Perspective Article

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A Brief Note on Eating Disorder

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Description

Eating disorders are psychological disorders defined by abnormal nutrition behavior that adversely affect physical or mental health. You can diagnose only one edible disorder at a constant time. The type of diet disorder contains a bingalge feeding disorder where the affected one is a short time in a short time. An anorexia that has focused fear to increase the weight and limit food and excess rate to address this fear. When the affected people eat large quantities, try to try to release themselves from food (rinse). PICA eats affected non-hood objects. Lumin syndrome where morb or minimal digested food has not been estimated. Avoidance/restricted food absorption that people have reduced or selective food intake for psychological reasons. And a group of other features of feed and eating disorder. Anxiety disorder, depression and drug abuse are common with people with eating disorders. These diseases do not contain obesity.

Biological and environmentally friendly factors play a role, but the cause of eating disorders is not clear. Both roles are considered to play. Individuals who experienced sexual abuse also develop more frequent feeding disorders. Some confusion, such as PICA and turbidity failures will occur more frequently with people with intellectual disabilities.

Treatment may be effective for many eating disorders. Treatment varies depending on the disability, reducing advice, nutritional advice, excessive movement, and reducing efforts to eliminate food. Pharmaceuticals can be used to help some of the associated symptoms. Hospital stay is necessary if it is more serious. Within 5 years, about 70% of people recover with the loss of appetite and 50% of people with overimpery. Only 10% of people with eating disorders are treated and do not mind the treatment for about 80% and its treatment. Many people are sent to the house faster than the recommended stay and are not provided to the necessary treatment. Binch eating disorder recovery is not clear, but is estimated at 20% to 60%. Both apologies and overwork increase the risk of death.

Classification of Eating Disorder

Estimation of the prevalence of eating disorders is the reflective difference between the gender, age and culture, and the reflective difference of the method used for diagnosis and measures. In the developed world, anorexia is interested in about 0.4% and bioprasosis affects 1.3% of young women. One year BINGE feeding disorder affects 1.6% of women and 0.8% of a given year man. According to one analysis, the percentage of women who experience anorexia at some point in their lives can reach 4% to 2% in the case of bulimia nervosa or bulimia nervosa. Eating disorders appear to be low in developing countries. Anorexia nervosa and bulimia nervosa are almost 10 times more common in women than in men. The typical onset of eating disorders is from late childhood to early adulthood. The rate of other eating disorders is not clear.

Anorexia Nervosa (AN) is a limitation based on the need for energy intake, resulting in significantly lower weight associated with age, gender, developmental history and physical health. It is accompanied by a strong fear of gaining and gaining weight and a disordered way of recognizing and assessing weight and body shape. There are two subtypes of AN, restricted and bulimia/purge. Restricted represents a presentation in which weight loss is achieved by dieting, fasting and (or) excessive exercise without binge eating/hunger behavior. The overeating/purging type represents a presentation in which an individual patient has repeatedly experienced episodes of overeating and purging behavior such as self-induced vomiting, laxative and diuretic abuse. The severity is determined by BMI, and a BMI of less than 15 is considered the most extreme case of the disease. Adolescent and post-pubertal women with anorexia often experience amenorrhea or menopause due to the extreme weight loss experienced by these individuals. Amenorrhea was a necessary criterion for diagnosing anorexia in DSMIV, but because of its exclusive nature in DSM5, men, postmenopausal women, or individuals without menopause for other reasons do not meet this criterion. Although the cause is not clear, women with bulimia may also experience amenorrhea.

Bulimia Nervosa (BN) includes recurrence of bulimia and subsequent vomiting (self-induced vomiting, diet until vomiting, excessive use of laxatives/diuretics, or excessive exercise). Characterized by compensatory behavior. Fasting can also be used as a post-binge detox method. However, unlike anorexia nervosa, weight is maintained above a minimum normal level. The severity of BN is determined by the number of episodes of inappropriate compensatory behavior per week.

Binge Eating is characterized by repeated binge eating without the inappropriate compensatory behavior present in the BN and a binge eating/purging subtypes. Binge eating episodes are eating much faster than usual, eating until uncomfortable full,

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eating large amounts without physical hunger, eating alone due to embarrassment about how much you are eating and/or guilty after eating, which is associated with feeling disgusted, depressed, or very much about yourself. To make a diagnosis of BED a major eating disorder must be present, and bulimia nervosa should occur on average once a week for 3 months. The severity of BED depends on the number of episodes of bulimia per week.

Lumin disorder covers the repetitive reflux of food, reserved, reserved or discharged. Because this guaranteed diagnostic is guaranteed, actions must remain at least one month, and the reflux of food cannot be returned to another medical condition. In addition, roaring disorders are unlikely to occur between 1, BN, floors, and alfids and thus cannot occur between one of these diseases. Avoidance/Restricted Food Absorption Disorder (ArFID) is a feeding or eating disorder. For example the absence of interest in food nutrition, avoidance based on sensual characteristics of food or concern based on food aversion episodes, it prevents nutritional nutrition decisions. It is often related to failing to meet weight loss, malnutrition, or growth pairs. In particular in the method in which the shape of body weight or body is experienced, ArFID is different from 1 and BN because there is no disturbance evidence. Disorders are not better explained by the lack of available food, cultural practices, co-diseases, or other mental illness.

Other Specific Feeding or Eating Disorders (OSFED) are diets or feed disorders that do not meet the complete DSM5 standard for BN or bed. Examples of other famous food disorders include individuals with non-resistant anorexiac. Heterotypic celloma that meets all the criteria of BN, except that there is little but not yet stopped. Cleaning disorder and at night feeding syndrome. Feeding or eating disorder does not explain the feeding and nutrition of disorders due to significant pain and disability functional functions, but one of other diagnoses It is not satisfied. A specific reason for the presentation does not meet the criteria of a particular failure has not been identified. For example, if there is not enough information to perform more specific diagnosis, for example, USFED diagnostics may be given in emergency treatment chamber settings.