INTRODUCTION

Concern with weight and shape is extremely common during the adolescent years. In addition to being exposed to the very real health risks of obesity and poor nutrition, teenagers are being exposed to the unrealistically thin beauty ideal that is portrayed in the media (1). Unfortunately, this overemphasis on the importance of being thin is internalized by youth who equate thinness with beauty, success and health. Through media exposure, teenagers are also exposed to a number of ways to lose weight and achieve this thin ideal. The sources of information available on health and nutrition are often dubious and unreliable, motivated less by scientific evidence than by fad trends and financial incentives. The net result is that many teenagers feel the cultural pressure to be thinner than is required for good health, and may try to achieve this goal through poor and sometimes dangerous nutritional choices.

Recent Canadian data demonstrate that nearly one-half of Ontario teenagers (12 to 18 years) attending public school feel unhappy about their weight (2). Even among preadolescents, a significant number of children have a desire to be thinner (3-5). It is not surprising, therefore, that strategies aimed at changing one’s weight and shape are also extremely prevalent. Canadian cross-sectional data suggest that more than one in five teenage girls are ‘on a diet’ at any given time (2). American (5-10), Australian (11-13) and British (14) data also suggest similar high rates of attempted weight loss among adolescents. A recent review (15) of adolescent dieting indicated that 41% to 66% of teenage girls and 20% to 31% of teenage boys have attempted weight loss at some time in the past.

DEFINITION OF DIETING

Teenagers’ reasons for dieting are varied, but body image dissatisfaction and a desire to be thinner is the motivating factor behind the majority (16). Attempts to lose weight can be associated with different behavioural changes such as alterations in eating habits and/or exercise frequency. Dieting is a poorly defined behaviour that undoubtedly has various meanings to patients and professionals alike, but to most, it suggests an intentional, often temporary, change in eating to achieve weight loss (3,17,18). Comparing studies of dieting status and degrees of dieting are problematic due to variations in definitions; however, there is consistency in defining self-induced emesis, laxative use and diet pill use as unhealthy or extreme dieting (13,18-20). In many studies (8,10,13), chronic dieting (more than 10 diets in a year), fad dieting, fasting and skipping meals are also classified as unhealthy strategies. Many authors (8,21) refer to the use of these behaviours to achieve weight loss as disordered eating if the behaviours are not sufficiently severe to warrant a diagnosis of an eating disorder.

The spectrum of behaviours captured by dieting represents a range from healthy to unhealthy. The choices made by a teen on a diet may be consistent with recommendations for healthy living, such as increasing fruit, vegetable and whole grain intake, moderate reductions in fat intake, and increased exercise (7). However, a significant percentage of teenagers, girls in particular, engage in unhealthy behaviours to control weight. Recent Canadian data reported that 8.2% of Ontario girls aged 12 to 18 years and 4% of British Columbian girls reported self-induced vomiting as a weight control strategy (2,4). Several large cross-sectional studies have investigated the frequency of specific weight control practices (7-9,13,18,20,22). Fasting, skipping meals and using crash diets are frequent (22% to 46%). Self-induced emesis has been found to occur in 5% to 12% of adolescent girls. Laxative and diuretic use is less frequent (1% to 4%), as is diet pill use (3% to 10%). Smoking cigarettes to control weight is reported by 12% to 18% of adolescent girls.

RISK FACTORS FOR DIETING

Determinants of dieting in teenagers are broad, therefore, identifying which teenagers are most at risk of dieting and health-compromising weight loss strategies is challenging (Table 1). In general, dieting and disordered eating behaviours in teenagers increase in frequency with age and are more prevalent among girls (8,10). Although there are some variations in socioeconomic status and ethnic groups, it is clear that no group is immune from body dissatisfaction and weight loss behaviours (8,10,23). Not surprisingly, girls who consider themselves overweight and are dissatisfied with their bodies are more likely to diet (2,3,6,20,24) and are also more likely to engage in unhealthy weight loss behaviours (20,21). As the degree of overweight increases,
so does the risk of dieting and disordered eating (11,20,25). However, despite this association, it is important to recognize the high prevalence of dieting among normal and even underweight teenagers (4,7,11,20). In one cross-sectional American study (20), 36% of normal weight girls were dieting, compared with 50% of overweight girls and 55% of obese girls. Distortion of body image is common among adolescents who frequently ‘feel fat’ even at a normal weight (13,26). It is clear that the perception of being overweight is a factor in a teenager’s decision to attempt weight loss, regardless of whether they are actually overweight. The majority of Canadian teenagers are at a normal weight (27), and many dieting teenagers seen in a clinical setting are, in fact, in a healthy weight range.

There are many individual factors that distinguish dieters from nondieters. In several large cross-sectional studies (4,8,28-31), self-esteem was found to be a strong factor differentiating teenagers who engage in unhealthy weight control practices from those who do not, even when controlled for body mass index (BMI). These same studies report that other positive attributes, such as having a sense of control over one’s life, family connectedness, having positive adult role models and positive involvement in school, protect youth from unhealthy dieting. Not surprisingly, studies (32-36) have also shown that parental criticism of a child’s weight, pressure to diet and parental role modeling of dieting are associated with increased dieting rates and increase risk of extreme dieting behaviours.

Body dissatisfaction and unhealthy weight loss practices have been found to be more common in teenagers affected by a chronic illness (diabetes, asthma, attention deficit disorder and epilepsy) (37,38). Teenagers who experience significant psychiatric symptoms, particularly depression and anxiety, are more likely to engage in extreme dieting practices (11,39). A history of weight-related teasing is also predictive of body dissatisfaction, weight loss attempts and eating disturbance (24,40). Peer group influence also has an impact because girls whose friends value thinness and engage in unhealthy weight loss strategies are also themselves more likely to engage in unhealthy weight control strategies (16,41,42). Vegetarianism in adolescence is associated with some positive nutritional choices, such as increased fruit, vegetable and fibre intake; however, girls who are vegetarians are more likely to report dieting and certain disordered eating behaviours, such as self-induced emesis and laxative use. For some teenagers, vegetarianism may occur along with unhealthy eating behaviours (22,43). Other identified risk factors include involvement in weight-related sports, such as dance and gymnastics (44), and early puberty (45).

Studies (4,18,31,46) have demonstrated that teenagers who engage in other risk activities, including substance use, unprotected sex and illegal activity, are also more likely to engage in health-compromising weight loss strategies. A prospective study (47) also found that adolescent girls who are concerned about their weight or who are dieting are more likely to initiate smoking. This evidence suggests that disordered eating in teenagers clusters with other health-compromising behaviours.

CONSEQUENCES OF DIETING

Although adolescent dieters may make some positive choices, changes are often temporary and we must consider possible physiological and psychological adverse effects of dieting, particularly, in light of the evidence that dieting is unlikely to be effective at achieving sustained weight loss. The majority of teenagers who diet do so without any apparent sequelae, but they may be putting themselves at risk of consequences with little chance of tangible benefit. Unfortunately, few studies have addressed possible negative consequences because most dieting in teenagers is done in an unstructured way and decisions on how to go about losing weight are haphazard and often short-lived. Several reviews (48,49) of the consequences of dieting have been undertaken, but unfortunately, the conclusions pertain to dieting adults, in whom rapid physical and psychological change is not occurring.

Physical consequences

Dieting is associated with potential negative physical health consequences. Nutritional deficiencies, particularly
of iron and calcium, can also pose short- and long-term risks. In growing children and teenagers, even a marginal reduction in energy intake can be associated with growth deceleration (50-52). Disordered eating, even in the absence of substantial weight loss, has been found to be associated with menstrual irregularity, including secondary amenorrhea in several cross-sectional studies (53-56). The long-term risk of osteopenia and osteoporosis in dieting girls, even in the absence of amenorrhea, is of considerable concern as well (54,57). The medical complications of any purging behaviour, such as self-induced emesis, laxative use or diuretic use, are well-established, as are the risks associated with stimulant weight loss medications.

Psychological consequences
The short- and long-term psychological effects of dieting and food restriction on adolescents is largely unknown. Studies (58) in adults suggest that chronic dieting is associated with a variety of symptoms including food preoccupation, distractibility, irritability, fatigue and a tendency to overeat, even binge eat. While it is not known if these effects are also true for children and youth, these symptoms could have serious implications on the immature adolescent who is undergoing rapid social and psychological development. Many lifestyle habits are established during the adolescent years and alterations in the eating habits of children and adolescents could have lifelong implications for dysfunctional eating.

It is recognized that teenagers with lower self-esteem are more likely to diet, often in an attempt to feel better about themselves if weight loss is successful. The process of dieting may make the situation worse and have a further negative impact on the young person's self-esteem because, during childhood and adolescence, self-esteem is, in part, defined by successes and failures. One study (59) examined the self-esteem of children before and after participation in a structured weight loss program and concluded that a decline in self-esteem and perception occurred. An adolescent study (60) found that self-esteem was negatively impacted by participation in a 12-week multidisciplinary weight loss program for obese teenagers. These studies were small and it is not possible to draw conclusions, but we should consider the negative impact of dieting, particularly unsuccessful dieting, on a young person's self-esteem. There are no data available on the impact of self-directed dieting on the self-esteem of youth.

One of the most worrisome issues to be considered is the relationship between dieting, disordered eating and eating disorders. Teenage dieting is the usual antecedent to anorexia and bulimia nervosa. In prospective studies (12,14), dieting has been associated with a fivefold to 18-fold increased risk of developing an eating disorder. However, it is unclear whether dieting causes, triggers or represents the first stage (prodrome) to the illness. The relationship between dieting and binge eating is also controversial. The National Task Force on the Prevention and Treatment of Obesity concluded in 2000 that in overweight and obese adults, dieting was not associated with eating disorder symptoms including binge eating (61). The review (61) focused mainly on adults in structured weight loss programs and did not address the widespread use of self-directed dieting or the impact of dieting on children and adolescents. Several other studies (10,46,62) have documented the risk of binge eating among dieting teenagers and a review (58) of the psychological consequences of food deprivation in adults concluded that deprivation resulted in a tendency to overeat and even binge eating.

Finally, there is mounting concern that dieting in preadolescents and adolescents may have the paradoxical effect of resulting in excess weight gain over time (60,63). In a recent large-scale study (63) involving over 15,000 children (nine to 14 years old) followed over a three-year period, it was observed that dieters gained significantly more weight than matched nondieters. The authors concluded that self-directed dieting in this age group was not only ineffective, but may promote weight gain.

SUMMARY AND RECOMMENDATIONS TO CLINICIANS
Weight dissatisfaction is frequent for teenagers in North America. Behaviours to control weight are very common and exist on a spectrum from healthy to potentially dangerous. The most important risk factors for unhealthy weight control behaviours are dissatisfaction with weight, obesity and low self-esteem. Teenagers who engage in unhealthy dieting are at risk for other health-compromising behaviours, including substance use, smoking and unprotected sex. Most dieting in teenagers is not associated with negative consequences but we must consider the physical and psychological sequelae, including eating disorders, binge eating and low self-esteem. Teenagers who diet are at risk of excess weight gain over time.

The Canadian Paediatric Society’s recommendations are as follows:

- For normal and overweight teenagers, encourage eating according to the Canada Food Guide (64). Discouragefad diets, fasting, skipping meals and dietary supplements to achieve weight loss. Advise teenagers to be wary of any weight loss scheme that tries to sell them anything, such as pills, vitamin shots or meal replacements.

- For normal and overweight teenagers, encourage age-appropriate physical activity in accordance with healthy active living guidelines (65). Teach teenagers that there are a variety of reasons to exercise, not just to control weight.

- Given the high prevalence of dieting behaviours in adolescent girls, screening should be included as part of routine health care. This screening can easily be incorporated into the frequently used adolescent Home, Education, Activities, Drugs, Dieting, Safety, Sexuality, Suicide/depression (HEADDSSSS) interview (66).
• Teenagers who are concerned about weight or shape should be educated about the difference between ‘healthy weight’ and ‘cosmetically desirable weight’. For teenagers, these may be very different, because many teenagers want to be thinner than is required for good health. Teenagers should be encouraged to accept a realistic weight for themselves. Calculating BMI and comparing it with BMI percentile curves is the most reliable way to assess whether a teen is in a healthy weight range (67).

• Clinicians should be aware that many weight loss attempts in teenagers are not required or justified on the basis of improved health and may reflect other issues in the adolescent’s life, such as low self-esteem, being teased about weight, family pressure to achieve a certain ideal or a serious psychiatric illness such as an eating disorder. For many dieting teenagers, the behaviour is not really about their weight.

• For teenagers engaging in more severe weight loss practices, screening for eating disorders should be done promptly and early referral made for assessment (68,69).

• Educate dieting teenagers about the health risks of self-induced vomiting, laxative and diuretic use, diet pills and crash diets.

• There is a paucity of data on effective interventions for obese adolescents; however, assessment and intervention should be undertaken in accordance with evidence-based and best practice guidelines (70-72).

There is no evidence that commercial weight loss programs are safe or effective for children or teenagers. Where available, referral to a multidisciplinary paediatric obesity program may be beneficial.

ACKNOWLEDGEMENTS: The authors thank the CPS Nutrition Committee for their review.

REFERENCES


59. Dr Sheri Findlay, McMaster’s Children’s Hospital – Hamilton HSC, Hamilton, Ontario

60. Liaison: Dr Karen Mary Leslie, The Hospital for Sick Children, Toronto, Ontario

61. Principal author: Dr Sheri Findlay, McMaster’s Children’s Hospital – Hamilton HSC, Hamilton, Ontario

The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.