

Risk of Eating Disorders among Adolescents Studying in Selected Schools of Dharan sub-metropolitan City

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How to cite this article: Dikshya Rai, Nirmala Pradhan, Sami Lama, Kriti Thapa. Risk of Eating Disorders among Adolescents Studying in Selected Schools of Dharan sub-metropolitan City. International Journal of Psychiatric Nursing / Vol 12 No. 1, January - June 2026

Abstract

Background: Eating disorders are serious mental health conditions characterized by abnormal eating behaviors and disturbances in body image. Adolescence is a critical developmental period during which concerns about body shape, weight, and appearance increase, making adolescents particularly vulnerable to eating disorders. Assessing the risk of eating disorders among adolescents and examining its association with selected socio-demographic variables are essential for identifying at-risk groups and informing preventive interventions. Therefore, this study aimed to assess the risk of eating disorders among adolescents studying in selected schools of Dharan and to determine its association with selected socio-demographic variables.

Methods: A descriptive cross-sectional study was carried out taking 311 adolescents from classes 9-12 in Dharan Sub-metropolitan City. Schools were selected using simple random sampling, and respondents were chosen using systematic sampling. Data were collected using a self-administered questionnaire, including socio-demographic information and the EAT-26 scale, with scores ≥ 20 indicating high eating-disorder risk. Descriptive statistics and chi-square tests were used for analysis.

Results: The majority of respondents (74.6%) were aged 15-17 years with a mean age of 16.17 years. Overall, 19.6% were at high risk of eating disorders. Females showed a significantly higher risk (29.7%) compared to males (12.8%), with females nearly three times more likely to be at risk (OR = 2.87, $p < 0.001$). Significant associations were found between eating-disorder risk and gender ($p = 0.000$), BMI ($p = 0.007$).

Conclusion: Over one-fifth of adolescents in Dharan are at high risk of developing eating disorders, with females showing significantly greater vulnerability. Gender, BMI and family history of mental illness were also associated with risk of eating disorders.

Keywords: Adolescents, Eating Disorders, BMI, Eat-26.

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Submission: May 2, 2026

Revision: June 5, 2026

Published date: June 18, 2026

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Introduction / Background:

Nutrition is the intake of food, considered in relation to the body's dietary needs. Good nutrition is an adequate, well balanced diet combined with regular physical activity that is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development and reduced productivity.¹⁹

An eating disorder is defined as a serious illness characterized by distress regarding someone's weight or body shape, as well as irregular eating habits.⁴ Further "the inability to regulate eating habits and the frequent tending to overuse or under use food interfere with biological, psychological and socio-cultural integrity".¹⁹ Eating disorders affect people of all ages but are mainly seen among adolescents.¹

According to the American Psychiatric Association eating disorder are characterized by severe disturbance in eating behavior of the individual intended to control body weight and accompanied by distorted body image. Furthermore, Eating Disorders are diagnosed by the criteria of Diagnostic and Statistical Manual of Mental Disorders fourth edition-text revised on (DSM-IV-TR) and include two specific types: anorexia nervosa (AN) and bulimia nervosa (BN). Eating disorder mostly begin during adolescence, they constitute a rather small but a most serious group of mental disturbances with elevated risk for Chronicity or death.²²

As, an adolescence is an intermediate phase of life distinguished by expeditious and intensely physical, emotional, and neural growth changes. In this period, adolescents experience rapid neurobiological and body changes, which may be followed by increased care and consciousness for individual body shape and size. It is influenced by societal pressures for slim body image for peer acceptance.⁷

As per WHO, almost 3 million children and adolescents experienced eating disorders.⁶ The prevalence of eating disorder behaviors is high in high-income countries, especially in conjunction with

obesity.²⁰ People with eating disorder are 56 times more likely to commit suicide than people without an eating disorders.²⁴ Study done in Bangladesh among university students showed that 37.6% of the students were at risk for an eating disorder.⁸

Adolescents reported with binge eating have an eating pattern that includes more carbohydrates, especially sweetened food, chocolates, packaged food, snacks, dessert items which results in high-calorie consumption compared to the need of the body. The prevalence of eating disorder behaviors is high in high-income countries, especially in conjunction with obesity.⁷

To raise awareness among public view, healthcare providers, and institutions and to reduce the hurdle to treatment and to improve the early identification of affected cases, knowledge about eating disorders among the general population may be an important determinant. Now a day's teens are too concerned about the physical maintenance of the body.⁷

As the adolescent population in Nepal is approximately 6 million or 24 percent of the total population. In Nepal, the peak age of onset of eating disorder is 15-25 years i.e. at a developmentally sensitive time. The eating disorders are highly distinctive psychiatric disorders.⁵

Rationale of the Study

Eating disorders that occur during adolescence interfere with adjustment to pubertal development and mastery of developmental tasks necessary to becoming a healthy, functioning adult.¹⁰ Adolescents are vulnerable to body image dissatisfaction and eating disorder, and this vulnerability might differ among females and males. Information about gender differences in prevalence and determinants of body image dissatisfaction and eating disorder in Nepalese adolescents is largely unknown.¹⁹

In 2019, 3 million children and adolescents experienced eating disorders.⁶ Studies emphasize a frequent association between eating disorders and other psychiatric conditions. Important findings include a lifetime incidence of affective disorders (especially depression) of 50%-80% for

both anorexia nervosa and bulimia nervosa; a 30%–65% lifetime incidence of anxiety disorders (especially obsessive-compulsive disorder and social phobia) for anorexia nervosa and bulimia nervosa; a 12%–21% rate of substance abuse for anorexia nervosa; and a 9%–55% rate for bulimia nervosa. Estimates of comorbid personality disorders among patients with eating disorders range from 20% to 80%.¹⁰

Adolescents population in Nepal is approximately 6 million or 24 percent of the total population.²¹ As, eating disorders leads to cause various mental disorders. Moreover, Adolescents are the most vulnerable age group among all the population. Therefore, this research has been conducted in order to find out the eating disorders among adolescents doing screening of the adolescents those who are at risk for having eating disorder and early management could be done.

Material and Methods

Study Design

Descriptive cross-sectional study design was adopted to conduct the study.

Study Setting

The study was conducted over a period of one year, from August 2024 to August 2025, in selected secondary schools of Dharan Sub-metropolitan City, Sunsari District, Koshi Province, Eastern Nepal. According to the records of Dharan Sub-metropolitan City (2082), there are 55 government and 102 private schools in Dharan, among which 14 government and 26 private schools operate classes up to grade 12. Approximately 7,358 students are enrolled at the secondary level.

Study Population

All adolescent students studying in class 9, 10, 11 and 12 of secondary schools of Dharan sub-metropolitan city.

Sampling Procedure

The study population comprised school-going adolescents studying in classes 9, 10, 11, and 12

who met the eligibility criteria. The required sample size was determined using the single population proportion formula at a 95% confidence interval:

$$N = (z^2 p^*q) / d^2$$

Where, $z = 1.96 \sim 2$ at 95% of confidence interval.

p = estimated prevalence (24.33%); according to Goswami V. et al, Eating disorders among adolescents studying in secondary level of India, Gorakhpur (2020)⁴

$$q = 1 - p (0.75)$$

d = allowable error i.e., 5 %

On calculating, the sample size was ~ 283 .

Now, adding 10% non-response rate on the sample size;

$$\text{Total sample size} = 283 + 28 = 311.$$

Therefore, a total of 311 school-going adolescents from classes 9, 10, 11, and 12 were included in the study.

Sampling Technique

A list of schools in Dharan was collected from Dharan Sub-Metropolitan Office. Then, two public and two private schools were selected by simple random technique (Lottery method) and students studying in class 9, 10, 11 and 12 were selected using systematic random sampling technique referring the classroom attendance register as sampling frame.

The researcher estimated the required sample size by using the formula;

$$K = N/n,$$

where K was sampling interval, N was total number of population and n was the required sample size. So, the first sample was chosen randomly from the sampling frame and rest of the samples was drawn adding sampling interval (K) respectively.

Data Collection

Research approval was obtained from the Institutional Review Committee (IRC), BPKIHS. Permission was taken from the Chief College of Nursing, BPKIHS, Head of Department of Psychiatric

Nursing, Head sub-metropolitan city and principals of the schools and parents. Informed written consent was taken from the concerned parents of the student's prior to data collection. Assent was taken from the adolescents below or within the age of 18 years and consent was taken from the adolescents above the age of 18 years. The participant's confidentiality was maintained by giving code number in the questionnaire instead of their name. Self-administered questionnaire was distributed and participants was given 15-20 minutes to fill up the form.

Data Analysis

The collected data was checked, organized, coded and entered in Microsoft excel and converted into SPSS 11.5 version. Descriptive statistics (frequency, mean, median, standard deviation and percentage) was calculated. Associations between eating disorders with socio- demographic variables was assessed using chi-square test.

Ethical Consideration including IRC Approval Number

Ethical clearance was taken from institutional review committee, BPKIHS, Dharan. Permission was taken from the school authority. Informed written consent was taken from the concerned participant's parents and eligible participants prior to data collection. All the information about participants in this study was kept confidential. The participants those who were at the risk of eating disorders was

referred to the concerned hospital. Information related to eating disorders was shared after the data collection. Institutional Review Committee of B.P.Koirala Institute of Health on date July 2025 ref no.IRC-19-082-083.

Tables and Figures

Data from 311 respondents were coded, entered into Microsoft Excel 2010, and analyzed using SPSS version 11.5. Statistical analyses were performed at a 95% confidence interval with a significance level of $p < 0.05$. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to describe socio-demographic characteristics and study variables. Inferential statistics, including Chi-square and Fisher's Exact tests, were applied to determine associations between socio-demographic variables and eating disorder risk. Findings were presented using tables and charts according to the study objectives.

Results

Table 1 shows that the majority of respondents (74.6%) were aged 15-17 years, with a mean age of 16.17 years. Male (50.2%) and female (49.8%) participants were nearly equally represented. Most respondents were Hindu (44.4%), followed by Kirat (37.3%), and the majority belonged to the Janajati ethnic group (75.6%). Nearly half (47.3%) reported a monthly family income of NRs. 26,000-50,000. Most respondents were non-vegetarian (91.6%), first-born children (54.0%), belonged to nuclear families (53.1%), and were living with their parents (76.5%).

Table 1. Socio-Demographic Characteristics of the respondents

n=311

Characteristics	Category	Frequency (n)	Percentage (%)
Age-group (in years)	Early adolescent (11-14)	30	9.6
	Middle adolescent (15-17)	232	74.6
	Late adolescent (18-21)	49	15.8
	Mean±SD (16.17±1.34)		

Continue....

Gender	Male	156	50.2
	Female	155	49.8
Class studying	9	76	24.4
	10	53	17.0
	11	105	33.8
	12	77	24.8
Religion	Hindu	138	44.4
	Buddhist	41	13.2
	Christian	15	4.8
	Muslim	1	0.3
	Kirat	116	37.3
Ethnicity	Brahmin	38	12.2
	Madhesi	15	4.8
	Janajati	235	75.6
	Muslim	1	0.3
	Dalit	22	7.1
Family income per month (Approx. NRs.)	<Rs.25000	47	15.1
	Rs.26000-50000	147	47.3
	Rs.51000-750000	42	13.5
	Rs.76000-100000	48	15.4
	>Rs.100000	27	8.7
	Median income = 50000		
Dietary practice	Vegetarian	26	8.4
	Non-vegetarian	285	91.6
Birth order	First	168	54.0
	Second	89	28.6
	Third	43	13.8
	Fourth	11	3.6

Continue....

Type of family	Nuclear	165	53.1
	Joint	116	37.3
	Extended	30	9.6
Staying currently	Hostel	12	3.9
	Parents	238	76.5
	Friends	7	2.3
	Relatives	54	17.3

Table 2 / Figure 1: Personal and family history of mental illness

n = 311

Characteristics	Category	Frequency (n)	Percentage (%)
Personal history of mental illness	Yes	-	-
	No	311	100

Table 2 shows that none of the respondents had personal history of mental illness.

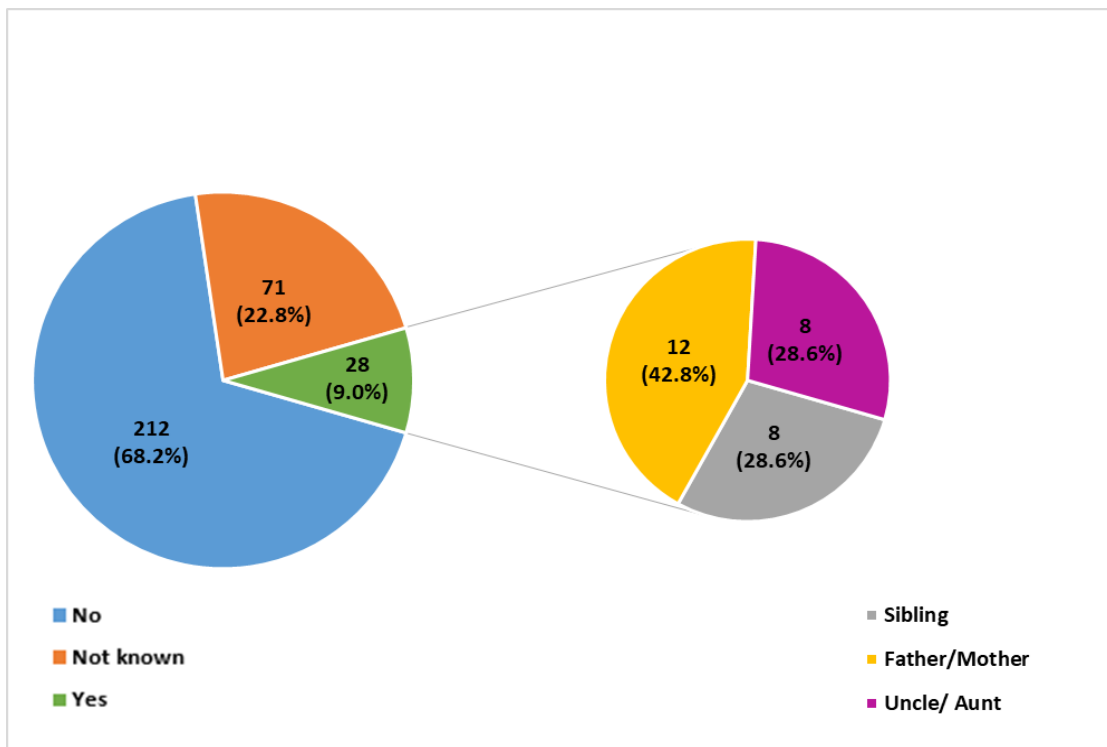


Figure 1: History of mental illness in the family

n=311

Figure 1 shows that 9% of the respondents had history of mental illness in the family, 22.8% were unknown and 68.2% had no any history of mental illness. Of those with history, nearly half of the

respondents (42.8%) had history of mental illness among their father/ mother.

Table 3 depicts that majority (83.3%) of the respondents had normal BMI followed by 10% underweight and 6.7% overweight.

Table 3. Body Mass Index of the respondents

n=311

Characteristics	Category	Frequency (n)	Percentage (%)
Height (cm)	<152.4	74	23.8
	>152.4	237	76.2
	Mean±SD (160.17±8.40)		
Weight (kg)	40-55	206	66.2
	56-70	100	32.2
	71-85	5	1.6
	Mean±SD (54.11±6.49)		
BMI (kg/m ²)	Underweight	31	10.0
	Normal	259	83.3
	Overweight	21	6.7

Table 4 shows that (19.6%) had high risk of eating disorders while (80.4%) had low risk of eating disorders.

Table 4. Risk of eating disorder among respondents

(n=311)

Characteristics	Category	Frequency	Percentage (%)
Risk of eating disorders	(Low risk) <20	250	80.4
	(High risk) >=20	61	19.6

Table 5 shows that 14.1% of respondents were always terrified of being overweight. Nearly half (41.5%) never avoided eating when hungry, while 34.7% were sometimes preoccupied with food. More than half (55.3%) had never experienced eating binges, and 46.0% had never cut food into

small pieces or monitored the calorie content of foods consumed. The majority of respondents never avoided high-carbohydrate foods (54.7%), never felt that others preferred them to eat more (55.0%), and never vomited after eating (75.9%).

Table 5. Frequency and percentage of EAT-26 items response by the respondents**n=311**

S. No.	Variables	Always f (%)	Usually f (%)	Often f (%)	Sometimes f (%)	Rarely f (%)	Never f (%)
1.	Am terrified about being overweight.	44(14.1)	15(4.8)	27(8.7)	89(28.6)	17(5.5)	119(38.3)
2.	Avoid eating when I am hungry.	6(1.9)	7(2.3)	23(7.4)	109(35)	37(11.9)	129(41.5)
3	Find myself preoccupied with food.	22(7.1)	23(7.4)	35(11.3)	108(34.7)	47(15.1)	76(24.4)
4.	Have gone on eating binges where I feel that I may not be able to stop.	26(8.4)	15(4.8)	25(8)	41(31.2)	32(10.3)	172(55.3)
5.	Cut my food into small pieces.	25(8)	31(10)	24(7.7)	55(17.7)	33(10.6)	143(46)
6.	Aware of the calorie content of foods that I eat.	35(11.3)	19(6.1)	25(8)	41(31.2)	32(10.3)	172(55.3)
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	11(13.5)	16(5.1)	26(8.4)	65(20.9)	23(7.4)	170(54.7)
8.	Feel that others would prefer if I ate more.	23(7.4)	18(5.8)	13(4.2)	50(16.1)	36(11.6)	171(55)
9.	Vomit after I have eaten.	1(0.3)	4(1.3)	5(1.6)	30(9.6)	35(11.6)	236(75.9)

Table 6 shows that the majority of respondents never felt extremely guilty after eating (60.5%). More than one-third were never preoccupied with a desire to be thinner (35.4%), never thought about burning calories during exercise (36.3%), and never believed that others considered them too thin (38.6%). Nearly

half (42.4%) were never concerned about having fat on their body, while 27.6% never took longer than others to eat meals. Additionally, 36.0% never avoided sugary foods, 35.4% never consumed diet foods, and 44.4% never felt that food controlled their life.

Table 6. Frequency and percentage of EAT-26 items response by the respondents**n=311**

S. No.	Variables	Always f (%)	Usually f (%)	Often f (%)	Sometimes f (%)	Rarely f (%)	Never f (%)
10.	Feel extremely guilty after eating.	23(7.4)	11(3.5)	8(2.6)	51(16.4)	30(9.6)	188(60.5)
11.	Am preoccupied with a desire to be thinner.	64(20.6)	15(4.8)	19(6.1)	72(23.2)	31(10)	110(35.4)
12.	Think about burning up calories when I exercise.	54(17.4)	25(8)	26(8.4)	56(18)	37(11.9)	113(36.3)
13.	Other people think that I am too thin.	65(20.9)	16(5.1)	39(12.5)	46(14.8)	25(8)	120(38.6)
14.	Am preoccupied with the thought of having fat on my body.	44(14.1)	22(7.1)	19(6.1)	60(19.3)	34(10.9)	132(42.4)
15.	Take longer than others to eat my meals.	43(13.8)	17(5.5)	37(11.9)	78(25.1)	50(16.1)	86(27.7)
16.	Avoid foods with sugar in them.	19(6.1)	34(10.9)	36(11.6)	75(24.1)	35(11.3)	112(36)
17.	Eat diet foods.	20(6.4)	26(8.4)	34(10.9)	82(26.4)	39(12.5)	110(35.4)
18.	Feel that food controls my life.	47(15.1)	20(6.4)	27(8.7)	52(16.7)	27(8.7)	138(44.4)

Table 7 shows that 22.2% respondents always display self-control around food. More than half (63.7%) of the respondents never feel that others pressure them to eat and 40.4% respondents never give too much time and thought to food. Nearly half (49.2%) of the respondents never feel uncomfortable

after eating sweets. More than half (55.6%) of the respondents never engage in dieting behavior. More than half (54.3%) of the respondents never like their stomach to be empty, 77.8% respondents never have the impulse to vomit after meals and 38.3% of the respondents always enjoy trying new rich foods.

Table 7. Frequency and percentage of EAT-26 item response by the respondents**n=311**

S. No.	Variables	Always f (%)	Usually f (%)	Often f (%)	Sometimes f (%)	Rarely f (%)	Never f (%)
19.	Display self-control around food.	69(22.2)	51(16.4)	38(12.2)	49(15.8)	35(11.3)	69(22.2)

Continue....

20.	Feel that others pressure me to eat.	18(5.8)	22(7.1)	13(4.2)	33(10.6)	27(8.7)	198(63.7)
21.	Give too much time and thought to food.	28(9)	26(8.4)	37(11.9)	54(17.4)	40(12.9)	126(40.5)
22.	Feel uncomfortable after eating sweets.	35(11.3)	21(6.8)	20(6.4)	50(16.1)	32(10.3)	153(49.2)
23.	Engage in dieting behavior.	18(5.8)	10(3.2)	23(7.4)	55(17.7)	32(10.3)	173(55.6)
24.	Like my stomach to be empty.	15(4.8)	15(4.8)	15(4.8)	55(17.7)	42(13.5)	169(54.3)
25.	Have the impulse to vomit after meals.	6(1.9)	3(1)	9(2.9)	29(9.3)	22(7.1)	242(77.8)
26.	Enjoy trying new rich foods.	119(38.3)	46(14.8)	22(7.1)	77(24.8)	24(7.7)	23(7.4)

Table 8 shows that a higher proportion of female respondents (29.7%) were at high risk of eating disorders compared to males (12.8%). Female respondents had significantly greater odds of being at high risk of eating disorders than males (OR = 2.87, $p < 0.001$). No significant associations were

observed between eating disorder risk and other socio-demographic characteristics. Although not statistically significant, non-vegetarians had slightly higher odds of eating disorder risk than vegetarians (OR = 1.14, $p = 0.795$).

Table 8. Association between the risk of eating disorders with Socio-demographic variables

(n=311)

Characteristics		Risk of eating disorders		Odds ratio	p-value
		Low Risk f (%)	High Risk f (%)		
Age group (years)	11-14	26 (86.7)	4 (13.3)	2.87	0.538*
	15-17	181 (78.0)	51 (22.0)		
	18-21	38 (77.6)	11 (22.4)		
Gender	Male	136(87.2)	20(12.8)	2.87	0.000*
	Female	109(70.3)	46(29.7)		
Class	9	62(81.6)	14(18.4)	0.904*	
	10	42(79.2)	11(20.8)		
	11	81(77.1)	24(22.9)		
	12	60(77.9)	17(22.1)		

Continue....

Dietary practice	Vegetarian	21(80.8)	5(19.2)	1.14	0.795*
	Non-vegetarian	224(78.6)	61(21.4)		
Birth order	First	130(77.4)	38(22.6)		0.748*
	Second	71(79.8)	18(20.2)		
	Third	34(79.1)	9(20.9)		
	Fourth	10(90.9)	1 (9.1)		
Type of family	Nuclear	132(80.0)	33(20.0)		0.574*
	Joint	88(75.9)	28(24.1)		
	Extended	25(83.3)	5(16.7)		

*Pearson Chi square test

Table 9 depicts that there was higher proportion of respondents with known history of mental illness in family (42.9%) had high risk of eating disorders than with no/ not known history (19.1%). Those respondents with known history of mental illness

in family had significantly 3.18 times higher odds of having high risk of eating disorders as compared to those who had any such family history (Odds ratio 3.18, p-value 0.003).

Table 9. Association between the risk of eating disorders with family history of mental illness variables (n=311)

Characteristics	Category	Risk of eating disorders		Odds ratio	p-value
		Low Risk f(%)	High Risk f(%)		
History of mental illness in family	Yes	16(57.1)	12(42.9)	3.18	0.003*
	No/ Not known	229(80.9)	54(19.1)		

*Pearson Chi square test

Table 10 highlights that there was a statistically significant association of risk of eating disorders with BMI (p-value 0.007).

Table 10. Association between the risk of eating disorders with BMI (n=311)

Characteristics	Category	Risk of eating disorders		p-value
		Low Risk f (%)	High Risk f (%)	
BMI (kg/m ²)	Underweight	29 (93.5)	2 (6.5)	0.007*
	Normal	204 (78.8)	55 (21.2)	
	Overweight	12 (57.1)	9 (42.9)	

*Pearson Chi square test

Discussion

The present study assessed the risk of eating disorders among adolescents in selected schools of Dharan Sub-Metropolitan City and examined its association with selected socio-demographic variables.

The majority of participants were middle adolescents, and the distribution of male and female respondents was nearly equal, similar to findings from previous studies.^{5,29} The study population was predominantly Hindu and Kirat, with most respondents belonging to the Janajati ethnic group, reflecting the demographic composition of the study area.²⁹

A notable proportion of adolescents were identified as being at risk of eating disorders. This finding is consistent with studies conducted in Nepal, Bangladesh, India, and China, which have reported a considerable burden of eating disorder risk among adolescents.^{12,29,34,35} Family history of eating disorders was reported by only a minority of respondents, similar to previous studies.¹

Age was not significantly associated with eating disorder risk, which differs from studies reporting higher vulnerability during middle adolescence.³¹ Gender showed a significant association, with females being more vulnerable than males, consistent with national and international literature.^{24,26,33,34,35}

Educational level and family income were not significantly associated with eating disorder risk. Similar findings have been reported in some studies, although contrasting evidence exists.^{5,36,37,38,39,40}

Dietary practice was also not associated with eating disorder risk, supporting findings from a previous Nepalese study.⁵

No significant associations were found between eating disorder risk and birth order, family type, or living arrangement, which is consistent with several previous studies.^{5,22,44,45,46}

A significant association was observed between eating disorder risk and family history of mental illness. Similar findings have been reported in

previous studies, indicating an increased risk among adolescents with a family history of mental health problems.^{26,27,28}

None of the respondents reported a personal history of mental illness. BMI was significantly associated with eating disorder risk, consistent with studies demonstrating a relationship between body weight status and disordered eating behaviors.^{1,43}

Conclusion, Implications, and Recommendations

This study found that a considerable proportion of adolescents studying in selected schools of Dharan Sub-Metropolitan City were at risk of eating disorders. Gender, family history of mental illness, and body mass index (BMI) were significantly associated with eating disorder risk.

These findings highlight the importance of early identification and prevention of eating disorders among adolescents. Psychiatric nurses can play a key role in screening, counseling, and referral of at-risk students. School-based mental health programs promoting healthy eating behaviors and positive body image may help reduce eating disorder risk.

Awareness and health education on eating disorders should be incorporated into school health services. Training for teachers and school health personnel, routine screening, and timely referral mechanisms are recommended to support early detection and intervention. Integration of eating disorder prevention strategies into school health policies may further strengthen adolescent mental health services.

Conflict of Interest: Nil

Source of Funding: Nil

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