

Global Proportion of Disordered Eating in Children and Adolescents

A Systematic Review and Meta-analysis

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IMPORTANCE The 5-item Sick, Control, One, Fat, Food (SCOFF) questionnaire is the most widely used screening measure for eating disorders. However, no previous systematic review and meta-analysis determined the proportion of disordered eating among children and adolescents.

OBJECTIVE To establish the proportion among children and adolescents of disordered eating as assessed with the SCOFF tool.

DATA SOURCES Four databases were systematically searched (PubMed, Scopus, Web of Science, and the Cochrane Library) with date limits from January 1999 to November 2022.

STUDY SELECTION Studies were required to meet the following criteria: (1) participants: studies of community samples of children and adolescents aged 6 to 18 years and (2) outcome: disordered eating assessed by the SCOFF questionnaire. The exclusion criteria included (1) studies conducted with young people who had a diagnosis of physical or mental disorders; (2) studies that were published before 1999 because the SCOFF questionnaire was designed in that year; (3) studies in which data were collected during COVID-19 because they could introduce selection bias; (4) studies based on data from the same surveys/studies to avoid duplication; and (5) systematic reviews and/or meta-analyses and qualitative and case studies.

DATA EXTRACTION AND SYNTHESIS A systematic review and meta-analysis was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline.

MAIN OUTCOMES AND MEASURES Proportion of disordered eating among children and adolescents assessed with the SCOFF tool.

RESULTS Thirty-two studies, including 63 181 participants, from 16 countries were included in this systematic review and meta-analysis. The overall proportion of children and adolescents with disordered eating was 22.36% (95% CI, 18.84%-26.09%; $P < .001$; $n = 63\ 181$) ($I^2 = 98.58\%$). Girls were significantly more likely to report disordered eating (30.03%; 95% CI, 25.61%-34.65%; $n = 27\ 548$) than boys (16.98%; 95% CI, 13.46%-20.81%; $n = 26\ 170$) ($P < .001$). Disordered eating became more elevated with increasing age ($B, 0.03$; 95% CI, 0-0.06; $P = .049$) and body mass index ($B, 0.03$; 95% CI, 0.01-0.05; $P < .001$).

CONCLUSIONS AND RELEVANCE In this systematic review and meta-analysis, the available evidence from 32 studies comprising large samples from 16 countries showed that 22% of children and adolescents showed disordered eating according to the SCOFF tool. Proportion of disordered eating was further elevated among girls, as well as with increasing age and body mass index. These high figures are concerning from a public health perspective and highlight the need to implement strategies for preventing eating disorders.

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Eating disorders are psychiatric disorders characterized by abnormal eating or weight control behaviors, which can lead to serious health problems.¹ These disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorder—not otherwise specified.^{2,3} They are defined according to individual signs and symptoms and with degrees of severity detailed in the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5*),² as well as in the World Health Organization *International Classification of Diseases, 11th Revision* (*ICD-11*).³ Similarly, they are recognized within the mental disorders included in the Global Burden of Diseases, Injuries, and Risk Factors Study 2019⁴ and are currently a public health concern in most mid- and high-income countries because their prevalence in young people has markedly increased over the past 50 years.¹ Furthermore, eating disorders are among the most life-threatening of all mental health conditions⁵ and accounted for 17 361.5 years of life lost (between 1990 and 2019) and caused 318.3 deaths worldwide in 2019.⁴

The etiology of eating disorders is very complex and, similar to other psychiatric disorders such as depression and anxiety, arises from the intersection of many risk factors.⁶ Although the prevalence varies according to study populations and definitions used,⁷ it is recognized that eating disorders are common in adolescents and even more common in young adults.⁸ Based on the *DSM-5*, the prevalence of eating disorders in children and adolescents (aged 11–19 years) has been stated to be between 1.2% (boys) and 5.7% (girls), with increasing incidence over recent decades.⁷ Considering that mid to late adolescence is a peak period of eating disorders and their symptoms, knowing and understanding the proportion of disordered eating among youths is a crucial issue.⁹

Because some children and adolescents with eating disorders may hide the core symptoms of the illness and delay seeking specialized care due to feelings of shame or stigmatization,¹⁰ it is reasonable to consider that eating disorders are underdiagnosed and undertreated.¹¹ In addition to diagnosed eating disorders, parents, guardians, and health care professionals should be aware of symptoms of disordered eating, which include behaviors such as weight loss dieting, binge eating, self-induced vomiting, excessive exercise, and the use of laxatives or diuretics (although not to the level to warrant a clinical diagnosis of an eating disorder).¹² Although these symptoms predict outcomes related to eating disorders and obesity in adolescents 5 years later,¹³ it is important to distinguish disordered eating from eating disorders.¹⁴ The term *disordered eating* is often used to describe and identify some of the different eating behaviors that do not necessarily meet the diagnostic criteria for an eating disorder and therefore cannot be classified as eating disorders per se.¹⁵ Notwithstanding, although its impact on health is often minimized, disordered eating should be closely evaluated because it can evolve into eating disorders.¹²

The Sick, Control, One, Fat, Food (SCOFF) questionnaire, developed in 1999 by Morgan et al,¹⁶ is the most widely used screening measure for eating disorders.¹⁷ It consists of 5 questions with dichotomic answers options (ie, yes or no)¹⁶: (1) Do you make yourself sick because you feel

Key Points

Question What is the global proportion of disordered eating in children and adolescents?

Findings In this systematic review and meta-analysis of 32 studies including 63 181 participants from 16 countries, 22% reported that children and adolescents showed disordered eating. The proportion was further elevated among girls, older adolescents, and those with higher body mass index.

Meaning Identifying the magnitude of disordered eating and its distribution in at-risk populations is crucial for planning and executing actions aimed at preventing, detecting, and dealing with them.

uncomfortably full? (2) Do you worry you have lost control over how much you eat? (3) Have you recently lost more than 1 stone in a 3-month period? (4) Do you believe yourself to be fat when others say you are too thin? (5) Would you say that food dominates your life? A positive screen is provided when a participant answers yes to 2 or more questions,¹⁶ which denotes a suspicion of an existing eating disorder (ie, disordered eating).¹⁷ Previous systematic reviews have examined the SCOFF questionnaire as a screening tool in primary care setting.^{17,18} For instance, a recent systematic review with meta-analysis including 25 validation studies found that the validity of the cutoff point of 2 or more on the SCOFF questionnaire was high across samples with a pooled sensitivity of 86.0% and specificity of 83.0%. Another recent systematic review for populations and settings relevant to primary care in the US found that a cutoff point of 2 or more on the SCOFF questionnaire had a pooled sensitivity of 84% and pooled specificity of 80% among adults.¹⁸ Among young people, previous studies have found that the cutoff point of 2 or more on the SCOFF questionnaire provided a sensitivity ranging from 64.1% to 81.9% and a specificity ranging from 77.7% to 87.2%.^{19–22}

Despite the above, thus far, no previous systematic review and meta-analysis determined the proportion of disordered eating among children and adolescents. From an epidemiological perspective, identifying the magnitude of disordered eating and its distribution in at-risk populations is crucial for planning and executing actions aimed at preventing, detecting, and dealing with them.²³ Therefore, the aim of the present study was to establish the proportion among children and adolescents of disordered eating as assessed with the SCOFF tool, one of the most widely used methods to study disordered eating in this population.⁸

Methods

This systematic review and meta-analysis was registered in the International Prospective Register of Systematic Reviews (PROSPERO) ([CRD42022350837](https://doi.org/10.1111/CRD4.2022350837)) and conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline.²⁴

Eligibility Criteria

Studies were required to meet the following criteria: (1) participants: studies of community samples of children and adolescents aged 6 to 18 years and (2) outcome: disordered eating assessed by the SCOFF questionnaire. Searching was not restricted to articles published in peer-reviewed journals of any particular language. For studies that included children/adolescents and adults, the articles were reviewed and, if reported, the child/adolescent samples were included.

The exclusion criteria included (1) studies conducted with young people who had a diagnosis of physical or mental disorders; (2) studies that were published before 1999 because the SCOFF questionnaire was designed in that year¹⁶; (3) studies in which data were collected during COVID-19 because they could introduce selection bias; (4) studies based on data from the same surveys/studies to avoid duplication; and (5) systematic reviews and/or meta-analyses and qualitative and case studies.

Information Sources and Search Strategy

Two researchers (J.F.L.-G. and D.V.-M.) systematically searched PubMed, Scopus, Web of Science, and the Cochrane Library with date limits from January 1999 to November 2022. Based on the participants, outcome, and study criteria, studies were identified using all possible combinations of the following groups of search terms: (1) child* OR adolescent* OR youth* OR teen* OR young* and (2) Sick, Control, One, Fat, Food OR SCOFF. The complete search strategy for each database is shown in eTable 1 in Supplement 1. In addition, the list of references of the studies included in this review and in a previous systematic review¹⁷ was thoroughly reviewed to ensure that no eligible studies were missed.

Selection Process

After identifying eligible studies, Mendeley (version for Windows 10; Elsevier) was used to remove duplicate studies. Two members of the research team (J.F.L.-G. and D.V.-M.) conducted the selection process independently and screened every title and abstract to identify potentially relevant articles to be reviewed in the full-text phase. A third researcher (A.G.-H.) participated to resolve any discrepancies.

Data Items

The proportion of participants with disordered eating (ie, cut-off point ≥ 2 on the SCOFF questionnaire) was extracted by 1 researcher (D.V.-M.). Another researcher (J.F.L.-G.) checked the data for accuracy. In case of a discrepancy between these 2 researchers, a third researcher (A.G.-H.) reviewed the information.

Risk of Bias Assessment

Information on the authors, affiliations, date, and source of each study included in this review was hidden to avoid bias in the assessment of the methodological quality of the articles. Two researchers (D.V.-M. and J.F.L.-G.) independently assessed the risk of study bias of the included studies. This assessment was performed using a specific tool by Hoy et al²⁵ for prevalence studies. The tool consists of 10 items that ad-

dress both the external and internal validity of prevalence studies. Each item can be classified as yes (low risk) or no (high risk), which equals 0 and 1 point, respectively. The overall risk of study bias is deemed to be at low risk of bias, moderate risk of bias, or high risk of bias if the points scored are 0 to 3, 4 to 6, or 7 to 9, respectively.

Outcome Measures

Proportion of disordered eating was computed based on the raw numerators (ie, participants who scored ≥ 2 on SCOFF questionnaire) and denominators (ie, total sample) found among the studies.

Synthesis Methods

Using RStudio software version 2022.07.2 + 576 (R Group for Statistical Computing) with the *meta* package,²⁶ a meta-analysis of single proportions (ie, *metaprop*) was pooled by applying a random-effects model that displayed the results as forest plots using the inverse variance method. The exact or Clopper-Pearson method was used to establish 95% CIs for proportion from the selected individual studies,²⁷ and a Freeman-Tukey double arcsine transformation was used to normalize the results before calculating the pooled proportion.²⁸ A continuity correction of 0.5 was used both to calculate individual study results with confidence limits and to conduct meta-analysis.

Heterogeneity between the included studies was determined by the I^2 statistic and its *P* value. Small study effects and publication bias were examined using the Doi plot and the Luis Furuya-Kanamori index.²⁹ No asymmetry, minor asymmetry, or major asymmetry were considered with values of less than -2, between -2 and -1, and more than -1, respectively.²⁹

Subgroup analyses were conducted by gender. Furthermore, random-effects meta-regression analyses using the method of moments were estimated to independently assess whether disordered eating differed by mean age or body mass index (BMI) (both as continuous variables).

Results

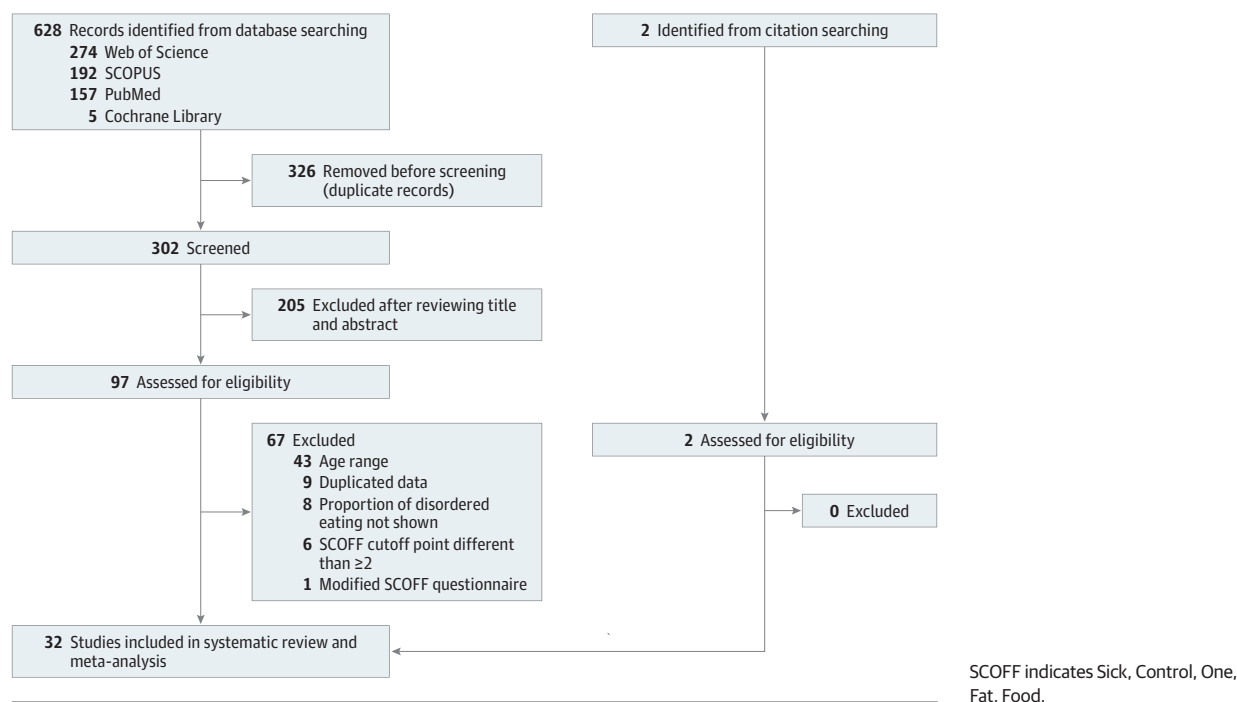
Study Selection

A total of 628 records were identified through database searches (Figure 1). After screening for duplicates, gray literature, and other reasons, 302 records remained. Finally, 97 records were obtained for full-text review. Of those studies, 67 were excluded for several reasons (eTable 2 in Supplement 1). Two studies were included via other methods (ie, citation searching). Finally, 32 studies, including 63 181 participants, were included in this systematic review, and all studies were included in the meta-analysis.

Study Characteristics

The main characteristics of the 32 included studies are summarized in the Table. Twenty-six of the studies were cross-sectional,^{19,20,30,31,34,36,37,39,41-46,48-59} 4 were longitudinal,^{32,33,35,40} 1 was a quasi-experimental study,⁴⁷ and 1 was a randomized clinical trial.³⁸ A total of 63 181 partici-

Figure 1. PRISMA Flowchart



pants (51.8% girls) aged 7 to 18 years were included in this systematic review and meta-analysis.

According to gender, 22 studies reported the overall proportion of children and adolescents with disordered eating in both girls and boys, and 2 studies included only 1 gender (ie, only girls^{44,55}). The remaining 8 studies did not report proportion segmented by gender. In terms of geographical regions, 16 different countries were identified, including 21 studies in Europe,^{19, 20, 30, 34-36, 40-43, 45, 46, 48-53, 56, 57, 59} 5 in Asia,^{33,37,47,55,58} 4 in North America,^{31,32,44,54} 1 in South America,³⁸ and 1 in Africa.³⁹ All the studies were conducted with participants from only 1 country.

Risk of Study Bias

All studies were deemed to be at low risk of bias, presenting scores ranging between 0 and 2 points (with the exception of the study by Hicks et al,⁴⁴ which presented 3 points). The main sources of bias were associated with the representativeness of the analyzed sample.^{19,20,30,31,35-39,41,44,46,47,50,52,54,55} A summary of the risk of bias scoring is shown in eTable 3 in Supplement 1.

Results of Syntheses

Figure 2 shows that the overall proportion of children and adolescents with disordered eating was 22.36% (95% CI, 18.84%-26.09%; $P < .001$; $n = 63\,181$) ($I^2 = 98.58\%$). The Luis Furuya-Kanamori index for the Doi plot showed no asymmetry, indicating no risk of publication bias (Luis Furuya-Kanamori index = -0.58) (eFigure in Supplement 1).

Figure 3 depicts the subgroup analysis according to gender. Girls were significantly more likely to report disordered

eating (30.03%; 95% CI, 25.61%-34.65%; $n = 27\,548$) than boys (16.98%; 95% CI, 13.46%-20.81%; $n = 26\,170$) ($P < .001$).

The random-effects meta-regression models between proportion of disordered eating and mean age or BMI are shown in Figure 4. Disordered eating became more elevated with increasing age (B , 0.03; 95% CI, 0-0.06; $P = .049$) (Figure 4A) and BMI (B , 0.03; 95% CI, 0.01-0.05; $P < .001$) (Figure 4B).

Discussion

To our knowledge, this is the first meta-analysis that has comprehensively examined the overall proportion of children and adolescents with disordered eating in terms of gender, mean age, and BMI. The main findings of this study are as follows: (1) a total of 14 856 of 63 181 children and adolescents (22.36%) from 16 countries showed disordered eating; (2) the proportion of children and adolescents with disordered eating was significantly higher in girls than in boys; and (3) the proportion of disordered eating among children and adolescents was positively associated with mean age and BMI. These findings can inform intervention priorities for disordered eating as a global health initiative to prevent possible health problems among young people,⁶⁰ particularly in girls and young people with higher BMI.

Our findings indicate that more than 1 in 5 children and adolescents presented with disordered eating. It is noteworthy that disordered eating and eating disorders are not similar because not all children and adolescents who reported disordered eating behaviors will necessarily be diagnosed with an eating disorder.¹⁵ However, disordered eating in childhood/

Table. Characteristics of the Studies Included (N = 32)

Source	Study design	Total, No.	Girls, %	Age, mean (range), y	BMI
Adelantado-Renau et al, ³⁰ 2018	Cross-sectional	261	47.1	13.9 (14-18)	20.3
Bean, ³¹ 2019	Cross-sectional	3356	52.6	NA (14-18)	NA
Berger et al, ¹⁹ 2011	Cross-sectional	807	52.7	12.0 (12)	NA
Breton et al, ³² 2022	Longitudinal	1336	52.2	12.0 (12)	NA
Chia and Lee, ³³ 2015	Longitudinal	137	40.1	12.7 (12-13)	NA
Cohrdes et al, ³⁴ 2019	Cross-sectional	13 232	50.3	NA (11-17)	NA
Esteban-Gonzalo et al, ³⁵ 2014	Longitudinal	2077	50.6	14.7 (13-17)	NA
Estecha-Querol et al, ³⁶ 2016	Cross-sectional	235	62.1	14.9 (13-18)	21.6
Feng and Abebe, ³⁷ 2017	Cross-sectional	389	48.8	15.1 (12-18)	NA
Galvão et al, ³⁸ 2022	Cluster randomized clinical trial	5208	49.9	13.3 (12-17)	NA
Ghafouri et al, ³⁹ 2021	Cross-sectional	471	84.7	17.3 (15-18)	22.0
Giel et al, ⁴⁰ 2013	Longitudinal	41	48.8	13.7 (12-13)	31.3
Gmeiner and Warschburger, ⁴¹ 2022	Cross-sectional	1061	52.1	11.0 (9-13)	NA
Grüttner, ⁴² 2018	Cross-sectional	1778	49.8	12.0 (12-13)	NA
Herpertz-Dahlmann et al, ⁴³ 2008	Cross-sectional	1843	48.7	14.6 (11-17)	NA
Hicks et al, ⁴⁴ 2013	Cross-sectional	126	0	13.9 (12-17)	NA
Horváth et al, ⁴⁵ 2020	Cross-sectional	5205	50.8	16.6 (15-18)	21.7
Jáuregui-Lobera et al, ⁴⁶ 2009	Cross-sectional	318	52.8	14.4 (12-18)	20.6
Lee et al, ⁴⁷ 2018	Quasi-experimental	169	50.9	12.3 (11-12)	19.6
Lommi et al, ⁴⁸ 2020	Cross-sectional	339	54.6	11.9 (10-15)	NA
López-Gil et al, ⁴⁹ 2022	Cross-sectional	855	54.6	14.0 (12-17)	22.8
Monteagudo et al, ⁵⁰ 2013	Cross-sectional	9340	50.2	15.0 (14-18)	NA
Muro-Sans et al, ²⁰ 2008	Cross-sectional	954	49.8	13.6 (11-17)	NA
Nolan et al, ⁵¹ 2022	Cross-sectional	1291	48.8	NA (11-19) ^a	NA
Philipp et al, ⁵² 2014	Cross-sectional	408	58.3	NA (10-18)	NA
Pustivšek et al, ⁵³ 2019	Cross-sectional	583	46.8	16.0 (15-17)	26.5
Read, ⁵⁴ 2021	Cross-sectional	125	53.6	15.9 (7-18)	NA
Rungta and Kudpi, ⁵⁵ 2019	Cross-sectional	200	100	13.5 (14-17)	17.7
Šabláturová et al, ⁵⁶ 2021	Cross-sectional	6867	50.1	13.5 (11-16)	NA
Štefanová et al, ⁵⁷ 2020	Cross-sectional	780	44.1	14.4 (11-15)	19.9
Watson et al, ⁵⁸ 2015	Cross-sectional	259	100	12.3 (12-17)	19.0
Zeiler et al, ⁵⁹ 2016	Cross-sectional	3610	55.3	14.5 (10-18)	NA

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared). NA, not available.

^a Only the sample between age 11 and 16 years (n = 811) was included.

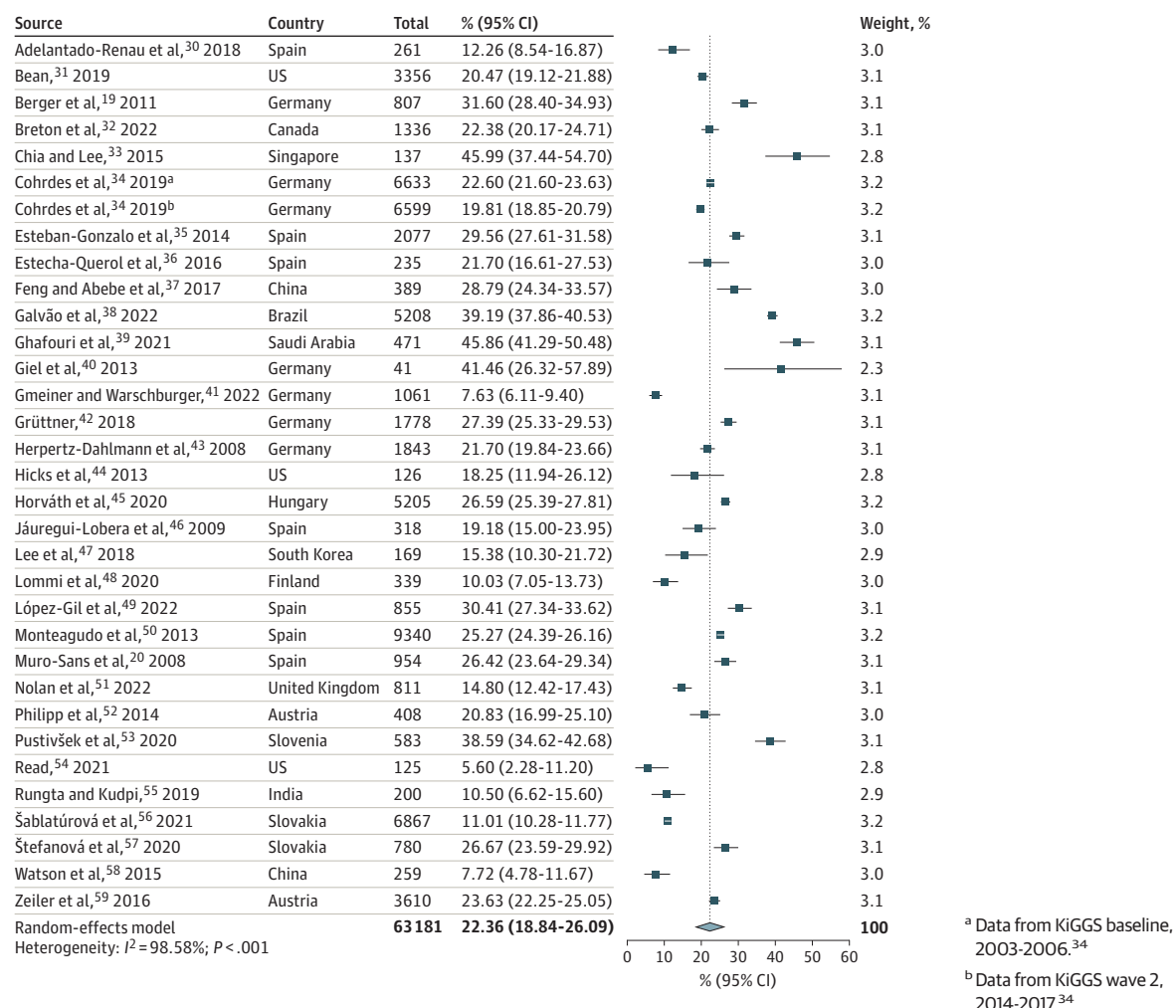
adolescence may predict outcomes associated with eating disorders in early adulthood.¹³ For this reason, this high proportion found is worrisome and call for urgent action to try to address this situation. In 2019, 14 million people experienced eating disorders including almost 3 million children and adolescents.⁶¹ The behaviors related to eating disorders may lead to greater risk or damage to health, significant distress, or significant impairment of functioning.⁶⁰ Indeed, eating disorders are among the most life-threatening psychiatric problems, and people with these conditions die 10 to 20 years younger than the general population.⁵

Our findings also indicated that the proportion of children and adolescents with disordered eating was higher in girls than in boys. Although sex differences in disordered eating seem to be relatively minor in adolescence,⁶² it is well known that these disorders are more prevalent among girls.⁶³ Conventionally, studies have focused principally on the female sex, but currently this is not considered as a female-specific matter. The reasons for sex disagreement in

the prevalence are not well known.⁶² It has been pointed out that disordered eating is frequently unobserved among boys.⁶⁴ Boys are presumed to underreport the problem because of the societal perception that these disorders mostly affect girls⁶⁵ and because disordered eating has usually been thought by the general population to be exclusive to girls and women.⁶⁴ Additionally, it has been noted that the current diagnostic criteria of eating disorder² fail to detect disordered eating behaviors more commonly observed in boys than in girls, such as intensely engaging in muscle mass and weight gain with the goal of improving body image satisfaction.⁶⁴

On the other hand, the proportion of young people with disordered eating increased with increasing age. This finding is in line with the scientific literature.⁶⁶⁻⁶⁸ The age at onset of eating disorders has classically been described in adolescence.⁶⁸ Adolescence represents a critical period for the onset of eating disorders.⁶⁶ Similarly, Swanson et al⁶⁷ found that the median age at onset of some eating disorders

Figure 2. Meta-analysis of Proportion of Disordered Eating Among Children and Adolescents



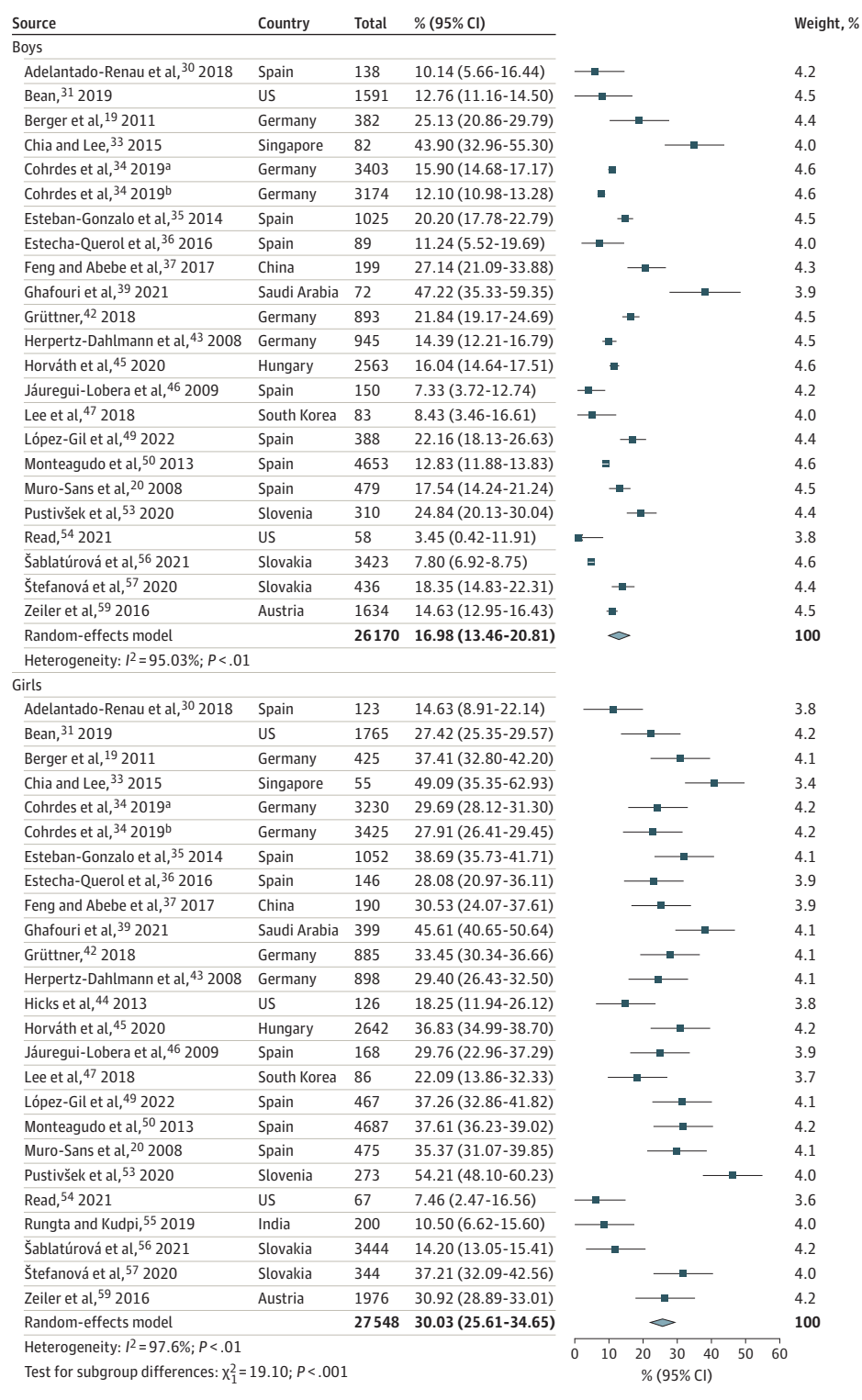
(eg, anorexia nervosa, bulimia nervosa, binge eating disorder) ranged from 12.3 to 12.6 years in a US nationally representative sample including 10 123 adolescents. As the analyzed sample in the present systematic review and meta-analysis ranged from age 7 to 18 years and only 3 studies included only children (ie, aged 7-10 years), it seems to corroborate these ages at onset.

Importantly, we found that the proportion of children and adolescents with disordered eating became more evaluated with increasing BMI. In this sense, the proportion of disordered eating is higher in young people with excess weight than in their counterparts with normal weight.^{37,69,70} Young people who have excess weight may follow disordered eating behaviors while attempting to lose body weight.⁷¹ Therefore, it has been described that young people with excess weight is the population that appears to experience symptoms of disordered eating most frequently (eg, unsupervised weight loss dieting may lead to eating disorder risk⁷²). Although most adolescents who develop an eating disorder do not report prior excess weight problems, some adolescents could misinterpret what eating healthy consists of and engage in unhealthy behaviors (eg, skipping

meals to generate a caloric deficit), which could then lead to development of an eating disorder.⁷³

The WHO's Comprehensive Mental Health Action Plan 2013-2030 recognizes the essential role of mental health in achieving health for all people, establishing some objectives/priorities.⁶⁰ For instance, among others, this plan tries to strengthen information systems, evidence, and research for mental health. In this sense, our systematic review and meta-analysis contributes to this aim by providing epidemiological evidence on the current situation of disordered eating that, if undetected and untreated, can lead to eating disorders with their harmful consequences for the individual, the family, and society. Similarly, the high proportion of disordered eating found in this systematic review and meta-analysis reinforce the importance of screening eating disorders in primary care setting. This is in line with the recommendations by the American Academy of Pediatrics⁷⁴ and the American Academy of Child and Adolescent Psychiatry,⁷⁵ which advise screening young people through longitudinal height and weight monitoring and looking for symptoms of disordered eating. In this sense, the SCOFF questionnaire is simple, memorable, and easy for applying and scoring,¹⁶ which

Figure 3. Meta-analysis of Proportion of Disordered Eating Among Children and Adolescents by Gender



^a Data from KiGGS baseline, 2003-2006.³⁴

^b Data from KiGGS wave 2, 2014-2017.³⁴

may be considered the first approach to identify the need for a more detailed and specialized evaluation.²⁰ However, positive results should be followed by further questioning, prior to an automatic referral to mental health professionals.⁷⁶

Limitations

The present study has certain limitations that must be acknowledged. First, only studies that analyzed disordered eating using the SCOFF questionnaire were included. This deci-

Figure 4. Meta-regression Analyses by Mean Age and Body Mass Index



sion is justified by the intention of homogenizing the proportion of global proportion of children and adolescents with disordered eating. In this sense, the SCOFF questionnaire is the most widely used screening tool for eating disorders, has been adapted and validated for its use in several languages, seems to be highly effective as a screening tool, and has been extensively used to raise the suspicion level of an eating disorder. Second, because of the cross-sectional nature of most of the included studies, a causal relationship cannot be established. Third, due to the inclusion of binge eating disorder and other specified eating disorders in the *DSM-5*, there is not enough evidence to support the use of SCOFF in primary care and community-based settings for screening all the range of eating disorders. However, a meta-analysis by Kutz et al¹⁷ concluded that the SCOFF is a useful and simple screening tool for the most prevalent eating disorders (ie, bulimia ner-

vosa, anorexia nervosa). Fourth, we included studies based on self-report questionnaires to assess disordered eating, and consequently, both social desirability and recall bias could influence the findings.

Conclusions

The available evidence from 32 studies comprising large samples from 16 countries showed that approximately 22% of children and adolescents showed disordered eating according to the SCOFF tool. The proportion of disordered eating was further elevated among girls as well as with increasing age and BMI. This high proportion is worrisome from a public health perspective and highlights the need to implement strategies for preventing eating disorders.⁶⁰

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