questions about whether work affects stress, sleep problems, anxiety and irritability in the European Working Conditions Survey (EWCS).). They find evidence that certain characteristics of the workplace (especially shift work and repetitiveness) and requirements (complexity and intensity of tasks) are positively associated with mental health issues. In a manner similar to Bryson et al. (2010), several studies have focused on the relationship between earnings and psychological health. French and Dunlap (1998) and Groot and Maassen van de Brink (1999) both find evidence of a compensatory wage gap associated with stress at work.

Psychosocial risks and burnout at the national level have rarely been systematically investigated. Based on data from the 2013 National Employee Survey, 15,000 full-time employees were surveyed. The types of sector were classified as 'public', 'private enterprise - large (LE)' and 'private enterprise - small and medium (SME)'; based on the definition of SMEs by the Taiwanese Ministry of Economic Affairs and the associations of types of sectors with self-reported burnout status (as measured by the Chinese version of the Copenhagen depletion inventory), taking into account other work characteristics and indicators of job instability. Significantly longer working hours and a higher perception of job insecurity were found among private sector employees than their public sector counterparts.

Thus, we can conclude that anxiety symptoms are more common among women in the private sector than in the public sector.

Hypothesis 3. *It is presumed that there is a positive correlation between behavioral disorders and dysfunctional attitudes in women in private organizations and women in public organizations.*

We start by verifying the confirmation or refutation of the hypothesis by identifying the statistical indices specific to it, which we find in Table 7.

Table 9 - Analysis of the statistical indices of the hypothesis

Descriptives			
		Statistic	Std. Error
Eating disorder risk scale	Mean	190,43	6,007
	Median	199,00	
	Std. Deviation	38,927	
Anxiety scale	Mean	61,02	2,889
	Median	62,00	
	Std. Deviation	18,722	

We notice that for eating disorders the average is equal to 190.43, the median is 199.00 and the standard deviation is 38.927. Also, for the variable dysfunctional attitudes the average is 61.02, the median is 62.00 and, last but not least, the standard deviation is equal to 18.722.

Table 10 - Test of Normality

Tests of Normality						
	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Eating disorder risk scale	,171	42	,003	,902	42	,002
Anxiety scale	,107	42	,200 [*]	,956	42	,110

Applying the normality test, which in this case is insignificant for the self-esteem variable, indicates that we need to apply a non-parametric method.

Below are the two histograms for the two variables:

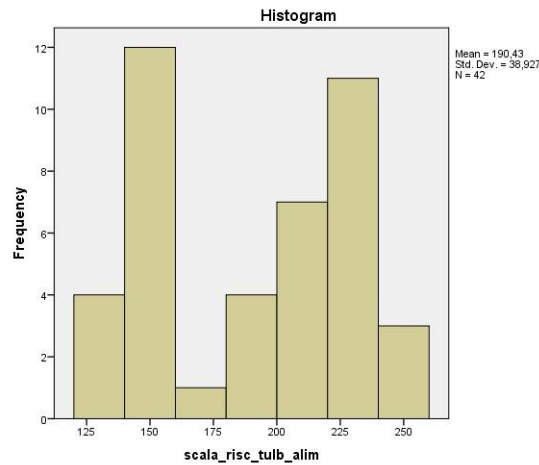


FIG. 5 - Histogram specific to eating disorders

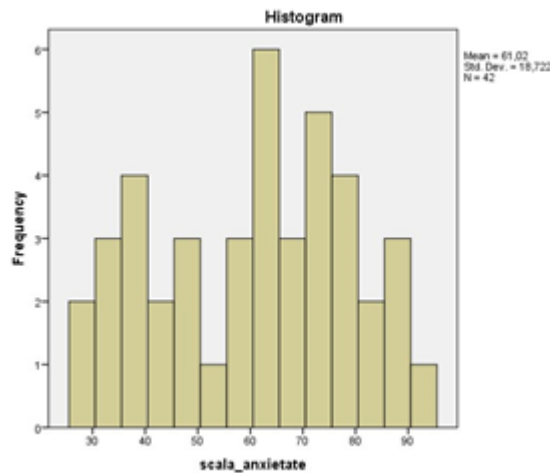


FIG. 6 - Histogram specific to dysfunctional attitudes

We recall the fact that for the variable dysfunctional attitudes Sig. obtained after applying the normality test was lower than the significance threshold of 0.05.

Given this fact, for the correlation between eating disorders and dysfunctional attitudes we will take into account the Spearman coefficient which is specific for a nonparametric distribution.

Table 11 - Spearman Correlation Coefficient

Correlations				
			Anxiety scale	Eating disorder risk scale
Spearman's rho	Anxiety scale	Correlation Coefficient	1,000	,701**
		Sig. (2-tailed)	.	,000
		N	42	42

The correlation table shows that there is a positive correlation between eating disorders and dysfunctional attitudes, given the positive value of the coefficient, and also shows a strong correlation between the two variables.

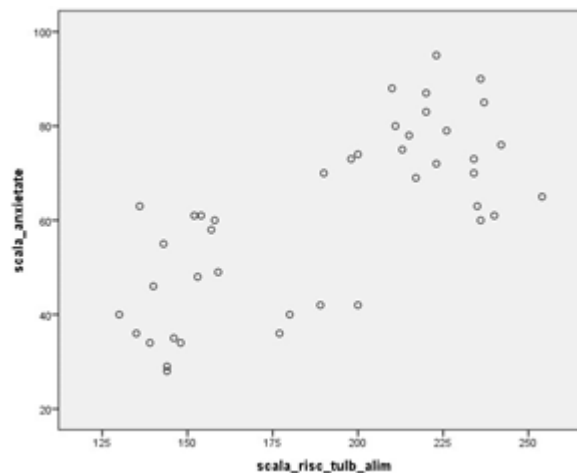


FIG. 7 - The point cloud

In another way, Figure. 7 demonstrates the positive correlation of the variables, the points in the graph increasing and not being scattered.

In conclusion, we can say that the statement according to which it is presumed that there is a positive correlation between behavioral disorders and dysfunctional attitudes in women in private organizations and women in public organizations, is confirmed.

In general, the quality of the organization, the work environment, and the work itself can affect employees' experience of stress at work. The findings of this study indicated that there were significant differences in work characteristics between public and private sector employees. Private sector employment has been associated with disadvantaged employment and high levels of workplace stress indicators.

Often, constant periods of stress can lead to psychosomatic disorders, such as eating disorders. People with an eating disorder called anorexia nervosa are overweight, even if they are dangerously weak. Many people with anorexia also have coexisting psychiatric and physical illnesses, including depression, anxiety, obsessive-compulsive behavior, substance abuse, cardiovascular and neurological complications, and affected physical development. Bulimia nervosa is characterized by recurrent and frequent episodes of consuming unusually large amounts of food and a feeling of lack of control over diet. This overeating is followed by purging (vomiting, excessive use of laxatives or diuretics), fasting or excessive exercise. People with bulimia usually weigh in a normal range, but like those who have anorexia, they are afraid to gain weight, want to lose weight and feel extremely dissatisfied with their body. And like those with anorexia, people with bulimia often have coexisting psychological illnesses, such as depression, anxiety, or substance abuse problems. Many physical conditions also result from their behavior, including electrolyte imbalances, gastrointestinal problems, and oral and tooth problems.

A 2004 study found that two-thirds of people with eating disorders had anxiety disorders at some point in their lives and that about 42% developed an anxiety disorder as a child long before their onset of anxiety. food. Other studies also confirm that an anxiety disorder is usually the onset of an eating disorder, but it is often followed by panic disorder.

Obsessive-compulsive disorder (OCD) is the most common anxiety disorder that occurs with an eating disorder. People with both disorders often develop compulsive eating-related rituals, such as weighing each piece of food or cutting it into tiny pieces or even excessive consumption.

The chances of developing bulimia are higher for women with post-traumatic stress disorder (PTSD), and social anxiety disorder is also common among people with an eating disorder.

Conclusions

From the results of the research, we can conclude that there is a significant difference between women working in public organizations and women working in private organizations in terms of both eating disorders and dysfunctional attitudes. In the case of women who are employed in private organizations, the results showed that they are more likely to have eating disorders, but also that they are more prone to dysfunctional attitudes compared to women employed in public organizations. . This can be caused by the fact that working in a private organization puts much more pressure than working in a public organization. Higher expectations and expectations are incomparably higher, creating a state of stress that ultimately leads to eating disorders and dysfunctional attitudes after a long period of time. These behaviors can affect both the mental well-being of women and their efficiency in the workplace. The occurrence of an anxiety disorder can have a major impact on their professional activities, in that they may refuse a promotion or other opportunity because it involves public speaking or traveling.

We found that dysfunctional attitudes, such as anxiety, were closely linked to the risk of eating disorders. To see if this is valid, we made a third hypothesis, which confirmed our assumption. Thus, the results showed that eating disorders and dysfunctional attitudes are in a directly proportional relationship, meaning that as dysfunctional attitudes increase, so does the risk of eating disorders. eating behavior.

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