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FEEDING AND EATING DISORDERS:
THE ROLE OF COMMUNICATION

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Abstract

Feeding and eating disorders (FEDs) are a widespread disease in Italy and the rest of the world, but they are still not given the importance they deserve in terms of communication. The role of communication should be to inform people about feeding and eating disorders, what they are and how different they are, and the importance of acting promptly and seeking help as soon as the first signs are seen.

However, only 85% of the population surveyed through a questionnaire claimed to know what FEDs are: a fact that underlines the need for more widespread information, given the high mortality rate of these illnesses. Of these people, 94% firmly believed that communication about feeding and eating disorders should be improved.

Feeding and eating disorders need to be introduced as early as primary school, as the age of onset is becoming earlier, and it is essential that communication is carried out by specialists with the appropriate skills and studies. The pillars of change include comprehensive communication that takes into account the broad spectrum of FEDs.

The aim of this dissertation is therefore to investigate the critical points of feeding and eating disorder communication and to propose solutions for an effective and concise communication.

Introduction

Feeding and eating disorders (FEDs) are mental disorders characterised by dysfunctional eating behaviour and excessive preoccupation with weight with altered body image perception, which cause an alteration in food consumption or absorption. In Italy, 3 million people suffer from a feeding and eating disorder and the figures are not reassuring: the number of patients is increasing and the age of onset is getting earlier and earlier. In 2023 alone, almost 4,000 people died from these disorders, which are the second most common cause of death among adolescents after road accidents (Ministero della Salute, 2024).

We need to intervene in terms of specialised centres and accessible treatment, we need to recognise these illnesses as such and give them the importance they deserve, but above all we need to educate people through a process of information that aims, through communication, to provide a framework for these illnesses and lead to their knowledge, so that stigmatisation ends and understanding begins.

The aim of my work is to analyse, by means of a questionnaire, people's opinions on the effectiveness of communication about feeding and eating disorders, to identify critical points and to propose solutions that can enable a widespread and functional information process. It is through the people to whom communication is directed, and especially through those who have suffered from feeding and eating disorders or have been close to those who have suffered from them, that it is possible to implement changes in the way FEDs are treated.

1. Feeding and Eating Disorders (FEDs)

Feeding and Eating disorders, merely known as Eating Disorders (EDs), are *characterized by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning* (APA, 2013, trad. it. p. 380). This definition, given by the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), written by the American Psychiatric Association, emphasises that Feeding and Eating disorders should be considered primarily as mental disorders.

This is in line with the definition provided by the Italian Ministry of Health, according to which eating disorders are complex pathologies characterised by dysfunctional eating behaviour, excessive preoccupation with weight and altered perception of body image (Italian Ministry of Health, 2023).

However, FEDs are a special case for several reasons. First of all, the symptomatology of eating disorders is varied, as is the clinical course, which is highly subjective; it follows that the delineation of symptoms and their treatment as well-defined pathologies is troublesome. Secondly, it is common to move from one eating disorder to another, perhaps developing into a third or returning to the previous one. A third point, which is extremely important, concerns the social dynamics that have a clear influence on EDs, outlining new ones. In addition, unlike many mental disorders, eating disorders require a multidisciplinary approach to treatment.

Eating disorders are manifold, and among the best known are syndromes that are unknown to most people.

1.1 Anorexia Nervosa

The discovery of anorexia nervosa occurred in 1873, when two crucial scientific articles were published: one on *anorexia nervosa* by the English physician William Withey Gull and one on *hysterical anorexia* by the French doctor Ernest-Charles Lasègue.

According to psychologist Julie Hepworth, it was the article of Gull that was decisive

> because prior to this time self-starvation had been associated with several different traditions of thinking including theology, anatomy and folklore. Following Gull's 1873 paper self-starvation became widely known as anorexia nervosa, a psychomedical condition (Hepworth, 1999, p. 2).

Following the articles by Gull and Lasègue, many studies were carried out on new patients whose main symptom was refusal to eat. In 1883, thanks to Henri Huchard, the hysterical matrix of the disorder was eliminated and FEDs began to be treated as specific disorders.

Anorexia nervosa gained importance for the World Health Organisation (WHO) in 1990 when it was included in the International Classification of Diseases (ICD-10) as an eating disorder, where it was defined as follows:

> A disorder characterized by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea, and the patients impose a low weight threshold on themselves. There is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics (WHO, 2016, p.258).

From a nutritional point of view, anorexia nervosa is characterised by protein-energy malnutrition (PEM) and restriction to such an extent that some British authors have defined it as *semi-starvation*. The diet is dominated by a high proportion of plant foods, excluding whole categories of foods such as animal and plant oils and fats, simple and complex carbohydrates and protein foods.

Calorie restriction aims to reduce energy intake in order to achieve weight loss or to control body weight (Bevere *et al*., 2013).

According to the American Psychiatric Association guidelines, the central criteria of anorexia nervosa are:

A. Restriction of calorie intake in relation to requirements, resulting in a significantly low weight, i.e. below the normal minimum;
B. Intense fear of gaining weight or becoming fat;
C. Altered levels of self-esteem, followed by a lack of recognition of the seriousness of being underweight.

It is also important to specify whether it is a restrictive type - weight loss is due to dieting, fasting and excessive exercise - or a binge or purge type - there have been recurrent episodes of binge or purge behaviour in the last three months, through self-induced vomiting, laxatives and diuretics.

In addition, partial remission occurs when criterion B or C is met but criterion A is not; complete remission occurs when none of the previous criteria is met for a significant period of time.

Finally, the Body Mass Index (BMI)[1] is introduced as a value to assess the severity of forms of anorexia. A distinction is made between mild (BMI 17 kg/m^2), moderate (BMI 16-16.99 kg/m^2), severe (BMI 15-15.99 kg/m^2) and extreme forms (BMI 15 kg/m^2) (APA, 2013).

The estimated incidence of anorexia nervosa is at least 8-9 new cases per 100,000 persons per year in women and between 0.02 and 1.4 new cases per 100,000 persons per year in men. In anorexia nervosa, the remission rate is 20-30% after 2-4 years, and 70-80% after 8 or more years. In 10-20% of cases, a chronic condition develops that lasts a lifetime (Ministero della Salute, 2024).

1.2 Bulimia Nervosa

The term bulimia derives from the Greek *bous* (ox) and *limos* (hunger) and literally means "ox hunger". It was coined in 1979 by the psychiatrist Gerald Russel who, after studying thirty patients, described it as «an ominous variant of anorexia nervosa» (Fairburn, Cooper, 1984).

These patients had a strong urge to binge, i.e. to eat large amounts of high-calorie food in response to a stimulus that was not hunger, and a dreadful fear of becoming fat. This was compounded by the use of practices to counteract weight gain, such as self-induced vomiting or the use of laxatives.

Bulimia nervosa, like anorexia, is characterised by a state of malnutrition[2], although less pronounced: the cause is not only inadequate nutrition but also compensatory mechanisms. However, this condition can occur at a range of weights or BMIs from severely underweight to severely overweight.

The central criteria of bulimia nervosa, reported in the DSM-5, are:

A. Recurrent episodes of binge eating, in which the person eats significantly more food in a given period of time than another person would in the same circumstances, and has the feeling of loss of control during the episode;
B. Recurrent compensatory behaviours to prevent weight gain, such as self-induced vomiting, laxatives, diuretics or other medicines, fasting and excessive exercise;
C. Binge eating and compensatory behaviours (points A and B) occur at least once a week for three months;
D. Levels of self-esteem are influenced by body shape and weight.

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1 BMI is a biometric data expressed as the ratio of a person's weight to the square of their height.

2 Malnutrition is defined as a health condition associated with an insufficient intake of protein, calories and other nutrients (Bresnahan *et al.*, 2014).

It is also important to specify:

I. whether it is a restrictive type - weight loss is due to dieting, fasting and excessive exercise - or a binge or purge type - there have been recurrent episodes of binge or purge behaviour in the last three months, through self-induced vomiting, laxatives and diuretics;
II. whether in partial remission, when some of the above criteria have been met for a considerable period of time, or in complete remission, when none of the criteria have been met for a long period of time.

There are also criteria for determining the severity of the condition, based on the frequency of compensatory behaviours: mild (1-3 episodes per week), moderate (4-7 episodes per week), severe (8-13 episodes per week) and extreme (14 or more episodes per week) (APA, 2013).

The estimated incidence of bulimia nervosa is at least 12 new cases per 100,000 persons per year in women and about 0.8 new cases per 100,000 persons per year in men (Ministero della Salute, 2024).

1.3 Binge-eating Disorder

The clinical picture of this FED is relatively recent, so there is no real history. In fact, the first formalised diagnostic criteria date back to 1992, thanks to the work of Spitzer and his collaborators, outlining the presence of binge eating over a defined period of 2 hours, eating a greater amount of food than other people would eat, characterised by a loss of control and an inability to stop.

Binge eating is characterised by features such as: rapidity, unpleasant feeling of fullness, eating large amounts of food without a sense of hunger, eating alone due to embarrassment, disgust and depression.

The diagnosis of this eating disorder, which only became part of the DSM-IV in 2000, also had a time criterion - different from the current one - i.e. at least 2 days of binge eating per week for 6 months.

Binge Eating disorder is a clinical condition characterised by malnutrition by excess, being typified by recurrent bulimic episodes without the use of compensatory behaviours as in bulimia nervosa (Beglin *et al.*, 1992). Such behaviour favours the development of obesity in predisposed individuals, representing a risk factor for the development of insulin resistance and type 2 diabetes (Birketvedt *et al*., 1999; Falati, 2002).

According to the American Psychiatric Association guidelines, the central criteria of anorexia nervosa are:

A. Recurrent episodes of binge eating, in which the person eats significantly more food in a given period of time than another person would in the same circumstances, and has the feeling of loss of control during the episode (as in bulimia nervosa);
B. Binge eating episodes are associated with three or more of the following:
    1. Eating much faster than normal;
    2. Eating to the point of feeling uncomfortably full;
    3. Eating large amounts of food even when not feeling hungry;
    4. Eating alone because of embarrassment about how much one eats;
    5. Feeling disgusted with oneself, depressed or very guilty after the episode;
C. There is a feeling of unease about bingeing;
D. Binge eating occurs at least once a week for three months;
E. Binge eating is not associated with compensation behaviours.

It is important to specify whether in partial remission, when binge-eating episodes are less than one episode per week for a considerable period of time, or in complete remission, when none of the criteria have been met for a long period of time.

The level of severity depends on the episodes of binge-eating: mild (1-3 episodes per week), moderate (4-7 episodes per week), severe (8-13 episodes per week) and extreme (14 or more episodes per week) (APA, 2013).

1.4 Avoidant / Restrictive Food Intake Disorder

The ARFID is extremely recent. In fact, the two cases described by Drs. Kraipe and Palomaki, which sparked the debate on this diagnosis, date back to 2012.

The first concerns a 14-year-old boy who only eats food prepared in a specific way, which must not touch each other on the plate and must be eaten in a specific order (smell, texture and colour cause him disgust and anxiety and he consequently avoids the food).

The second case concerns a 10-year-old girl who, after a risk of choking, develops an aversion to all foods that are not soft.

These food restrictions lead to weight loss, but without concern for weight and body image: this is what differentiates the diagnosis of this eating disorder from anorexia nervosa.

The criteria to be fulfilled for the DSM-5 diagnostic framework are as follows:
A. A feeding and eating disorder that is manifested by a persistent inability to meet appropriate nutritional and/or energy needs, associated with one or more of the following:

1. significant weight loss (or failure to achieve expected weight gain);
2. significant nutritional deficit;
3. dependence on parental nutrition or oral nutritional supplements;
4. marked interference with psychosocial functioning;

B. The disorder is not explained by a lack of food availability or related cultural practice;
C. The disorder does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no association with the way weight and body image are experienced;
D. It is not attributable to a concomitant medical condition or an additional mental disorder.

Specify if in remission, when the previously listed criteria of the avoidant / restrictive food intake disorder are not met for a substantial period of time (APA, 2013).

1.5 Pica

Pica is an eating disorder characterised by people who eat objects that are not food and therefore have no nutritional value and are inedible (e.g. paper, clay, dirt, hair, chalk, string, wool). The name comes from a bird, called Pica pica, which is used to feed on unusual objects.

Pica does not cause serious medical damages, but the ingestion of certain elements can lead to complications such as intestinal obstruction, lead poisoning and parasitic infestation (following the ingestion of dirt).

It is common in children under the age of two (in fact, this eating disorder cannot be diagnosed at this age, as it is part of normal childhood development), in pregnant women, and in patients who already suffer from other mental disorders (Attia, Walsh, 2022).

Pica is diagnosed when:

A. A patient eats non-nutritive, non-food material persistently for more than 1 month;
B. Ingestion of these materials is inappropriate for the patient's developmental level;
C. Ingestion of these materials is not part of a cultural tradition;
D. If ingestion occurs in a patient with another disorder, it is sufficiently persistent and severe to require specific treatment.

Assessment of nutritional status for weight loss and nutritional deficiencies is an important factor in the diagnosis of this eating disorder (APA, 2013).

1.6 Rumination Disorder

The rumination disorder involves regurgitation of food following ingestion, not involving nausea or involuntary retching.

Some patients are aware that the behaviour is socially undesirable and attempt to disguise it by putting a hand over their mouth or limiting their food intake: this leads to weight loss and nutritional deficiencies (Attia, Walsh, 2022).

Rumination disorder is diagnosed when:

A. Patients repeatedly regurgitate food for more than 1 month;
B. Have been excluded gastrointestinal disorders (GI) or other EDs that can lead to regurgitation;
C. If regurgitation occurs in a patient with another disorder, it is severe enough to warrant specific treatment (APA, 2013).

1.7 Other Feeding and Eating Disorders

There are also a number of possible eating disorders that should be mentioned because they are becoming increasingly common. The number and typology of eating disorders are potentially infinite because of the infinite number of possible issues involved in this area and the personal, familial, social and cultural interpretations of the role of food, the meaning of eating, the sense of personal and physical well-being, the judgement associated with eating behaviour and body image (Spitoni, *et al.*, 2023).

1.7.1 Night Eating Syndrome

It is a syndrome that affects people who wake up at night to eat (they have an altered circadian rhythm, eating little in the morning and binge eating in the evening and at night). The consequences are obesity, loss of control and shame.

However, since nocturnal binges are also common in people who suffer from bulimia nervosa or binge-eating disorder, researchers are not extremely certain whether night eating syndrome is actually a syndrome or a symptom present within already codified eating disorders (Spitoni, Aragona, 2023).

1.7.2 Chewing and Spitting Syndrome

It concerns those people who put food in their mouth, even in large quantities, and chew it but without swallowing it. It does not happen so much out of fear of choking, but rather to try to ingest as few calories as possible without having to resort to vomiting as a compensatory behaviour (Spitoni, Aragona, 2023).

1.7.3 Bigorexia

Bigorexia, also known as Muscle Dysmorphia, involves a focused and rigid focus on muscular shape and development, characterised by a selection of nutrients, such as protein, that are consumed in excess and an almost total elimination of carbohydrates. Formerly known as 'the male equivalent of anorexia', it shares with anorexia a dysmorphic view of body shape, rigid ideas about food and the body, and a fixation on self-image and diet (Spitoni, Aragona, 2023).

1.7.4 Chronic Dieting Syndrome

This disorder involves excessive weight control, with a focus on diet that is so excessive that it interferes with normal social life. Although it can be similar to anorexia and orthorexia, it differs from the former in that the weight does not fall below the normal range, and from the latter in that there is no fixation on healthy eating, although the fear of gaining weight is present (Spitoni, Aragona, 2023).

1.7.5 Pregorexia

It occurs during pregnancy when women, who do not accept the weight gain caused by this condition, go on a diet and exercise to counteract the weight gain. This syndrome can be detrimental to the health of the woman and her unborn child (Spitoni, Aragona, 2023).

1.7.6 Emetophobia

Emetophobia is the unjustified fear of vomiting, especially in public, which leads to eating less to avoid the feeling of fullness and consequently to weight loss (Spitoni, Aragona, 2023).

1.7.7 Diabulimia

It is a condition that mainly affects people with type 1 diabetes, who decrease their insulin dose to reduce fat storage and keep their body weight under control (Spitoni, Aragona, 2023).

1.8 Obesity and Orthorexia Nervosa

Obesity and orthorexia nervosa, for reasons that will be discussed later, are not included as FEDs in the Diagnostic and Statistical Manual of Mental Disorders.

Unlike the previous classification (1.7), which included eating disorders not mentioned in the DSM-5, obesity and orthorexia require separate treatment because of their social impact.

1.8.1 Obesity

Obesity is a vast, heterogeneous and factorial syndrome, with boundaries that go beyond its diagnostic criteria. From a medical point of view, obesity became a problem in the 17th century, before which it was regarded positively as a sign of wealth and health. With the Renaissance, however, fat became synonymous with laziness, heaviness and uselessness (Arnoult, Vigarello, 2013). Known in France as "polysarcia", obesity was named in the 19th century from the Latin *obesitas*, meaning fatness.

In modern medicine, obesity became clinically relevant with its inclusion in the sixth edition of the International Classification of Diseases (ICD-6) in 1948 (WHO, 1948).

The body mass index (BMI) is used to diagnose the disease. The World Health Organisation distinguishes three degrees of obesity: obesity grade I (BMI = 30-34.9 kg/m^2), II (BMI = 35-39.9 kg/m^2) and III (BMI 40 kg/m^2).

ICD-11 (WHO, 2018) lists it as a nutritional disorder, a condition caused by excess body fat associated with unbalanced energy intake, medications and genetic disorders.

It is important to emphasise that these classifications are medical, as obesity is not considered a mental health problem. For this reason, the DSM-5 does not include obesity among the feeding and eating disorders, but only refers to it in the introductory paragraph as a pathology of excess body fat due to an imbalance between the calories consumed and the individual's needs, associated with problems of an organic nature, but which may develop into psychopathological syndromes (Spitoni, Aragona, 2023).

However, a large body of research suggests that some forms of non-binge eating obesity may be associated with psychological problems such as low self-esteem, body image disturbances, emotional eating, anxiety, depression and traits of psychoticism (Schwartz, Brownell, 2004; Scott *et al*, 2008; Villarejo *et al*, 2014).

1.8.2 Orthorexia Nervosa

The name was coined by nutritionist Steven Bratman in 1997 to describe a dietary obsession with healthy and natural foods.

The clinical picture includes an excessive preoccupation with the quality of the food eaten, to the extent that it becomes more important than interpersonal relationships and career (Bağci Bosi, Camur, Güler, 2007).

This disorder leads to an inflexible and ritualised approach to food; only products that are considered healthy are chosen, and all foods that are considered 'unhealthy', such as those containing artificial colours, preservatives, high levels of

salt and sugar, or genetically modified ingredients, are excluded. Transgression is often followed by guilt, disgust and increased restriction.

Despite the fact that it is not recognised and included in the DSM-5, researchers debate the possible place of orthorexia nervosa. There are those who argue that it is an eating disorder, in which a person is forced to follow a restrictive diet of only healthy foods; those who argue that it is an obsessive-compulsive disorder, in which a person is obsessed with healthy eating; and others who argue that it is a phobia or an avoidant / restrictive food intake disorder.

1.9 Epidemiology of Feeding and Eating Disorders

Figure 1.1 shows the 40% increase in eating disorders that occurred in Italy from the first half of 2019 to the first half of 2020, while figure 1.2 shows how the number of cases of eating disorders increased significantly from 2019 to 2023. In fact, more than 3 million people in Italy currently suffer from a feeding and eating disorder and 3780 people died from them in 2023 (Ministero della Salute, 2024).

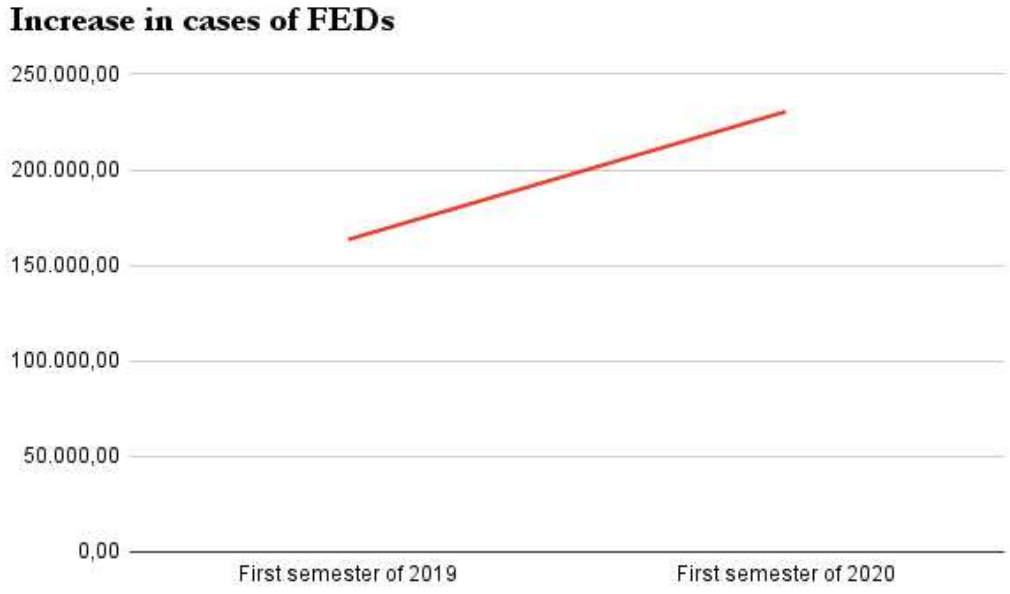

Figure 1.1: Increase in disease in Italy from the first half of 2019 to the first half of 2020 (image adapted from Ministero della Salute, 2024)

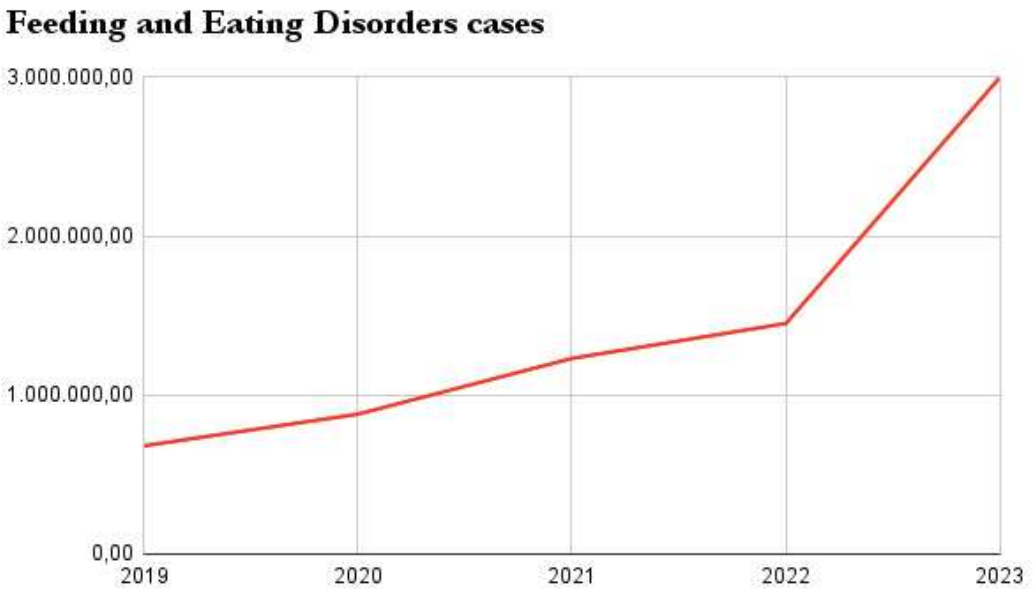

Figure 1.2: Number of cases of FEDs in Italy from 2019 to 2023
(image adapted from Ministero della Salute, 2024)

It is extremely important to emphasise that the figures collected never correspond to the truth; despite the fact that the research is carried out by the Ministry of Health or the American Psychological Association, there is always a so-called 'hidden' rate when it comes to eating disorders, as there are always a large number of patients who suffer from these illnesses but do not have access to treatment.

2. Communication

2.1 Definition of Communication

The word "communication" comes from the ancient Sanskrit root *com*, meaning "to put in common"; it evolved into the Latin *communis*, composed of the union of *cum* (together) and *munis* (obligation, debt, gift). The concept of reciprocity and the collective bond that this word evokes, referring to a noun with which it shares the same root, the word "community", can be inferred. Therefore, communicating also means sharing and it is through communication that we perform one of the rituals through which we reproduce the glue of society (Paccagnella, 2004).

Communication, which consists of the exchange of meanings between individuals through a common system of symbols, was defined in 1928 by literary critic Ivor Armstrong Richards as "what takes place when one mind so acts upon its environment that another mind is influenced, and in that other mind an experience occurs which is like the experience in the first mind, and is caused in part by that experience".

Communication is the transmission of information from a sender to a receiver through a channel, using a code, i.e. a common language, which needs not necessarily be verbal.[1] Even the simplest communication process contains the elements mentioned above: information, sender, receiver, channel and code.

However, communication is not just about transmitting information, because for communication to work it has to be effective, and that happens when the information has meaning and is correctly understood by the recipient (Crepet, 2015).

2.2 The Lasswell model

Harold Dwight Lasswell (1902-1978), an American sociologist, was among the first to elaborate a scheme of the communicative act.

The theoretical model he developed in 1948 attempts to answer the question "Who says what to whom with what effect?"; indeed, there are five fundamental questions at the heart of every act of communication:

– Who?
– What do you say?
– Through which channel?
– To whom?
– With what effect?

[1] Non-verbal communication is defined as any interactive behaviour that does not involve the use of natural language.

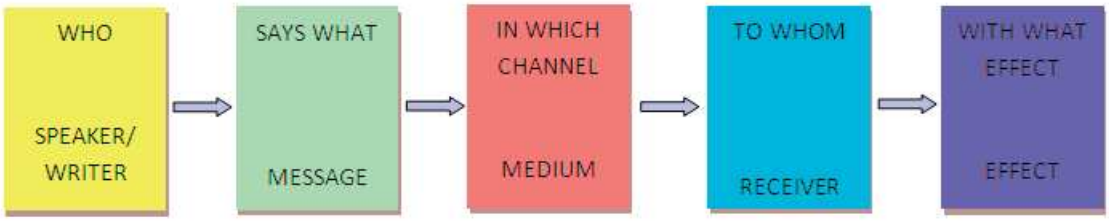

Figure 2.1: The Lasswell Model (image adapted from Crepet, 2015)

The first question (Who?) concerns the communicator, the one who conveys the message; whether it is a person, a group or an institution, it is the conscious promoter of the message to whom intentionality is attributed.

The second question (What do you say?) has to do with the message, the content of what is being communicated; the object of the communication exchange can be an information, an idea, but also an emotion.

The channel is the instrument we use to transmit the message (for example, it can be a telephone channel or simply your own voice).

The fourth question (To whom?) refers to the recipient receiving the message.

The last point (With what effect?) questions the purpose of the communication and the results obtained (Crepet, 2015).

Although Lasswell's model has been a mainstay of communication theory, it has nevertheless been judged by researchers to be mechanical and abstract. Among the reasons:

1. The model represents a communicative asymmetry: the one-way arrow involves an active sender - who sends a message - and a passive receiver - who cannot react;
2. The principle that all communication has an involuntary and unpredictable component is excluded, as the communicator has full control over the act of communication;
3. The message has an immediate effect on the recipient, excluding secondary and indirect effects of the communication;
4. The sender and receiver do not interact with each other because they are at two isolated poles and are therefore not uprooted from their social, economic and cultural context (Crepet, 2015).

2.3 Shannon and Weaver's information theory

In the same years that Lasswell presented his model, mathematicians Claude Elwood Shannon (1916-2001) and Warren Weaver (1894-1978) developed the mathematical theory of communication, according to which communication is a process of transmitting and processing information.

It should be emphasised that, given Shannon and Weaver's scientific background, the two mathematicians were interested in the purely technical act of communication: they were not concerned with the content of the message, but rather with the transmission and reception of the signal.

The founding principle of the theory is that information is treated like any other physical quantity, be it mass or energy. The outcome of communication, therefore, does not depend on the content, but rather on the accuracy of the transmission and the quality of the reception.

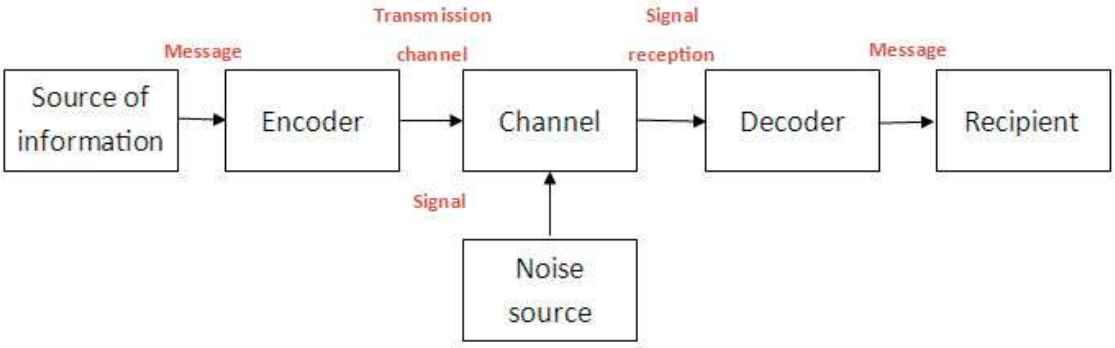

Figure 2.2: The Shannon and Weaver model (image adapted from Crepet, 2015)

As can be seen in the figure 2.2, in contrast to Lasswell's model, two crucial steps are described: encoding and decoding.

Encoding is the activity that the sender carries out in order to transform the ideas in his mind into sounds, gestures and signs that can be understood: he/she translates his message into a specific code.

The reverse process is decoding, which is carried out by the receiver, who must translate the message into ideas and mental concepts in order to decode it correctly. Thus, in order to be understood, the message must be translated into a system of signs with shared meanings (code).

Consequently, according to the mathematical model of Shannon and Weaver, communication takes place to the extent that the process of encryption and decryption of the message by the sender and receiver is performed correctly.

However, this theory has an important limitation in that it does not take into account the relational and social context in which all meaning processing in communication takes place (the interpersonal dimension) (Crepet, 2015).

2.4 The Gerbner model

The American scholar George Gerbner (1919-2005) took up Shannon and Weaver's model, but introduced a cognitive science orientation to communication studies.

Gerbner argues that the communicative process begins with a subject (defined as 'M') perceiving an external event (defined as 'E'). The perception of the event is called 'El', so that the external event ('E') can never be perceived in its entirety, since the perception will always be the result of a precise selection.

The subject ('M') can be a machine or a human being. In the first case, the selection process depends on technical and physical characteristics; in the second case, however, exposure - the process by which the subject comes into contact with the event - and attention - the process by which the subject devotes some of its cognitive resources to the event - come into play. In addition, people filter the event through their own inner heritage of ideas and their own cultural experience: therefore, each individual's experience and cultural context influence the meaning of the event (Crepet, 2015).

After the process of selection and attribution of meaning, the actual communication begins where the perception is transformed into a message with a form and content. Again, selection is very important to understand which form is best suited to communicate the content.

Gerbner was mainly referring to the mass media, talking about channel access and media control (a journalist, for example, not only turns an event 'E' into a news 'El', but also makes a second selection, choosing the form in which it is presented, according to his or her own world view).

Thus, the scholar firmly believed that the media becomes a key element in the control of power, as those who control the channels of communication are able to impose their version of the facts because they have the power to select the message before it is disseminated.

Thanks to Gerbner, we move away from a mechanical conception of the communication process - thanks also to the concepts of negotiation and meaning - since once the message is received, the receiver will negotiate its meaning (Crepet, 2015).

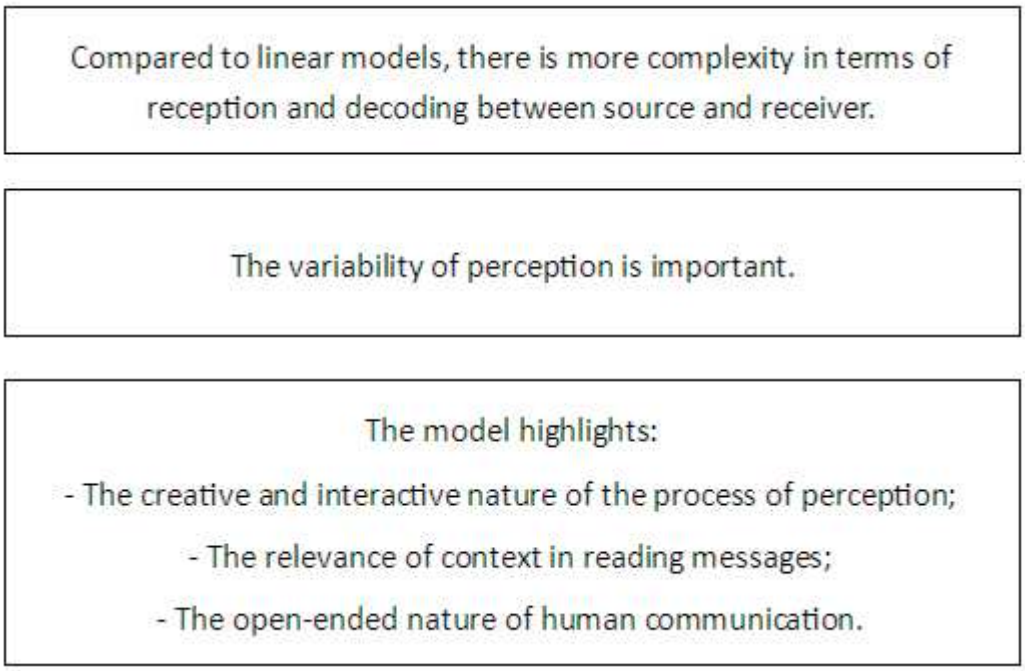

Figure 2.3: The Gerbner model (image adapted from Crepet, 2015)

2.5 Jakobson and the functions of communication

The Russian linguist and semiologist Roman Jakobson (1896-1982) reworked information theory as a function of human communication, and linguistic communication in particular, identifying six fundamental elements.

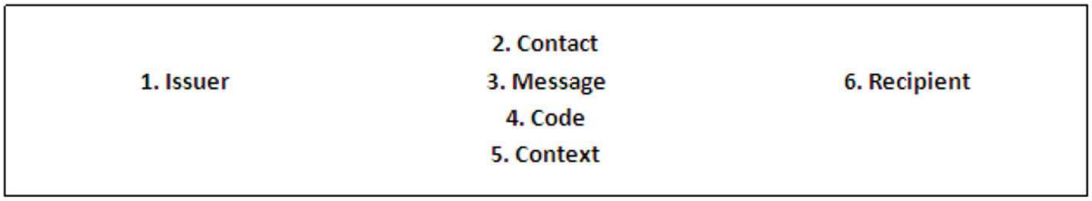

Figure 2.4: Elements of Communication (image adapted from Crepet, 2015)

The sender, understood as a person or a group of persons, produces a message that he/she sends to the receiver, realised according to a code that must be at least partially shared between the two parties.

In order for the message to reach its destination, a contact must be established between the sender and the recipient, i.e. a physical apparatus (letter, telephone) and a psychological connection. Also important is the context in which the communication takes place, i.e. the conditions that form the shared reality between sender and receiver.

Jakobson corresponds as many functions of communication to the six elements identified (Crepet, 2015).

Figure 2.5: Functions of communication (image adapted from Crepet, 2015)

1. The emotional function concerns the possibility of the sender to express himself/herself, his/her values, his/her feelings and his/her personality;
2. The phatic function aims to establish and maintain contact between the two interlocutors (through forms such as: «Do you understand?»);
3. The poetic function occurs when the message attracts the recipient's attention because of its form;
4. The metalinguistic function refers to the language in which the message is expressed, i.e. the code used between the interlocutors;
5. The referential function is the ability to refer to objects and their relationship to reality;
6. The conative function (from the Latin *conatus* = impulse, thrust) concerns the effect of the message on the receiver.

Jakobson's model highlights a very important factor within communication, the context, which significantly influences both the transmission and interpretation of the message. Thus, the context influences the production and meaning of the message, and the receiver is forced to engage in interpretive processes (Crepet, 2015).

2.6 New forms of communication

In recent decades, we have witnessed a change in communication processes due to the emergence of new technologies; new media[2] constitute a new communicative space, called cyberspace, characterised by distributive communication (replacing one-to-one communication).

The characteristics of computer-mediated communication[3] make it a hybrid tool that is neither entirely interpersonal nor mass media; it represents an overcoming of

[2] New media refers to the forms of communication in the digital world, which takes place mainly online via the Internet: it is any media – from newspapers to blogs, from music to podcasts – that is delivered digitally (Siapera, 2017).

[3] Computer-mediated communication (CMC), according to linguist Susan Herring, *is communication that takes place between human beings via the instrumentality of computers* (Herring, 1996).

the rigid opposition between individual-to-individual and mass communication. Such communication has limitations that face-to-face communication does not, such as the lack of metacommunication[4].

The technology of modern mass communication is the result of a combination of many kinds of inventions and discoveries, some of which actually predate the Industrial Revolution, such as the printing press. It was mainly in the 19th and 20th centuries that new means of mass communication were developed, in particular broadcasting, without which today's near-global distribution of printed words, images and sounds would not have been possible.

However, technology was not the only prerequisite for the development of mass communication in the West; a large audience of literate citizens was needed before publishing and newspapers could use existing communication technology to satisfy widespread desires or needs for popular reading material (Encyclopaedia Britannica, 2024).

Wealth and interest have been, and still are, prerequisites for the maintenance of radio, television and recording industries, institutions that are in fact more developed in rich and industrialised nations. Even in countries where public communication is largely used for government propaganda, certain minimum economic and educational standards must be achieved before this belief is accepted by the general public.

The debate on the effects that mass communication has on people is constantly evolving: there are sociologists who believe that mass communication only influences people's attitudes when it influences values already accepted by the culture; other scholars, close to psychology and psychiatry, believe instead that it represents a form of persuasion and informal education (Encyclopaedia Britannica, 2024).

What is certain is that most people today form their view of social reality through the messages presented by public communication, which therefore has a strong civil and social responsibility to inform people in the right way.

2.7 Social Media Communication

2.7.1 Definition of Social Media

The term social media (SM), first used in 1994 in Tokyo, is defined as *a group of Internet-based applications that builds on the ideological and technological*

[4] Metacommunication refers to the non-verbal level of communication used to reinforce or negate the content of verbal communication (e.g. winks, gestures and generally any other element that interacts with verbal communication) (Enciclopedia Treccani).

foundations of Web 2.0, and that allows the creation and exchange of user-generated content (Kaplan, Haenlein, 2010).

Social media, as hybrid media platforms for interpersonal and group communication, are characterised by digitalization, interactivity and real-time access to information that can be easily created, distributed and shared by users (Zhong, 2022).

More specifically:

> Social media are a networked communication platform, in which participants 1) have uniquely identifiable profiles that consist of user-supplied content, content provided by other users, and/or system-level data; 2) can publicly articulate connections that can be viewed and traversed by others; and 3) can consume, produce, and/or interact with streams of users generated content provided by their connections on the site (Ellison, Boyd, 2013).

2.7.2 Social Media and Computer-Mediated Communication

Social change is defined by sociologists as any *significant alteration over time in behaviour patterns and culture, including norms and values* and it is *the unintended effect of technology process* (Schaefer, 2008).

Social change often has profound social consequences, disrupting human development at a societal level. Thus, social media have emerged as a new form of computer-mediated communication.

Social media communication is mediated by the way we perceive and use computer-mediated communication, such as mobile phones, mobile technology, artificial intelligence and robotics (Zhong, 2022).

Social Information Processing Theory (SIP) suggests that people can overcome the limitations of communication channels to achieve their communication goals: communicators try to achieve communication goals in online settings as well as in offline settings. When the lack of available signals in an online environment creates barriers to achieving their goals, users adapt their behaviour to the signals that are available.

Studies conducted by academics Lisa Collins Tidwell and Joseph B. Walther show that people communicating with a stranger through computer-mediated communication were more likely to ask direct questions designed to elicit more information than would have been the case in face-to-face communication (Zhong, 2022).

Before the advent of social media, information and communication technology had led to the emergence of applications such as audio and video chat, email and instant messaging; applications that could give users the ‘communication hope’ to

overcome the narrowness of civil society and realise a distant, national community (Zhong, 2022). Progress in information and communication technology was expected to lead to stronger personal networks and community activities: for this reason we speak of 'communication hope'. New types of communication, therefore, mean new hope for social change.

Research conducted on social media as new forms of computer-mediated communication has shown that they are not neutral, as they have caused numerous changes in the way individuals communicate with each other, altering their communication patterns and social networks. Indeed, human interaction is changing day by day, allowing people to live a large part of their lives on social media. Users claim to use the new media platforms mainly to maintain and strengthen existing relationships and, in general, to communicate, a communication that includes all processes such as thinking, perceiving, evaluating, feeling and interpreting (Zhong, 2022).

The popularity of social media is also due to its asynchronous nature, which is able to meet the communication needs of users.

Social media, like other forms of mass media, are used not only for bi-directional and interpersonal communication - as mentioned above - but also for multidirectional communication, applied to mobilize community members and organize collective actions and to create a more collaborative culture among users (Zhong, 2022).

2.8 Institutional Communication

2.8.1 Definition of Institutional Communication

Professor José Maria La Porte defined institutional communication as

> the type of communication carried out in an organised manner by an institution or its representatives and directed at the people and groups in the social environment in which it operates. It aims to establish quality relations between the institution and the public with which it is in contact, in order to achieve social prestige and a public image that is commensurate with the institution's objectives and activities (La Porte, 2024).

2.8.2 History of Institutional Communication

Institutional communication has existed as long as there have been institutions, i.e. as long as people have organised themselves to achieve a common goal. Clearly, as time passed and societies developed, communication changed and institutions were created to respond to different functions (cultural, political, defence, commercial).

The institutional dissemination of ideas was given a powerful boost with the invention of the printing press, thanks to which religious and political struggles saw a diffusion of their cardinal principles.

Then, with the rise of the bourgeoisie and the development of commerce, the first newspapers appeared. Initially linked to commercial information and politics, the press gradually developed to spread ideas on the most important events of the 18th and 19th centuries.

Between the 19th and 20th centuries, economic-industrial development led to the discovery of new media with extraordinary broadcasting potential, such as radio, television and, later, the Internet, giving rise to the information society, in which the media are at the centre of political, religious, commercial and ideological debate (La Porte, 2024).

2.8.3 Information activity of institutional communication

Law No. 150 of 7 June 2000 represents an important milestone for public administration[5] communication in Italy, as it regulates the information and communication activities of public administrations (Cistaro, 2023).

This law regulates the public administration's information activities with the mass media, including the press, audiovisual and telematic tools, with the aim of disseminating the public administration's image in a homogeneous and coherent manner.

Information activities focus on promoting and disseminating the organisation's activities, services, policies, regulations and culture. The public body is therefore committed to communicating effectively and transparently - in accordance with Law 150/2000 - its activities, *modus operandi*, available services, the rules that govern its actions and the values that inspire it (Cistaro, 2023).

This type of communication aims at informing citizens about the activities of the institution, helping to promote understanding and awareness of its policies and objectives, and thus encouraging greater participation and involvement of the community.

[5] Public administration is the set of bodies and activities directly dedicated to the concrete pursuit of tasks or purposes considered to be of public interest in a state community (Cistaro, 2023).

3. Health Communication

3.1 Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion is an international agreement signed in November 1986 at the First International Conference on Health Promotion organised by the World Health Organization (WHO).

Within the document, health promotion is defined as *the process of enabling people to increase control over, and to improve, their health*, where health is seen as *a resource for everyday life, not the objective of living* (WHO, 2024).

The Ottawa Charter defines the modalities of health promotion, which are:

1. Supporting the causes of health: political, economic, social, cultural, environmental, behavioural and biological factors can promote or undermine health;
2. Equal opportunities and resources: information is the key concept that can create an enabling environment for equal opportunities and resources;
3. Involving all sectors of society: while the health sector is important in health communication, coordinated action by all stakeholders, from citizens to industry, from media to governments, is also essential;
4. Adapt to needs and opportunities: health promotion programmes should be adapted to the needs and possibilities of individual countries and regions;
5. Building public policy for health: those who make policy decisions must consider health as a primary need;
6. Creating enabling environments: a social-ecological approach to health is needed;
7. Empowering community action: local communities have a very important role to play in strategies to improve health, not a centralised approach;
8. Empowering individuals: health education is needed to make health-promoting choices, with institutions playing a key role;
9. Refocusing health services: health services need to adopt a broader remit that supports the needs of individuals (ISS, 2012).

3.2 Definition of Health Communication

According to the World Health Organization, Communication for Health (C4H)

> works to leverage the full power of communication to improve health outcomes at the individual, community and societal levels. It brings together a set of principles and practices to help ensure communication interventions are strategic and evidence informed (WHO, 2024).

Communication for health consists of disseminating information within the community on socially relevant health issues and activating communication flows between citizens, public institutions and the media system: the aim is to inform.

Communication, like any health education and promotion intervention, must take into account social inequalities, particularly in access to services and to information itself, in order to identify and reach the most vulnerable populations.

3.3 Health communication characteristics and objectives

According to the US Office of Disease Prevention and Health Promotion, effective health communication must have the following characteristics:

- Accuracy: the content must be valid and accurate;
- Accessibility: the ways and contexts in which the message is disseminated must be accessible to citizens;
- Balanced: both the risks and benefits of a particular behaviour must be highlighted;
- Evidence-based: the content must be based on current scientific evidence;
- Culturally relevant: the cultural, social and ethnic specificities of the recipient must be taken into account;
- Outreach: the accessibility of the information must be as wide as possible;
- Reliability: the credibility of the source is very important, as is the content, which must be constantly updated;
- Repetition: in order to increase the impact of the message and to try to reach a wider audience, the message must be repeated several times;
- Timeliness: the message must be disseminated when the recipient needs the information most;
- Understandability: the language and medium of the message must be appropriate to the recipient's ability to understand (ISS, 2012).

The aims of health communication are:

- To increase knowledge and awareness of a health issue, highlighting problems and solutions;
- Influence beliefs and attitudes that can change social norms;
- Encourage action and reinforce knowledge;
- Illustrate healthy behaviours;
- Dispel myths and stereotypes;
- Increase demand for health services;
- Strengthen relationships between organisations.

Furthermore, combining communication with other strategies can be a highly successful element to create lasting change in the adoption and maintenance of healthy behaviours and to help overcome systemic barriers or problems, such as inadequate access to health services (ISS, 2012).

3.4 Linguistic Style

The linguistic style of the message conveyed is very important as it has the task of capturing the attention of the recipient. Depending on the communicative objective, there are different styles that best reflect the needs of the communication; these include:

- Paternalistic: a language that was mostly used in the past, appealing to the conscience and guilt of the recipients;
- Informative: the target of this language is the rationality of the addressee;
- Reassuring: this language is aimed at spreading confidence in the solution of a health problem;
- Fear arousing appeal: the aim of this message is to arouse fear in order to induce the recipient to change their harmful behaviour. Visual and verbal representations are often used to reinforce this;
- Irony: humour is used to engage the recipient emotionally;
- Transversal strategies: include the use of testimonials to reinforce the message (ISS, 2012).

3.5 The importance of communication in health: SARS-CoV-2 coronavirus infection

During the COVID-19 pandemic, health communication played a primary role. In a historical period marked by a global pandemic, there were many aspects that aroused public concern and led the public to seek help through the most accessible means available to them, i.e. the internet or the media, including the press and broadcast options. The way news was reported changes people's behaviour and attitudes, as highlighted in a study published in 2016 by Yan Q. et al. on the 2009 H1N1 influenza outbreak, where media reports on the spread of the disease increased people's fear and awareness. While people took necessary protective measures, some people started to stigmatise those who were sick (Yan Q., 2016).

With the advent of the lockdown, the use of social media increased by 87%. While social media has helped to spread the importance of 'social distancing' and 'staying indoors' through frequent and widespread announcements, it has also given rise to much misinformation about the virus (Anwar *et al.*, 2020).

All in all, it can be said that the media played a very important role around the world in monitoring the coronavirus outbreak and keeping citizens informed in real time. During that period, the media reinforced daily disease prevention guidelines, encouraging people to use telehealth as an aid for their health needs. The study conducted by Anwar et al. highlighted the potential of the media to unite people and end discrimination by raising awareness, as racial and socio-economic discrimination was evident during the quarantine and inaccessibility to equal health care exacerbated the situation (Anwar *et al.,* 2020).

The role of the media in health communication has been, and continues to be, to enable equal access to health care and to end discrimination and social stigma.

However, in addition to social media, figures such as political leaders and public health experts played an important role throughout the pandemic and had a strong responsibility to provide accurate information to the public; health communication has been instrumental in saving many lives by addressing fear and uncertainty in society (Finset *et al.*, 2020).

4. Ministry of Health of the Italian Republic and Feeding and Eating Disorders

4.1 Ministry of Health

The Ministry of Health was established on 13 March 1958 to implement article 32 of the Italian Constitution, which states that

> The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person (Ministero della Salute, 2018).

The Italian Ministry of Health is structured according to the 'one health' model, which takes a unified approach to health, extending its responsibilities to animal health and food safety.

The functions of the Ministry of Health are:

- Protection of human health;
- Coordination of the National Health System (NHS);
- Veterinary health;
- Occupational health protection;
- Food hygiene and safety.

The activities of the Ministry of Health in the area of health protection and promotion can be described as follows:

- Ensuring fairness, quality and efficiency of the system for all citizens, including through appropriate and adequate communication;
- Highlighting inequalities and inequities, promoting corrective actions;
- Working with the Italian regions to assess, correct and improve their health reality;
- To innovate and address emergencies that threaten public health (Ministero della Salute, 2018).

4.1.1 Health in all policies

According to the constitution of the World Health Organization, health is *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (WHO, 2020). This definition triggered a major cultural revolution, since it refers not only to the absence of disease and infirmity, but also to a state of psychophysical and socio-relational well-being.

This vision has given rise to the concept of 'health in all policies', whereby governments, institutions and communities gear their socio-economic, technological, environmental and labour policies to the health of their citizens.

4.2 Feeding and Eating disorders on the Ministry of Health website

As defined by the Ministry of Health itself, one of its objectives is adequate and effective communication so that citizens are informed.

The Ministry of Health dedicates a page on its website, more precisely within the section on mental disorders, to communication on feeding and eating disorders (Ministero della Salute, 2024). The page is divided into nine sections with the aim of presenting different arguments in relation to FEDs.

1. What are Feeding and Eating Disorders (FEDs): there is a brief explanation of what feeding and eating disorders are, with reference to the low self-esteem associated with them and the need for early intervention. Reference is also made to the proclamation of the National Lilac Ribbon Day - dedicated to feeding and eating disorders - and a link is provided to the National Guidelines for Nutritional Rehabilitation in Eating Disorders.
2. Map of FEDs Care Services and Associations: it talks about the feeding and eating disorder treatment facilities and the team that works there, mainly psychologists, psychiatrists, nutritionists and nurses.
3. Guidelines on Feeding and Eating Disorders: documents are presented and proposed to support the Ministerial Guidelines approved at the Conference of States and Regions, with the aim of *providing a practical tool for health professionals involved in the treatment of eating disorders to correctly identify people in need of nutritional support and to implement integrated and appropriate treatments* (Ministero della Salute, 2024). There is a document for the triage, assessment and care of frail individuals presenting to the emergency department in an urgent condition and a document containing recommendations for family members.
4. Early Recognition of FEDs: the importance of prompt treatment is emphasised and the definition of feeding and eating disorders is reiterated.
5. National fund to combat FEDs: the Fund for the Fight against Eating Disorders, provided for in the Budget Law No. 234 of 30 December 2021, is presented. The objective of the economic resources allocated is to *finance regional and provincial intervention plans aimed at improving the care of people with FEDs, both in terms of clinical effectiveness and organisational adaptation, guaranteeing what is recommended by guidelines and the scientific community* (Ministero della Salute, 2024). This fund, with an initial allocation of 25 million

euros for 2022 and 2023, was increased by 10 million euros for 2024 by Law No. 18 of 23 February 2024.

In recent times, however, the most widespread information about feeding and eating disorders has been about the contrast fund. At the beginning of 2024, the Minister of Health had declared that the Italian state would not renew the funds for the fight against FEDs, thus risking the closure of treatment centres. Following protests from associations, patients' families and health professionals, the fund was renewed with a budget of 10 million euros.

6. Epidemiological survey: few data are presented on the number of people suffering from feeding and eating disorders and the lowering of the age of onset.
7. Nutritional interventions in FEDs treatment: it explains the different modalities of nutritional rehabilitation, which aim to help patients gradually regain proper nutrition by reducing restriction, binge eating and elimination behaviours. The core concept is that *a lenient approach is likely to be more accettable to patients than a punitive one and less likely to impair self-esteem* (Ministero della Salute, 2024).
8. Classification of Feeding and Eating Disorders: reference is made to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) written by the American Psychiatric Association (APA) and its diagnostic categories, but in practice only anorexia nervosa and bulimia nervosa are explained, with no space given to the other diagnosed feeding and eating disorders or those not included in the DSM-5.
9. National Health Service (NHS) assistance for Feeding and Eating Disorders: a study of emergency department admissions, hospital discharges and patient care by area is presented for the three-year period 2019-2021.

There are also four campaigns with accompanying brochures carried out by the Ministry of Health: *Eating Disorders, Bulimia Nervosa* (2019), *Eating Disorders, Anorexia Nervosa* (2019), *Mental Health. Facts and figures against stigma* (2019) and *Knowing, managing and overcoming feeding and eating disorders* (2021).

A 2021 digital campaign is also presented, created through the creation of four short videos in which the subjects tell their stories and convey the message of asking for help and turning to the doctor.

The Ministry of Health's website and outdated advertising campaigns try to provide information about feeding and eating disorders.
But is this information enough?

More than 3 million people in Italy are affected by FEDs and 3780 people died from them in 2023 (Ministero della Salute, 2024). This is a very high number and it is constantly increasing.

It is a disease that can manifest itself in different ways, but which can be fatal if not treated in time; a disease that affects not only the sufferer directly, but also their whole family and those close to them.

In spite of this, it seems that the communication of feeding and eating disorders only takes place on the occasion of the day dedicated to the fight against FEDs and on those occasions when the actions of the State trigger the judgement of public opinion, as was the case with the non-renewal of the fund for the fight against feeding and eating disorders.

The aim should be to inform the public about such an important issue, to enable everyone to learn about the disease and to act accordingly, and at the same time to reduce the stigma attached to it, a stigma that is perpetuated over time due to lack of knowledge, leading to ever-increasing damage for the patient.

So I wondered about the role of communication in relation to feeding and eating disorders and whether or not it leads to good information.

Such a high number of people in Italy and worldwide suffering from a disease that is becoming more and more widespread made me wonder about the work that should be done to promote adequate knowledge. For this reason, I thought that the best way to answer these questions was to turn to the people, firstly to find out their level of knowledge, and secondly to find out what practices should be put in place to promote correct information about FEDs. Of course, there is no lack of focus on those who have suffered directly or indirectly from feeding and eating disorders, cases in which it is important to know whether correct communication and adequate information have or should have helped the condition, from prevention to development.

I have therefore developed a questionnaire with the aim of exploring multiple dimensions pertaining to communication in the area of feeding and eating disorders. The final objective of the questionnaire I have carried out is therefore to determine the level of adequacy of communication and information in Italy and, above all, to highlight the critical points and propose ways of acting so that eating disorders are given the dignity and recognition they deserve, starting from primary education.

5. Materials and Methods

5.1 Investigation of how communication influences Feeding and Eating Disorders (FEDs)

To investigate the relationship between feeding and eating disorders and communication, I designed a questionnaire to find out what people in Italy and elsewhere know about feeding and eating disorders, to explore their opinions on an issue that has such an impact on public health, and to find out their criticisms and strengths.

The questionnaire, administered in Italian and English, was launched online in December 2023 and received almost 500 responses.

The purpose of the survey was to obtain a sample that was as broad as possible in several respects (gender, age, level of knowledge of the subject, direct experience of the disease), in order to obtain a sample with good representation of the population.

The questionnaire was structured with several cornerstones based on the responses of the persons involved. The first and most important distinction was the presence or absence of knowledge about feeding and eating disorders. Those "who do not know" were not asked all the questions that presuppose knowledge of the disorders and its effects, but were asked to answer two questions aimed at understanding the reasons for their lack of information. The second difference applied to those who have suffered from eating disorders in the past, currently suffer from them or have been close to people who have suffered from them, in order to be able to analyse the substantial differences in the responses of those who have and those who have not suffered from feeding and eating disorders.

5.2 The questionnaire questions

A total of 21 questions were included in the questionnaire, all or some of which were presented to the participants depending on the course followed.

The questions presented were intended to be exploratory about different aspects:

1. The population interviewed;
2. Knowledge of the topic;
3. The presence or absence of direct or indirect involvement with feeding and eating disorders;
4. The respondents' perception of the impact of communication on feeding and eating disorders;
5. The presence or absence of proposed interventions to improve communication.

5.2.1 The population interviewed

In order to study the characteristics of the population interviewed, they were asked about their age, sex, place of residence and level of education. The aim was to obtain information about the respondents that would allow us to understand their position in society and also their geographical location, in order to assess whether they are representative of the Italian territory, and not only, or not.

5.2.2 Knowledge of the topic

One of the cornerstones of the questionnaire was to explore people's level of knowledge about feeding and eating disorders, to understand how they know the problem and, if they were unaware, what caused this lack of information.

Based on the answer to question "Are you aware of what Feeding and Eating Disorders (FEDs) are?", those who answered 'no' - indicating that they "did not know" about feeding and eating disorders - were asked what the reasons were for this lack of knowledge, and were asked to assign a level of agreement (a lot, quite a lot, not very, not at all) to the causes "personal disinterest" and "lack of communication".

Those who were aware of feeding and eating disorders were asked how they became aware of them.

5.2.3 Presence or absence of experience of FEDs

This section contained a series of questions designed to explore the presence or absence of a link between the participants and feeding and eating disorders. Respondents were asked if they have ever suffered from an eating disorder in the past. If the answer was yes, they were asked if feeding and eating disorder communication has played a role in the healing process and how it came about, with the aim of understanding whether the communication of FEDs has been efficient enough to help them in the recovery process, through a good process of information about the disease and access to appropriate treatment.

Next, people were asked whether they currently suffer from a feeding and eating disorder. If the answer was no, they were asked if they have ever been close to a person who has suffered from a FED. The aim was to understand if they have been exposed to the disease, even if not directly, but indirectly through being close to someone who has it (and this is not to be underestimated, as it is just as complicated if you are not informed and do not know how to act).

5.2.4 Respondents' perceptions of the impact of communication on FEDs

This section contained all the questions that aimed to investigate the impact of feeding and eating disorder information on participants, through inquiries that examine the effectiveness and perception on people.

These were the questions presented:

- "Do you think that information related to FEDs is efficient?";
- "Do you think that communicating about feeding and eating disorders through information channels such as television, newspapers or social media can help to raise awareness and help those suffering from FEDs?";
- "Why?";
- "Do you think that talking about FEDs within social media (Instagram, TikTok, Facebook) allows a rapprochement with the topic and leads to positive outcomes, or can it create the opposite effect?";
- "Do you think that social media can contribute to an idea of idealised bodies and an unhealthy diet and nutrition, creating models that people try to achieve?";
- "Are you aware of the plans of the Ministry of Health? For example: the information campaign carried out on social media in 2021 to raise awareness of the issue, or the national DNA fund allocated for 2022-2023";
- "Do you think that if you had known about FEDs and the Ministry of Health guidelines, you would have taken a different route or been more helpful in supporting an eating disorder sufferer?".

5.2.5 Proposed improvements in communication related to FEDs

Finally, the participants were asked if they thought that something should be improved in the field of communication about feeding and eating disorders and, if so, what. The aim was to do a survey of the possible solutions to the lack of information and communication by analysing the problems and solutions identified and proposed by the participants.

6. Results and discussion

6.1 Information on the population surveyed

The surveyed population shows that they belong to various age groups: between 14 and 25 years for 47.4%, between 26 and 39 years for 25.3% and over 40 years for 27.3% (Figure 6.1).

As predicted, no one under the age of 14 replied to the questionnaire (0%), probably due to a mismatch between age and the possibility of receiving the questionnaire; however, I wanted to include this age group because the age of onset of feeding and eating disorders is getting lower and lower over time, so much so that it affects children as young as 8 years old (Save the Children, 2024). Furthermore, an epidemiological survey carried out by the Ministry of Health showed that 30% of the sick population is under the age of 14 (Ministero della Salute, 2024).

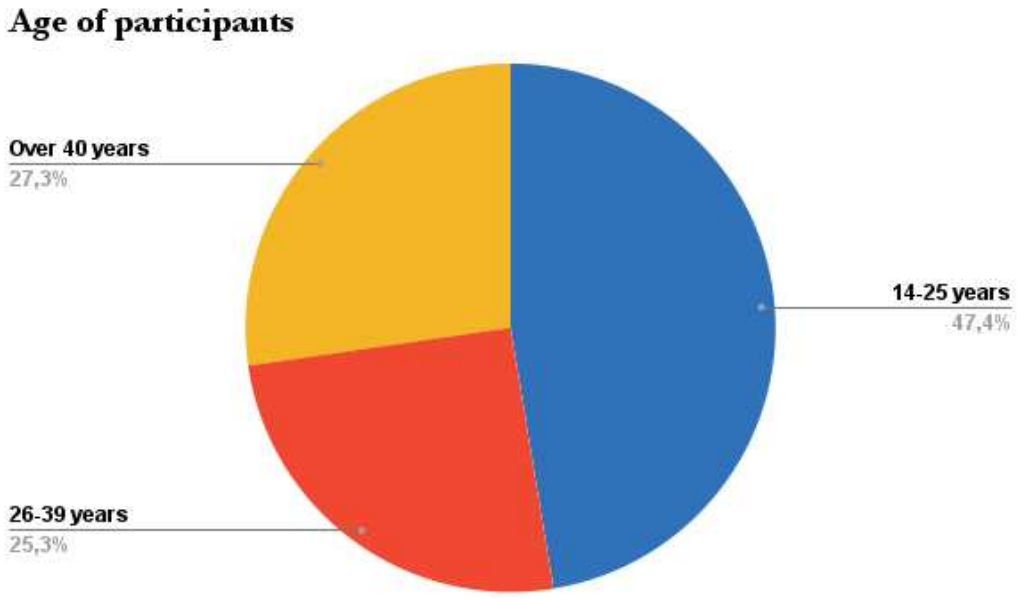

Figure 6.1: Age of participants

The vast majority of respondents were female (77.6%), with a smaller number of males (21.8%). 0.6% of respondents chose not to answer the gender question (Figure 6.2).

It is important to look at the gender of the participants in order to understand possible associations between gender type and disease and to compare the data obtained in the field with the scientific literature. In fact, many studies claim that feeding and eating disorders are diseases that affect women more than men.

A German study by Halbeisen et al. (2024) stated that men and women have different manifestations: the study showed that the prevalence estimates for men are 0.2% for anorexia nervosa, 0.6% for bulimia nervosa and 1% for binge eating disorder; the corresponding figures for women are 1.4%, 1.9% and 2.8%.

In 2019, the Ministry of Health stated that the epidemiological data available at the time indicated that *the estimated incidence of anorexia nervosa is at least 8-9 new cases per 100,000 persons per year in females and between 0.02 and 1.4 new cases per 100,000 persons per year in males* (Ministero della Salute, 2019).

Recently, however, data have emerged showing a significantly higher prevalence of feeding and eating disorders in the male population, more specifically in the 12-17 age group, at 10% (Ministero della Salute, 2024).

A study conducted on the relationship between gender and eating disorders by Støving et al. (2011) showed a different remission time depending on the gender of the subjects. The sample analysed was 1015 patients, of whom 356 (35%) were diagnosed with anorexia nervosa (AN), 298 (29%) with eating disorder not otherwise specified (EDNOS) and 361 (36%) with bulimia nervosa (BN). Male gender was similar in AN and EDNOS, but significantly lower in BN. The study showed that the median time from onset to remission for AN patients was significantly shorter for males: 7 years for females versus 3 years for males, with an AN remission rate of 39% for females and 59% for males. The median time to remission for EDNOS patients was similar to that for AN: 6 years for women versus 3 years for men, with 45% of women achieving remission within 5 years versus 77% of men. In terms of weight gain and cessation of compensatory behaviour, this study suggested a better outcome for men than for women (Støving *et al.*, 2011).

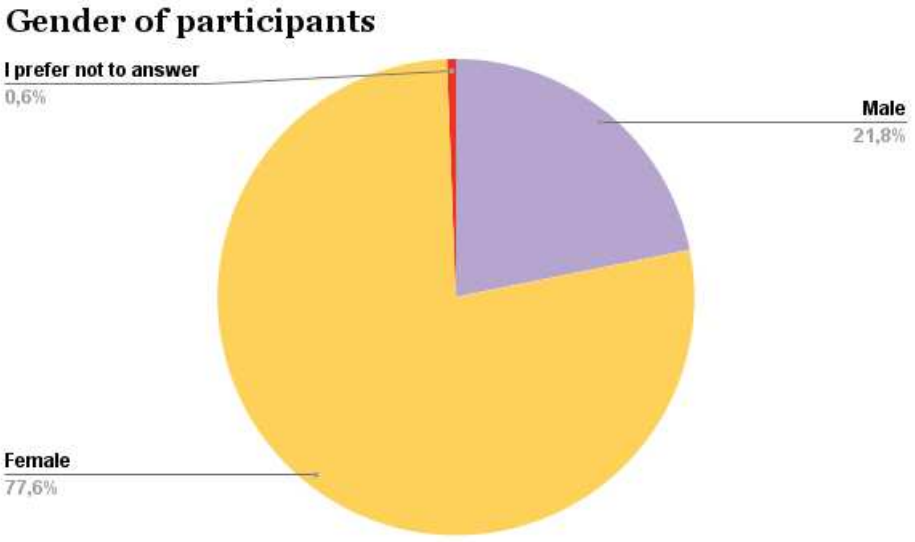

Figure 6.2: Gender of participants

The data showed that most regions and areas of the Peninsula were represented in the survey, with a greater presence in the northern part of Italy and a higher turnout in the regions of Liguria (33,4%) and Veneto (31,1%). Non-Italian areas were represented to a lesser extent in terms of percentages, with Japan (Tokyo), the United Kingdom (London), France (Paris) and Belgium (Brussels) (Figure 6.3).

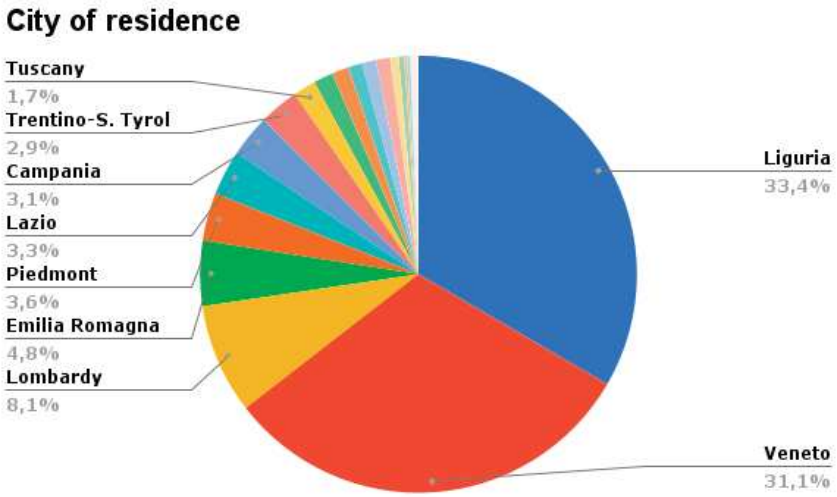

Figure 6.3: City of residence

Figure 6.4 shows that the Italian territory was fairly evenly represented, with a majority in the northern part, where all regions are represented, and a smaller proportion in the central part, in the south and on the Islands. Although with very low percentages - 0.21% per city - three cities belonging to the European continent and one belonging to the Asian continent were included.

Figure 6.4: Distribution of Italian cities

The educational level of the surveyed population was medium-high (Figure 6.5). Here are the figures:

1. Primary school diploma: 1 person (0,21%);
2. Secondary school diploma: 34 people (7,07%);
3. High school diploma: 252 people (52,39%);
4. Bachelor's degree: 92 people (19,13%);
5. Master's degree or single-cycle degree: 94 people (19,54%);
6. Postgraduate school: 8 person (1,66%).

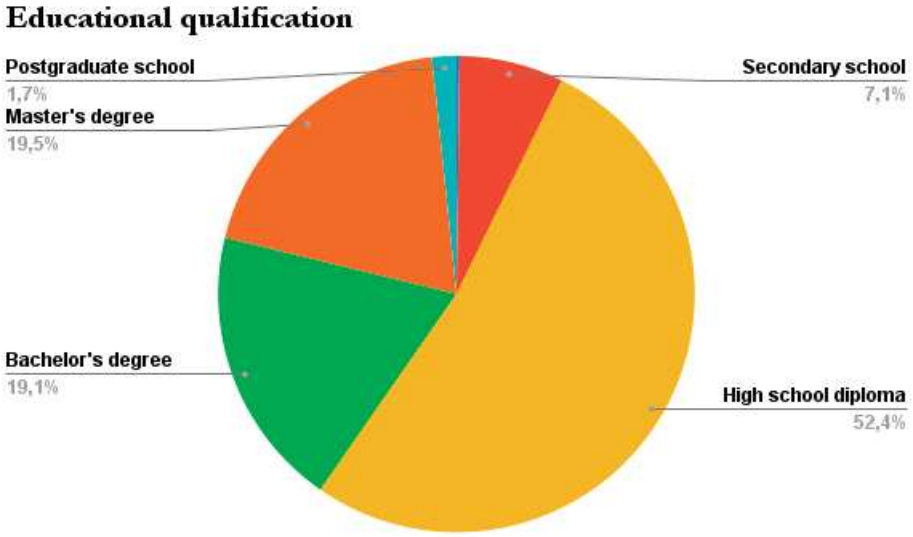

Figure 6.5: Educational qualification

6.2 Participants' knowledge of FEDs

The majority of the population, a total of 85.4%, were aware of what feeding and eating disorders are. However, there were 70 people (14.6%) who were unaware of FEDs. Unfortunately, there are still many people who are unaware of such important diseases that affect millions and millions of people every year, as well as 5% of the Italian population (Ministero della Salute, 2024).

The causes that these 70 people attributed to lack of knowledge about feeding and eating disorders were personal disinterest (Figure 6.6), mostly fairly and not very high, and lack of communication (Figure 6.7), fairly and very high.

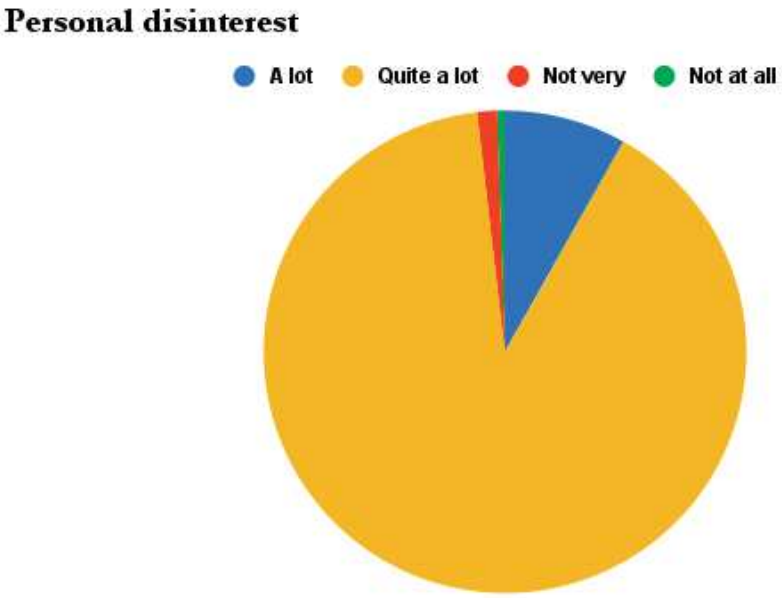

Figure 6.6: Personal disinterest

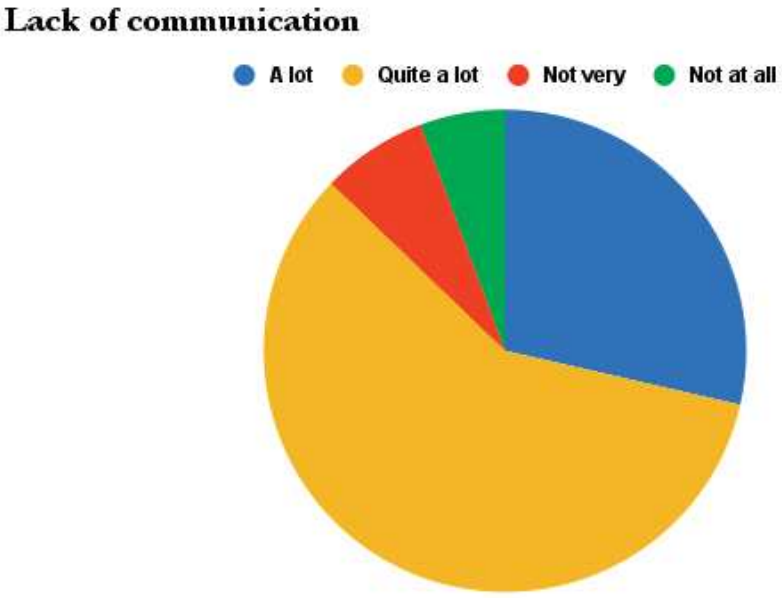

Figure 6.7: Lack of communication

Most people have become aware of what feeding and eating disorders are through direct or indirect experience. Social media was the second most important means of raising awareness, followed by the internet. The impact of school studies has been also important (Figure 6.8).

The hypotheses confirm the results obtained: the main reason why people know about feeding and eating disorders is through direct or indirect experience of the disease, a factor that must be reversed by a good information process. In line with good education, I expected more people to learn about FEDs through their schooling.

In response to this need, the Ministry of Education has launched *Scuola&Cibo*, an educational programme from pre-school to secondary school that aims to integrate nutritional education in schools (Ministero dell'Istruzione, 2024). Within the European Union, however, nutrition education is compulsory in nineteen countries, with the exception of Italy (Antonelli, 2020).

However, more knowledge through experience means becoming aware of the disease when it is too late. Information and communication must be preventive, must be acquired as a basic skill and not as a result of a given experience.

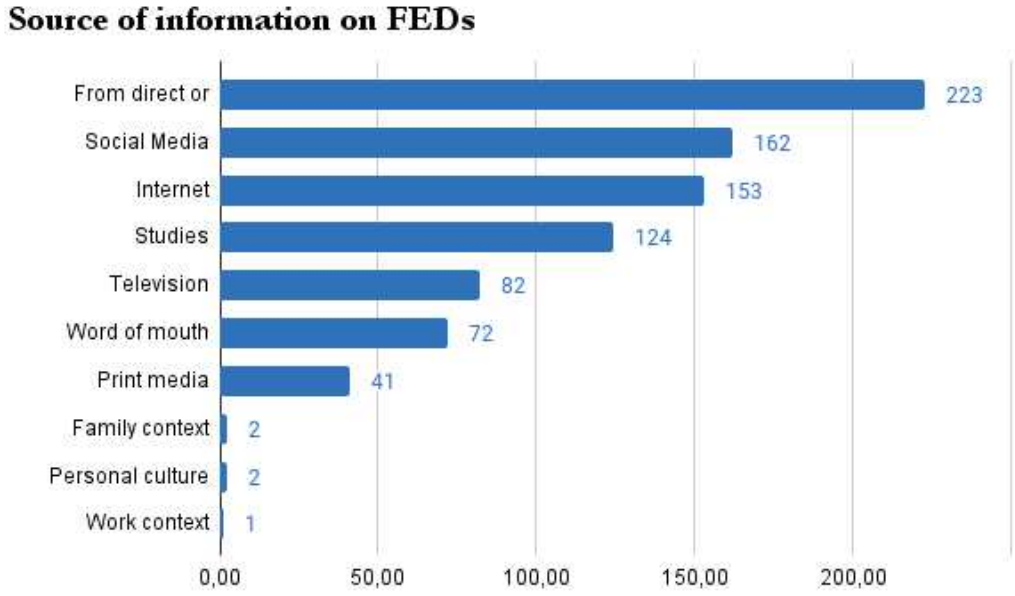

Figure 6.8: Source of information on Feeding and Eating Disorders (FEDs)

6.3 Direct or indirect involvement in FEDs

More than half of the respondents (59%) had never suffered from an eating disorder in the past, while 40.6% had.

Of the 166 people with a history of an eating disorder, 154 were female, 10 were male and 2 preferred not to answer the biological sex question (Figure 6.9).

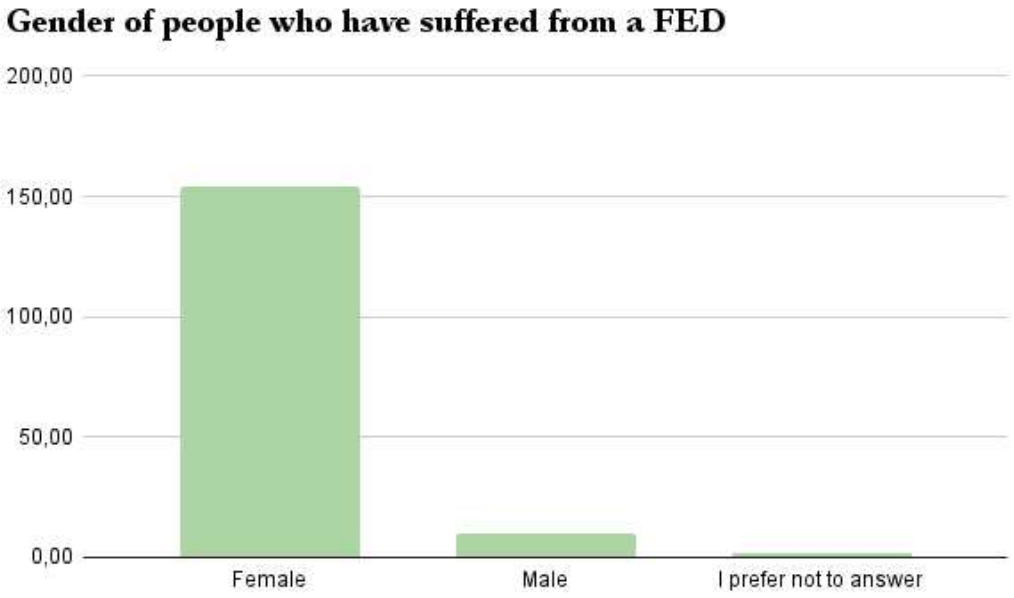

Figure 6.9: Gender of people who have suffered from a Feeding and Eating Disorder

As the studies in section 6.1 show, the prevalence of people with a feeding and eating disorder is female. However, this should not be taken to mean that men do not also suffer from FEDs; in fact, the number is increasing (Ministero della Salute, 2024).

In total, 62.1% of people who have suffered from a feeding and eating disorder in the past claimed that communication about FEDs has played a role in the healing process, while 63 people (37.95%) claimed the opposite. The data support the important role that health communication has and will continue to play in our society.

There are indeed a number of projects that aim to disseminate information about feeding and eating disorders, from treatment to access to care, with the aim of providing information on how to manage the disease, how and where to seek help, and what to do if you are close to someone who suffers. One of them is *Animenta*, a non-profit organisation that deals with FEDs through prevention, support and activities with companies, and does a lot of work at school and social level so that information reaches as many people as possible (Animenta, 2023).

Most respondents (78.3%) did not currently suffer from a feeding and eating disorder, while 21.7% did; of these, 84 were women, 4 were men and 1 preferred not to answer (Figure 6.10). Among those who did not currently suffer from a feeding and eating disorder, more than half (65.9%) said that they had been close to someone who did have a FED.

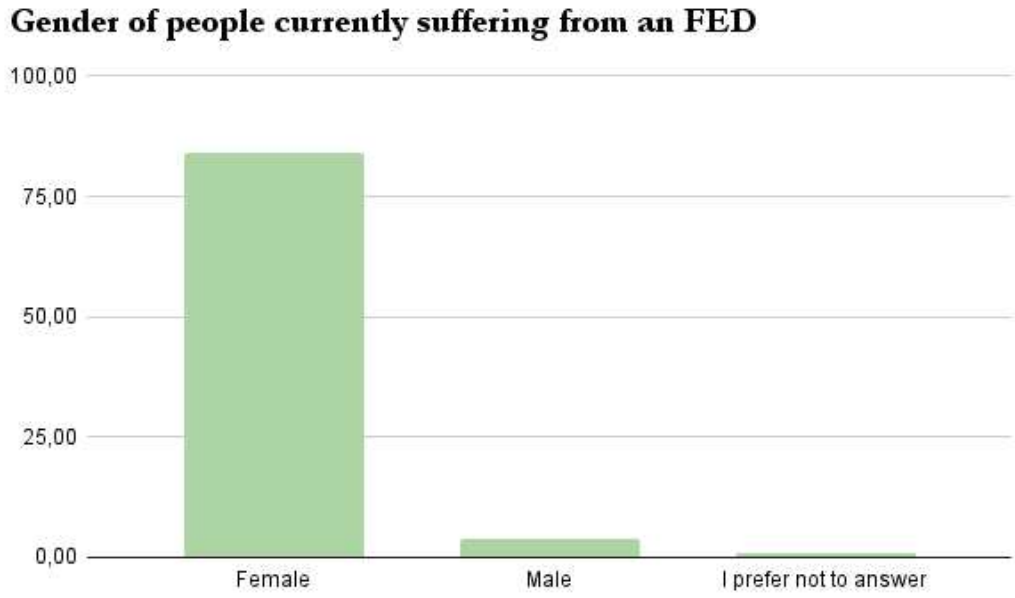

Figure 6.10: Gender of people currently suffering from a Feeding and Eating Disorder

6.4 The impact of communication on FEDs

The majority of people (58.9%) said that communication about FEDs is ineffective. This figure is extremely relevant as it shows the perception of the people to whom the information should be addressed. It is from these people, therefore, that it is necessary to learn what strategies could be put in place to remedy the inefficiency of communication, as indicated by the 309 people (75.5%) who described it as 'not very' or 'not at all' efficient.

The vast majority of the population surveyed (93,4%) believed that media-mediated communication through information channels such as television, newspapers or social media would help in raising awareness of feeding and eating disorders and also have a positive impact on those who suffer from them.

People firmly maintained that:

1. Thanks to modern mass media, communication about feeding and eating disorders can reach a large number of people; unlike in the past, there is therefore an opportunity to ride the wave of globalisation to reach as many people as possible and to inform them in the right way (prevention, treatment, risks, correct approach);
2. Through communication, a correct information process can be carried out, which is necessary first of all to make people aware of the disease, starting with the very youngest; it is necessary to make people aware of an issue that is still not given the right importance, and also to teach them to use the right language to express themselves; it is necessary to help those who suffer and to educate the people around them;

3. Through communication, people can learn that asking for help is extremely important and is not and never will be a sign of weakness. It is the first step in becoming aware of the disease and the first step on the road to recovery;
4. Communication is needed to stop or at least reduce misinformation. False information is everywhere and accessible to everyone, which is why an information pathway on feeding and eating disorders is proposed, starting in schools. The need for authoritative information, which is often lacking, is particularly emphasised.

On the other hand, some argued that a series of meetings with experts may be more necessary than communication through the mass media (again stressing the need for authoritative sources).

Here are some of the responses that best and most accurately express the points listed above:

> "Because it can help those who are outside these situations to understand how to make themselves useful and help, supporting those who suffer from feeding and eating disorders; therefore, more than talking about the eating disorder itself, I think it is necessary to find a way to unhinge the ideal of perfection that lies within society and especially the models of 'beauty' that are proposed within all environments. Obviously, these disorders are not only related to issues of mere physicality but are inevitably linked to a lack of relationality or communication".

> "Because without knowledge, without information, one cannot give an explanation for the 'state of malaise' in which one finds oneself. You feel that you are ill, but you do not know why, you know that something is wrong, but you cannot put a name to it. Instead, hearing about it makes us aware, makes us say 'I am not the only one who feels this, I am not alone, I find myself in this description' and makes us more inclined to look for a solution, for help: if we do not know how to identify a problem, we will never know how to move towards solving it.
>
> Furthermore, if everyone is more informed and aware of these disorders, it will also be easier to relate to others, to communicate what one is feeling and to feel more understood.
>
> On the other hand, I think it would also be crucial for people who are close to someone with FED to be informed. I found myself in this situation and realised that I did not know how to relate to the person who was suffering at the time, but also that I did not know who to ask for help in this regard".

> "I believe that knowledge about eating disorders is the first step towards prevention. One of the main problems is that they are still not always seen as real illnesses".

"Knowledge is still very limited to a few disorders (anorexia, bulimia), whereas the reality is much broader. There is also a lot of misinformation about the complexity of these disorders, even at a psychological level".

"Because for too long, many people (myself included) have underestimated the problem. I have seen my daughter reborn in every way after overcoming bulimia, supported by excellent professionals, psychologists and nutritionists".

"Because I realised I had an eating disorder when I was 14, by taking a test in a magazine. I just knew I was fat, not sick".

"Because by reaching out to everyone, everyone would have a better chance of recognising unbalanced behaviour in themselves or in others, of understanding that they are not alone in suffering and that there are ways out of it, of not feeling judged when they ask for help, of making everyone aware that some behaviour is not due to personal quirks, laziness or sloppiness, but to real problems that are not always known to others".

"I think a lot of times, especially with male FEDs, we really struggle to recognise that there is a problem, knowingly or unknowingly disguising it as a phase, just a craving or I don't know what. Naming the problem defines it and characterises it, giving people the opportunity to recognise that there is a problem, which is the first step in the healing process: recognising that they are ill".

Overall, 82,3% of people claimed that social media, as it is accessible to most people, as well as to the youngest age groups, is a good medium for conveying information about feeding and eating disorders and that talking about FEDs within social media (Instagram, TikTok, Facebook) allows a rapprochement with the topic and leads to positive outcomes. Indeed, the work carried out by scientific disseminators, associations and people on social networking sites, sharing personal experiences or information related to eating disorders, is very important: it is information work that, as such, leads to positive results.

However, it is necessary to take into account the fact that TikTok, through some videos posted by users, spreads physical shame, which has a negative impact on mental and physical health (Liu, 2021). In fact, almost all respondents believed that social media can contribute to an idea of idealised bodies and an unhealthy diet and nutrition, creating models that people try to achieve (Figure 6.11).

TikTok's social media algorithm suggests videos based on content that specifically catches the user's attention. So, if a user accidentally sees a video about a feeding and eating disorder on the homepage and is intrigued enough to search for more similar videos, the algorithm will continue to suggest such videos, contributing

to the development of compulsive behaviour. However, these algorithms are not yet able to distinguish between harmless and harmful content. For example, anorexia entered TikTok's platform through 'pro-ana' (pro-anorexia) videos, in which users supported and encouraged each other to lose weight, exchanging advice and challenging each other. Although the platform has blocked most of these videos, some are still easily circumventing the controls. Currently, 'anti-pro-ana' (anti-anorexia) videos, which aim to raise awareness about anorexia, are much more popular (Logrieco *et al*., 2021).

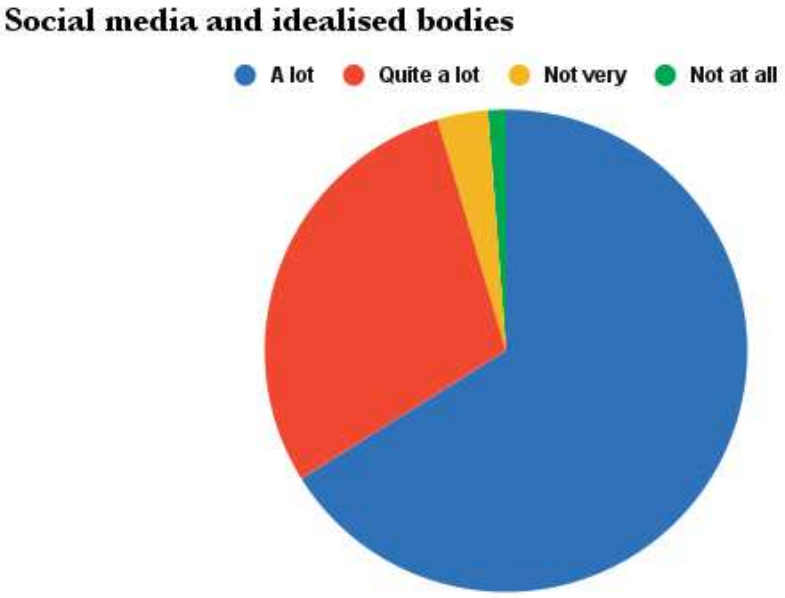

Figure 6.11: Link between social media and the idea of idealised bodies and incorrect nutrition

The article by Marks *et al.* (2011) highlighted how research has shown that there is a socio-cultural factor that contributes to the development of feeding and eating disorders: media exposure to body type ideals; the risk is higher in cultures where body type ideals have been internalised. Research has shown that Instagram content focused on appearance and fitness is associated with an increased risk of feeding and eating disorders. Of people who have social accounts, 54% use them to discover and share food experiences and 42% use them to seek advice about food, showing a link between social media content and vulnerability to FEDs.

Furthermore, a study conducted by Wilksch et al. (2019) on a group of 996 adolescents with a mean age of 13 years showed that girls with Snapchat and Tumblr accounts and boys with Snapchat, Facebook and Instagram were significantly more likely to have feeding and eating disorders. In addition, greater daily time spent on Instagram was associated with significantly higher FED behaviours in girls, as was Snapchat use.

The data obtained from the questionnaire on the basis of one's personal experiences and thoughts were therefore in agreement with the scientific literature.

In 2021, on the occasion of the National Day of the lilac ribbon, the Ministry of Health, in collaboration with Never Give Up onlus, has carried out a publicity campaign through the creation of 4 videos with the testimonies of girls and boys who face the health and social discomfort that these pathologies cause.

The target audience for the digital communication campaign was the general population, especially young people. The key messages were mainly two: "If you have an eating disorder, don't give up. Go to the doctor" and "If someone close to you has an eating disorder, make them feel that you are there and advise them to go to the doctor" (Ministero della Salute, 2019).

Overall, 85% of people were not aware of the advertising campaign or the national fund set up to combat feeding and eating disorders. This shows that the government's communication efforts are not well received and therefore not very effective. It is therefore extremely important that the communication is implemented in such a way that as many people as possible are informed in the right way.

Slightly more than half of the people (56.2%) claimed that correct information would have helped them to take a different path, probably one of awareness and knowledge.

Of the 228 people who said that knowledge would have allowed them to manage their illness differently, 143 people (62.7%) have never had a feeding and eating disorder and do not currently have one. This means that the majority of people believe that good communication has a certain influence on the course of the disease, a majority of people who have never had the disease. Therefore, good communication is seen as a very powerful tool by those who have no direct experience of FEDs.

6.5 Proposed interventions to improve communication about FEDs

The overwhelming majority of people, 94.4%, believed that there is a need to improve communication about feeding and eating disorders. The key points that the respondents consider crucial to improving communication were:

Education and information about these diseases must start at school level, where action is needed to ensure that correct information leads to prevention and the possibility of seeking help;

Communication must be done by professionals who have studied and have the skills to deal with the subject; it only takes one wrong word or action to send the

wrong message (nowadays more and more people claim the right to speak without knowing: good communication has a lot of study behind it);

Information must be complete and extended to all feeding and eating disorders. There are many FEDs and often not all of them are known; we only talk about the most common ones, such as anorexia nervosa and bulimia nervosa, at the risk of never mentioning the other eating disorders and the broad spectrum of this disease. It is necessary to learn in order to know what to deal with and to be able to name things;

It is said that communication needs to be designed not only for those who are directly affected by the disease, but also for those around them: targeted communication is therefore necessary to learn what actions need to be taken in the right way to help those around us;

Better use of social media is another proposed solution to improve communication. In a society like ours, where everyone has a mobile device and can get the message out however they want, it is important to use these channels to get the right message across. Social media is a great way to communicate quickly and with a very wide audience, from the youngest to the oldest age groups, so it is crucial to use it to inform people authoritatively and make them aware of feeding and eating disorders.

Beyond communication per se, there were two recurring themes that need to be improved in the treatment of feeding and eating disorders:

Faster access to treatment, given the very long waiting times required to keep up with the public health service. In fact, in Italy, therapeutic support involves considerable waiting times because, once the hurdle of obtaining an adequate diagnosis has been overcome, the waiting lists are very long due to the scarce presence of specialised centres in the territory, which are unevenly distributed throughout Italy (Giancipoli, 2024). According to the National Eating Disorder Collaboration, an Australian eating disorder industry initiative funded by the Australian Government, the number of people with a feeding and eating disorder accessing treatment in a given year is significantly lower (19-36%) than people with other types of mental disorders. Of these, only 35-40% receive treatment specifically for their FED. It is also estimated that, on average, treatment for a feeding and eating disorder is sought between 5 and 15 years after the onset of the disorder (NEDC, 2024);

Government intervention to make certain treatments necessary to the healing process, such as psychotherapy sessions, accessible at lower prices and thus a prerogative of all (such as the psychologist bonus granted by the National Social Security Institute in 2024).

The respondents had the opportunity to express critical issues related to the communication of feeding and eating disorders, to propose solutions and to point out aspects that should be improved. The following answers, reported by some of the respondents, summarise the main messages expressed by the almost 500 people who took part and mark the achievement of the questionnaire's objective, i.e. to highlight the criticalities and limitations of communication related to FEDs and the subsequent proposal for improvements directly from the people who are victims of inefficient information on a daily basis.

Here are the words of the respondents:

"The first thing to do is to start recognising feeding and eating disorders as illnesses, whereas they are often trivialised as being 'just mental".

"Having been close to a person with FEDs, I believe that communication about how to be close to the sufferer should be improved.

Furthermore, as much as I think that communication via social media is fundamental for sufferers, so that they can identify with something they may not know and also feel less alone and wrong, I also think that it can have negative implications. In fact, the line between a positive and a negative message is extremely thin because of the important role of interpretation. That is why you have to be very careful in the way you approach the discourse: you have to make people want to feel better, not want to fall into this vortex. Let me explain: a little boy or girl who sees a video on TikTok of the smiling girl or boy who had an eating disorder and talks about it lightly should not be driven to want to stop eating, for example, to emulate him/her.

I'm not saying you shouldn't talk about it, on the contrary, but you have to be careful not to use an extremely heavy tone (which would distract from the information) and to convey the knowledge that these are disorders that make you really sick, that it's not a game, that you're talking about life".

"The attitude of adults (doctors, teachers, parents) towards young people, i.e. being able to recognise the first symptoms of the problem. But also, and above all, not sending out the wrong messages through behaviour or comments that may seem 'normal' but which in fact have a strong impact on people who are still in education. In general, a cultural change is needed. First of all, families need to be educated about a healthy relationship with food, which unfortunately becomes an instrument of control or comfort, and in any case leads to excesses that cause serious damage. The relationship with the body is another important issue; constant body shaming is a scourge, the result of widespread ignorance and superficiality".

"We need more free or contracted centres throughout Italy with properly trained teams; in my region, for example, there are only three clinics and they are full, so treatment is not always guaranteed".

"In addition to individuals, I think it is particularly important to raise awareness and inform parents who have the opportunity to monitor their children. From my own experience, I have noticed that these problems tend to arise in adolescence and are often 'carried' or even worsened over the years. I was lucky that my parents were always there for me during difficult times or times of not accepting my body. I think the same can help others. Maybe talking about it more in schools could also help, we are often the first ones to bully and we don't think about the consequences".

"I think there is still a 'fatphobic' approach: people who do not know about these disorders think that it is only the restrictive type and identify the eating disorder with anorexia because, for obvious reasons of mortality risk, it is much more widely communicated. Communication should be more comprehensive to make everyone aware that overweight and obese people can also suffer from a disorder and to help patients themselves to recognise that they have a problem. So many people suffer unknowingly for too long".

"The target audience is not clear, and there is still too much of a tendency to assign a gender to this kind of problem, when in fact it affects so many different categories of people and is intersectional. There is too often a tendency to tell the medicalised side of this disorder, and little of how much the roots of these problems lie in the Western cultural model and the rigid canons that exist for bodies, and therefore a collective problem and not just an 'individual pathology'. For me, effective communication is communication that makes those who do not suffer from this pathology, who are strangers to it, realise that they are part of the problem when they make certain comments about other people's bodies, even if they are famous people. Communication that is inclusive of all subjectivities, because this pathology has no age limit and people can develop an unhealthy relationship with food at any point in their lives".

"It should not be demonised, but recognised and treated as such. The FED spectrum is broad and we should talk about all eating problems. Over the years, people have often talked about anorexia nervosa as a disease to be cured and obesity as a choice. We need to change this perception so that we can help people recognise the disease in a practical way, without condemning or justifying bad behaviour, but by giving everyone the right information".

Conclusions

The questionnaire carried out allowed us to understand, through a sample of almost 500 people, the role that communication plays in feeding and eating disorders. What emerged was the need to provide information at school level, so that people can begin to understand from an early age a disease that is increasingly targeted at younger and younger people: knowing what you are dealing with is the first step in the right direction.

It is also essential that communication is carried out by those who have the appropriate skills to deal with certain topics, as ignorance of the subject and the appropriate language is not helpful and can lead to harmful misinformation.

Therefore, in addition to the need to implement preventive measures to prevent the onset of feeding and eating disorders, work also needs to be done at the treatment level, from the need for more specialised centres to better accessibility of treatment in terms of money and time.

Attention must be paid to social media, which in the society we live in is a tool within everyone's reach, and which can sometimes be used to convey incorrect or unclear messages: it is necessary to regulate the communication conveyed through this tool so that it is correct and functional.

At the level of communication about feeding and eating disorders, all information about the disease cannot be ignored: FEDs are diverse and constantly evolving, they are not limited to the best known; for this reason, it is essential to provide quality information.

My work is only the very first step towards awareness of the communicative limits of feeding and eating disorders; it is necessary to act on several fronts and at several levels. For this reason, it would be effective to carry out studies analysing the impact of the changes proposed by people in public and private communication, so that feedback on changes in communication goals and their implementation can be verified on a practical level.

It is only through correct information that an aware and responsible society can emerge, one in which feeding and eating disorders are not seen as a whim or wishful thinking on the part of the individual, but as a real illness that should not be stigmatised and ridiculed as such. It is extremely wrong to force people to behave differently, for example by telling them to eat more because they are too thin, or not to engage in compensatory behaviours because it is not necessary: you have to start by recognising these behaviours, understanding how to act, and encouraging people to seek help. Eating disorders are not a choice.

The road to change is certainly a long one, but it cannot wait much longer as the number of deaths from these diseases continues to rise. However, change can come from the words and thoughts of the people who, through the questionnaire, provided the basis for the work to be done to achieve an effective level of information through communication.

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AD MAIORA SEMPER

If you would like to take a look at my questionnaire