ASSESS THE PREVALENCE OF EATING DISORDERS AMONG CHILDRENS IN SELECTED VILLAGE

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Abstract: **Eating disorders (ED), including anorexia nervosa and bulimia nervosa (BN), along with their variants are serious medical illness that often have a variety of medical complication, some of them being irreversible and life-threatening and have significant psychiatric comorbidity. Until recently these disorders have been often regarded as "Western culture-bound syndromes" arising in societies with the excessive emphasis on weight, shape and appearance. They have far common among females than males, mirroring cross-cultural differences in the importance of thinness for women. The thin-ideal of famine beauty is widely promoted by the media image have flooded western societies since the second half of the twenty centuries, during a period when icons of Americans beauty have become thinner and women's magazines have published significantly more articles on methods for weight loss. Research suggests that the thin-ideal body is liked to body image disturbance in women and plays a central part in eating disorders. Quantitative research was conducted among 50 children. A non-purposive sampling technique was used to select the samples. Self-structured questionnaires were used to collect demographic data. The study results show that the diagnosis made and medical and psychiatric co-morbidity seen in the sample. Nine children received a diagnosis of anorexia nervosa. One child received the diagnosis of atypical anorexia nervosa. Eating disorder unspecified diagnosed in 2 children having severe depression with psychotic symptom's as well as body image distortion and high avoidance of calorie foods. No patients in the sample received the diagnosis of bulimia nervosa and other psychological disturbances, p<0.001. Thereby, this indicates that the prevalence of eating disorders among children in selected village.**

Keywords: **Prevalence, Eating Disorder, Assess, children.**

1. INTRODUCTION

Eating disorders (ED), including anorexia nervosa and bulimia nervosa (BN), along with their variants are serious medical illness that often have a variety of medical complication, some of them being irreversible and life-threatening and have significant psychiatric comorbidity. Until recently these disorders have been often regarded as "Western culture-bound syndromes" arising in societies with the excessive emphasis on weight, shape and appearance. They have far common among females than males, mirroring cross-cultural differences in the importance of thinness for women. The thin-ideal of famine beauty is widely promoted by the media image have flooded western societies since the second half of the twenty centuries, during a period when icons of Americans beauty have become thinner and women's magazines have published significantly more articles on methods for weight loss. Research suggests that the thin-ideal body is liked to body image disturbance in women and plays a central part in eating disorders.

On the other hand, it is generally believed that Anorexia nervosa and Bulimia nervosa are uncommon in the non-western world, although the evidence from various studies is contraindicatory. A literature review comparing the prevalence of eating disorders between western and non-western countries is showed that the prevalence of eating disorders is lower than

that of western countries but appears to be increasing. More recently, a systemic analysis of data collected by the eating disorder inventory revealed that the symptoms of eating disorders are more pronounced in Non-western countries

Eating disorder are a range of psychological condition that cause unhealthy eating habits to develop. They might start with an obsession with food, body weight, or body shape. In severe case, eating disorder can cause serious health consequences and may even result in death if left untreated. In fact, eating disorders are among the deadliest mental illness, second to opioid overdose. People with eating disorder can have a variety of symptoms. Common symptoms include severe restriction of food, food binges, and purging behaviors like vomiting or over exercising. Although eating disorder can affect people of any gender at any life stage, they are increasingly common in me and gender non-conforming people. These population often seek treatment at lower rate or may not report their eating disorder symptoms.

Different types of eating disorder have different symptoms, but each condition involve an extreme focus on issues related to food and eating, and some focus on weight. This preoccupation with food and weight may make it hard to focus on other aspects of life. Mental and behavior sign may include dramatic weight loss, concern about eating in public, preoccupation with weight, food, calories, fat. grams or dieting, complains of constipation, excess to avoid mealtime, intense fear if weight gain. A variety of factors may contribute to eating disorder. One of these is genetics. People who have sibling or parent with ana eating disorder seem to be increased risk of developing one. Personality traits are another factor. In particular neuroticism, are these personality traits often linked to a high risk of developing an eating disorder. Other potential causes include perceived pressure to be thon, cultural preferences for thinness, and exposure to media promoting these ideals.

Eating disorder are a group of related condition involving extreme food and weight loss and weight issues, but each disorder has unique symptoms and diagnosis criteria. Here are six common eating disorder and their symptoms. Anorexia nervosa is likely most well-known eating disorder. It generally developed during adolescence or young adulthood and tends more to affect women than men. People with Anorexia nervosa generally view themselves as over-weight, even if they are dangerously overweight. They tend to constantly monitor their weight, avoid eating certain types of foods, and severely restrict their calorie intake. Common symptoms are very restricted eating patterns, intense fear of getting weight gain, a relentless pursuit of thinness, heavy influence of body weight, distorted body image.

Individuals with binge eating and purging type may binge on large amounts of foods or eat even little. In both the cases, after they eat, they purge using activities such as vomiting, taking laxatives or diuretics, or excessively exercising.

Treatment can be effective for many eating disorder. Treatment varies by disorder and may involve disorder may involve counselling, dietary advise, reducing excessive exercise, and the reduction of efforts to eliminate foods. Medications may be used to help with some of associated symptoms. Hospitalization may be needed in some serious cases. About 70% of people with anorexia and 50% of people with bulimia recover within 5 years. Only 5% of people with eating disorder receive treatment, of those, approximately 80% do not receive proper care. Many are sent homes weeks earlier than the recommended stay and are not provided with the necessary treatment. Recovery from binge eating disorder is less clear and estimated at 20% to 60%. Both anorexia and bulimia increase the risk of death.

Estimates the prevalence of eating disorder vary widely, reflecting difference in gender, age, and culture as well as methods used for diagnosis and measurement. In the developed countries, anorexia affects about 0.4% and bulimia affects 1.3% of women and 0.8% in men in a given year. Binge eating disorder affects about 1.6% of women in a given year. Rates of eating disorder appear to be lower in less developed countries. Anorexia and bulimia occur nearly ten times more often in females than males. The typical onset of eating disorder in late adulthood. Rates of other eating disorder are not clear.

Eating disorder is a complex process controlled by the neuroendocrine system, of which the hypothalamus- pituitary- adrenal-axis is a major component. Dysregulation of HPA axis has been associated with eating disorders, such as irregularities in the manufacture, amount or transmission of certain neurotransmitters, hormones or neuropeptides and amino acids such as homocysteine, elevated levels of which are found in Anorexia and Bulimia nervosa as well as depression.

A study was conducted to assess the prevalence of eating disorders among children in selected village. 50 samples were selected for this study. Self- structured question was asked to collect the data. The data were analyzed through statistical inference and chi-square interpretation The data interpreted is found to be statistically proven to be significant. The study results show that the diagnosis made and medical and psychiatric co-morbidity seen in the sample. Nine children received a diagnosis of anorexia nervosa. One child received the diagnosis of atypical anorexia nervosa. Eating disorder unspecified diagnosed in 2 children having severe depression with psychotic symptom's as well as body image distortion and high

avoidance of calorie foods. No patients in the sample received the diagnosis of bulimia nervosa and other psychological disturbances, p<0.001. Thereby, this indicates that the prevalence of eating disorders among children in selected village.

The purpose of the study [1] To assess the prevalence of eating disorders among children in selected village.[2] To evaluate the prevalence of eating disorders among children in selected village. [3] To compare the prevalence of eating disorders in selected village.

2. METHODS AND MATERIALS

A quantitative research approach with a descripitional research design was used to conduct the study in Kondancheri in Kancheepuram district. Purpose of the study was explained to the subjects. The subjects were assured about anonymity and confidentiality of the information provided by them and written consent was taken from the parents of the selected samples. Total 50 children were selected by using non- purposive sampling technique. The criteria for sample collections are children with symptoms of eating disorders. Children with the age group of 3-12 years, who are Willing to participate in the study, Children and their parents who can speak, write and read Tamil and English. The exclusion criteria for the sample selections are children who have been diagnosed with chronic disease, low cognition (mentally challenged). Children and their parents who are not willing to participate in this study were excluded.

The data collection period was done with prior permission from the institutions. . Self-structured questionnaires were used to collect demographic data. The study results show that the diagnosis made and medical and psychiatric co-morbidity seen in the sample. Nine children received a diagnosis of anorexia nervosa. One child received the diagnosis of atypical anorexia nervosa. Eating disorder unspecified diagnosed in 2 children having severe depression with psychotic symptom's as well as body image distortion and high avoidance of calorie foods. No patients in the sample received the diagnosis of bulimia nervosa and other psychological disturbances, p<0.001. Thereby, this indicates that the prevalence of eating disorders among children in selected village.

3. RESULTS AND DISCUSSION

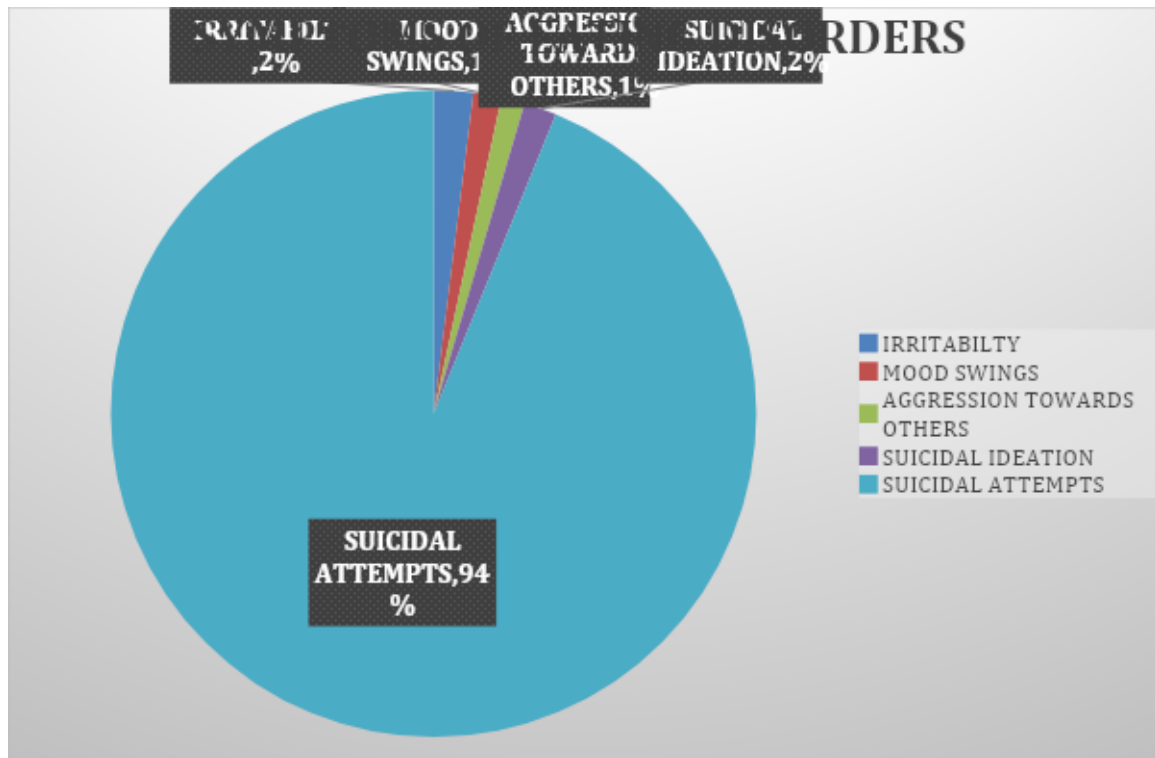**DESCRIPTION OF THE DEMOGRAPHIC VARIABLES OF CHILDRENS:**

Table 1: Frequency and percentage distribution of demographic variables of children.

The table 1 shows that in rural area out of 30 samples 3-6 years of age are 18(60%) and 11-12 years of age are12(40%), the children's who belongs to Hindu religion is 18(60%) and children belong to Christian are8(26.7%) and the children belong to Muslim are 4(13.3%). The sample who belongs to nuclear family are 8(36.7) and high school are10(33.3%) and higher secondary are 6(20%) and degree are 6(20%), mother's education who are illiterate are10(33.3%) and high school are8(26.7%) and degree are4(33.3%)), father occupation who are unemployed are 0(0 and coolie are 14(46.6%) and private employee are4(33.3%), mother occupation who are house wife are 10(33.3%) and self-employee are 3(10%) and private employee are 14(46.7%) and government are 5(33.3%), socio economic status of the family belongs to the low class family 9(30%) and middle-class family are19(63.3%) and upper class family are 2(6.7%), the samples who were belongs vegetarian are 3(10%) and non-vegetarian is 27(90%), the samples who takes one time meal per day 0(0) and two-time meal per day 7(23%) and three-time meal per day are 23.7(77%)four-time meal per day are 0(0).

SECTION B:SECTION b: DESCRIPTION OF THE CLINICAL VARIABLES:

Table 2: Common symptoms/signs and psychological variables.

The table 2 shows that the common signs and symptoms and psychological variables in eating disorders in rural area out of 25 samples the children avoid high calorie food are12(100%), body image distortion of dread of fatness are 11(91.7%), weight loss is 10(83.3%), fear of loss control over for are 9(75.9%), 9(75.9%), self-induced vomiting is 5(41.7%), bingeing is 2(16.7%) and purging is 2(16.7%). The sample who has other symptoms are irritability is 12(100%), mood swings are 11(91.7%), aggression to others is 5(41.7%), suicidal ideation is 7(58.3%), suicidal attempts are 4(33.3%). The sample who BMI are severe thinness (>3SD) ARE 3(50%, thinness(>2SD) ARE 3(25%), Normal are 3(25%). The sample who has psychological and psychosocial Variables such as low self-esteem is 8(66.7%), comparison with peer groups is 10(83.3%), high parental expectation is 7(58.3%), and not going to school are 5(42.7%).

Percentage distribution of symptoms of eating disorder in children's

SECTION C: ASSOCIATION IN BETWWEN THE PREVALENCE OF EATING DISORDERS ANOREXIA NERVOSA AND BULIIA NERVOSA IN RURAL AREA DEMOGRAPHIC VARIABLES OF CHILDRENS:

Table 3: Frequency and percentage distribution of demographic variables of children.

Table 3 show that demographic variables in prevalence of eating disorders among children in rural area in years, type of family, mother's education, father's education, socio economic status of the family, are scientifically significant.

The table 3 shows that the clinical variable family history eating disorders (χ^2=**6.661, p = 0.036**) had shown statistically significant association prevalence of eating disorders among children at $p<0.05$. The other demographic variables had not shown statistically significant association with eating disorders

Table 3: Frequency and percentage distribution of demographic variables of children.

n=50

Variables	FREQUENCY (F)	PERCENTAGE%	CHI-SQUARE VALUE
Age in years			X= 2.778 DF=2 P=0.249 S
3 – 6 years	18	60%	
7 – 10 years	12	20%	
11 – 12 years	18	20%	
Type of family			X= 1.528 DF=4 P=0.821 NS
Nuclear family	8	26.7%	
Joint family	19	63.3%	
Extended family	3	10%	
Religion			X= 3.558 DF=4 P=0.466 S
Hindu	18	60%	
Christian	8	26.7%	

Variables	FREQUENCY (F)	PERCENTAGE%	CHI-SQUARE VALUE
Muslim	4	13.3%	
Father's education			X= 3.058 DF=6 P=0.8015 NS
Illiterate	8	26.7	
High school	10	33.3%	
Higher secondary	8	20%	
Mother's education			X= 7.5 DF=6 P=0.277 S
Illiterate	10	33.3%	
High school	8	26.7%	
Higher secondary	8	26.7%	
Father's occupation			X= 11.524 DF=6 P=0.074 S**
Unemployed	0	0%	
Coolie	14	46.7%	
Government employee	12	40%	
Mother's occupation			X= 2.368 DF=6 P=0.883 S
House wife	10	33.3%	
Private employee	3	10%	
Government employee	14	46.7%	
Type of food pattern			X= 0.741 DF=2 P=0.690 NS
Vegetarian	3	10%	
Non-vegetarian	27	80%	
Mixed	1	10%	
Socio economic status of the family			X= 3.605 DF=4 P=0.462 S
Low class family	9	30%	
Middle class family	19	63.3%	
Upper class family	2	6.7%	
No of meals per day			X= 0.186 DF=6 P=0.099 NS
1 time meal per day	0	0%	
2-time meal per day	7	23.3%	
3-time meal per day	23	76.7%	
4-time meal per day	0	0%	

4. CONCLUSION

Eating disorder are a range of psychological condition that cause unhealthy eating habits to develop. They might start with an obsession with food, body weight, or body shape. In severe case, eating disorder can cause serious health consequences and may even result in death if left untreated. From the result of the study, it was concluded the prevalence of eating disorders among children in selected village.

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AUTHORS CONTRIBUTION

All the authors actively participated in the work of the study. All authors read and approved the final manuscript.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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