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Dieting and Disordered Eating Behaviors from Adolescence to Young Adulthood: Findings from a 10-Year Longitudinal Study

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ABSTRACT

Background Disordered eating behaviors are prevalent in adolescence and can have harmful consequences. An important question is whether use of these behaviors in adolescence sets the pattern for continued use into young adulthood.

Objective To examine the prevalence and tracking of dieting, unhealthy and extreme weight control behaviors, and binge eating from adolescence to young adulthood.

Design Population-based, 10-year longitudinal study (Project EAT-III: Eating Among Teens and Young Adults, 1999-2010).

Participants/setting The study population included 2,287 young adults (55% girls, 52% nonwhite). The sample included a younger group (mean age 12.8 ± 0.7 years at baseline and 23.2 ± 1.0 years at follow-up) and an older

group (mean age 15.9 ± 0.8 at baseline and 26.2 ± 0.9 years at follow-up).

Statistical analyses performed Longitudinal trends in prevalence of behaviors were tested using generalized estimating equations. Tracking of behaviors were estimated using the relative risk of behaviors at follow-up given presence at baseline.

Results In general, the prevalence of dieting and disordered eating was high and remained constant, or increased, from adolescence to young adulthood. Furthermore, behaviors tended to track within individuals and, in general, participants who engaged in dieting and disordered eating behaviors during adolescence were at increased risk for these behaviors 10 years later. Tracking was particularly consistent for the older girls and boys transitioning from middle adolescence to middle young adulthood.

Conclusions Study findings indicate that disordered eating behaviors are not just an adolescent problem, but continue to be prevalent among young adults. The tracking of dieting and disordered eating within individuals suggests that early use is likely to set the stage for ongoing use. Findings suggest a need for both early prevention efforts before the onset of harmful behavioral patterns as well as ongoing prevention and treatment interventions to address the high prevalence of disordered eating throughout adolescence and young adulthood.

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Dieting, unhealthy weight control practices, and binge eating are often associated with poorer dietary intake (1-3). For example, in a population-based sample of Canadian adolescents, Woodruff and col-



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leagues (2) found that overall dietary quality was lower among youth who were dieting and had weight concerns, compared to those not dieting and not weight concerned. Furthermore, dieting and disordered eating behaviors have been found to predict a number of problematic outcomes, including increased risk for weight gain (4-8), obesity (6-8), and eating disorders (9-12) in adolescents (4,6,7,12) and young adults (5,12,13). For example, in an analysis from an earlier study wave on the population participating in our study (8), we found that adolescents engaging in dieting and those reporting unhealthy weight control behaviors were at two to three times greater risk for being overweight 5 years later, compared to adolescents who did not engage in these behaviors at baseline. Given the harmful consequences associated with disordered eating behaviors, it is important to develop interventions aimed at their prevention.

A frequently asked question regards the best timing for interventions aimed at preventing disordered eating. A high prevalence of disordered eating behaviors during adolescence would support early prevention efforts, with the goal of intervening before the onset of these behaviors. If the prevalence of disordered eating remains stable or increases as young people transition throughout adolescence, then prevention efforts should be continued throughout these life transitions. Although cross-sectional studies have shown a high prevalence of disordered eating during early and middle adolescence (14-16), longitudinal studies examining the course of disordered eating from early adolescence to young adulthood are limited in number and scope, and findings have not been consistent, possibly due to small samples and differences in participant characteristics and study methodologies (13,17-22). Information regarding whether or not disordered eating tracks within individuals is also important in setting program priorities. Most research suggests that disordered eating behaviors during early adolescence are predictive of continued use of these behaviors, as well as progression to a clinical eating disorder during later adolescence or young adulthood (18,19,21-25). However, previous studies have limited generalizability given that most have been conducted within predominantly white samples (13,17,18,20,21) of women (19-23), primarily of high socioeconomic status (21,22).

Our study expands upon the existing literature by examining the prevalence and tracking of dieting and disordered eating behaviors, including unhealthy weight control behaviors, extreme weight control behaviors, and binge eating with loss of control, longitudinally during a 10-year transitional period from adolescence to young adulthood, in a large and diverse population-based sample of young women and men. The first aim of the study was to assess the prevalence of dieting and disordered eating as adolescents move into young adulthood. The second study aim was to determine whether these behaviors track within individuals over time. Specifically, we examined whether adolescents who diet and engage in disordered eating behaviors are at increased risk for these behaviors in young adulthood.

METHODS

Study Design and Population

Project EAT-III (Eating and Activity in Teens and Young Adults) is a 10-year longitudinal study aimed at examining eating, activity, and weight-related variables among young people. The sample for our study included 1,030 young men and 1,257 young women. One third of participants (29.9%) were in the younger cohort; at baseline they were in early adolescence (mean age 12.8 ± 0.7 years), and at 10-year follow-up they were in early young adulthood (mean age 23.2 ± 1.0 years). Two thirds of participants (70.1%) were in the older cohort; at baseline they were in middle adolescence (mean age 15.9 ± 0.8 years), and at follow-up they were in middle young adulthood (mean age 26.2 ± 0.9 years).

At baseline (EAT-I: 1998-1999), 4,746 junior and senior high school students at 31 public schools in the Minneapolis/St Paul, MN, metropolitan area completed in-class surveys and anthropometric measures (15,26). At 10-year follow-up (EAT-III: 2008-2009) participants were mailed letters inviting them to complete online or paper surveys. Data were also collected at 5-year follow-up and longitudinal trends in weight control behaviors have previously been described (27). The 5-year follow-up data are not included in this analysis to focus on long-term changes in the prevalence and tracking of behavior patterns and determine whether behaviors begun in adolescence predict similar behaviors in young adulthood. All study protocols were approved by the University of Minnesota's Institutional Review Board Human Subjects Committee. Parental consent and written assent from participants was obtained at baseline. For follow-up surveys, participants reviewed a consent form as part of the online survey or were mailed a consent form with their paper survey. Completion of the Project EAT-III survey implied written consent.

At 10-year follow-up, survey data were collected from 66.4% of those for whom correct contact information was available, representing 48.2% of the original cohort, for a final sample of 2,287 young adults. Attrition was not equal across sociodemographic characteristics. When compared to nonrespondents in Project EAT-III, respondents were more likely to be girls, white, and of higher socioeconomic status (SES). Thus, in all analyses, we weighted our data to allow for the longitudinal sample to be more similar to the original cohort, and more representative of an adolescent/young adult population. Data were weighted using the response propensity method (28) where the inverse of the estimated probability that an individual responded at follow-up was used as the weight. We compared responders at follow-up with nonresponders for the variables being examined in this analysis (ie, dieting, unhealthy and extreme weight control behaviors, and binge eating with loss of control). These comparison analyses were stratified by sex and adjusted for SES, ethnicity/race, and nonresponse weights. In all but one case (responding boys reported lower extreme weight control behaviors than nonresponders) there were no significant differences found for the targeted variables at baseline, indicating that the weighting was generally successful in correcting for any response bias. The final weighted sample was 48.4% white, 18.6% African American, 19.6% Asian, 5.9% Hispanic, 3.3% Native American,

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