



RISK EATING BEHAVIORS, LIFESTYLE AND LEVEL OF RESILIENCE IN HIGH SCHOOL STUDENTS OF PUBLIC INSTITUTIONS

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ABSTRACT

Adolescents have heterogeneous health problems; Currently, the presence of risky eating behaviors CAR (for its acronym in Spanish) and unhealthy lifestyles in young people has increased, contributing to the figures of overweight, obesity and problems such as eating disorders and food ingestion. **Objective.** Determine the relationship between risky eating behaviors, lifestyle and resilience level of upper secondary education students from public institutions in the municipality of Santiago de Querétaro. **Methodology.** It was a cross-sectional and analytical study, where 385 adolescents enrolled in public schools of 14-19 years, both sexes, were included. Weight, height was measured and the body mass index for age was calculated. A battery of instruments was applied to measure the variables risk eating behaviors, lifestyle, and level of resilience. Descriptive statistics were used for data analysis. The relationship of the study variables was determined with the X² test. **Results:** The findings show that 23.4% of adolescents were overweight (men 23.5%; women 23.2%) while 9.4% were obese (men 8.0%; women 10.6%). Risk eating behaviors are related to the level of resilience regarding the dimensions, social competence (X² = 13.03) and personal competence (X² = 9.86), as well as with the lifestyle in the feeding dimensions (X² = 8.64), drug use (X² = 7.09), sleep (X² = 5.91) and self-perceived emotional state (X² = 8.51). **Conclusions** A low and medium level of resilience in dimensions of social competence and personal competence is related to the adoption of CAR. Adolescents who presented CAR tend to carry out unhealthy lifestyle practices in dimensions of diet, drug use, sleep, and self-perceived emotional state.

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INTRODUCTION

The World Health Organization (WHO) considers adolescence as a stage of the life cycle from 10 to 19 years old (WHO, 2018). At the Latin American and Caribbean level, adolescents have a significant participation in society, since they represent 30% of the population (PAHO, 2013). According to the National Health and Nutrition Survey Medio Camino 2016 (ENSANUT), for the year 2016 in Mexico, there were 18, 492, 890 adolescents (INSP, 2016).

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weight. These types of unhealthy behaviors have become, to a certain extent, a daily habit among young people without them being clear to what extent they are healthy or unhealthy (Unikel *et al.*, 2017).

The clinical practice guide for eating disorders of the National Institute of Psychiatry "Ramón de la Fuente Muñoz" recognizes that CAR are more frequent than eating disorders and food ingestion (Unikel & Caballero, 2010). Various authors point them out as a prior stage for the development of an eating disorder and food ingestion such as anorexia, bulimia or binge eating disorder (Nuño *et al.*, 2009); situations that

usually coexist with anxiety, depression and / or substance abuse problems (WHO, 2018).

The figures at the national level of CAR show a progressive increase, going from 0.8% in 2006 to 1.3% in 2012. Research carried out on the adolescent population of the city of Querétaro, reports figures from 8.7% in adolescents and young adults (Ortiz, 2016), up to 19.5% in adolescents from 14 to 19 years old (Barajas, 2018).

The multiple and significant physical, psychological and social changes, including exposure to factors such as poverty, abuse or violence, are different scenarios that make adolescents vulnerable to the development of physical and mental health problems (WHO, 2018).

A resilient adolescent is capable of facing such adverse situations for their health and strengthening their interpersonal relationships (García *et al.*, 2016). Resilience is defined by Ruvalcaba *et al.* (2015) as a “protective factor that through a process or mechanism contributes to a good result”. His study in the adolescent population has focused on elucidating aspects such as level of adaptation due to tasks of this life cycle, school performance or establishing social relationships (Leiva *et al.*, 2013).

Knowing aspects such as eating behavior, lifestyle and resilience of adolescents can help protect them and enhance prosperity and well-being in adolescence and later in adulthood, regarding physical and mental health (WHO, 2018). The WHO considers it a priority to address the current epidemiology of eating disorders and food intake in the adolescent population, because they are a vulnerable age group and the appearance of CAR or mental illness, such as anorexia, bulimia or binge eating disorder, have a considerable impact on the health and quality of life of those who suffer from them (Gil *et al.*, 2003). It is recognized that these mental problems rank third (5%) among the most frequent chronic diseases in adolescents. The detection and early care of adolescents who perform CAR will significantly improve the prognosis of health complications (Gaete *et al.*, 2012) and will help prevent unhealthy habits, acquired early in the life cycle.

Identifying eating behaviors and practices related to eating disorders and food intake, as well as aspects of lifestyle and components of resilience, helps to characterize and focus the critical points in which adolescents are compromising their health condition.

The following hypotheses were managed

Hypothesis 1

Adolescents with a low and medium level of resilience have moderate and high-risk eating behaviors.

Hypothesis 2

Adolescents with moderate risk and severe risk eating behaviors present unhealthy practices in the dimensions of interpersonal skills, coping and perceived emotional state of lifestyle.

The general objective was to determine the relationship between risky eating behaviors, lifestyle and level of resilience in upper secondary education students from public institutions in the Municipality of Santiago de Querétaro, Querétaro.

METHODOLOGY

A cross-sectional and analytical study was carried out, the universe was made up of students from upper secondary education, from public, urban educational establishments, with a school system, from the municipality of Santiago de Querétaro, Querétaro. A multi-stage sampling was carried out. The schools were randomly selected from the Querétaro state education secretary register for upper secondary education for the 2017-2018 school year. The sample size was determined using the formula for a finite population of a universe of 23,897 adolescents, with a confidence interval of 95%, obtaining for this study a sample of 264 adolescents. The sampling frame was obtained through a proportional sampling of each of the participating schools. For the selection of the analysis units, a convenience sampling was applied. Data collection was carried out at each school in time and facilities provided by the academic authorities so as not to affect the student's school activities.

The applied instrument consisted of two sections. The first corresponded to sociodemographic data, inherited family and pathological personal history; The second included the questionnaires to measure the variables of risky eating behaviors, lifestyle, and level of resilience, which have values of reliability and validity appropriate to the objective of the study.

Likewise, measurements of weight and height were made, based on the standardized method of the International Society for the Advancement of Kinanthropometry (ISAK, 2011) using a TANITA BC-568 Segmental Composition Monitor and SECA 213 portable stadiometer scale. The Z score of the Body Mass Index for age and sex was calculated using the WHO Anthro Plus v. 1.0.4.

Following the criteria of the World Health Organization (WHO, 2018), adolescents were classified according to the Z score, with low weight if they present values less than -2 standard deviations, overweight if they have values above +1 standard deviation, and obese if they have values above +2 standard deviations. The percentage of body fat in adolescents was classified using the cut-off points proposed by Escobar *et al.* (2016).

To measure the variable risk eating behaviors, the questionnaire validated by Unikel *et al.* (2004) was applied, which consists of 10 Likert-type questions, concerning about gaining weight, binge eating, eating restriction or purging behaviors. In each question, only one answer is indicated, ranging from never or almost never, sometimes frequently, and very frequently; the sum of points of each answer was classified according to the cut-off points established by the authors and categorized as: no risk, moderate risk or high risk. For the variable lifestyles, the lifestyle questionnaire (CEVJU-R) by the authors Salazar *et al.* (2010) was used, consists of 68 questions, Linkert type multiple choice. It is divided into 8 dimensions: Exercise and physical activity, leisure time, food, alcohol consumption, cigarettes and illegal drugs, sleep, interpersonal skills, coping and self-perceived emotional state. Each dimension is made up of certain questions whose answers take on a certain value; the sum of points for each dimension was classified according to cut-off points established by the authors of the instrument for each dimension, categorizing lifestyle practices as healthy or unhealthy.

The measurement of the level of resilience was carried out by applying the READ Scale of Resilience for Adolescents, made up of 28 questions with Likert-type answers (strongly agree, agree, normal, disagree, strongly disagree). Assessing five dimensions of resilience: family cohesion, social competence, personal competence, social resources, and goal orientation. Each dimension is made up of certain questions whose answer takes a certain value; The sum of points for each dimension was classified according to cut-off points established by the authors of the instrument for each dimension, categorizing the level of resilience by dimension as low, medium, or high (Ruvalcaba *et al.*, 2015).

The data was analyzed with descriptive and inferential statistics using the SPSS Statistics v23.0 statistical package. In the continuous variables, means and standard deviations were used; Frequencies were used in the categorical variables. To determine the relationship between the main variables, the X² statistical test was used.

Study Ethics

The protocol was evaluated and approved by the Bioethics Committee of the Faculty of Natural Sciences with registration number 11FCN2017.

This investigation was carried out in compliance with the Regulations of the General Law on Health in matters of research (LGS, 2014).

RESULTS AND DISCUSSION

398 adolescents participated, of which 13 subjects were eliminated because they did not complete a 100% the battery of applied instruments.

The results correspond to 385 adolescents, 48.6% (187) were men and 51.4% (198) women, with a minimum age of 14 years and a maximum of 19 years (□=16.0±0.9), belonging to five public educational institutions upper middle of the municipality of Santiago de Querétaro. Of the participants, 15.6% (60) of the young people study and work, 93% have siblings and 57.1% (220) are children of working mothers. The main diseases reported in a family history were obesity (89.4%) and diabetes mellitus (83.6%) and personal was obesity (13.0%) (Table 6.2). Likewise, Table 6.3 shows the average value of the anthropometric variables of the study population.

Table 6.2 Sociodemographic characteristics, hereditary family history and personal history of adolescents.

Variable		fx	%
Sociodemographic data	Men	187	48.6
	Women	198	51.4
	Students who study and work	60	15.6
	Students who have siblings	358	93.0
	Students born to working mothers	220	57.1
Hereditary family history	Students born of working parents	353	91.7
	Obesity	344	89.4
	Mellitus diabetes	322	83.6
	Arterial hypertension	160	41.6
	Psychiatric illness	27	7.0
Personal history	Obesity	50	13.0
	Mellitus diabetes	0	0
	Arterial hypertension	0	0
	Psychiatric illness	6	1.6

Table 6.3 Anthropometric variables of adolescents.

Variables	General (n=385)	Men (n=187)	Women (n=198)
	Mean±DE	Mean±DE	Mean±DE
Weight (kg)	61.3±13.5	65.1±14.6	57.8±11.3
Height (cm)	163.7±8.8	170.2±6.	157.5±5.7
Body mass index (kg/m ²)	22.8±4.2	22.3±4.3	23.2±3.9
Average of fat (%)	26.4±8.1	21.4±6.2	31.0±6.8

Regarding risky eating behaviors (CAR), it was found that 34.8% (men 34.6%; women 34.85%) of the adolescents in the study population presented this type of unhealthy eating behavior (Table 4). Observing 21.9% of CAR with moderate risk in men and 16.6% of CAR with high risk in women.

Table 6.4 Risky eating behaviors of the study population.

Risky eating behaviors	General (n=385)		Men (n=187)		Women (n=198)	
	fx	%	fx	%	fx	%
Risk free	251	65.2	122	65.2	129	65.1
Moderate risk	76	19.7	40	21.3	36	18.1
High risk	58	15.1	25	13.3	33	16.6

However, Ortiz (2016) in his research on young people from Querétaro reported that 8.4% (men 2.2%; women 6.3%) presented CAR; years later, Barajas (2018) in a sample with 128 adolescents found that 19.5% (men 19.2%; women 23.2%) of adolescents from 14 to 17 years old, incurred CAR, with men presenting the highest proportion of CAR with high risk (9.4%). These results are lower and differ with what was found in the study population (34.8%). Despite the variability in the figures, it should be noted that this health problem, considered in its beginnings only in women and upper-class people (Unikel *et al.* 2010), has spread notably in the adolescent population, presenting itself every more often not only in women but also in men.

According to the Body Mass Index for Age (BMI / E), it was found that 2.6% of adolescents were underweight (men 3.7%; women 1.5%), 23.4% overweight (men 23.5%; women 23.2%), and 9.4% obesity (men 8.0%; women 10.6%).

Table 6.5 Nutritional diagnosis according to the BMI / E of the study population

IMC/E	General (n=385)		Men (n=187)		Women (n=198)	
	fx	%	fx	%	fx	%
Underweight	10	2.6	7	03.7	3	1.5
Regular	249	64.7	121	64.7	128	64.6
Overweight	90	23.4	44	23.5	46	23.2
Obesity	36	9.4	15	08.0	21	10.6

Under weight = ≤-2 DE; Regular=>-2 DE y <1 DE; Overweight= ≥1 DE; Obesity= ≥2 DE. WHO (2018).

The data found in the study population in relation to overweight are similar to those reported in the ENSANUT MC 2016 (22.4% men 18.5%; women 22.4%), affecting mainly women.

However, the obesity figure reported in such a survey was 13.9% (men 15.0%; women 13.9%), which indicates that it is 4.5 percentage points higher than that found in the study population; being 7.0% higher for men and 3.3% for women. Overweight and obesity are a public health problem at a national and global level, therefore, overweight and obese young people should be cared for from a comprehensive approach due to the presence of cardiovascular, endocrine-metabolic, and psychosocial complications, which they put them at a higher risk of dying at an early age. This condition also victimizes young people of social isolation, difficulty

relating to their peers, low self-esteem, stress, anxiety, and depression, as well as adopting binge-type eating behaviors (Martínez, 2017).

Regarding the percentage of body fat in adolescents, 16.9% (men 19.8%; women 14.1%) had excess body fat, and 14.5% (men 8.6%; women 20.2%) were obese due to adiposity.

Table 6.6 Body fat percentage for the age and sex of the study population.

Body fat percentage	General n=385		Men (n=187)		Women (n=198)	
	fx	%	fx	%	fx	%
Low body fat	1	0.3	0	0.0	1	0.5
Normal body fat	263	68.3	134	71.7	129	65.2
Excess body fat	65	16.9	37	19.8	28	14.1
Obesity by adiposity	56	14.5	16	8.6	40	20.2

Low body fat = $\leq p3$; Normal body fat $\Rightarrow p3$ and $< p90$; Excess body fat = $\geq p90$ and $< p97$; Obesity by adiposity = $\geq p97$. Escobar *et al.* (2016). 31.4% (men 28.4%; women 34.2%) of the adolescents presented a high percentage of body fat for their age and sex, considering the categories of excess body fat and obesity due to adiposity.

These data are different from what was found in the research carried out by Aguilera & Millán (2006) where it is mentioned that 72% (men 70.0%; women 74.0%) of the adolescents from public and private schools in the municipality of Santiago de Querétaro, they presented a high percentage of body fat, such situation being more common in adolescents from public schools and female population. However, it should be taken into account that during adolescence there is a considerable change in body composition according to sex and age, the effect of diet, physical activity, and disease must also be considered (González, 2013). In itself, women experience a considerable increase in body fat tissue reserves and men a greater synthesis of muscle mass (Güemes *et al.* 2017). What is worrying is when such an increase in both men and women is above the recommended and affects the physiological state of young people, hence the importance of not only identifying those young people with high BMI but also those with unhealthy fat percentages.

Regarding lifestyle, the dimensions with the highest presence of unhealthy practices were exercise and physical activity 38.2% (men 27.8%; women 47.9%), sleep 21.3% (men 19.2%; women 23.2%) and self-perceived emotional state 34.3% (men 28.8; women 39.9%).

Table 6.7 Lifestyle (dimensions) of the study population.

Lifestyle	General (n=385)				Hombres (n=187)				Mujeres (n=198)			
	Healthy		No Healthy		Healthy		No Healthy		Healthy		No Healthy	
	fx	%	fx	%	fx	%	fx	%	fx	%	fx	%
Exercise and physical activity	238	61.8	147	38.2	135	72.1	52	27.8	103	52.0	95	47.9
Leisure time	319	82.9	66	17.1	164	87.7	23	12.3	155	78.2	43	21.7
Feeding	341	88.6	44	11.4	166	88.7	21	11.2	175	88.3	23	11.6
Consumption of drugs	353	91.7	32	8.3	167	89.3	20	10.7	186	93.9	12	6.0
sleeping	303	78.7	82	21.3	151	80.7	36	19.2	152	76.7	46	23.2
Interpersonal skills	335	87.0	50	13.0	164	87.7	23	12.3	171	86.3	27	13.6
Coping	350	90.9	35	9.1	173	92.5	14	7.4	177	89.3	21	10.6
Self-perceived emotional state	253	65.7	132	34.3	134	71.6	53	28.3	119	60.1	79	39.9

The data described above coincide with that reported by Tamayo *et al.* (2015) since in his research he showed that young people in Colombia mainly presented unhealthy practices in the dimensions of the sleep lifestyle (72%), and self-perceived emotional state (50.9%). Regarding exercise and physical activity, the data is similar to that reported in the

ENSANUT MC 2016, which reported that 39.2% of adolescents from 12 to 19 years old do not perform recommended physical activity. Also, the data is similar to that found by Barajas (2018), in a sample of adolescents, 34.4% (men 26.4%; women 38.7%) presented unhealthy practices in the dimension of exercise and physical activity and 33.6% (men 28.3%; women 38.7%) in the dimension of self-perceived emotional state.

Adolescents' lifestyle involves daily actions that eventually become habits that directly impact their health, hence the importance of promoting a healthy lifestyle as a protective factor against chronic non-communicable diseases. In fact, García *et al.* (2012) mentions that carrying out unhealthy practices specifically in aspects such as diet and physical activity has been related to the presence of overweight and obesity.

The level of resilience was reported using the five dimensions that make up the measurement instrument. Las dimensiones con menor proporción de resiliencia alta fueron competencia personal (hombres 21.39%; mujeres 15.15%), competencia social (hombres 24.06%; mujeres 12.12%), y orientación a metas (hombres 20.32%; mujeres 14.14%).

Table 6.8 Resilience level (dimensions) of the study population

Resilience	General (n=385)						Men (n=187)						Women (n=198)					
	Low		Moderate		High		Low		Moderate		High		Low		Moderate		High	
	fx	%	fx	%	fx	%	fx	%	fx	%	fx	%	fx	%	fx	%	fx	%
Family cohesion	100	26.0	208	54.0	77	20.0	36	19.2	104	55.6	47	25.1	64	32.3	104	52.5	30	15.1
Personal competence	159	41.3	156	40.5	70	18.2	69	36.9	78	41.7	40	21.3	90	45.4	78	39.3	30	15.1
Social competence	102	26.5	214	55.6	69	17.9	33	17.6	109	58.2	45	24.0	69	34.8	105	53.0	24	12.1
Social resources	119	30.9	162	42.1	104	27.0	50	26.7	83	44.3	54	28.8	69	34.8	79	39.9	50	25.2
Goal orientation	115	29.9	204	53.0	66	17.1	47	25.1	102	54.5	38	20.3	68	34.3	102	51.5	28	14.1

González *et al.* (2013) in their research on the level of total resilience in children, adolescents, young adults and average adults, found that the mentioned groups had a higher prevalence of high resilience; however, adolescents (15%) and young adults (23%) achieved better figures compared to the group of children (14%) and average adults (11.3%). These data differ from that found in the present investigation because the high resilience frequency in the five dimensions evaluated ranged from 17.1% to 28.0%, figures greater than 15% reported by González *et al.* (2013).

Most of the adolescents studied presented a low and medium level of resilience in aspects such as personal and social competence and goal orientation. Situation that should be considered since Dias *et al.* (2017), López *et al.* (2008) and Leiva *et al.* (2013) mention that these aspects are good predictors of a high level of resilience in adolescents. The fact that young people have a high level of resilience helps them to act better in the face of the new challenges and responsibilities of adolescence, and psychosocial problems, for this reason, this characteristic should be encouraged and strengthened (Del Toro & Chávez, 2017).

To determine the relationship of the main variables, the X² statistical test was applied, which assumes that the distribution of the variables is normal. A statistically significant relationship was found when relating the resilience variable with risky eating behaviors, in the dimensions of social competence (X²= 13.03) and personal competence (X²= 9.86) (table 6.9).

Table 6.9 Relationship of the study variables: level of resilience and CAR.

Variable	Relation	X ²
Resilience	Family cohesion and risky eating behaviors	2.26
	Social competence and risky eating behaviors	13.03*
	Personal competence and risky eating behaviors	9.86*
	Social resources and risky eating behaviors	2.84
	Orientation to goals and risky eating behaviors	4.34

Statistical test X²: * Value of p <0.05.

In the investigation carried out by Fuentes (2018) in adolescents from 12 to 14 years of age, it was not possible to establish a correlation between the variables resilience and CAR, since the Pearson's statistical correlation test yielded a value of R -0.38, with a value of P of 0.71, which indicates that such correlation does not have a statistically significant value. Despite this, the literature recognizes that resilience is a protective factor, related to aspects of family, social support and personal attributes of adolescents, which influences the obtaining of successful results in the presence of risk situations (Salas, Hodgson, Figueroa & Urrejola, 2011).

On the other hand, when relating the variables risky eating behaviors and lifestyle, a statistically significant relationship with dimensions was found: diet (X²= 8.64), drug use (X²= 7.09), sleep (5.91), and self-perceived emotional state (X²= 8.51) (Table 6.10).

Table 6.10 Relation of the study variables: CAR and lifestyle.

Variable	Relation	X ²
Lifestyle	Risk eating behaviors and exercise and physical activity	3.48
	Risk eating behaviors and leisure time	1.39
	Risk eating behaviors and feeding	8.64*
	Risk eating behaviors and drug use	7.09*
	Risk eating behaviors and sleep	5.91*
	Risk eating behaviors and interpersonal skills	1.63
	Risk eating behaviors and coping	3.36
	Risk eating behaviors and self-perceived emotional state	8.51*

Statistical test X²: * Value of p <0.05.

It is currently recognized that an abnormal eating pattern followed by individuals with an eating disorder and food intake can range from fasting to overfeeding or coexist, depending on the type of disorder that occurs (López & Magaña, 2014). Salas *et al.* 2011, in their research they found a relationship between the presence of bulimia and the monitoring of low-energy diets; Since 37% of patients with such a psychiatric disorder, 25% presented unhealthy eating practices, given that they followed low-energy diets. Which coincides with what was found in the present investigation.

During adolescence, young people tend to be more susceptible to the consumption of legal or illegal drugs, in the case of tobacco consumption, according to Cruz, *et al* (2013), They are usually used as appetite suppressants and thus achieve to maintain or decrease body weight, additionally, those young people who consume alcohol have a higher amount of CAR compared to those who do not consume it. Studies such as that reported by Bisseto *et al.* (2012) delve into the relationship between CAR and the consumption of different drugs.

Sleep problems are a common situation in adolescents, especially women. A relationship has been found between the presence of anorexia with lower sleep efficiency, insomnia, shorter sleep duration and early awakening, the latter as body weight is lost (Seigel *et al.*, 2004). Guirardo&Ballester (2005) in their research found a statistically significant correlation

between the presence of CAR and presenting unhealthy practices for sleeping at night (r = 0.16; p = 0.00), consuming alcohol and drugs (r = 0.11; p = <0.00).

Finally, both Guirardo&Ballester (2005) and Castillo (sf) mention that those adolescents who do not feel happy (r = 0.09; p = <0.01) or who present sadness (f = 112.06; p = 0.00), resort to the adoption of CAR, respectively. Although the mechanism by which there is an influence between eating behavior and emotions and mood is currently unknown exactly, The following hypothesis is suggested: “unpleasant emotions induce feeding to regulate these emotions; intense emotions tend to suppress food intake; pleasant and unpleasant emotions hinder cognitive control of eating behavior; the control of food choices depends on the emotion induced by the food itself”(Macht, 2008).

CONCLUSION

Analyzing what the literature mentions and from the results obtained, it is concluded that adolescents are a population group susceptible to carrying out unhealthy behaviors and / or practices in their eating behavior.

The presence of overweight and obesity was notorious, both for the body mass index for age and percentage of body fat, which indicates that adolescents, If they do not correct these behaviors, they are at a latent risk of presenting different types of chronic non-communicable diseases such as diabetes, high blood pressure, dyslipidemias, or risky eating behaviors during their young adult stage.

The youth lifestyle was mainly characterized by healthy practices. However, the dimensions of exercise and physical activity, sleep and self-perceived emotional state were the ones that reached the highest proportions of adolescents with unhealthy practices. That is why it is important to strengthen and promote healthy lifestyles where they are promoted and propose strategies to improve this type of behavior so that lifestyle serves as a key factor for maintaining health in young and future adults.

Resilience emerges as a protective factor for adolescent health, hence the importance of seeking to promote and strengthen this characteristic in young people. In the case of the studied population, there was a greater trend towards a low and moderate level of resilience. This indicates that there are a large number of adolescents who are susceptible to situations of risk to their health. The fact of characterizing what are the behaviors and practices that adolescents are carrying out, helps to propose focused strategies for the promotion, prevention and maintenance of health in this population group, through the development of comprehensive health care programs working together in the health and education sectors.

Regarding the established hypotheses, hypothesis 1 was accepted, which mentions that there is a relationship between the presence of a low and medium level of resilience with risky eating behaviors; In this case, a statistically significant relationship was found specifically with the dimensions of social competence and personal competence. However, hypothesis 2 was rejected, since only a statistically significant relationship was found with the dimension of lifestyle, self-perceived emotional state, and the presence of risky eating behaviors, not so for the dimensions of interpersonal skills and coping.

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