



Reciprocal prospective associations between disordered eating and other psychological problems in a community sample of Swedish adolescent girls



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ABSTRACT

Disordered eating and its associations with psychological difficulties and body satisfaction were prospectively studied in a community sample of 13–15 year old adolescent girls ($N = 428$). General psychological difficulties (including hyperactivity–inattention) and lower levels of body satisfaction at T1 were found to predict disordered eating at follow-up one year later (T2). Furthermore, reciprocal associations were found between disordered eating and psychological difficulties (but not body dissatisfaction) so that disordered eating at T1 predicted general psychological difficulties (including hyperactivity–inattention) at T2. The results support the notion of a vicious interplay between disordered eating and other subclinical psychological problems, which may represent a potential mechanism for the development of clinically significant eating disorders. It is suggested that it could be important to identify these kinds of bidirectional processes at an early stage, in order to prevent further developments of clinical forms of psychopathology.

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1. Introduction

Eating-related problems are common among adolescent girls. Studies from the Nordic countries report percentages of eating-related problems in around 15–30% of adolescent girls (Hautala et al., 2008; Kjelsås, Bjørnstrøm, & Götestam, 2004; Thorsteinsdóttir & Ulfarsdóttir, 2008; Viborg, Wångby-Lundh, Lundh, & Johnsson, 2012; Waadegaard, Davidsen, & Kjølser, 2009). Similar rates of eating-related problems have also been observed among girls in Spain (Ferreiro, Seoane, & Senra, 2012), Italy (Toselli et al., 2005), Germany (Herpertz-Dahlmann et al., 2008), and in North America (Croll, Neumark-Sztainer, Story, & Ireland, 2002; Haines et al., 2011; Haley, Hedberg, & Leman, 2010). Although these different studies used different terminologies (disordered eating, unhealthy weight loss practices, etc.) and various cut-offs and criteria for their respective classifications of eating-related problems, the results strongly indicate that disordered eating is a major public health issue among adolescent girls.

To increase our knowledge about these matters, there is a need for more research on the development of disordered eating in community samples, and its associations over time with other forms of problems. For example, what counts as risk factors for disordered eating during

early adolescence, and to what extent does disordered eating during this period represent a risk factor for the development of other problems? Although research on the development of disordered eating in this wider sense is limited, research on clinical eating disorders (EDs) with prospective longitudinal designs may also be used to derive hypotheses concerning the development of disordered eating in adolescents. To what extent can we find similar risk factors and developmental processes in the study of subclinical forms of disordered eating as has been found in research on clinical EDs? According to the continuity hypothesis of eating pathology, EDs represent the endpoint of a continuum along which subclinical forms of disordered eating differ only by degree (e.g., Stice, Killen, Hayward, & Taylor, 1998); if this hypothesis is true, we may expect to find similar risk factors for nonclinical forms of disordered eating as for clinical EDs.

EDs typically develop during adolescence, especially among young females (Eddy, Herzog, & Zucker, 2011; Golden et al., 2003) and are associated with a number of other mental disorders and health problems, including mood and anxiety disorders, impulse control disorders and substance use disorder (Halmi, 2010; Herpertz-Dahlmann, 2009; Hudson, Hiripi, Pope, & Kessler, 2007). According to Jacobi, Jones, and Beintner (2011), the most potent and best replicated risk factors for Bulimia Nervosa (BN) and to a lesser degree also Anorexia Nervosa (AN) are gender, weight and shape concerns, various forms of negative affect, neuroticism and general psychiatric morbidity. In an 8-year prospective study, Stice, Marti, and Durant (2011) found that the most potent predictor for the onset of EDs in adolescent girls was body dissatisfaction, and that depressive symptoms interacted with body dissatisfaction in the prediction of ED onset. In a longitudinal study with a Spanish community-based

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sample of young adolescent girls, [Ferreiro et al. \(2012\)](#) similarly found that body dissatisfaction and depressive symptoms, as well as BMI and perfectionism, predicted the development of disordered eating.

As pointed out by [Slane, Burt, and Klump \(2010\)](#), much of the research on risk factors for disordered eating has focused on internalizing problems, whereas little research has been done on externalizing problems. There is, however, some evidence that ADHD symptoms represent risk factors for the development of EDs. For example, a prospective study by [Biederman et al. \(2007\)](#) found that adolescent girls with ADHD were 3.5 times more likely to develop an ED and 5.6 times more likely to develop BN throughout the follow-up period compared to a control group. A five-year longitudinal study by [Mikami, Hinshaw, Patterson, and Lee \(2008\)](#) similarly found that children and adolescents (mean age 14.2 years) with the combined subtype of ADHD showed more eating pathology (body dissatisfaction and BN symptoms) at follow-up compared to a control group. Further, [Francis \(2011\)](#) used longitudinal data available for 940 families and reported that externalizing problems at age 3, and all time points thereafter, were consistently positively associated with disordered eating characteristics at age 15.

Another relevant question is if there are also prospective associations in the other direction. That is, does disordered eating (or clinical ED) represent a risk factor for the development of other psychological problems (or psychiatric disorders)? According to [Herpertz-Dahlmann \(2009\)](#), some studies suggest that depression precedes EDs, and others that EDs precede depression. Interestingly, reciprocal relations between depressive and bulimic symptoms were found in an 8-year longitudinal study of adolescents, which showed both that depressive symptoms predicted future increases in bulimic symptoms and vice versa ([Presnell, Stice, Seidel, & Madeley, 2009](#)). This raises the question to what extent such processes may lead to “vicious cycles” or “vicious spirals”, where disordered eating and depressive symptoms reciprocally reinforce each other, leading into successively aggravated problems.

The same question may be raised with regard to externalizing problems. A recent prospective study of a Finnish community sample ([Viinamäki, Marttunen, Fröjd, Ruuska, & Kaltiala-Heino, 2013](#)) showed that 15-year old girls with subclinical bulimia were at risk for conduct disorder at the age of 17, whereas the opposite was not the case – that is, conduct disorder at age 15 was not predictive of subclinical bulimia at age 17. In view of other results which suggest that ADHD symptoms (e.g., [Biederman et al., 2007](#); [Mikami et al., 2008](#)) and externalizing problems ([Francis, 2011](#)) may predict the future development of disordered eating or EDs, however, the possibility of a reciprocal association between disordered eating and externalizing problems deserves more study.

As pointed out by [Racine, Root, Klump, and Bulik \(2011\)](#), the identification and reversal of early symptoms of EDs may be important to prevent the development of chronic conditions that are less amenable to intervention. If “vicious cycle” processes (e.g., between disordered eating and other psychological difficulties) can be identified already at a subclinical level, the early detection of symptoms might make it possible to intervene before such processes expand into clinical forms of psychopathology.

The purpose of the present study was to prospectively investigate if certain previously described risk factors for EDs and non-clinical forms of disordered eating predict disordered eating in a community sample of Swedish adolescent girls, and also to test for the possibility of reciprocal associations over time between disordered eating and other psychological problems. Based on previous findings, it was expected that body dissatisfaction (Hypothesis 1) and general psychological difficulties (Hypothesis 2) would be predictive of disordered eating over a one-year period. Further, based on the results from [Presnell et al. \(2009\)](#), who described a reciprocal relation between depression and EDs, it was hypothesized (Hypothesis 3) that disordered eating would predict general psychological difficulties over the same one-year period. Support for both Hypotheses 2 and 3 would be evidence for a reciprocal, bidirectional relationship between general psychological difficulties and disordered eating. Finally, with regard to more specific forms of

psychological difficulties, we also expected that emotional symptoms (Hypothesis 4) and hyperactivity–inattention (Hypothesis 5) would predict disordered eating; further, we also explored if these associations were reciprocal.

2. Method

2.1. Participants

The participants were a community sample of all female students in two grades of regular school in a Swedish municipality who took part in a two-wave longitudinal study with a one-year interval. This municipality had approximately 40,000 inhabitants and five schools with 504 female students in Grades 7–8 at T1. At T2 they attended Grades 8–9; the test–retest interval for the different schools ranged from 12 months and 7 days to 13 months and 11 days. The municipality was fairly representative of Sweden in terms of demographics, although slightly more rural, and with a slightly lower mean income level and lower educational level than the rest of Sweden (for more detailed information, see [Lundh, Wångby-Lundh, & Bjärehed, 2008](#)). There were complete data on the RiBED-8 for 484 girls at T1. At T2, there were complete data for 477 girls. Imputing 0 for each missing value in participants with at most 3 missing values (10 individuals at T1 and 19 individuals at T2), the final number of participants with RiBED-8 data was 494 girls at T1 and 496 girls at T2. In total, there were longitudinal data on RiBED-8 for 445 girls, representing 85% of all female students who were eligible for inclusion at T1.

2.2. Instruments

2.2.1. Risk Behaviour related to Eating disorders (RiBED-8; [Waaddegaard, Thoning, & Petersson, 2003](#))

Risk Behaviour related to Eating disorders (RiBED-8; [Waaddegaard et al., 2003](#)) is an eight-item instrument where participants are asked to rate statements about eating-related behaviors and attitudes as to how often each statement applies to them, on a scale from 1 to 4 (with the response alternatives “never”, “seldom”, “often”, and “very often”). The RiBED-8 was specifically designed to capture risk behavior for eating disorders and has been found to be successful in predicting clinical eating disorders in a Danish sample ([Waaddegaard et al., 2003](#)). The RiBED-8 comprises the following questions: (1) “I diet”, (2) “I have a bad conscience because I eat sweets”, (3) “I throw up to get rid of food that I have eaten”, (4) “I am satisfied with my eating habits”, (5) “I feel I have to control my eating either by maintaining a strict diet or in some other way”, (6) “I’m afraid of not being able to stop eating once I’ve started”, (7) “I feel that my desire to lose weight has completely taken over”, and (8) “I feel uncomfortable when I eat with others”. The original Danish version of the RiBED-8 showed good psychometric properties for girls but not for boys. Also, the Swedish version of RiBED-8 (validated by [Viborg et al., 2012](#)) showed good reliability and validity for girls, but not for boys.

2.2.2. The Strengths and Difficulties Questionnaire – self-report version (SDQ-s; [Goodman, 2001](#))

The Strengths and Difficulties Questionnaire – self-report version (SDQ-s; [Goodman, 2001](#)) is a widely used screening instrument for psychological problems among children and adolescents, which contains 25 statements. The participants are instructed to respond to each item on the basis of how things have been for them during the last six months. The items are divided into four difficulty scales (hyperactivity–inattention, emotional symptoms, conduct problems, peer problems) and one prosocial scale (with five items each). The items are scored 0 for “not true”, 1 for “somewhat true” and 2 for “certainly true”. The four first-mentioned scales are summed to generate a Total Difficulties score. The SDQ was translated into Swedish by

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