Critically eating disorder (ufed); these two categories aim

Critically evaluate the relativeimportance of Biological, psychological and social factors in the prevention of eatingdisordersAbstract DefinitionThe American Psychiatric Association (APA) describeseating disorders as characterized by a chronic disturbance of eating thatdamages health and/or psychosocial functioning (APA, 2013). The fifth and last version of the Diagnostic andStatistical Manual of Mental Disorders (DSM-5), from the American PsychiatricAssociation, distinguishes between five types of eating disorders: AnorexiaNervosa (AN), Bulimia Nervosa (BN), Binge-Eating Disorder (BEN) andAvoidant/Restrictive Food Intake Disorder (ARFID), which is more common inchildren (Treasure, 2016). Furthermore, the DSM-5 includes two new categories ofeating disorders that are: Other Specific Feeding or Eating Disorder (OSFED)and Unspecified Feeding or Eating Disorder (UFED); these two categories aim toacknowledge the conditions that do not fit more precisely in any of the eatingdisorders mentioned previously (Eatingdisorders, 2016). The disorder or Anorexia Nervosa is diagnosedwhen someone’s weight is 15% below the expected weight for them according totheir height, age and sex; together with a strong aversion to gain weight andan excessive preoccupation with their weight and food intake (Treasure, 2016). Thereare two subtypes of AN depending on the presence or absence of binge eating orpurging: the restrictive type – patients employ restrictive behaviours such asunder eating and over exercising – and the purging type – patients use vomitingand laxative abuse (Beumont, 2002).

The Bulimia Nervosa shares some commonfeatures with AN (Garfinkel, 2002), such as an intense preoccupation with bodyweight and shape. It

occurs when someone experiences regular episodes ofuncontrolled overeating and then takes extreme measures of counteracting weightgain (such as vomiting and laxative abuse); in BN, patient’s weight fluctuateswithin the normal range (Hay & Claudino, 2010). Binge Eating Disorder is the most commondisorder amongst adults, its main features are frequent and constant overeatingepisodes that are connected with feelings of loss of control over eating; thesebehaviours are not accompanied by inappropriate compensatory behaviours as inBN (Turan, Poyraz & Özdemir, 2015). Patients with Avoidant/Restrictive FoodIntake Disorder may present similarities to patients with AN as both disorderslead to deficient food intake (Strandjord et al., 2015). However, ARFIDpatients’ goal is not to control weight; they want to avoid the potentialconsequences of eating (such as vomiting or chocking) or they might lack of theinterest on food intake (Nicely et al.

, 2015). Diagnosis andprevalenceEating disorders and similar behaviours are ausual problem in pre-adolescents and adolescents (Nicholls, 2011). A study on aconsiderable sample of American young people (aged between 9 and 14 years old)found that 34% of boys and 43, 5% of girls had an eating disorder trait (Treasure, 2016). These results show how relevant the issue of eating disorders is withinteenagers’ population. The lifetime female prevalence rates are around0. 9% for AN, 1.

5% for BN, 3. 5% for BED and 10% for subclinical disorders (Treasure, 2016). However, less than a 20% of cases of eating disorder agree to receive atreatment (Hoek, 2016). In a study that aimed to estimate the annual incidenceof diagnosed eating disorders in primary care over a 10-year period

(between2000 and 2009) in the UK, it was found that the incidence of BED increased to25 per 100000, with its peak onset at 18 years old; the incidence of BNstabilized, following its rapid increase in the 90s, at 22 per 100000; and theincidence of AN has been stable at 15 per 100000 over the last forty years, most commonly beginning at the age of 16 (Micali et al.

, 2013). In 2016, Treasure identified some genderdifferences across diagnosis and setting. For instance, the female: male ratiowas 10: 1 for AN and BN; however, in the community and child and adolescentsettings, she found that the ratio was 3: 1. This finding suggests that thereare limitations in reference to recognize and to accept an illness that isusually attributed to the female gender.

Community-based studies showed that binge eatingdisorder is more common in obese populations (Grilo, 2002). Unlike BN and AN, the gender ratio in BED is more equalized, being around 1. 5: 1 female to maleratio (Smink, Van Hoeken & Hoek, 2012).

BED is also the most common eatingdisorder in adult populations (Turan, Poyraz & Özdemir, 2015). These data shows how eating disorders influencean important part of the population and suggests the need for interventions toprevent these illnesses and to stop these numbers from increasing. Preventing the conditionFamily, biological, social and cultural factorsplay an important role in the development and/or maintenance of eatingdisorders (Treasures, 2016). Most of the early prevention programsapproached a single social factor, generated for the media, of cultural pressurefor thinness.

These prevention programs aimed to emphasize healthy nutritionand weight management, as well as cease the unrealistic pressure for leanness (Stice, 2002). SusceptiblepopulationsEpidemiological studies have shown that eatingdisorders are not randomly distributed among the population (Hoek, 2002). Youngwomen seem to be the most vulnerable group. This might be associated to thesubordinate position of women’s in society, the gender role socialization andthe current female ideal of excessive thinness (Striegel-Moore & Smolak, 2002). This idea has led research to study the relationship between eatingdisorders and social and cultural factors.