Prevalence of Eating Disorders among Medical Students: A Study from Lahore, Pakistan

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Abstract

Background: Globally, eating disorders rank as the 12th leading cause of disability-adjusted life years (DALYs), underscoring their significant impact on health and well-being. Previous research on the prevalence of eating disorders among Pakistani medical students is limited.

Objective: This study investigated the prevalence of disordered eating attitudes and behaviors among medical students at a private medical college in Lahore, Pakistan.

Methods: Using a cross-sectional design, 234 medical students (134 females, 100 males) completed the Eating Attitudes Test-26 (EAT-26) questionnaire *via* Google Forms distributed through class WhatsApp groups. Data collection occurred between June to October 2024. Descriptive statistics, independent samples t-tests, and one-way ANOVAs were used for analysis.

Results: The study included 234 participants, of whom 134 (57.3%) were female and 100 (42.7%) were male. The mean age of study participants was 22.4±1.3 years. The study found a high overall prevalence of at-risk eating behaviors (37.6%). No statistically significant differences were found between participants scoring above and below the EAT-26 cut-off in terms of gender (p=0.661), age (p=0.527), study year (p=0.692), or residence (p=0.587). A statistically significant gender difference emerged on the Oral Control subscale (p=0.035), with male students exhibiting a higher mean score than female students.

Conclusion: These findings underscore the need for increased awareness, targeted interventions, and support services within medical education settings to address disordered eating and promote positive mental health among future healthcare professionals.

Keywords: *Eating disorders, prevalence, medical students, anorexia nervosa, bulimia nervosa.*

INTRODUCTION

Eating disorders, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [1], are characterized by persistent disruptions in eating patterns and behaviors that significantly impact physical or psychosocial functioning. Recent research [2] indicates a growing prevalence of these disorders across various populations. While sociocultural factors have traditionally been linked to a higher incidence of eating disorders in Western cultures, recent research suggests that globalization, Western media influence, and shifting cultural ideals have contributed to an increasing recognition and prevalence of these disorders in Eastern populations as well [3-5].

Eating disorders are particularly common among adolescents and young adults, with prevalence peaking in the late teens to mid-twenties — a period marked by identity formation, heightened self-consciousness about body image, and exposure to social comparison through peers and media [6]. As most medical students fall within this vulnerable age range (around 21 years in our sample), they may be especially susceptible to developing disordered eating attitudes and behaviors. Globally, eating disorders rank as the 12th leading cause of disability-adjusted life years (DALYs), underscoring their significant impact on health and well-being [6].

Eating disorders encompass a range of conditions, including anorexia nervosa, bulimia nervosa, binge eating disorder, and avoidant/restrictive food intake disorder (ARFID). Anorexia nervosa is characterized by an intense fear of gaining weight, leading to severely restricted dietary intake, often accompanied by purging behaviors, excessive exercise, or fasting. While individuals with bulimia nervosa may maintain a normal weight, they experience recurrent episodes of binge eating followed by compensatory behaviors such as purging or self-induced vomiting. Binge eating disorder involves frequent episodes of excessive eating without subsequent compensatory behaviors. In contrast, ARFID is characterized by a persistent aversion to or avoidance of food, often resulting in underweight status and nutritional deficiencies [7].

Eating disorders are associated with a range of medical and psychiatric complications, including cardiac muscle wasting, delayed puberty, osteopenia, pancytopenia, hypothermia, hypotension, and cardiac arrhythmias. Notably, the mortality risk for individuals with anorexia nervosa and bulimia nervosa is five times higher than

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that of the general population [8]. Recovery from anorexia nervosa and bulimia nervosa requires a multifaceted approach. Psychological support, physical health improvement, social and emotional connection, and addressing underlying causes are essential factors. Establishing a therapeutic relationship, providing person-centered care, educating patients, and maintaining a positive attitude toward patients can also significantly aid in recovery [9, 10]. Previous research on the prevalence of eating disorders among Pakistani medical students is limited.

Historically, eating disorders were considered predominantly Western phenomena, largely attributed to cultural ideals that equate thinness with beauty, discipline, and success. In contrast, in many developing societies — including Pakistan and Arab countries — a fuller or "chubbier" body shape has traditionally been associated with good health, prosperity, and attractiveness [11]. However, with increasing globalization, urbanization, and exposure to Western media, these cultural norms have begun to shift, leading to greater internalization of thin-ideal standards and a corresponding rise in body dissatisfaction and disordered eating behaviors among younger populations [12].

This study aimed to estimate the prevalence of disordered eating attitudes and behaviors among medical students in Pakistan and to explore gender and age-related differences in these patterns.

MATERIALS AND METHODS

This was a cross-sectional study conducted at Azra Naheed Medical College, Lahore, a private medical institution with approximately 750 MBBS students enrolled in years 1 to 5. Data collection spanned from June to October 2024. Ethical approval for the study was obtained from the Institutional Review Board of Azra Naheed Medical College, Lahore (IRB/ANMC/2024/09). The study included all medical students currently enrolled at Azra Naheed Medical College (years 1 through 5) who provided consent and completed the questionnaire. Students who did not consent to participate were excluded from the study. Participation was entirely voluntary; completion of the Google Form was considered implied informed consent, and strict anonymity was maintained throughout the data collection process, with no personal identifiers such as phone numbers or email addresses collected. Information regarding prior or comorbid mental health conditions was not collected as part of this study.

The sample size was computed using the formula for estimating a single population proportion. Based on an estimated prevalence rate of 15 % [13], a 5% margin of error (d) (0.05), and a 95% confidence interval (Z-score for 95% CI = 1.96), the calculated sample size was 196. This calculation was performed using the Raosoft sample size calculator.

A Google Form incorporating the Eating Attitudes Test-26 (EAT-26) questionnaire and demographic questions was distributed *via* each class's official WhatsApp group. This allowed for an anonymous, remote survey approach rather than a face-to-face interaction. Participants received a brief introduction explaining the study's rationale and instructions for completing the questionnaire, which typically took approximately five minutes. To maximize participation, up to three reminders were sent to the WhatsApp groups, and the students were also reminded once during their on-campus lectures.

The EAT-26 questionnaire [13] used in this study is one of the most commonly employed questionnaires and has a 26-item and a 40-item version [14]. In the current study, the 26-item version of the questionnaire was used. It has three subscales: Bulimia and Food Preoccupation (items 3, 4, 9, 18, 21, 25), Dieting (items 1, 6, 7, 10, 11, 12, 14, 16, 17, 22, 23, 24, 26), and Oral Control (items 2, 5, 8, 13, 15, 19, 20). Although EAT-26 is useful as a screening instrument, it is not designed to diagnose eating disorders on its own. Individuals who score 20 or higher are considered to be at high risk of having an eating disorder and should be evaluated by a healthcare professional to confirm the presence or absence of a disorder. Similarly, as denial is a common problem in the general population, having low scores on the EAT-26 does not mean that an individual does not have the disorder. In addition to the 26 items on the questionnaire, information is also gathered about the BMI, as well as five behavioral questions aimed at assessing measures that counteract the increase in weight, such as purging, self-induced vomiting, or exercising. However, only the first 26 items of the EAT-26 were analyzed, and the additional behavioral questions and BMI data were collected but not included in the statistical analysis, as a significant proportion of respondents provided incomplete or inconsistent entries for these items. Therefore, only EAT-26 scores were used to ensure data reliability. The Eating Attitudes Test (EAT-26) consists of 26 items, each rated on a six-point Likert scale: Always, Usually, Often, Sometimes, Rarely, and Never. For scoring purposes, responses were coded as follows: Always = 3, Usually = 2, Often = 1, and Sometimes/Rarely/Never = 0. Items 1-25 are positively keyed; item 26 is reverse-scored. Total score ranges from 0-78; scores ≥20 indicate an elevated risk of having an eating disorder.

All collected data and student information were kept strictly confidential and were accessible only to the study authors. The data were entered and analyzed using an SPSS version 27. Descriptive statistics were used to summarize the characteristics of the study population and key variables. Before applying parametric tests, the normality of continuous variables was assessed using the Shapiro-Wilk test and visual inspection of Q-Q plots. Independent samples t-tests were employed to compare means between relevant groups, while one-way ANOVA

was used to study differences between the participants based on residence status. Pearson's chi-squared test was used to analyze the characteristics of students who scored below and above the cut-off score of 20. P-value <0.05 was taken as statistically significant.

The article was written in its entirety by the authors. However, once the write-up was complete, Google Gemini 2.0 was used to improve the grammar as well as the flow of the article.

RESULTS

The study included 234 participants, of whom 134 (57.3%) were female and 100 (42.7%) were male. The mean age of study participants was 22.4 years (SD: 1.3; age range: 20-26 years, majority clustered around 21-23). The distribution across academic years was as follows: 68 (29.1%) second-year MBBS students, 90 (38.5%) third-year MBBS students, 74 (31.6%) final-year MBBS students, and 2 (0.9%) first-year MBBS students. Most participants (67.1%) reported predominantly urban residences, while 25.2% were from predominantly rural areas, and 7.7% reported mixed urban and rural backgrounds. A total of 88 students (37.6%) scored at or above the EAT-26 cut-off score of 20, indicating they were at increased risk for disordered eating behaviors and may warrant further clinical evaluation.

A comparison of student features among those who scored above and below the cut-off score is given in Table **1**. No statistically significant differences were found between participants scoring above and below the EAT-26 cut-off in terms of gender (p=0.661), age (p=0.527), study year (p=0.692), or residence (p=0.587).

Table 1: Comparison of characteristics of participants who scored above and below the EAT-26 cut-off score of 20.

Characteristics	EAT-26 score <20 (n=146), n (%)	EAT-26 score ≥20 (n=88), n (%)	p-value
Gender			
Male	64 (43.8)	36 (40.9)	0.661
Female	82 (56.2)	52 (59.1)	
Age			
18–20 years	23 (15.8)	19 (21.6)	0.527
21–25 years	121 (82.9)	68 (77.3)	
26–30 years	2 (1.4)	1 (1.3)	
Study year			
1st year	1 (0.7)	1 (1.1)	0.692
2nd year	42 (28.8)	26 (29.5)	
3rd year	53 (36.3)	37 (42)	
5th year	50 (34.2)	24 (27.3)	
Residence			
Primarily urban	95 (65.1)	62 (71.3)	0.587
Primarily rural	12 (8.2)	5 (5.7)	
Both urban and rural	39 (26.7)	20 (23)	

GENDER DIFFERENCES

An independent samples t-test was conducted to compare overall EAT-26 scores between male and female participants. No statistically significant gender difference was found (p=0.950), indicating similar levels of disordered eating risk across genders. This is further detailed in Table **2**.

Table 2: Independent samples t-test on overall score and subscales of EAT-26.

Score	Mean (males)	Mean (females)	p-value	95% CI (Lower)	95% CI (Upper)
Overall score	17.03 (10.41)	17.11 (11.62)	0.956	-2.977	2.813
Bulimia and Food Preoccupation	3.15 (2.93)	3.08 (3.32)	0.871	-0.756	0.891
Dieting Subscale	8.95 (6.89)	10.10 (7.95)	0.249	-3.105	0.811
Oral Control Subscale	4.93 (3.63)	3.93 (3.50)	0.035*	0.071	1.923

*p<0.05 indicates statistical significance.

Residence Status Differences

A one-way analysis of variance (ANOVA) was conducted to compare overall EAT-26 scores among participants from three residential backgrounds: predominantly urban, predominantly rural, and mixed urban/rural. The results indicated no statistically significant differences in EAT-26 scores based on residence (p=0.450).

Age Group Comparisons

A second one-way ANOVA was conducted to assess differences in EAT-26 total scores across three predefined age groups (16-20, 21-25, and 26-30 years). The analysis revealed no statistically significant variation across groups (p=0.903), supporting consistent demographic representation within these strata (**Table 3**).

Table 3: One-way ANOVA of EAT-26 total scores across age groups.

Age group (years)	N	Mean (SD) Total Score	F(df)	p-value	Partial η^2
18–20	42	16.38 (10.13)	0.102 (2,231)	0.903	0.001
21–25	189	17.22 (11.36)			
26–30	3	17.67 (9.87)			
Total	234	17.08 (11.09)			

Partial η^2 interpretation: 0.01 (small), 0.06 (medium), 0.14 (large). Post-hoc tests showed no significant differences.

Gender Differences on Subscales

Independent samples t-tests were used to examine gender differences on each subscale. No significant gender differences were found on the Bulimia and Food Preoccupation (p=0.871) or Dieting (p=0.249) subscales. However, a statistically significant gender difference emerged on the Oral Control subscale (p=0.035), with male students exhibiting a higher mean score than female students. Table **2** provides further details regarding this comparison.

DISCUSSION

Our study yielded two key findings regarding the prevalence of eating disorders among Pakistani medical students. First, we observed a high prevalence (37.6%) based on the EAT-26 questionnaire. Second, we found

no significant gender difference in the prevalence of eating disorders. Although a greater proportion of female students scored above the EAT-26 cut-off, this difference was not statistically significant, suggesting similar risk levels across genders. This high prevalence exceeds rates in general populations of developing nations, likely reflecting the heightened pressures and Western media exposure specific to high-SES, urban medical student cohorts. Furthermore, the absence of a significant gender difference aligns with recent South Asian and Muslim-majority country literature, suggesting that rising male body pressures are narrowing the traditional gap. Previous research from Pakistan and neighboring countries has reported similarly high rates. A cross-sectional study from Karachi found that 21.7% of medical students were at risk for eating disorders using the EAT-26 [15]. Similarly, a study of 354 female university students from the University of Lahore, the University of South Asia, and Riphah International University found a prevalence of 42.9% using the EAT-26 [16]. Another study of 427 engineering students in Nawabshah, using both the EAT-26 and SCOFF questionnaires, reported prevalence rates of 35.9% and 48.9%, respectively [17]. A study at King Abdulaziz University, surveying 417 medical students with the EAT-26, found a prevalence of 32.1%, with female gender and preclinical study stage associated with significantly higher risk [18]. Additionally, a study at Central Park Medical College in Lahore, using the SCOFF questionnaire on 196 female medical students, reported a 45.5% prevalence, with urban residence and nuclear family structure identified as risk factors [19]. The consistency of these findings from Pakistan and Saudi Arabia with our results strengthens our confidence in the reported prevalence.

A systematic review and meta-analysis of studies from Western Asia reported a 22.07% prevalence of eating disorders using the EAT-26/40 (17 studies) and 22.8% using the SCOFF questionnaire. Prevalence was significantly lower when assessed *via* semi-structured interviews (1.59% for Anorexia Nervosa, 2.41% for Bulimia Nervosa) [20]. Another systematic review and meta-analysis of 19 studies from nine countries found an overall pooled prevalence of 10.4% (range: 2.2-29.1%) [21]. A meta-analysis of 81 studies on eating disorders in the Arab world, primarily among student populations, reported a prevalence ranging from 2% to 54.8%, with females at higher risk. Factors associated with eating disorders in this meta-analysis included desire for thinness, body dissatisfaction, disturbed eating patterns, and dieting. Correlates included media use, increased affluence, obesity, and Western cultural influence [22]. These findings suggest that the prevalence of eating disorders in other parts of the world is generally lower than that reported in Pakistani studies [23]. This discrepancy is noteworthy, as even in high-resource Western countries, many individuals with eating disorders delay or avoid seeking treatment due to stigma and limited access to care. This tendency may be even more pronounced in settings like Pakistan, where awareness and specialized services remain limited [24]. The discrepancy warrants attention, particularly when considering the traditional cultural value placed on a fuller figure in South Asian/Pakistani societies—a value that historically offered some protection against Westernized thin ideals but is rapidly eroding in urban centers like Lahore. Although we did not collect specific data on religion or ethnicity, our finding reflects the accelerated modernization and acculturation occurring among high-SES urban students, which overrides traditional cultural and subcultural protections against disordered eating.

A key finding of our study is the significantly higher mean scores observed in male medical students compared to their female counterparts on the Oral Control subscale of the EAT-26. Within Pakistani culture, a muscular physique and traditionally masculine appearance are often considered more desirable and appreciated in males. Conversely, thinness and a lean appearance are frequently considered socially desirable for females, while thin or lean males may face teasing and criticism. Consequently, it is plausible that male medical students reported higher mean scores on items such as “I feel that others would prefer if I ate more,” “Other people think that I am too thin,” and “I feel that others pressure me to eat.” This intriguing finding warrants further investigation in future research to explore this phenomenon in more detail.

This study has several strengths. It addresses a gap in the literature by examining eating disorder prevalence within a specific population of Pakistani medical students, contributing valuable data from a region where such research is limited. The use of the EAT-26, a well-established and validated screening tool, enhances the reliability and comparability of our findings with other studies. The relatively large sample size of 234 participants provides reasonable statistical power. Furthermore, the study’s focus on both overall prevalence and subscale analysis offers a more nuanced understanding of eating attitudes and behaviors. However, several limitations should be acknowledged. The use of a non-probability convenience sampling method, relying on voluntary participation through WhatsApp groups, introduces the potential for selection bias, limiting the generalizability of the findings to all medical students in Pakistan. The cross-sectional design precludes any conclusions about causality or the trajectory of eating disorders over time. Reliance on self-reported data from the EAT-26 also carries the risk of response bias, such as social desirability bias. Another limitation is the lack of direct, quantitative socioeconomic data for individual participants. However, the private medical college setting and high prevalence of urban residents strongly suggest a predominantly upper-middle to high socioeconomic status, a group globally recognized for its higher exposure to Westernized thin ideals and ED risk. The study did not include an assessment of

comorbid psychiatric conditions, which may influence eating attitudes and behaviors. Finally, the EAT-26 is a screening tool, not a diagnostic instrument; therefore, the reported prevalence reflects the proportion of students at risk rather than those with clinically diagnosed eating disorders. Future studies employing more rigorous sampling methods, longitudinal designs, and clinical interviews are needed to further explore these issues.

Given the high prevalence observed, medical colleges should consider implementing regular mental health screening, awareness campaigns on healthy body image, and easily accessible counseling services. Integrating brief psychoeducation modules into existing behavioral science or community medicine curricula could also help normalize help-seeking for disordered eating. Institutional policies that promote a supportive and stigma-free environment are essential to reduce the burden of undiagnosed eating disorders among students.

CONCLUSION

This study provides valuable insights into the prevalence of disordered eating attitudes and behaviors among medical students in a private medical college in Lahore. The findings reveal a high prevalence of at-risk eating behaviors (37.6%) as measured by the EAT-26, highlighting the need for increased awareness and intervention efforts within this population. Contrary to some previous research, no significant gender difference was found in overall prevalence; however, male students reported significantly higher scores on the Oral Control subscale, suggesting potential cultural influences on body image and eating concerns among males in this context. These findings, while consistent with some regional studies, contrast with lower global estimates, emphasizing the importance of context-specific research. While this study contributes important data, limitations such as the convenience sampling method and reliance on self-report measures should be considered when interpreting the results. Future research employing more robust methodologies, including diagnostic interviews, and exploring the specific cultural and environmental factors contributing to these findings, is warranted. Ultimately, these findings underscore the need for targeted interventions and support services within medical education settings to address disordered eating and promote positive body image and mental health among future healthcare professionals.

ETHICS APPROVAL

The study was approved by the Institutional Review Board, Azra Naheed Medical College, Lahore (IRB/ANMC/2024/09). All procedures performed in studies involving human participants were following the ethical standards of the institutional and/ or national research committee and the Helsinki Declaration.

CONSENT FOR PUBLICATION

Participation was voluntary, and completion of the online questionnaire was considered implied informed consent.

AVAILABILITY OF DATA

The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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None.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Declared none.

AUTHORS' CONTRIBUTION

[OH] conceived the study and supervised data collection; wrote the first draft of the manuscript; [KM, AATKK] performed the statistical analysis and took part in data collection; [MAQ and MZL] contributed to the literature review and drafting the manuscript. All authors read and approved the final version.

GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work the authors limitedly used ChatGPT (GPT-4, OpenAI) to get language suggestions and do minor proofreading in some parts of the manuscript. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): American Psychiatric Publishing; 2013.
2. Túry F, Szabó P, Dukay-Szabó S, Szumska I, Simon D, Rathner G. Eating disorder characteristics among Hungarian medical students: Changes between 1989 and 2011. J Behav Addict 2021; 9(4): 1079-87. DOI: https://doi.org/10.1556/2006.2020.00078
3. Azzouzi N, Ahid S, Bragazzi NL, Berhili N, Aarab C, Aalouane R, *et al.* Eating disorders among Moroccan medical students: Cognition and Behavior. Psychol Res Behav Manag 2019: 129-35. DOI: https://doi.org/10.2147/PRBM.S165114
4. Bizri M, Geagea L, Kobeissy F, Talih F. Prevalence of eating disorders among medical students in a Lebanese medical school: A cross-sectional study. Neuropsychiatr Dis Treat 2020: 1879-87. DOI: https://doi.org/10.2147/NDT.S266241
5. Ali EA, Shehata WM. Eating disorder risk among medical students at Tanta University, Egypt. Egyptian J Community Med 2020; 38(4):17-22. DOI: https://doi.org/10.21608/ejcm.2020.119410
6. Erskine HE, Whiteford HA, Pike KM. The global burden of eating disorders. Curr Opin Psychiatry 2016; 29(6): 346-53. DOI: https://doi.org/10.1097/YCO.0000000000000276
7. Hay P. Current approach to eating disorders: A clinical update. Intern Med J 2020; 50(1): 24-9. DOI: https://doi.org/10.1111/imj.14691

8. Rome ES, Ammerman S. Medical complications of eating disorders: An update. J Adolesc Health 2003; 33(6): 418-26. DOI: https://doi.org/10.1016/j.jadohealth.2003.07.002

9. Conti JE, Joyce C, Hay P, Meade T. Finding my own identity: A qualitative metasynthesis of adult anorexia nervosa treatment experiences. BMC Psychol 2020; 8: 110. DOI: https://doi.org/10.1186/s40359-020-00476-4

10. Albano G, Teti A, Scrò A, Bonfanti RC, Fortunato L, Lo Coco G. A systematic review on the role of therapist characteristics in the treatment of eating disorders. Res Psychother 2024; 27(2): 750. DOI: https://doi.org/10.4081/ripppo.2024.750

11. Swami V, Frederick DA, Aavik T, Alcalay L, Allik J, Anderson D, *et al.* The attractive female body weight and female body dissatisfaction in 26 countries across 10 world regions: Results of the International Body Project I. Pers Soc Psychol Rev 2010; 36(3): 309-25. DOI: https://doi.org/10.1177/0146167209359702

12. Jill Thompson A, Poyrazli S, Miller E. Western media and body image dissatisfaction in young women in developing nations. Eurasian J Educ Res 2020; 90: 45-66. DOI: https://doi.org/10.14689/ejer.2020.90.3

13. Garner D, Olmsted M, Bohr Y, Garfinkel P. The eating attitudes test: psychometric features and clinical correlates. Psychol Med 1982; 12: 871-78. DOI: https://doi.org/10.1017/s0033291700049163

14. Garner DM, Garfinkel PE. The eating attitudes test: An index of the symptoms of anorexia nervosa. Psychol Med 1979; 9(2): 273-9. DOI: https://doi.org/10.1017/S0033291700030762

15. Memon AA, Adil SE, Siddiqui EU, Naeem SS, Ali SA, Mehmood K. Eating disorders in medical students of Karachi, Pakistan-a cross-sectional study. BMC Res Notes 2012; 5: 84. DOI: doi:10.1186/1756-0500-5-84

16. Waris M, Dawood K, Mukhtar T, Noor R, Bashir MS. Frequency of anorexia nervosa among female university students of Lahore, Pakistan. Rawal Med J 2020; 45(4): 780-2.

17. Jamali YA, Memon SF, Lagahri ZA, Shaikh SA, Warsi J, Arain AA. Prevalence of eating disorders among students of Quest University, Nawabshah, Pakistan. Merit Res J Med Med Sci 2020; 8(4): 81-4. DOI: https://doi.org/10.5281/zenodo.3764134

18. Ghamri RA, Alahmari AM, Alghamdi LS, Alamoudi SF, Barashid MM. Prevalence and predictors of eating disorders: A cross-sectional survey of medical students at King Abdul-Aziz University, Jeddah. Pak J Med Sci 2022; 38(6): 1633-8. DOI: https://doi.org/10.12669/pjms.38.6.5033

19. Hassnain S, Kazmi T, Shahid N, Khan S. Appraisal of eating disorders in females of reproductive age by using Scoff Questionnaire. JSHMDC 2023; 4(1): 4-10. DOI: https://doi.org/10.53685/jshmdc.v4i1.141

20. Alfalahi M, Mahadevan S, Balushi RA, Chan MF, Saadon MA, Al-Adawi S, *et al.* Prevalence of eating disorders and disordered eating in Western Asia: A systematic review and meta-Analysis. Eat Disord 2022; 30(5): 556-85. DOI: https://doi.org/10.1080/10640266.2021.1969495

21. Jahrami H, Sater M, Abdulla A, Faris ME, AlAnsari A. Eating disorders risk among medical students: A global systematic review and meta-analysis. Eat Weight Disord 2019; 24: 397-410. DOI: https://doi.org/10.1007/s40519-018-0516-z

22. Melisse B, de Beurs E, van Furth EF. Eating disorders in the Arab world: A literature review. J Eat Disord 2020; 8: 1-9. DOI: https://doi.org/10.1186/s40337-020-00336-x

23. Galmiche M, Déchelotte P, Tack J, Palmer P. Prevalence of eating disorders in adolescents and adults: A systematic review and meta-analysis. Am J Clin Nutr 2019; 10: 650. DOI: https://doi.org/10.1093/ajcn/nqy342

24. Nicula M, Pellegrini D, Grennan L, Bhatnagar N, McVey G, Couturier J. Help-seeking attitudes and behaviours among youth with eating disorders: A scoping review. J Eat Disord 2022; 10(1): 21. DOI: https://doi.org/10.1186/s40337-022-00543-8