

in treatment are based on mainly anecdotal evidence, and even the one study which demonstrated a reduction of mortality rate following treatment in a specialist unit²⁴, failed to address adequately the issues of patient selection and motivation.

The data on prevention, in a situation where the problem is likely to be increasing, are basically non-existent. Nevertheless, it is possible to draw on studies of aetiology and pathogenesis to advance prevention programmes. Where introduced, it must be acknowledged that outcomes will be uncertain and, therefore, that such programmes must be tested and evaluated.

As yet, evidence relating to primary interventions is sparse. The efficacy of preventive programmes has been variable, possibly because their scope and duration have been too limited. Assessment measures have been inadequate, and the effect of participation in the programme has been uncertain. For instance, has the programme actually increased interest in weight-losing behaviours rather than deterred engagement? Many interventions, particularly in teenage populations, risk glamorising and popularising the behaviour they have been intended to prevent. On the other hand, initiatives directed at an older group of women, as in the "undieting" groups described earlier, appear to have been more successful. But, again, better documentation, and assessment with better measures, are required before their success can be attested.

Because the societal influences that contribute to unhealthy eating attitudes and body dissatisfaction begin even before puberty, this perhaps is the optimal time for primary intervention. As yet, no such programmes have been undertaken. In this regard, the KEDS appears to be a promising instrument with which to survey school-aged children and to assess changes.

Dieting disorders are potentially lethal conditions and virtually the only "hard data" available supports the need for weight restoration in AN leading to protein repletion, resumption of linear growth, restoration of bone mass, improvement of renal function, and survival. In the purging form of AN, and in BN, blood biochemistry and cardiometabolic assessment are essential to prevent untimely fatalities⁸².

Goals and targets

In accord with recommendations in other areas, it may be possible to define these, at least for some at-risk groups:

Goal:

To reduce the prevalence of Eating Disorders in Australia in high risk groups, notably young women, occupational groups like ballet dancers and jockeys, and the elderly.

Aims:

- (1) To understand factors leading to eating disorders in each at risk group - eg.
 - (a) Young women (Child abuse, pressure for scholastic achievements, an unrealistic fashion industry)
 - (b) Ballet Dancers and Jockeys (The inappropriate public expectations of performers or riders; the family pressure and dynamics)
 - (c) Elderly (The distorted food-health beliefs; efforts to overcome problems in physical health like incontinence; decreased energy needs).
- (2) To provide assistance at the individual, family or group, and community level.

Targets and strategies:

- (1) To prevent any further increase in the prevalence of anorexia nervosa and/or bulimia amongst *young women* by the year 2000 by:
 - (a) Health Protection
 - a change in advertising code in the Fashion Industry
 - implementation of a Code of Practice in the Weight Loss Industry
 - (b) Health Education
 - introduction of material into school curriculum
 - (c) Preventive Medicine
 - identification of weight change in young women in medical practice
- (2) To reduce the prevalence of restricted eating and bulimia amongst ballet dancers and of dehydration amongst jockey by:
 - (a) meetings with organising bodies
 - (b) feature articles in occupational journals
- (3) To reduce eating disorders amongst elderly people by:
 - (a) revising health messages and dietary guidelines for elderly people
 - (b) early detection of body compositional change attributable to food intake disturbance

Discussion

Obviously there is a pressing need in dieting disorders for continuing research into both primary and secondary preventive strategies. The latter should include outcome studies of current therapeutic interventions and questions related to these: how quickly to accomplish weight restoration or achieve abstinence from purging behaviours with a minimum of containment? What is adequate weight restoration? And how can this be determined? There is already good evidence from studies of protein repletion, linear growth, bone density and renal function that full restoration to pre-morbid weight levels and complete cessation of weight-losing behaviours are essential to full recovery. This indicates that attention to body composition is more important than to weight, which may be an inappropriate focus for many at risk and for sufferers.

Early recognition and intervention would be preferable and require more attention, including suitable methods of screening and education of those professionals who would be well placed to accomplish this objective.

With respect to primary preventive programmes, more needs to be known about the optimal approach. Evidence thus far suggests that information-gathering is required, rather than premature prescription of remedy. The NSW Department of Education initiative would appear to be an example of excellent intentions producing at best controversial results. Nevertheless, the usefulness of some form of preventive intervention is likely to be demonstrated in the future. The study by Childress *et al*²⁵ justifies optimism in that regard. But exactly what form this intervention should take remains unclear, and further study of societal forces such as media influence, applied learning theory, and the psychology of the target populations, is required. In the meantime, because of the public health seriousness of eating disorders, preventive strategies, with related goals and targets are justifiable.

Prevention of dieting disorders: screening and preventive intervention (the NHMRC initiative)

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*Asia Pacific Journal of Clinical Nutrition (1997) Volume 6, Number 3: 153-161***飲食混亂症的預防: 普查以及預防干預****摘要**

篩選檢查學齡兒童, 青少年以及青年婦女(20-30歲)的飲食混亂症和對體重、體形和食物的病態心理及行爲將會爲澳大利亞設計醫療診所提供有價值的人口統計學情報。這種對易患人群的普查可能不自主地起了相反的作用, 導致厭食症的發展。而對普查中發現的高危人群尚無有效的預防干預措施。因此這種普查方法僅限于科研使用。

另外, 飲食混亂的合并症具有相當高的死亡率, 并且涉及到範圍廣泛的生理紊亂。當務之急是建立對這種合并症的普查措施。不幸的是越來越多的非醫務人員管理飲食混亂症, 遺漏了上述合并症的發現。所有醫生和醫護人員在治療這類患者時, 應注意這一合并症, 同時給予適當的檢查。

特別重要的是:

- 由初級保健行醫者對高危人群進行普查。
- 普查應讓親屬獲知詳情; 應定期記錄體重和身高; 應了解一般的健康情況, 或許能得知厭食症或善饑性神經質的先兆; 應了解青年婦女的月經史; 應注意體力運動情況; 應注意到運動界和舞蹈界的名流也在此行列。
- 在國立營養監測規劃中, 應將“飲食混亂症”列入調查項目。
- 學校和高等教育的衛生教育科目亦應注重這一問題。
- 與廣告和時裝界密切聯系。
- 將告知有飲食混亂危險人群列入減肥業的行業條例。
- 建立對飲食混亂症進行普查和預防的目標。

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