

The Dangers of Disordered Eating

The Problem

Prevention experts from the field of eating disorders (EDs) have expressed concern that messaging resulting from obesity (OB) prevention initiatives might unintentionally trigger weight and shape preoccupation among children and youth.¹ There is a potential for children and families to misinterpret individual and population-level health messages related to weight, food and body image. Monitoring of weight to help promote healthy weights can have the unintended consequence of promoting obsession with weight and shape.² In other words, children and youth might adopt unhealthy means to attain a healthy weight.

Why are prevention experts concerned? In our current environment, there are extremely strong pressures to be thin, focus on weight, and very high levels of weight stigmatization, all of which lead to body dissatisfaction. Body dissatisfaction is associated with the use of unhealthy weight control behaviours, which in turn pose a risk for the development of disordered eating and/or EDs. Disordered eating (DE) is much more prevalent than EDs.³ Generally speaking, DE includes more subtle criteria such as abnormal body image perception and weight concerns. Two broader classes of concepts of DE are outlined in a discussion document on the possible integration of OB and ED. *Attitudes* include desire to lose weight, concern about weight and shape, body dissatisfaction, low body esteem and poor body image. *Behaviours* include a range from less extreme (skipping meals, fasting, crash/fad and chronic dieting) to more extreme unhealthy weight control practices (self-induced vomiting, laxative, diuretic and diet pill use, excessive exercise and smoking for the purpose of weight loss). Disordered eating, including "negative body image," is a risk factor for a variety of problems, notably eating disorders and depression in adolescent females. There is also some evidence that DE is associated with use and abuse of substances, including tobacco and alcohol.⁴ The burden of EDs, notwithstanding, body dissatisfaction also places children and youth at risk for overweight/OB.⁵ Eating related problems, including childhood overweight/OB, are complex problems deserving of complex solutions. A focus on OB, in terms of weight and BMI, is potentially misleading because it assumes, without basis, that (a) overweight and even obese people cannot be healthy; and (b) those who are not overweight are eating and behaving in a healthy fashion--even though we know that this is not the case at all.

Prevalence

A Burlington based support centre for Eating Disorders and Disordered Eating has seen a 30% increase in attendance in their programs which cover topic areas such as breaking the binge cycle, stress relief, art therapy, and support groups. Of those attending groups 87% are female and almost 1 in 5 are on waiting list for treatment.⁶

An information centre specializing in eating disorders fields, on average, 150 inquires a year about disordered eating, including specific questions about unhealthy dieting, weight preoccupation, and over-exercising.⁷

One organization in Toronto which offers groups that focus on support, body image, expressive arts and skill building have over **3000** registrants in a single year.⁸

A survey conducted with students found that one in four teen girls engage in DE. Another found that 30% of girls and 25% of boys have dieted to lose weight despite being within a healthy weight range.⁹ It has been shown that over a three year period adolescent females who had been severely dieting at baseline were 18 times more likely to develop a full ED, and those who dieted moderately were 5 times more likely to develop full or partial ED.¹⁰

EDs and OB are usually seen as very different problems but actually share many similarities. ED, OB and other eating-related disorders may overlap as children and youth move from one problem, unhealthy dieting, to another such as OB. Some of the common factors linked to both OB and ED include body dissatisfaction and unhealthy dieting, binge eating, and the environment as a contributing factor.^{11,12}

The Cost

Although not as prevalent as DE, Anorexia nervosa (AN) and bulimia nervosa (BN) are serious psychiatric conditions recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).¹³ The frequency of EDs in Ontario has been established in a large non clinical community sample. The lifetime prevalence of BN was found to be 1.1% for female subjects and 0.1% for male subjects.¹⁴ The lifetime prevalence of AN was found to be 0.56% for females and 0.16 for males.¹⁵ EDs are associated with medical and psychiatric co-morbidity, and can **have a devastating impact on the sufferers and their families**. There is evidence of long-term health effects, especially in AN, in a sizable proportion of cases.¹⁶

So what is the plan as waiting lists begin to increase due to the

rising

rates of Disordered Eating
and Eating Disorders?

The Proposed Solution

First Do No Harm

A "First do no harm" approach has been adopted by prevention experts in the field of EDs. Lessons learned from this body of knowledge could help guide the development of both ED and OB prevention strategies and the integration of the two. An emphasis on defining, promoting, and sustaining HEALTH through a multi systems ecological approach can help to prevent numerous eating-related (or weight-related) disorders (and their underlying issues), all the while offsetting the entrenched myth that thin(ner) = healthy and good, while fat(ter) = unhealthy and bad. Ecological models take into consideration the multiple factors (individual, social, environmental) that influence health, weight, and lifestyle practices. Emphasis is placed on optimizing environments and promoting life skills that empower and support children and youth to adopt health-promoting behaviours.²⁰

Human Costs of ED/DE

AN is the most lethal among all other psychiatric disorders, including Schizophrenia and Major Depression. This is because fatalities in AN occur for medical reasons e.g. cardiovascular problems, and by suicide out of despair and hopelessness. A recent review revealed mortality rates as high as 5-8%.¹⁷

Social Costs of ED/DE

Research indicates that the longer the disorder persists, the harder it is to treat. Clients who fail to recover remain impaired in terms of their psychosocial and work/school functioning.¹⁸

Financial costs of ED/DE

ED treatment costs are more than twice as high as those for schizophrenia and six times as high as those for substance abuse. Additionally, average length of stay in treatment is the longest for those suffering from EDs.

We could save over 5.5 million dollars in the Ontario health care system by having adequate provincial services available to treat eating disorders.¹⁹

A Case for a Shared Risk Factor Model of Prevention

Examples of emerging integrative approaches:

Healthy Schools Healthy Kids - A comprehensive school-based universal prevention program involving male and female students, parents, teachers, school administrators and local public health professionals aimed at increasing body satisfaction, size acceptance, and decreasing disordered eating, and weight-based teasing. The Healthy Schools-Healthy Kids (HS-HK) program had a positive influence by reducing the internalization of media ideals among male and female students and by reducing disordered eating among female students.²¹

Planet Health - A School-based interdisciplinary health behaviour intervention on obesity focusing on decreasing television viewing, decreasing consumption of high-fat foods, increasing fruit and vegetable intake, and increasing moderate and vigorous physical activity through teacher training workshops, classroom lessons, physical education materials, wellness sessions, and fitness funds. Measures of extreme dieting behaviour were examined to assess whether the intervention could have produced unintended side effects. Results showed a decrease in television watching, increasing in vegetable intake, and a decrease in the prevalence of OB. Also, levels of extreme dieting behaviour did not increase.²²

Tri-Delta - This intervention uses a cognitive dissonance approach in an American Sorority and aims to promote sorority empowerment, and suggest options for sorority policy change. Sessions focus on discouraging pursuit of the thin-ideal through exercises, role-play, discussions, and explanation of the costs of pursuing the thin-ideal. Groups also brainstorm ideas for positive policy change, barriers to change, and ways to overcome these barriers. Results showed reductions in restraint, eating pathology, thin-ideal internalization, and body dissatisfaction²²

VIK (Very Important Kids) - a school based, multi-level intervention using a generalized no-teasing message, conveyed through a participatory approach, with interventions targeting the individuals, family and school climates, aimed at preventing teasing and unhealthy weight-control behaviours in an ethnically diverse, primarily low-income sample of fourth to sixth grade students. The after-school program was determined as the most effective aspect of intervention²⁴

Other opportunities for cross-curricular integration include:

- Embed weight-based teasing into existing bullying prevention initiatives (school-based and otherwise)
- Embed size acceptance/diversity into Equity curriculum/standards
- Integrate substance abuse prevention/mental health promotion prevention curriculum with eating-related disorder prevention initiatives

Risk factors common to both overweight/obesity and disordered eating/ eating disorders are:

- weight-based teasing
- media use
- restrictive dieting and
- unhealthy weight control variables²⁵

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