



Secretive eating among youth with overweight or obesity



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ABSTRACT

Purpose: Secretive eating, characterized by eating privately to conceal being seen, may reflect eating- and/or body-related shame, be associated with depression, and correlate with binge eating, which predicts weight gain and eating disorder onset. Increasing understanding of secretive eating in youth may improve weight status and reduce eating disorder risk. This study evaluated the prevalence and correlates of secretive eating in youth with overweight or obesity.

Methods: Youth ($N = 577$) presented to five research/clinical institutions. Using a cross-sectional design, secretive eating was evaluated in relation to eating-related and general psychopathology via linear and logistic regression analyses.

Results: Secretive eating was endorsed by 111 youth, who were, on average, older than youth who denied secretive eating (mean age = 12.07 ± 2.83 versus 10.97 ± 2.31). Controlling for study site and age, youth who endorsed secretive eating had higher eating-related psychopathology and were more likely to endorse loss of control eating and purging than their counterparts who did not endorse secretive eating. Groups did not differ in excessive exercise or behavioral problems. Dietary restraint and purging were elevated among adolescents ($\geq 13y$) but not children ($<13y$) who endorsed secretive eating; depression was elevated among children, but not adolescents, who endorsed secretive eating.

Conclusions: Secretive eating may portend heightened risk for eating disorders, and correlates of secretive eating may differ across pediatric development. Screening for secretive eating may inform identification of problematic eating behaviors, and understanding factors motivating secretive eating may improve intervention tailoring.

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1. Introduction

Pediatric obesity is a significant public health issue, with over one third of United States (US) youth meeting criteria for overweight or obesity (Ogden, Carroll, Kit, & Flegal, 2014). Overweight

and obesity are associated with medical comorbidities and impaired psychosocial functioning and confer risk for serious diseases (BeLue, Francis, & Colaco, 2009; Juonala et al., 2011). Moreover, obesity is associated with all-cause mortality compared to normal weight (Flegal, Kit, Orpana, & Graubard, 2013), and it is projected that this generation will “live sicker and die younger” than previous generations (National Collaborative on Childhood Obesity Research, 2009; Olshansky et al., 2005). Thus, research is needed to understand problematic eating behaviors that may

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contribute to excess weight or weight gain over time.

Secretive eating, a problematic eating behavior characterized by eating privately to conceal being seen, is relatively common in children and adolescents, with rates of endorsement ranging from 18.1% to 27.2% in children (Sonneville, Rifas-Shiman et al., 2013; Stice, Agras, & Hammer, 1999) and 34% in adolescents (Knatz, Maginot, Story, Neumark-Sztainer, & Boutelle, 2011). Secretive eating may occur in response to eating- or body-related shame, is associated with depressive symptomatology in adolescents with overweight or obesity (Knatz et al., 2011), and may correlate with binge eating (Marcus & Kalarchian, 2003; Stice et al., 1999), which itself predicts excess weight gain and eating disorder onset (Sonneville, Horton et al., 2013; Tanofsky-Kraff et al., 2011). Indeed, cognitive-behavioral theories of eating disorders posit that overvaluation and control of shape and weight lead to problematic eating behaviors (which perpetuate weight/shape concerns), the cycle of which can be exacerbated by negative affect or interpersonal events (Fairburn, Cooper, & Shafran, 2003). Thus, increasing our understanding of secretive eating by evaluating its psychological correlates (using both cognitive and behavioral indices of eating-related pathology and general symptomatology) may help to identify intervention targets for addressing this problematic eating behavior. Moreover, because secretive eating may be a marker for other forms of disordered eating and risk for weight gain, increasing understanding of secretive eating may facilitate efforts to improve weight outcomes and reduce eating disorder risk.

To date, studies of secretive eating in youth have focused on children or adolescents (Cromley et al., 2012; Knatz et al., 2011; Sonneville, Rifas-Shiman et al., 2013; Stice et al., 1999); however, to our knowledge, no study has evaluated this construct across the developmental age spectrum of youth. It is possible that secretive eating is more common among adolescents than children. Rates of secretive eating are higher in past studies of adolescents than of children (Knatz et al., 2011; Sonneville, Rifas-Shiman et al., 2013; Stice et al., 1999), although these groups have not been compared within the same sample. Developmental differences could be driven by the fact that adolescents may have increased capacity to obtain food without the assistance of caregivers (e.g., due to greater access to money and transportation to obtain food). Adolescents may also have a greater understanding of secretive eating as a problematic (e.g., shameful) behavior and therefore secretive eating in this age group may be more likely to be associated with adverse correlates.

Given these potential differences that may occur with pediatric development, examining secretive eating across a broader age range of children and adolescents may provide unique insight into differences in symptom profiles, thus improving our understanding of problematic eating behaviors in youth. Accordingly, this study aimed to evaluate the prevalence and psychosocial correlates of secretive eating among children and adolescents ages 6–18 with overweight or obesity. This multi-site investigation—using data drawn from five institutions of varying regions across the US—represents the largest sample of youth assessed for secretive eating to date. Moreover, this is the first evaluation of secretive eating using child-reported responses to semi-structured interviews, which enables a clear operationalization and objective rating of this construct compared to questionnaires or parent report. Although past literature on the association between secretive eating and psychopathology among youth is limited, we generated hypotheses based on the literature to date that guided our analysis of this aberrant eating behavior and its relation to psychopathology. Specifically, we hypothesized that youth who endorsed any secretive eating would have higher rates of eating-related and general psychopathology than youth who did not

endorse secretive eating, given past associations between this behavior and clinical pathology (Knatz et al., 2011; Marcus & Kalarchian, 2003; Stice et al., 1999). We also hypothesized that rates of secretive eating and pathology would be higher among adolescents than children, given that rates of secretive eating that have been documented in studies with adolescents are higher than the rates that have been documented in studies with children (Knatz et al., 2011; Sonneville, Rifas-Shiman et al., 2013; Stice et al., 1999).

2. Methods

2.1. Participants

The sample was comprised of 577 youth ages 6 to 18 (mean age = 11.18 ± 2.45) who met criteria for overweight or obesity. Overweight was defined as BMI ≥ 85 th and < 95 th percentile for age and sex, and obesity was defined as BMI ≥ 95 th percentile for age and sex (Kuczmarski et al., 2000). Participants identified as primarily female (66%) and Caucasian (55%; see Table 1).

Data were derived from a convenience sample of youth presenting to research studies or for eating disorder or obesity treatment at five institutions across the US. Data from these locations were combined as all of these institutions had data from children and/or adolescents with overweight or obesity who completed a semi-structured interview assessing eating disorder pathology, including secretive eating. Combining these data allowed us to aggregate the largest sample of youth with varying ages who were assessed for secretive eating, which also increased generalizability. A brief description of the sample populations for each of the distinct studies is provided.

2.1.1. Washington University School of Medicine, Missouri

Data from this site were obtained from two research studies of children and adolescents with overweight or obesity. The first study assessed eating pathology in girls ($n = 51$) ages 6–12 years (Goldschmidt, Tanofsky-Kraff, & Wilfley, 2011). Participants were excluded if they had a current diagnosis of bulimia nervosa; had a medical condition or were taking medications that impacted appetite, weight, or attention; had restricted or limited food preferences; or were psychotic or suicidal. The second study was comprised of adolescents ($n = 35$) ages 12–17 years presenting to enroll in an online weight loss intervention (Doyle et al., 2008). Participants were excluded if they had a diagnosis of a full-syndrome eating disorder; had a medical condition precluding moderate physical activity or that altered weight; or were taking medication that affected weight.

2.1.2. Children's Hospital Boston, Massachusetts

Youth in this sample ($n = 122$) were ages 8–18 years presenting for behavioral weight loss treatment (Eddy et al., 2007). Exclusion criteria included developmental disorders associated with cognitive impairment; obesity-related disorders associated with intellectual disability; and psychotic disorders.

2.1.3. San Diego State University/University of California San Diego, California

This sample was comprised of children ($n = 201$) ages 7–12 years entering a behavioral weight loss maintenance treatment trial (Wilfley et al., 2007). Participants were excluded if they had a medical condition precluding moderate physical activity or that altered weight; were taking medication that affected weight; or were receiving weight loss or psychological treatment.

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