Life course, sociocultural factors and disordered eating in adult Mexican women

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ABSTRACT

Disordered eating (DE) can appear in women of all ages and in diverse sociocultural contexts, however most research focuses on younger women in higher income countries. The purpose of this article was to explore the association of life course markers with DE, considering the effects of sociocultural factors, in a sample of adult women in Tijuana, Mexico. We employed data from a household survey (n = 2322) conducted in 2014, to evaluate the associations of DE with age, occupation, marital status and having children (life course markers), and indicators of social position and exposure to modernization (sociocultural factors). The prevalence of weight preoccupation was 69.2% (CI95% 67.3,71.1), the prevalence of dieting 24.8% (CI95% 22.4,27.3), and 2.0% (CI95% 1.4,3.0) had a probable eating disorder according to the questionnaire cutoff score. In the adjusted model, younger age, being employed, higher social position and indicators of exposure to modernization had positive associations with DE. There were interactions between marital status and body mass index, and between age and region of birth. The interaction terms showed that overweight was positively associated with DE among single and cohabiting participants, but not among the married ones; and that the negative association between DE and age was apparent from younger age groups in women born in less developed regions of Mexico. Our results replicate others in showing DE to be present in women through the life course, and point to at-risk groups in the confluences of life course, social position and modernization.

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1. Introduction

The term "disordered eating" (DE) refers to attitudes and behaviors that are similar to those that appear in eating disorders, without meeting the clinical criteria for the latter. Examples include weight-related preoccupation, dieting, use of medical and non-medical substances such as laxatives or diuretics, and self-provoked vomiting. Whether DE is a subclinical form, a prodrome or a risk factor for eating disorders is still unclear (Stice, Ng, & Shaw, 2010), but it can be harmful to health in itself, and people with DE report similar levels of affective disorders, anxiety and suicidality as those with well-established eating disorder diagnoses (Solmi, Hatch, Hotopf, Treasure, & Micali, 2014). DE is also associated with poorer quality of life (Herpertz-Dahlmann et al., 2008; Wade, Wilksch, & Lee, 2012).

Risk factors for DE are manifold, including genetics, personality, cognitive style and adverse life events (Kally & Cumella, 2008; Stice, Marti, & Durant, 2011; Stice et al., 2010). At the same time, the increase in the prevalence of DE in the 20th century evidences the importance of sociocultural aspects, and particularly of the social construction of femininity, as DE appears to have increased in parallel with changes in female gender roles (Bordo, 1993; Nichter, 2001; Paquette & Raine, 2004; Rodin, Silberstein, & Striegel-Moore, 1984). These changes are part of a general process of social and cultural modernization, in which the production of a successful identity that includes a certain type of body becomes more and more a central personal project (Giddens, 1991; Turner, 1984). In combination with the thin ideal (the cultural norm that considers slimness as essential for female beauty), the importance attributed to personal cultivation via practices that modify the body (Crossley, 2006) provides the sociocultural context in which DE arises. In more recent times, the public health discourse against obesity has

added to the discourses that promote the thin ideal (Kwan, 2009), increasing the risk of DE.

Given the strong association of DE with gender-related social expectations, and the changes in these expectations as women pass through the life course, the manifestations and factors associated with DE in women of different age groups are topics worth of study. While most research on DE focuses on adolescents or young women, an increasing number of studies show that DE behaviors and attitudes are present well into adulthood (Fiske, Fallon, Blissmer, & Redding, 2014; Kilpela, Becker, Wesley, & Stewart, 2015; Slevec & Tiggemann, 2011). In this regard, most research shows a negative association between age and DE (Gadalla & Piran, 2008; Solmi et al., 2014), or an inverted U-shaped relationship that peaks between the ages of 30 and 40 (Matthiasdottir, Jonsson, & Kristjansson, 2012; Mitchison, Hay, Slewa-Younan, & Mond, 2014; Runfola et al., 2013; Tiggemann & Lynch, 2001). However, body shape concerns can also increase as the aging body deviates from the cultural ideal of slimness and youth (Becker, Diedrichs, Jankowski, & Werchan, 2013; Slevec & Tiggemann, 2011) and pre-occupation over the body's functioning might also increase (McLean, Paxton, & Wertheim, 2010). At the same time, some studies have found that age decreases the importance attributed to appearance, which might result in less body dissatisfaction and DE (Kilpela et al., 2015). Most of this research has been conducted in upper-income countries (mainly English-speaking), so there is a lack of information about the association of age and DE in other societies.

As for the effect of other life course markers, some studies have reported that marriage and motherhood are associated with decrease in DE (Keel, Baxter, Heatherton, & Joiner, 2007), while others find that pregnancy and the postpartum period increase it (Lai, Tang, & Tse, 2006). Some authors suggest that achievement of life course markers such as establishing a career, having children and having a committed long-term relationship might decrease the perceived importance of body shape (Tiggemann, 2015), and qualitative studies have shown that the significance that women attach to their relational identities as mothers can be a protective factor as it helps them to oppose the discourse of self-enhancement through weight control (Bojorquez-Chapela, Unikel, Mendoza, & de Lachica, 2014; Warin, Turner, Moore, & Davies, 2008).

While there can be similarities between the experiences of women in different social groups, the life course also interacts with other aspects of the social position to produce experiences of the body, of the importance of weight control and of DE, that are shared with persons in similar positions. Thus, quantitative studies of the association of social position and DE in adults in different regions of the world show that the upper classes are more likely to engage in weight control practices and to be dissatisfied with their appearance even while at a normal weight (Alwan, Viswanathan, Williams, Paccaud, & Bovet, 2010; Machado, Silveira, & Silveira, 2012; Mangweth-Matzek et al., 2014; von Lengerke, Mielck & KORA Study Group, 2012; Williams, Germov, & Young, 2011). The qualitative studies mentioned above also show that upper-class mothers are more conscious of the social expectation of thinness (Bojorquez-Chapela et al., 2014; Warin et al., 2008).

On the other hand, while differences by social class in the prevalence of weight-related preoccupation and weight control practices are clear, comparisons between countries show a more complicated picture. If DE is related to modernization, a gradient from lower to higher income countries should be apparent, inasmuch as economic development is associated with other modernizing social processes. However, the World Health Organization worldwide surveys found no clear gradient in the case of

eating disorders (Kessler et al., 2013), and the use of different instruments and special-population samples limits comparisons between countries of the prevalence of DE. The association of exposure to social modernization with DE is still an interesting subject of study, and countries with ample differences in socio-economic and human development, and varying local and regional cultures, are sites where these associations can be explored (Lee & Lee, 2000).

To summarize, the life course, social position, and exposure to modernization, all play a role in DE, but their independent effects and possible interactions are still unclear. Most research in this area has been conducted in high-income countries of Europe and North America, with adolescents or young women, or with special populations such as students. In this article, we assess the association of life course markers with DE in adult women, at the same time exploring the independent effects of indicators of social position and of exposure to modernization, and their interactions with the life course. Following from the literature referenced above, we hypothesized that higher social position and indicators of exposure to modernization would be positively associated with DE. As most literature reports a negative association between life course markers and DE, our second set of hypotheses was that older age, being employed, being married and having children would be associated negatively with DE. Finally, we expected that social position and indicators of exposure to modernization would modify the association between life course markers and DE.

2. Methods

2.1. Site and sample

In February–April 2014, we conducted a cross-sectional survey on a representative sample of the population of women ages 18 to 65 living in Tijuana, Mexico. Tijuana is a city with over 1.5 million inhabitants on the Mexico-United States (US) border, it has a high rate of internal migration, and is also a transit city for migrants heading to the US(International Organization for Migration (IOM) (2015)). The city has intense dynamics of cross-border relations, with over 40 million annual border crossings (del Castillo, Peschard-Sverdrup, & Fuentes, 2007), and can in many respects be regarded as an intermediate place between Mexican and US culture (Valenzuela, 2003).

The survey had a probabilistic, stratified, multi-stage cluster sample design. In the first stage, Basic Statistical Geographical Areas as defined by Mexico's National Institute of Statistics and Geography (INEGI) were divided into strata according to a Marginalization Index reported by Mexico's National Population Council (CONAPO). The Marginalization Index classifies geographical areas by level of social development, and is computed from indicators such as literacy rate, percentage of dwellings with electricity and percentage of population with low income. In the second stage, blocks were randomly selected from each area. All households on the block were visited, and one woman of the required age was randomly selected from each household and invited to participate in the survey. A required sample size of 2500 respondents was predefined. The eligibility criteria were: 1) being 18–65 years old, and 2) agreeing to take part in the survey after a process of informed consent. Potential participants were told of the purpose of the project and the nature of participation, and asked to sign a letter of consent. All procedures were approved by the Ethics Committee of El Colegio de la Frontera Norte. Questionnaires were administered face to face by previously trained interviewers, who also weighed and measured participants using Tanita BF-683W