

Disordered Eating and Eating Disorders: Pediatric Obesity

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Abstract

While the precise prevalence of disordered eating among overweight and obese youth remains uncertain, research indicates that young adults (aged 18 year-24 year) with obesity are 2.45 times more likely to engage in disordered eating behaviors compared to their peers with Body Mass Indexes (BMI) within the normal range. This review aims to underscore the significance of disordered eating and eating disorders in the context of pediatric obesity and emphasizes the importance of conducting screenings for these conditions. Detecting and evaluating disordered eating can have a substantial impact on the direction of treatment. Lacking insight into the relationship between obesity and disordered eating, healthcare providers may persist with conventional treatment approaches. This approach could unintentionally reinforce internalized weight bias in individuals with obesity and worsen their symptoms and behaviors related to disorder eating. Furthermore, comprehending the varying degrees of disordered eating within pediatric patients dealing with obesity enables healthcare providers to personalize treatments, engage in different discussions about nutrition and physical activity, and determine the appropriate moments to refer patients to specialists in eating disorders for ongoing care.

Keywords: Disordered eating behaviors • Eating disorders • Pediatrics • Quality of life • Health

Introduction

Eating Disorders (EDs) are severe physical and mental illnesses characterized by complex and detrimental relationships with food, eating habits, physical activity, and body image. These disorders can affect individuals of all genders, age groups, ethnic backgrounds, body sizes, socioeconomic statuses, religions, and sexes. Globally, EDs impact at least 9% of the population. In the United States, approximately 28.8 million Americans, or 9% of the population, will experience an eating disorder during their lifetime. It's worth noting that fewer than 6% of individuals with an ED receive a medical diagnosis of "underweight". Having an increased level of adiposity is a risk factor for developing an ED, even among culturally diverse individuals and males. Furthermore, individuals with Binge Eating Disorder (BED) and Bulimia Nervosa (BN) often experience weight gain as a common outcome. Despite these facts, individuals with higher adiposity are only half as likely as those with average or below-average BMIs to receive an ED diagnosis.

Difference between disordered eating and eating disorders

The differentiation between disordered eating and eating disorders hinges on the extent. Although Disordered Eating (DE) and Eating Disorders (ED) are

frequently used interchangeably, their distinction lies in the intensity and regularity of the behaviors exhibited. In this review, we will use the term "Disordered Eating Behaviors (DEBs)" to encompass the spectrum of disordered eating behaviors, encompassing subclinical manifestations of eating disorders. Disordered eating comprises various components, such as holding a negative perception of one's weight and shape, engaging in unhealthy weight control tactics, and experiencing episodes of binge eating. In contrast, eating disorders are categorized as psychiatric conditions that lead to aberrant eating or weight control behaviors, with health professionals diagnosing them according to the diagnostic criteria found in the DSM-5-TR. The constructs found within disordered eating are also typically present in eating disorders, often causing challenges in distinguishing between the two. Nevertheless, the critical distinction between disordered eating and eating disorders lies in the frequency and severity of the atypical eating patterns.

As an example, consider the diagnosis of Binge Eating Disorder (BED). To be diagnosed with BED, an individual should experience episodes where they consume a significant quantity of food while feeling a loss of control over their eating, occurring at least once a week on average for the past three months. Moreover, the individual must meet at least three of the following criteria: eating more rapidly than usual, eating until uncomfortably full, consuming large quantities of food when not hungry, eating alone because of embarrassment about the amount of food consumed, and experiencing feelings of disgust, depression, or guilt following a binge eating episode.

Prevalence of obesity and DEBs

The prevalence of Disordered Eating Behaviors (DEBs) and eating disorders (EDs) among children and adolescents with obesity remains uncertain. However, a study involving 3,043 adolescents in Canada revealed that the occurrence of estimated subclinical or full-threshold eating disorders was higher in adolescents with obesity (9.3% among males and 20.2% among females) compared to their counterparts with a healthy weight (2.1% among males and 8.4% among females). As per the Centers for Disease Control and Prevention (CDC), obesity, defined as having a BMI above the 95th percentile for age, affected approximately 14.7 million children and adolescents in 2020. Children with obesity exhibit higher rates of DEBs compared to children with normal weight. The onset of eating disorders and disordered eating behaviors typically occurs between childhood and adolescence in both boys and girls. Many male eating disorder patients report being overweight or having obesity during their developmental stages in childhood or adolescence.

Screening for DEBs

In the context of pediatric weight management, the treatment of children and adolescents with disordered eating and eating disorders deviates from the typical standard of care. The conventional approach for children and adolescents with obesity usually involves promoting healthy eating behaviors, physical activity, and adopting healthful behavioral changes [20]. For instance, families often receive guidance on modifying eating habits, such as portion control or reducing the intake of energy-dense/low-nutrient foods. Children and adolescents with obesity are also encouraged to establish goals and identify targets for behavior change, like increasing physical activity or achieving weight reduction. However, these recommendations can pose challenges for individuals with obesity who also grapple with disordered eating. For instance, imposing strict categorizations of foods as either "good" or "bad," or "healthy" or "unhealthy," can trigger heightened food restriction, black-and-white thinking, and the elimination of

entire food groups. Similarly, prescribing a specific number of daily physical activities can induce excessive or compensatory physical activity in young people with obesity who also experience disordered eating behaviors. It's important to note, though, that structured obesity treatment has demonstrated an association with reduced prevalence, risk, and symptoms of eating disorders. In the context of pediatric obesity treatment, it is important to include screenings for risk factors related to eating disorders and disordered eating behaviors both before and after interventions and during follow-up assessments. The timely identification of DEBs in children and adolescents with obesity is crucial for improving their health and overall quality of life. Healthcare providers have a significant role to play in recognizing disordered eating behaviors and managing symptoms that could potentially develop into a full-fledged eating disorder. Additionally, medical professionals are pivotal in the process of screening for DEBs in young individuals with obesity. Identifying DEBs, addressing associated symptoms, and screening for eating disorders enable providers to tailor treatment plans to best suit the needs of the patient.

It's worth noting that with the recent introduction of Anti-Obesity Medications (AOMs) such as GLP-1 agonists, there is currently a lack of data regarding the effects of these medications on existing DEBs. This area presents an avenue for future research.

Effects on pediatric obesity

Medical: Children and adolescents should undergo screenings to assess their risk for cardio metabolic and obesity-related complications. The impact of Disordered Eating Behaviors (DEBs) on pediatric obesity and overall health can vary. For instance, episodes of loss of control or binge eating characterized by foods rich in refined carbohydrates and saturated fats can influence conditions like diabetes, fatty liver disease, and abnormal lipid levels. LOC eating is also linked to and can predict psychological symptoms, increased weight, and aggravated cardio metabolic health. Conversely, rigid beliefs about food or restricting certain food groups can lead to malnutrition, fatigue, hair loss, disrupted sleep, and deteriorating mood. It's crucial to note that eating disorders have one of the highest mortality rates among all mental health conditions. Even with recent advances in treatment, individuals diagnosed with Anorexia Nervosa (AN) and Bulimia Nervosa still face elevated mortality risks. In those who have received inpatient treatment, the risk of mortality is five times higher than that of individuals of the same age who do not have AN or BN.

Interestingly, there might also exist a two-way relationship between sleep patterns and disordered eating. Inadequate sleep and untreated sleep disturbances (such as poor sleep habits, delayed sleep onset, obstructive sleep apnea, and so on) are linked to increased appetite, reduced self-control, indulging in eating when not hungry, and a preference for high-

sugar and high-fat foods. Furthermore, individuals with emotional eating tendencies may be more responsive to changes in sleep, such as altered mood and an increased desire for food as a reward. Conversely, for some people, eating serves as a way to combat feelings of sleepiness or fatigue. While the exact mechanisms underlying the connection between sleep and disordered eating are not fully understood, it is likely related, at least in part, to the dysregulation of hunger and satiety hormones like ghrelin and insulin, among others.

Psychological: Disordered Eating Behaviors (DEBs) can give rise to a variety of psychological challenges in children and adolescents. These challenges encompass distorted thought processes and self-perceptions, difficulties in regulating emotions, experiences of shame and guilt, anxiety, depression, withdrawal from social interactions, and trouble with concentration. In particular, episodes of loss of control eating are associated with both higher body weight in children and adolescents and heightened psychosocial impairment. Consequently, these psychological issues often contribute to and intensify DEBs, forming a cycle of negative thought patterns that can, in turn, lead to emotional dysregulation. Emotional dysregulation frequently contributes to DEBs, as individuals may use them as a way to cope with their thoughts and emotions, subsequently increasing the likelihood of developing overweight or obesity.

Quality of life

Both the physical and psychological consequences of disordered eating behaviors often have a notable impact on an individual's quality of life. Quality of life is a term that encompasses an individual's overall well-being, encompassing their health, comfort, and happiness. Fontaine and Barofsky (2001) define health-related quality of life as a "multidimensional construct that includes emotional, physical, social, and subjective well-being, reflecting how an individual subjectively evaluates and responds to their health or illness". In the case of some young individuals, obesity can influence not only their mood but also their sleep patterns, motivation, physical mobility, and body image. Furthermore, obesity can have adverse effects on their interactions with peers and family members, including their ability to participate in activities or experiences typical of their peers of the same age. Lastly, obesity increases the risk of developing cardio metabolic conditions, such as type 2 diabetes mellitus. Research indicates a connection between DEBs and impairments particularly in the emotional functioning domain, among children and youth with obesity.