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Body dissatisfaction and dietary restraint influence binge eating behavior



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ABSTRACT

As binge eating is a common behavior throughout the general population, we hypothesized that body dissatisfaction would produce binge eating via its prediction of dieting. Six hundred eight individuals were nonrandomly recruited from the community. The mean age and body mass index of participants were 34.76 years (SD, 14.41) and 27.82 kg/m² (SD, 9.54), respectively. Participants were asked to complete several self-report questionnaires, which included measures of dieting status, binge eating behavior, body dissatisfaction, overvaluation of weight and shape, and self-esteem. The results showed that dieting was a common behavior; 38.1% of participants reported dieting during the past year. Binge eating during the previous 6 months was reported by 9.9% of the sample and was associated with a higher body mass index as well as more frequent dieting. A model including dieting status, overvaluation of weight and shape, shape satisfaction, and self-esteem showed the best fit for the prediction of binge eating behavior. Moreover, those who dieted and overvalued their weight and shape were 2.01 and 2.31 times more likely, respectively, to binge eat. Structural equation modeling revealed that body dissatisfaction caused dietary restraint, thus triggering binge eating. Both dieting and overvaluation of weight and shape are important risk factors for the development of binge eating disorders. Dieting and binge eating are common behaviors that represent a risk for the development of both excess weight and eating disorders. The structural model proposed in this study could be beneficial in understanding this causal relationship.

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1. Introduction

Binge eating is a prevalent eating disorder that appears to increase the risk of the onset and maintenance of obesity and

plays an important role in the development of eating disorders [1–3]. The prevalence of overweight and obesity has now reached epidemic proportions in western countries [4]. Binge eating disorder (BED) is the most common eating

Abbreviations: BED, binge eating disorder; BMI, body mass index; CFI, Comparative Fit Index; EAT-40, Eating Attitudes Test 40; EDI-2, Eating Disorders Inventory 2; IFI, Incremental Index of Fit; MW, minimum wage; QEWP-R, Questionnaire on Eating and Weight Patterns, Revised; SRMR, standardized root mean square residual; TLI, Tucker-Lewis index; WALI, Weight and Lifestyle Inventory.

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disorder, affecting a significant segment of the obese population and even individuals of normal weight [5,6]. For these reasons, binge eating behaviors are an important area of study in the general population.

With the increasing prevalence of obesity in western countries and the growing pressure to be thin in response to societal ideals related to body size, dieting strategies are widespread throughout the population [7,8]. Dieting is the practice of intentionally restricting food intake for reasons of altering shape or weight [9]. However, it is often unsupervised and may involve unhealthy behaviors [10]. Despite its limited efficacy as a method of reducing weight in the long term, dietary restraint is widely advocated as the treatment of choice for weight management [11]. Ironically, this dieting predicts future weight gain and obesity as well as the onset of subthreshold binge eating [10,12].

Binge eating is characterized by the consumption of a larger amount of food than most people would eat during a similar period and in similar circumstances [13]. Its prevalence in the community is estimated to be between 4.9% and 12.2% [6,14,15]. Previous research has focused mainly on the study of binge eating correlates in treatment-seeking populations with eating disorders or obesity, community samples of adolescents and young adults, and women [1,16,17]. However, although researchers have advocated the study of binge eating in the general population [18,19], little is known about the distribution and correlates of binge eating in the broader community. The effect of sex has also been examined, suggesting that females are significantly more likely to develop a BED [20]; however, in contrast, other studies report no sex effect in the proportion of men and women presenting binge eating tendencies [21,22]. The effect of sex on overeating has also been studied among adolescents. Goldschmidt et al [23] found that girls are more susceptible to interpersonal influences on disordered eating than boys and girls are also more distressed about eating and more likely to hide their binge eating.

The dual-pathway model, proposed by Stice [2], was the first to link sociocultural pressures to bulimic symptomatology to explain the relationship between dietary restraint and binge eating and has received strong empirical support in recent years [24]. This model suggests that exposure to pressure to be thin leads to the internalization of the thin ideal, thus resulting in body dissatisfaction. Body dissatisfaction is thought to predict binge eating via its prediction of dietary restraint. Restraint may trigger binge eating when breaking strict dietary rules results in disinhibited eating [24]. In support of this model, several authors found a strong correlation between body dissatisfaction and binge eating [25], and moreover, there is clear evidence linking binge eating and a history of dietary restraint [6,19,26,27]. In a 10-year longitudinal study, Goldschmidt et al [10] confirmed that dieters were at higher risk for binge eating onset than nondieters. However, these authors pointed out that dieting may not be the only factor promoting the initiation of bingeing, as the prediction of binge eating onset was improved by the consideration of other psychological variables, such as self-esteem, in addition to dieting behaviors. In fact, O'Dea [28] reported that the development of self-esteem is a protective factor against body dissatisfaction and disordered eating.

Based on previous reports, we postulated that body dissatisfaction would predict dietary restraint and, thus, trigger binge eating behavior. We also hypothesized that women would be more likely to present binge eating and that dieting status would predict the presence of overeating with loss of control. Therefore, we evaluated the relationship between dieting and binge eating behavior in a community-based sample. To test our hypotheses, the specific aims of the present study were (a) to determine the presence of binge eating behavior in a community sample, (b) to identify variables that predict the presence of binge eating behavior, and (c) to examine the causal relationship between body dissatisfaction, dietary restraint, and binge eating behavior.

2. Methods and materials

2.1. Participants

Six hundred eight people were nonrandomly recruited from the community in the city of Barcelona and the surrounding area. Questionnaires were originally distributed to 1032 individuals, with only 816 responding. Of the 816 returned questionnaires, 608 were complete and included in the subsequent analyses. The overall response rate was 58.9%. Written informed consent was obtained from all participants, and the study was approved by the ethics committees of the 2 main hospitals at which recruitment took place. Inclusion criteria included being older than 18 years and not pregnant at the time of assessment. Participation was entirely voluntary, and no incentives were given. Participants were recruited by opportunistic sampling of adults in the following settings: undergraduate and postgraduate students from the University of Barcelona were invited to participate during class ($n = 200$), and patients attending a psychotherapy service attached to this university were invited to participate by their psychotherapist. Furthermore, they were all encouraged to invite their relatives to participate in the study ($n = 49$). A convenience sample of adults was also directly approached by the researchers by means of snowball sampling among University of Barcelona staff and their relatives ($n = 167$). The researchers and psychotherapists involved in the recruitment procedure provided a brief description of the content of the questionnaires to the participants. The participants were then requested to complete the questionnaires at home and return them to the researchers.

People attending routine appointments at primary care centers or hospitals in the area of Barcelona were also invited to participate in the study ($n = 192$). The family physician or nurse presented the invitation, and they also provided participants with a brief description of the content in the questionnaires. Patients who did not have enough time to complete (by self-report) the questionnaires at the center were asked to fill them in at home and return them to the researchers via post in a complementary envelope. Table 1 shows the demographic characteristics of the sample, such as sex, age, body mass index (BMI), educational level, and income (in terms of minimum wage [MW]).

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