

ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF MEDICINE, DEPARTMENT OF PSYCHIATRY

UNDERSTANDING EATING BEHAVIORS AMONG ADOLESCENTS WITH COMMON MENTAL DISORDERS IN SELECTED OUTPATIENT CLINICS IN ADDIS ABABA, ETHIOPIA

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A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR A SPECIALITY CERTIFICATE IN PSYCHIATRY

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I) Abbreviations and acronyms

AAU: Addis Ababa university

AN: Anorexia Nervosa

BED: Binge eating disorder

BN: Bulimia Nervosa

CMD: Common mental disorders

CSA: Central statistical agency

DEA: Disordered eating attitude

EMHDS: Ethiopian mini demographic and health survey

GAD: Generalized anxiety disorder

GBD: Global burden of diseases

MDD: Major depressive disorder

PTSD: posttraumatic stress disorder

SSD: Somatic symptom and related disorder

WHO: World health organization

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ABSTRACT

Background: Eating problems are a growing global concern. Adolescents and young people, particularly those with emotional and behavioral difficulties, represent one of the most affected groups. However, in the Ethiopian context, there is a dearth of evidence regarding the subjective experiences of eating behaviors among adolescents. Understanding these experiences, especially within clinical populations, is crucial for identifying themes that are closely related to their mental health.

Objectives:

This study aimed to understand the eating behaviors of adolescents with common mental health disorders at follow up in two outpatient clinics in Addis Ababa, Ethiopia.

Methods:

An institution-based semi structured interview was conducted for a descriptive phenomenological qualitative design study using in depth semi structured interviews among 12 adolescents aged 10-19. Data were collected over the period of December 1, 2025 - March 1, 2026 and analyzed using a thematic approach to identify recurrent, core themes related to eating behaviors of adolescents with common mental health disorders.

Results: Six primary themes were identified in this study. Knowledge and perception of healthy eating, eating patterns, influences of eating patterns, body image and identification, impact of eating habits and actions to improve eating habits. Although participants exhibited adequate awareness of health eating, their dietary practices were described as irregular and under/overeating. These practices appeared to be related to their peer relationships, social expectations and emotions. Eating behaviors were also linked to body image and maintaining social ideals.

Conclusions: Adolescent eating behaviors in this setting are more intertwined with emotion regulation and social acceptance than solely by nutritional knowledge.

Recommendations: Clinical interventions should move beyond general education toward individualized case conceptualizations that address emotional eating and the somatic impacts of mental distress.

Keywords: eating habits, adolescents, common mental disorders

1. INTRODUCTION

1.2 Background

The WHO defines adolescence as the time between the ages of 10 and 19. This period is usually misconceived as a phase of life without health complications. However, 1 in 5 adolescents undergo mental health problems during this period (1). Between 2016 and 2023, there has been a significant increment in the prevalence of anxiety and depressive conditions which have shown over 50% increment from the past (2).

Early adolescence is a crucial period with major bodily changes during puberty. During this period self-identity is still in the process of formation, thus there is high potential of uncertainty in self-esteem (3). This places these individuals at vulnerability to appearance-related concerns and pose a risk for adverse eating habits (4,5). During this transition from childhood to adolescence, mental health disorders could be a leading factor to disordered eating behaviors or vice versa (6).

Feeding and eating disorders represent a serious wide spectrum of weight and body image related concerns primarily common in the adolescence period and among women (7). However, “Disordered eating” is qualitatively distinct from eating disorders such as bulimia nervosa and anorexia nervosa, which are clinical diagnosis that peak during childhood to mid-late adolescence (8,9). Disordered eating attitudes/behaviors may be present as part of an eating disorder and signify disordered thoughts, beliefs and feelings towards food and weight regulation. It may include subclinical forms of overeating episodes without loss of control, meal irregularities, purging behaviors or eating despite absence of hunger. These patterns don’t cause impairment or distress as compared to eating disorders; however, they may contribute to the development of obesity and may progress to eating disorders in the future (10).

DEAs are thus conditions which are between the spectrum of normal eating behavior to eating disorders. Although it may appear to be a non-risky behavior, it could eventually lead to a clinical form of eating disorder (11).

Eating problems may be present as symptoms of mood and anxiety disorders, but they may also be a comorbid condition occurring separately from other mental health conditions. These occurrences may indicate that a similar pathological process to be present with comorbid diagnosis (12).

One common pathological process between the two entities is the biological association with appetite curbing hormone GLP-1 receptor agonist which is hypothesized to be an effective treatment of BED and in reduction of depressive symptoms. Additionally, common brain regions have been identified in appetite responses and depressive symptoms (13). Presentations of common mental disorders include changes in appetite and weight. While some individuals present with an increase in appetite, others experience the opposite and some don't share these experiences at all (14).

Furthermore, eating behaviors may change episodically due to symptoms or worsening. These changes may include appetite loss or lack of control in eating behaviors (15).

Additionally, psychiatric medications are also implicated in causing negative affect towards eating behaviors or serve as precipitators while certain diets are associated with increased prevalence and severity of CMDs and healthy diet are supported as lifestyle interventions among diagnosed individuals (16,17).

In Ethiopia, only a few studies have been conducted on eating behaviors of adolescents. These studies were all quantitative determination of eating problems observing a significantly affected population (18–20) that was comparable to studies done in middle income countries (21,22), however these studies didn't include the clinical population even though they are affected more than the general population with eating problems. Furthermore, exploratory studies on the lived experiences of adolescents with mental disorders and their eating attitudes are even more scarce worldwide (23–25).

The purpose of this research study is to narrow the gap in knowledge about the subjective experiences of appetite, eating attitudes, and dietary experiences of adolescents with common mental disorders where there is still lacking qualitative data. It is possible that findings from this study will shed more light on the hypothesis that eating

problems may be of higher concern amongst the young clinical population through the exploration of changes in eating behaviors pre, during and post diagnosis and subjective influencing factors.

1.3 Statement of the problem

Adolescence is a developmental period of unique experiences with changes in psychological and physiological processes (26). They are prone to health concerns due to their eating habits and lifestyle as well as to common mental problems (27). Globally, it is estimated that 10-20% of children and adolescents are affected with mental health conditions (28). According to the UNICEF, common mental disorders which affect individuals of early age have a significant impact on quality of life.

As for weight controlling behaviors youth transitioning from adolescence; have a higher incidence of dieting and disordered eating behaviors which has been found to be a risk factor to the persistence of these issues into young adulthood (7).

The global prevalence of disordered eating behavior has been increasing substantially over the past 3 decades (29) with anorexia nervosa and bulimia nervosa which are serious conditions that create a global burden estimated to contribute 1.9 million disability-adjusted life years among young females (30). Recent epidemiological data have revealed a rapid spread of disordered eating attitudes in several parts of the world and an increasing number of individuals to be affected despite prior studies showing high rates of eating disorder in developed countries (31).

The etiology of eating concerns is multi-factorial including biology, cultural, and interpersonal influences (32). Emotional eating, which is a coping mechanism, occurs in response to certain emotional cues that are mainly of negative contents (33). The variability in these emotions may increase or decrease eating behaviors depending on individuals indicating subjective exploration of these experiences as important (34).

The American psychiatry association attributes appetite and weight disturbances as part of symptoms to certain mental conditions indicating a correlation between the two conditions. While women with CMDs have increased rates of eating disorders (35), individuals with bipolar disorder have higher rates of stress induced eating (36). These

correlations are further exemplified in longitudinal studies among community samples reporting depressive disorders and depressed mood to have a higher risk of developing disordered eating and higher chance of recurrence in those with prior eating disorder diagnosis(37,38).In contrast, other prospective studies show a reverse relationship with eating disorder diagnosed youths having higher depressive symptoms (39,40).

Anxiety symptoms and eating disorder symptoms also commonly co-occur in adolescents, and a bidirectional relationship between these conditions is presumed. Similar to depressive symptoms, anxiety disorders are associated with subsequent eating disorder symptoms and increment in symptoms (41). Moreover, generalized anxiety in childhood period is predictive of future eating disorders in early adolescence (42). Meanwhile, somatic symptoms are reported to be associated with eating disorders like BED with severity in physical symptoms being indicative of increment in binge eating behaviors. Conversely, individuals with BED are found to have higher likelihood of reporting physical complaints (43,44).

Mental disorders disrupt day-to-day routines, ranging from occupational to social engagements. Emotional eating is common during acute mental distress, as the context of dietary behavior is emotional rather than physical (15). Nearly half of severely mentally ill individuals are affected by emotional eating behaviors (45).

A study done in an Ethiopian context among adult population indicates a higher prevalence of undernutrition in the clinical population as compared to the general population implying further assessment on eating behaviors of these populations as essential (46).

Notably, both CMDs and DEAs can be precipitated by chronic body dissatisfaction that is highest during adolescence when pubertal changes to the body and peer influence are the highest via promotion of the cycle of negative self-evaluation (47). Body image may influence the motivation to change eating behaviors either positively or negatively (48).

These results suggest that there is a complex relationship between common mental health problems and eating attitudes/behaviors and vice versa, thus progressively

affecting psychological well-being through young adulthood. The inter-relationship between mental disorders and eating behaviors needs further exploration to ascertain the subjective impact among individuals with clinical assessment.

2. RATIONALE OF THE STUDY

According to the Ethiopian Mini-Demographic and Health Survey (EMDHS) the country is characterized by a young population with 15-19 aged adolescents accounting for 10.6% of the population (CSA 2014).

Symptoms of common mental health disorders that occur during the transition from childhood to adolescence have a higher likelihood of fostering disordered eating. Both conditions increase during adolescence, particularly among girls, and tend to co-occur (6).

While some studies including adolescents show Individuals with common mental disorders to be associated with higher prevalence of obesity (49) others indicate the opposite with higher risk of anorexia nervosa diagnosis in those who report childhood anxiety (50).

Despite these evidences, only few research have explored eating attitudes of individuals with common mental health disorders and it is difficult to determine how these conditions are different for adolescent girls and boys at different developmental stages.

As the national adolescent and youth health strategy (2016-2020) demonstrates the readiness to comply with the SDG goals of ensuring mental health among these specific populations, these issues are a major concern of study in the developing countries where there is scarcity of data.

The purpose of this study is to address the scarcity of data on this topic, which indicates the need to qualitatively explore which factors influence adolescents' eating behavior in the clinical population. Furthermore, conducting this study will possibly reflect the need for further studies on qualitative samples based on the results and suggest individually tailored interventions for these individuals.

2) LITERATURE REVIEW

2.1 Common mental disorders in adolescents

Common mental disorders are mental health conditions that usually comprise depressive and anxiety disorder (51). Global studies estimate 25-30% of adolescents to be affected by these disorders (52). Depression frequently arises during the adolescence period with dramatic increment of prevalence from 1% in children under 12 years to 17-25% by late adolescence to persist into adulthood (53,54). Another common condition among adolescents are somatic symptoms with 31% of prevalence amongst adolescents and 3.3% diagnosed with somatic symptom and related disorders (55).

A national study in the USA demonstrates more than 5.3 million adolescents ages 12-17 years to have been diagnosed with mental and/or behavioral conditions with 16.1% and 8.4% accounting for anxiety and depressive disorders respectively(2) Studies in Europe also indicate anxiety and depressive disorder to account as the major mental health concerns amongst adolescents (56).

Developing countries are not exempt from the high impact observed amongst adolescents with studies from Sub-Saharan countries detecting 1 in 5 adolescents to have depressive or anxiety disorders, both conditions being the most common mental health problems reported (57).

Studies in Ethiopia show an overall prevalence of common mental disorders in adolescents to be 32.4% while the prevalence of depression, anxiety, and somatic symptoms has been observed to be 28.21%, 25.05%, and 25.24% respectively (58,59).

2.2 Disordered Eating Attitudes

According to Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2019 eating disorders impact about 42 million people globally (30). Eating disorders such as anorexia nervosa and bulimia nervosa are reported to occur across both Western and non-Western regions.

DEAs have been increasing substantially over the past 3 decades, with studies showing an increase in prevalence (29,60). Similarly, studies indicate that abnormal eating attitudes in non-Western countries have also been increasing (60,61).

A systematic review and meta-analysis of global studies indicate the overall proportion of children and adolescents with disordered eating to be 22.36%, with observed elevation with increasing age (62). While studies from Brazil, India and Arab countries display similarly affected population (27,63–65), studies from Europe and China indicate a higher prevalence with around one third of the female adolescents affected (66,67).

On the other hand, studies done in Africa indicate the high burden of DEAs even in developing countries despite prior assumptions of DEAs being a western concern. While a study from Nigeria, found a higher prevalence of disordered eating attitudes in young females (21.9%) compared to males (11.6%), a study from South Africa displayed a disproportionately high frequency of disordered eating attitudes with 41% of at-risk adolescent individuals. (61,68). A study from Ethiopia indicates the prevalence of disordered eating attitude among adolescents in the general population to be 8.6% while a similar study done amongst late adolescent girls found a slightly higher prevalence of 9.7% (18,19).

Children and adolescents may have maladaptive eating behaviors associated with their emotions, idleness, and external factors. These behaviors may progress to uncontrollable eating patterns affected by socioeconomic states where unhealthy food choices must be made to maintain financial constraints and stressful living conditions that maintain this behavior. Culture and historical contexts play a major role in shaping dietary attitudes, diet changes, and food choices. The social belief about food in general, the accessibility and acceptability of the food may be driving factors for the

development of weight and appetite concerns, especially challenging vulnerable individuals. (24)

2.3 Eating behaviors in Individuals with mental health conditions

It is notable that poor mental health, including depression, has a significant positive relationship between depression and eating disorders and in contrast, a negative relationship between body image and depression. Meanwhile, a positive association between body image dissatisfaction and eating disorder has been reported (69,70) thus indicating a mediating process between eating attitudes and depression.

Disordered eating attitudes are common amongst adolescents with common mental disorders occurring in 4.3% of individuals with major depression disorder and 5.1% of individuals with anxiety disorder (71).

Changes in appetite range in severity across different mental illnesses. Higher scores in appetite are related to the current medication and diagnosis of bipolar disorder while average scores are noted in relation to personality trait of neurosis and specific medication. Lower appetite scores are found to be common in individuals with endogenous depression. Body weight change and food quantity are also correlated with appetite scores (72).

There is a bidirectional relationship between depressive and bulimic symptoms among adolescents (73). This extends to a significant association between eating disorders and co-occurring anxiety and depressive disorders in adolescence period (74). Weight and appetite changes are reported as higher in depressed adolescents more than their counterparts; these changes may be present either in increment or decrement (75).

Anxiety disorders are also connected to disordered eating behaviors as part of the anxiety symptom or may occur during pre and postdating anxiety symptoms. Studies indicate anxiety disorders to be significantly associated with obesity, eating disorders, and subclinical forms of eating disorders (76–78). Notably, around 65% of individuals with eating disorders are found to have at least one anxiety disorder predating the occurrence of eating disorder and persisting following its resolution (79).

Although there haven't been any studies assessing the eating attitudes of clinical population in Ethiopia; studies assessing the nutritional status of individuals with diagnosed mental disorders revealed the proportion of undernutrition to be 20.0% and 31.4% and overnutrition 23.4% indicating a possible link to disordered eating behaviors among these population (25,46).

2.4 A qualitative exploration of eating behaviors among adolescents

There are scarce literatures qualitatively examining the eating attitudes and experiences of adolescents with common mental health disorders. Studies done are either on the general adolescent population or inpatient samples.

Studies thus far have explored both positive and negative implications of dietary habits in individuals with mental health disorders. Individuals with anxiety and depression specify their concerns regarding appetite extends from changes in the quantitative dietary intake to qualitative dietary choices, with changes in weight and to unsuccessful attempts in weight management described (80).

The relationship of trauma exposure with eating habits can be acknowledged through the comorbid experiences of emotional distress, maladaptive thoughts and self-esteem – with participant descriptions of negative emotions of shame, anger, guilt and apathy driving disordered eating habits as means of self-punishment and as form of detachment from reality (81). Additionally, the experience of eating by itself appears to serve as a reminder of trauma while problematic eating behaviors may be a way of altering the physical self as protection from repeated trauma or avoidance of trauma related pain (81,82).

These wide range of descriptions indicate that eating behaviors are qualitatively unique to individual experiences in trauma exposed population, and while adjusted eating behaviors can provide short-term relief from emotional distress, changes don't extend into long term. Furthermore, treatment provisions provided for mental disorders intermediate eating habit changes both positively and negatively (24). Notably, themes of non-hungry eating were related to negative emotions and perceived lack of internal locus of control (24,83).

Study participants describe a strong inward struggle regarding their dietary behavior. A common theme identified in these studies is the mental burden related to body weight, with most individuals describing their unhappiness with their current weight. Related to this, feelings of shame, self-blame, guilt, and perceived stigma were of significant importance related to dietary behavior and negative body perception. These were accompanied by attempts to lose weight (24,83).

Disordered eating behaviors have been reported to be related to several subjective experiences. The daily function of an individual, physical and emotional hunger are explored as core motives to eating habits. Although physical hunger is one driving force for eating concerns with difficulties in identifying hunger and satiety noted in individuals, emotional hunger takes precedence in determining dietary behavior (15,24,81).

Individuals with mental disorders attribute their emotional eating for various reasons; maladaptive coping, eating as a reward, financial constraints and social conformity (15). These dietary habits are further explored in severely mental ill individuals with descriptions of food addiction, uncontrollable eating behaviors or loss of appetite related to stress and difficulty with capacity for meal preparations (24). Changes in daily routine with lack of structure, drive and exhaustion which can be a common symptom and outcome among individuals with severe mental illness further impacts their eating habits (24). In some individuals the difficulties with drive and motivation may lead to unhealthy eating choices with binge-eating or restrictive eating as a form of self-medication while in others binge eating behaviors were noted to lead to weight changes and consequently to negative feelings (82,83).

Emotional eating behaviors related to reward are described in most CMDs, higher BMI in women and anger in men perpetuating the cycle of negative mood and eating (24). Eating as a reward is further observed in anxiety, depression, and greater BMI in females, and more anger/frustration in males (84). This is similarly reported by adolescents who describe that their emotional state and stress to have influence over their eating habits: these changes range from lack of appetite to emotional eating behaviors (85). Additionally, academic pressure and busy schedules are implicated in impacting dietary behaviors and physical activity of adolescents (85).

Adolescents express the influence of body image on their dietary habits to have a complex interaction between self-esteem and peer/family pressure to maintain a socially appealing body ideal. Economically transitioned areas appear to promote thin or curvy ideals while overweighing promoted dysfunctional eating and unhealthy weight regulating strategies (85,86). In contrast, some populations of adolescents observe thinness as a sign of stress or physical ailment, muscle definition as a state of poverty in girls and obesity to be associated with economic prosperity (86).

Disordered eating behaviors are observed in multitude of ways in adolescents, from skipping meals due to food scarcity to maintaining body ideal through diet modifications. In some studies parents were observed to encourage dysfunctional weight modifying dietary practices that are harmful to the adolescent (86,87). Several of the studies explore that adolescents who engaged with restrictive eating behaviors described their dissatisfaction with their body (85,86).

A study in Ethiopia indicates that although adolescents demonstrated thorough knowledgeability on healthy eating and food choices, their choices were rather determined by personal taste and food appearance; this was similarly explored in another east African study (85,88). Other influencing themes were gender, sociocultural acceptance, economical constraints and family meal choices. Access and availability of food resources may be a crucial defining factor especially amongst low income countries and adolescents in rural settings (86,88).

The impact of family care on eating attitudes and behaviors in adolescent groups who are under the care of their parents isn't to be underestimated as adolescents reside with family members and have lesser autonomy over their dietary behaviors. Their lifestyle choices may further be shaped by behaviors of their primary caretakers or siblings (83).

Positive themes about diet and current body size are also identified in some of these studies. These positive effects were related to feelings of personal power, physical and mental well-being, self-efficacy and self-protective strategies with diet choices, and increased body weight (24,83). Overall, these studies imply the presence of a bidirectional relationship between their physical and mental health indicating there were advantages to regular eating behaviors (24).

3) THEORETICAL FRAMEWORK

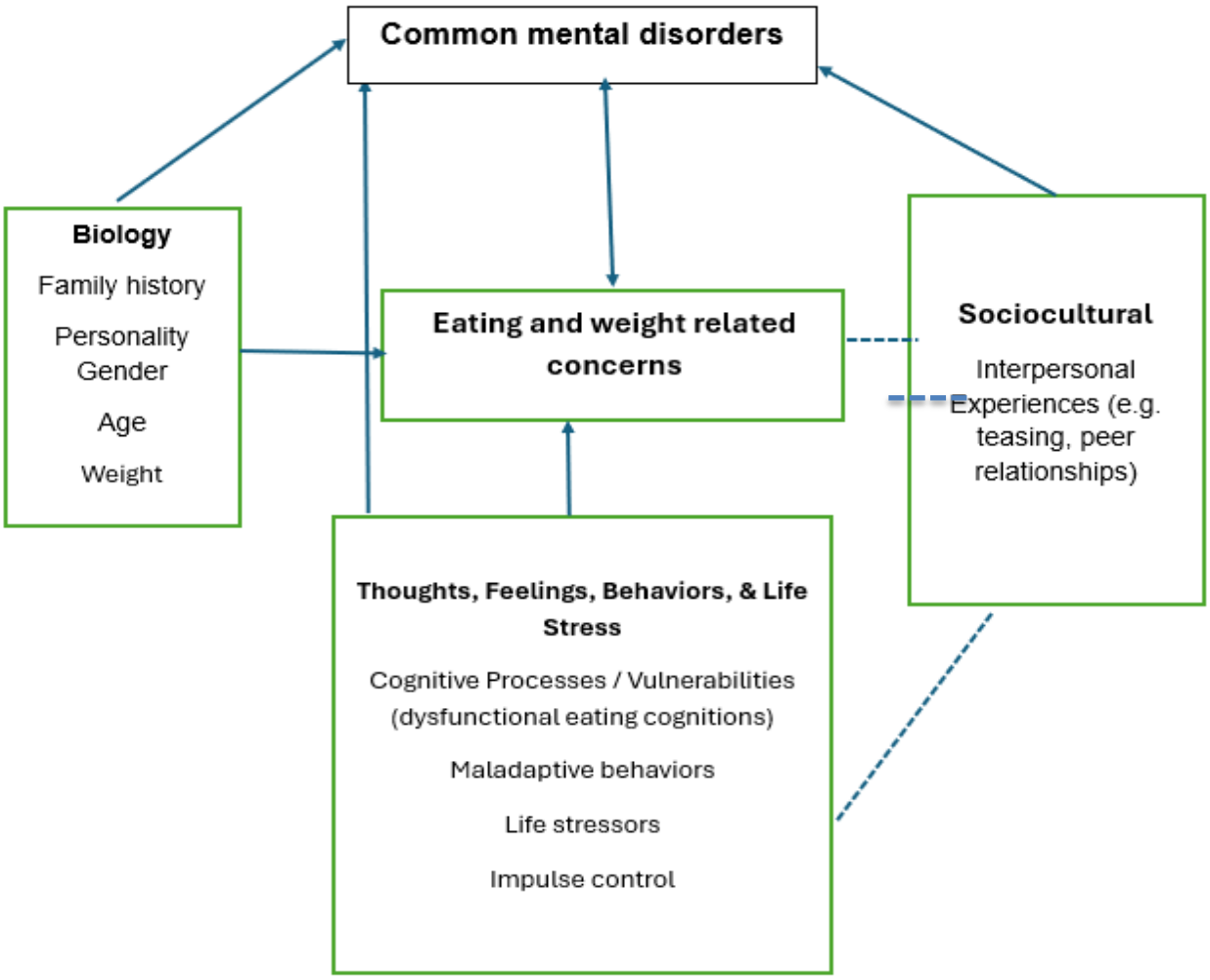


Figure 1: Theoretical framework of eating behaviors and common mental disorders

4) RESEARCH QUESTIONS

1. How do adolescents with common mental health disorders describe their eating attitudes and daily eating behaviors?
2. What are the factors that influence their eating attitudes?
3. How does their mental health and emotional experiences influence their eating attitudes and behaviors?
4. How do adolescents with CMD understand the changes in their appetite and eating behaviors?
5. How do adolescents cope with eating difficulties while dealing with mental health concerns?

5) OBJECTIVES OF THE STUDY

5.1 General objective

1. To explore and understand the eating attitudes and related experiences of adolescents with common mental health problems on follow up at outpatient clinics in Zewditu memorial hospital and Tikur Anbessa Specialized hospital, Addis Ababa, Ethiopia, 2025.

5.2 Specific objectives

1. To describe how adolescents with common mental health disorders perceive their eating behavior.
2. To examine the perceived factors that influence their eating behavior.
3. To examine the relationship between emotional state and eating behaviors.

6) RESEARCH METHODS AND MATERIALS

6.1 Study area

According to the Ethiopian Mini Demographic and health survey, the country has a young population characterized by 67% of the population being younger than 30 years of age. Tikur Anbessa Specialized hospital is the largest specialized hospital in Ethiopia, situated in Addis Ababa, with over 700 beds and psychiatry outpatient services and one of the few child and adolescent psychiatry outpatients treating hospitals.

Zewditu Memorial Hospital is a general hospital found in the capital city providing multiple specialty services and housing one of the few children and adolescent psychiatry outpatient treating hospitals.

6.2 Study design and period

An institutional based phenomenological qualitative study design was conducted to explore the lived experiences of eating attitudes and behaviors of adolescents on follow up at the outpatient clinics at Zewditu memorial hospital and Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia during the period of December 1/2025 – March 1 /2026.

6.3 Source population

All adolescents aged 10-19 on outpatient clinic follow up, in Addis Ababa, Ethiopia during this study period

6.4 Study population with eligibility criteria

Inclusion criteria: All adolescents aged 10-19 on outpatient clinic follow up with the diagnosis of common mental health disorders such as anxiety, depression (no psychotic symptoms) and somatic symptom and related disorders, in Addis Ababa, Ethiopia with guardians who can give informed consent for the study.

Exclusion criteria: Participants with severe mental illness such as psychotic disorders-Schizophrenia, Bipolar disorder, MDD with psychotic features, intellectual disability, comorbid acute or chronic medical illness, acute phase of common mental illness, current diagnosis of an eating disorder.

6.5 Sample size determination

Total number of study participants was determined when saturation level was acquired at 12 participants.

6.6 Sampling technique/procedure

Purposive sampling was used to obtain a diverse sample of clinical population from the child and adolescence outpatient clinic with maximum variation in key demographic factors (age, gender, diagnosis) to get as rich and diverse information as possible.

An interview guide was developed based on research questions. It included open-ended questions. Interviews were conducted in a quiet room by the principal investigator, agreed upon by the participant and the participant's guardians.

6.7 Operational definitions

Common mental disorders: mental health conditions that require outpatient follow up primarily indicating major depressive disorder, adjustment disorder, generalized anxiety disorder, post-traumatic stress disorder, somatic symptom and related disorder.

Eating behaviors: aspects such as appetite, speed of eating, structure of meals, emotional and binge eating, and overnight eating.

Disordered eating attitudes/behaviors: harmful and unhealthy behaviors related to body image, dieting, and eating habits that do not meet the full criteria for an eating disorder but still cause distress.

6.8 Methods of data collection

The semi-structured topic guide constituted two parts. The first part was socio demographic, clinical characteristics and current weight and height that was measured objectively while the second part was open-ended questions on current study topic based on the topic guide prepared.

6.9 Data collection procedures

Data collection was carried out using semi-structured interviews conducted face to face in a private room within the outpatient clinic to ensure comfort and confidentiality. Each interview lasted 30-60 minutes with the average being 34 minutes. Field notes were taken immediately after interview to capture contextual details and researcher reflections. During the interview, participants were given space to talk about themselves and their experiences as an adolescent with common mental disorders. In the process, questions and probes focusing on their eating habits, concerns of life, support mechanisms and challenges they had faced were explored.

Before every interview, written consent and permission for audio recording was obtained from all 18+ participants. Participant's guardian consent was included for underage participants in addition to the adolescent's consent). Each participant was reimbursed with 300 ETB for transportation; however, this was done at the end of the interview with no offer of reimbursement to be made to participants prior to interview completion.

6.10 Data processing and management

After data collection, each questionnaire was transcribed verbatim and de-identified. A master list linking codes to identities was stored separately in another software. Transcripts were translated to English before data analysis. Data was analyzed using thematic analysis with familiarization of the data by the researcher followed by generation of codes and searching, then labeling themes. Sub-themes were created after the themes. Open code software was used to manage and organize data. All data was stored on password protected devices. Backups were maintained on different encrypted software.

6.11 Data synthesis

Code book was developed prior to data collection, and amendment was done during and after data collection was completed. Analysis of data started and was done simultaneously with data collection. Information stored on audio recorder was listened repeatedly and transcribed verbatim by the interviewer and translated to English language. Preliminary analysis was done to see for saturation of the information and emerged theme. After compiling all transcribed word documents, coding and categorization were done using Open Code version 4.02 software. Significant representative quotations were taken from the transcripts as example data to support the themes being derived from the content (89).

6.12 Data quality assurance

To ensure data quality, the study employed triangulation with field notes, An audit trail was maintained. This included the preservation of raw transcripts, dated coding schemes, and reflexive memos that documented the evolution of themes throughout the analysis process.

7) Findings

Following socio demographic characteristics, the major findings of the study are summarized under six themes, 1) knowledge and perception of healthy eating which includes basic understanding and personal perception of food 2) Eating patterns which includes food choices and dysregulated eating patterns 3) Influences of eating patterns which includes over responsibility, physical symptoms and medications and emotional drive 4) Body image and identification which includes external comments, body perception, desire linked to aspirations 5) Impact of eating habits which includes physical and cognitive impacts 6) Actions to improve eating habits which include holding off food as means to regain appetite, external factors and suggestions for support.

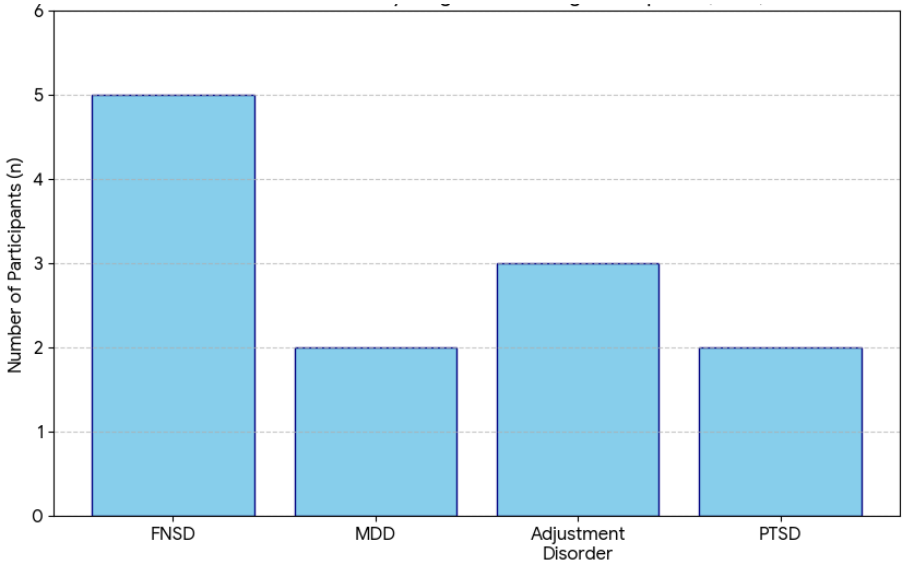
7.1 Socio demographic characteristics of study participants

12 adolescents who were outpatient follow up at Zewditu Memorial and Tikur Anbessa hospital participated in this study. The study population consisted of 12 adolescents with a mean age of 14.6 years $\pm$ 2.75 with the most frequent age being 15 years (n=3).

Category	Characteristic	n	Percentage (%)
Sex	Female	9	75.0%
	Male	3	25.0%
Religion	Muslim	6	50.0%
	Christian	6	50.0%
Age Group	< 15 years	5	41.7%
	15 years	3	25.0%
	> 15 years	4	33.3%
Education	Age-appropriate	8	66.7%
	Delayed / Discontinued	4	33.3%
Living Arrangement	Both/single Parents	10	83.3%
	Close Relatives	2	16.7%
Nutritional Status	Underweight	6	50.0%
	Normal BMI	5	41.7%
	Overweight	1	8.3%

Table 1: Sociodemographic characteristics of study participants

Figure 2: Primary clinical diagnosis across participants (n=12)



All but three participants were receiving psychological management only, receiving no other medical management.

7.2 Thematic analysis

8.2.1. Theme 1: Knowledge of healthy eating and perception of food

This theme explores how adolescents understand and perceive food personally and how this subjective perception aligns/misaligns with their knowledge of healthy eating habits.

Category 1: Basic understanding

All participants had a basic understanding of healthy eating, with most reflecting that healthy eating consists of food choices, amount and timing, hygiene and as affected by availability.

I think it is any type of food you love but if it is made with hygiene, eating any type of food in a nice way is a healthy way of eating. Us, children under 18 years old are under the care of our family members, and they can make whatever food they want so I think they have an advantage. As a person grows up, appetite increases, right? As you get bigger, you finish more, so I think adults eat more than us. ***(18 female participant)***

Another participant noted a contrasting difference in appetite and eating habits in adolescents in comparison to adults while another expressed the need to consider individual differences as relevant in making healthy eating choices.

We adolescents feel hungry quickly while the adults may not sense they are hungry since they are focused on their jobs. There is also fasting, during that time some might fast up to 3pm or 6pm, if so, they don't focus on food most of the time. ***(11, female participant)***

*I think the best way is to eat things in moderation and focus on what actually agrees with your body. For example, if I eat things like oranges or other foods that don't suit my stomach, I'm just inviting another illness. My stomach gets very upset, and once it's irritated by even a small thing, it 100% leads to continuous vomiting****. (14, male participant)***

Category 2: Personal perception of food

Participants demonstrated an ability to distinguish between "healthy" and "unhealthy" foods. However, in some participants their personal perception was shaped by their subjective experiences and food did not appear just as a nutritional factor with some of the participants expressing their dislike for food.

I really hate food; nowadays because I fast, I may eat. I don't know, I think it will make me fat. If I become fat, it would mean that I have changed. My mom tells me to eat a lot. Imagine this, having a pot belly like my mom- in the name of Christ- the potbelly I have now, at least then when I grow up to be big around 30 and stuff, it could happen. ***(10, female participant)***

The following participant experienced food to be a source of distress and this distress extending to the point of feeling triggered by the mere observation of others eating.

Food doesn't excite me much. I used to think a person could live without food. I wished food would disappear from the world. It's my mom who remembers and serves me food. I don't feel like it, I wish others didn't talk about it. When I see food, I feel like crying. I

feel like throwing it all away. I don't even want to see other people eating. ***(15, female participant)***

Another participant noted the lack of interest in food and experiencing food as a task rather than an enjoyable activity.

Food doesn't make much sense to me. I would even be happy if I didn't have to eat at all. It is stressful. If it was possible not to eat, I would be the first person to stop. It is exhausting. It comes from my lack of interest in food; I haven't considered why that is. ***(18, male participant)***

8.2.2 Theme 2: Eating patterns

The findings indicated that these adolescents struggled with maintaining healthy eating with their eating behaviors being irregular and selective. Most of the participants expressed undereating as compared to their peers; however, overeating patterns were also observed.

Category 1: Food choices

Some of the participants acknowledged that their choices of food were unhealthy with increased intake of fast food, snacks, or sweets, however, they noted they struggled with making healthy changes in their food choices due to subjective taste preference of these foods.

One participant expressed concern over their extreme use of sugary foods and a perceived subjective lack of control over the amount of sweets she would intake.

It hasn't changed; instead of other meals, I eat a lot of sweets. I'm not big on salt and I don't use chili much because that used to aggravate my stomach. At some point, I stopped eating sweets but over the past 3 years I have been using them. It's not healthy because I usually eat sweets, if I eat one piece roll of injera I would spend the remaining day eating sweets. It's tough to control sweets. Aside from Mirinda, I used to struggle to stop my use of soft drinks like Coca Cola or juices, I would plan to drink just one, but then I would end up drinking 5 or 6. It makes me feel nauseous. ***(15, female participant)***

Another participant described the choice of diet was determined by the food they enjoyed eating rather than from the knowledge of a balanced diet while also attributing the amount they intake to the knowledge of a balanced diet.

I don't think I have healthy eating because I don't like vegetables most of the time. I don't use oily food or salt much, but I just don't like vegetables. Uh, for example my lunch box is large but even if they fill it up with small amounts, I still go back home eating just half, I don't overeat because our teacher also told us that. ***(11, female participant)***

An additional observation mentioned by a participant was appetite affecting food choice and the use of a specific diet as way of suppressing appetite.

I don't feel like eating. I don't have the appetite, or I eat very sugary meals so it can quickly shut off my appetite. I lose my appetite before I even try it, it could be something that I eat another day, but I would lose interest in it. Or when I feel like it, I would look for something else and eat it. If you bring me something I don't want, then I won't eat it. ***(15, female participant)***

Category 2: Dysregulated eating patterns

Most participants admitted that their eating habits were dysregulated. Undereating was the most experienced eating habit while others acknowledged a fluctuating eating habit.

"My eating pattern is inconsistent. At some point, I would eat every minute, while at school I can't help but open my lunch box and eat in class. My current status is that I have really declined eating and my weight has also dropped. I am fasting for Ramadan right now and when I break my fast, I would just eat a bit like 2 or 3 bites. I want to eat but even looking at it grosses me out. It's similar at times when it's not fasting season, though sometimes it's okay and I eat." ***(18, female participant)***

In addition to undereating and skipping meals, another pattern expressed was unstructured routine.

"I don't like to overeat. And I don't eat much food; if I eat it's at breakfast. If I've had breakfast, I won't eat lunch. I'll skip one. I just eat whatever is available. Most of the

time, I spend more hours not eating at all. I usually eat when I get back from school at night. Since I'm in high school, there is no food there. Even on Saturdays and Sundays, I don't really check what I eat that much. I don't have a specific routine I can point to." ***(17, female participant)***

8.2.3 Theme 3: Influences on eating patterns

This theme identifies the motives behind eating patterns influenced by biological, psychological, and social explanations. It explores the relationship between physical experiences of distress and appetite, psychotropic drugs and unplanned eating disruptions, social burden and diet changes, psychological stress and emotional eating/restricting.

Category 1: Over responsibility

A few participants noted the impact of domestic and social burden as the central reason for a dysregulated eating pattern. One participant mentioned that the absence of a parental figure led to the burden of managing the household with eating habits transforming into a means of managing household expenses.

"I have had responsibilities since I was a child. When my mother left for Saudi, the responsibility for the other children fell on me. On days the children were difficult, I wouldn't eat. Often, I wouldn't eat. Even when I was hungry, I wouldn't eat. Even if the food was sitting right in front of me, I wouldn't eat. I am the firstborn, and it's for their sake that I don't eat. Because they are children, they don't know when to say they are full, so I give the food to them. Even if I do eat, I only eat once a day. I feel a sense of shame considering what is available. It is my mother and father who work and bring it; it's not my own so I think to myself that my share be saved. My diet has improved now after my mother returned few months back. But I fear I might overdo it and get used to it, and in case something like before happens again it would become new to me" ***(17, female participant)***

One other participant described overthinking about family members and herself as a reason for appetite disruption.

“It is the thoughts. At first, I used to worry about school and my grades during the first semester. But then, that wasn't enough. There are things that need to be fulfilled, things I need to do for myself and my family. I worry about the little ones, I worry about the older ones, I worry about everything regarding my family. I worry about my own life too. And like that, my appetite decreases. My appetite decreases significantly”. ***(18, female participant)***

Category 2: Physical symptoms and medications

In some participants, physical barriers were identified as the major setback from maintaining healthy eating. Side effects of medications were included to relate to changes in appetite, weight, and gastric health with participants stating the need to attempt intentionality with their diet as a contrast to their prior eating habits.

“I only eat because someone says to me, 'Come on, eat!' I just stay on my phone. I use my phone so that I don't even think about food; I'll spend the whole day on it. Because [the food] just comes back up anyway. Even for you, if you throw up just once, it would be over, it’s no big deal. But if it happens every single day, you’d hate it. What bothers me is that I eat slowly while on my phone but then having to go out and throw it all up is what I find disgusting." ***(14, male participant)***

Similarly, another participant mentioned the need to adjust eating time when in group settings.

I take a lunchbox; we don't eat together. I would be eating while talking to distract myself; I would say 'wait, help me wash my hands, I'm done eating' while talking to them. Then I wash up; while I'm sat laughing and stuff, I will go vomit. Here at Zewditu, during our group therapy, they give us food- I would pack that up and eat it outside, not to bother them, by throwing up in front of them. When I say not to bother them, if I'm eating and I leave to vomit, it might ruin their appetite. I would feel a gagging sensation, and it just comes out without me intending it”. ***(12, female participant)***

Another participant described the experience of discomfort due to changes in appetite since medication initiation.

“It makes me eat for no reason: my food intake and weight is increasing day by day, I don’t know why. I take medications. Actually, I don’t know if it has to do with the medications- it makes me eat: it has been a year now, I am taking 2 tablets of Fluoxetine and 1 tablet of Olanzapine. It is after I started these that my appetite increased. I eat two to three times a day but I eat quickly when compared with my grandparents. I try hard not to eat too much at nighttime, but I just can't help it. “ ***(19, female participant)***

Category 3: Emotional drive

In some of the participants, food served as a means of expressing internal emotions and wishes. In most of the participants, sadness and anger were identified as the most common emotions associated with shift in eating patterns.

I think it expresses my emotions. Now, Coca Cola is said to be harmful. Because, I think it will harm me, I drink it in an empty stomach. Since I go to school, I take the service bus, so nobody sees me. I would buy two or three coca colas then I would drink it all in an empty stomach and I was sick. I don’t know, but I want it to harm me. ***(15, female participant)***

One participant noted the absence of specific food choices when emotionally regulated, however, negative shift in emotion led to odd cravings.

Sometimes, when you are feeling down, you can’t do anything. Meanwhile, you may have done something you wanted, or you may have had a good time with your friends; in that space, you wouldn't focus on the thing that's making you feel depressed so you may eat whatever. Sometimes, when I am not feeling good, I would leave due to the smell of food being cooked. Instead of the routine food you eat, you would crave odd things, and you would detest the food you enjoy. ***(Another 15, female participant)***

8.2.4 Theme 4: Body image and identity formation

Most participants observed weight changes involving both weight loss and weight gain over recent times. Some of the participants described high levels of sensitivity to how their body was characterized by family and peers. For a few participants, the labels

assigned to them in the past regarding weight served as motivation to maintain current weight.

Category 1: External comments

Some participants described comments from peers that contributed to changes in the perception of their own body. These participants described experiencing emotional distress due to the social pressure imposed on them regarding their size.

Well, a human being can last a whole 7 days without food. But I was not eating food since I would lose my fat on the way. At times when I didn't eat while hungry, my weight had gone down. My anger motivated me. Now, I eat food intermittently, that is how I like it. I thought it was better to be called skinny rather than fat. For me, being fat is being greedy. My friends would say 'you, always eating'; now though, I wouldn't feel anything if they called me fat, back then I would go into the classroom and sit. At the time, because I used to follow what the kids would say to me, I didn't like my body- I thought it was better to lose weight. ***(11, male participant)***

Another participant perceived her physique to be an object of social recognition, noting the reception of external pressure to maintain current weight from social circle despite the absence of internal motive to do so.

"At home, they get angry with me about my eating habits. Sometimes I eat, and sometimes I stop. When I do that, they think I'm doing it just for my body shape; they tell me to stop. On the other hand, everyone admires my figure. Some of my family members say, 'You have a long neck, why don't you become a model?' Before this, I had an interest in becoming a model or designer. People tell me, 'Don't get fat, you can be a model, you have a perfect body.' They encourage me not to gain weight." ***(18, female participant)***

Additionally, another participant described an internalized drive to maintain underweight status.

I am even the center of mockery. You skinny- they say- she is so thin, that they consider me as the friend of a toothpick. Hearing that makes me happy that I am skinny, I don't

want to be fat. My mom says I would get insulted because I am skinny, even if I fall on my own, she will say 'you see, this is why I told you that you won't be able to be equal to your friends'. ***(10, female participant)***

Category 2: Body perception

In some participants, a discrepancy between their actual physical state and their internal body image was noted. A participant explained concerns about external perceptions of her stunted height and the significant impact it has had on her overall body perception.

"I feel inferior because they are tall, while I look like I'm in 5th, 6th or 3rd grade; now when they look at me, they assume I'm in 1st or 2nd grade, so I say, 'do I really look like a first grader, do I really look like a second grader'. I have never looked at my body in the mirror; I look at my face. The mirror shows the whole body, but I don't look, I don't want to. I don't look at my height and stuff. I don't know why, I just don't want to look at a mirror. I think I could grow, I do wish I could grow taller, it isn't like I imagined." (15, female participant)

In contrast, positive observations were made by some participants about their body with one participant expressing changes in her body to be a relief from past distress.

I really love this body; I used to be skinny in the past almost until I turned 12 and they used to call me 'Lucy in skin'. Even trousers used to be a dress for me. Because I was like that, now I really love this one. My mother used to cry giving me a bath and it used to make me feel something. I used to really hate it; because I hated it so much, I wouldn't stand in front of a mirror. If I did, I would be reminded of Lucy from school with poking bones. I would worry that people would fear me because I am Lucy. At night, my sister and I used to count my ribs to fall asleep. (15, female participant)

Another participant noted the fear of being 'fat' as the major body concern and fixation over certain body parts was also noted.

Now, to myself, I am really fat; look at my arm, it is so big. Yeah, look at me, I'm also big right here (pointing to abdomen). I don't want to gain weight, I don't know but I like thin people. I want to be skinny, I am happy with my weight, I don't feel anything when I look

in the mirror, I even have a potbelly. Look, look at it, no more than this. (10, female participant)

For another participant, body perception appeared to center around functional capacity of body rather than aesthetic appearance, despite an acknowledged discrepancy between ideal and current physique.

It doesn't matter to me much; what matters is I am able to walk upright. Whether I am skinny or fat, I am a person after all. There is the thought that I am thin; because my friends say, 'you are really thin', I do want to try. I want to improve this, but my body doesn't accept it. My idea of perfect physique is a body builder's, not exactly like theirs, but a bit smaller than that. I am on the very low side. ***(17, male participant)***

Category 3: Desire linked to aspiration

Personal goals were noted as the motivation to maintain certain eating patterns and body status with a participant expressing making lifestyle changes to fulfil this purpose.

If I eat breakfast, I don't eat lunch. I wanted to be a model in the past and back then I wouldn't eat because I would think of being thin. Mostly on Sundays, my father and I used to go out together to exercise. And you know, I don't eat too much food so I can stay thin. ***(11, female participant)***

8.2.5 Theme 5: Impact of eating patterns

This theme explores the contrasting effect of eating habits on physical and cognitive states; participants experience a significant impact on their daily functioning and physical states.

Category 1: Physical consequences

A dysregulated physical state was described in the most of individuals who had significant eating alterations. Participants expressed diminished energy consumption in schoolwork, play, and physical functionality. One participant described how significant physical changes due to eating behavior led to strained relationships with teachers and peers.

“It has harmed me a lot, especially my stomach. When I go to the hospital, they all tell me to stop sweets, I get tired easily. I couldn’t walk, I would feel tired even while I am sitting. Not eating made me ill, because I used to get very ill, but I didn’t use to learn. Because I get extremely tired, I sleep while at school; when I sleep, there are teachers who bully me saying “This is not your mother’s house that you sleep as you want”; the students would laugh; and after the teacher has left, the student would give you names like “the one that sleeps in class”. ***(15, female participant)***

For another participant, in addition to physical consequences, eating patterns were related to bullying perpetuation at school.

“It has led me to be ill. During exam time, I was absent for three days while the other kids were taking exams. Without eating food and playing on an empty stomach, I had fallen and while I was crying saying I was ill, the kids fed me soil and a rotten banana leading me to have an infection”. ***(11, male participant)***

Category 2: Cognitive impact

Some of the participants expressed changes in sleeping patterns and maintaining focus which impacted their social interaction and school engagement.

“I wasn’t eating well last year. And I stopped school. I would sleep a lot then. Even while sitting and others are talking, I would drift off. Even while having a conversation, I would feel sleepy”. ***(14, male participant)***

“If I don’t eat, I feel tired. I would feel sleepy, I would feel better after I eat, I can't stay long without eating. I can't fast or something like that. Because I have food deficiency, I would either faint or feel sleepy then faint”. ***(15, female participant)***

8.2.6 Theme 6: Actions to improve eating habits

Participants appeared to attempt different coping strategies to manage their eating patterns.

Category 1: Holding off food as means to regain appetite

In some participants, delaying mealtimes were explored as an effective way of improving appetite and physical symptoms that were expressed as a hindrance to eating.

I have noticed that often, I build an appetite by staying without food for some time. Now, when I spend the day at home, what I usually do when we are on the afternoon shift at school is that after waking up in the morning and taking care of tasks if there are any, I would eat well before leaving. I wouldn't call it well actually but still I would eat after eating. ***(17, male participant)***

As the vomiting was present until recently, since I got better recently, my appetite will increase slowly. I'm fasting so my stomach has found what suits it. After the fast, when I eat in the evening, it digests it well because there is no other food that crowds it. My stomach works directly. Even now, I haven't had anything. ***(14, male participant)***

Category 2: External involvement

Beyond the clinical setting, a participant described finding relief through religious practices.

I think what has helped is my faith. I used to get sick if I missed a few minutes without eating, let alone without taking medications. This is the work of the divine. ***(17, male participant)***

Category 3: Suggestion for support

Some of the participants emphasized restricted medication use as their preferred method of clinical support with recommendation on profiling of physical state of individuals prior to medication initiation.

It differs from person to person how they are receptive to medications, so before starting medications, checking their stomachs and prescribing medications that wouldn't affect that may be helpful. ***(18, female participant)***

8) DISCUSSION

The present study explored the complex relationship of eating behaviors, mental health, and socio-economic factors among adolescents in an Ethiopian clinical setting. The findings of this study reveal that adolescents with common mental disorders struggle with their eating habits and that these habits are shaped by various explanations.

Adolescents in this study described struggling with various mental health disorders. They shared that their mental health disorder had an impact on their social engagement, academic performance and emotion regulation. Many of these adolescents expressed their struggle with emotion dysregulation and somatic symptoms. While some of these adolescents noticed their eating habits as low from baseline, most of them described changes in their habits during times of stress and emotional distress and noted weight and body changes added to their emotional distress during their clinical care. These changes were alarming in some individuals, leading to reception of family concerns over their eating habits and in some participants leading to medical complaints.

These participants explored the relationship between food, cognition and emotion further by noting food not as a mere substance of nutritional value but as a way that reflects their emotional state, their perception of world and oneself. Adolescents who have been on medications expressed the moderating effect of drugs on their appetite, food choices and physical health. Additionally, the alteration of weight related to psychotropic drugs were described as influencing the adolescent's perception of body which then affected eating patterns and emotional wellbeing.

In this study, the adolescents maintained relatively high food literacy as participants explained having the awareness of what is good for their health. They indicated that healthy eating habits are determined by food choices with vegetables being described the most to maintain health, with other participants adding timing, amount and individualized meals as necessary for maintaining healthy eating.

The participants expressed the relationship between food choices and family members, making note of the fact that adolescents live under their guardians who make most of

the routine dietary choices and made a unique point of sibling rivalry/mutuality influencing the type and amount of food they decide to have. Preferences of food by one adolescent may be shared by another sibling leaving fewer desirable choices for the other. In some study participants, they described family burden as extending to them with expectations of bearing household and emotional responsibility at early age; these responsibilities were a source of anxiety in these adolescents who may have had a genetic predisposition to mental health disorders. These burdens extended from worries of financially supporting family members with low economic status, to becoming the primary caretaker of younger siblings, to having to bear the responsibility of becoming the sole caretaker of a physically disabled primary caregiver. These social burdens were explained as a major source of influence in dietary choices and eating patterns.

Although a fair understanding of healthy eating was described by most study participants, one gap was a comprehensive understanding of adolescents as a risk group of nutritional deficiency and high requirements of calories. The adolescents in this study described the need for lowered amounts of dietary intake in their age group despite the scientific implications of elevated energy expenditure and need for increased dietary intake in these age groups with participants mentioning “Those our age eat less, based on our capabilities while adults eat more” (90).

Additionally, many of the participants noted that their knowledge of healthy eating didn’t align with their personal eating habits. These adolescents expressed their knowledge towards unhealthy eating as related to their view of increasing weight as socially undesirable, and that gaining weight meant being unhealthy. This skewed view was used as a rationalization to their dysregulated eating habits in some of the participants.

Studies done in Europe, Middle east and Ethiopia suggest food choices are factored primarily by personal taste preferences rather than food literacy (85,88,91). Similarly, participants in this study continued to struggle with negative dietary outcomes but were unable to change their behavior despite reporting a theoretical knowledge of healthy eating. These findings can be understood from a social construction theory which states the role, backgrounds, values of main groups lead to different perceptions, meaning

making and expressions (92). Through this lens the lived experiences of these adolescents can be translated through various subjective realities that are diverse and consequential of their social environment.

The potential universal adolescent pattern of preference for immediate gratification, emotional influences to diet rather than having long term health focus could reflect a normative developmental characteristics in this age group where high reward seeking behaviors are observed (93). This can be understood through psychosocial development theory which clarifies these behaviors as a developmental stage of experimentation in adolescence, while cognitive behavioral theorists expand more through inclusion of stress vulnerability model, especially among adolescents with mental disorders who may demonstrate genetic vulnerability to impulsive eating, negative life events which affects their current eating habits psychologically or socially (94).

Most participants described their choices of food as affected by their state of mood with complaints about alterations of their taste buds. Participants described a preference to unhealthy diets; some of the participants expressed their craving to more gustatorily intense foods with sweets, salty and sour tasting foods becoming their preferences with a participant mentioning that “Rather than food I eat routinely, I crave odd foods like lemon when I’m not in the mood”. This aligns with a study done at the inpatients settings with dietary choices implied to be related to certain mood. Additionally, the current study shared a similar subtheme of dysregulated eating patterns with another study that ranged from no appetite to irregularity and lack of routine to eating time (82).

The results of this paper identified a change in body image related to external and intrinsic factors. The most preferred body was thin in most participants which was similar to a study from South Africa, contrasting with another study which noted the pressure to be ‘fuller body shape’; these differences may be due to cultural differences in ideal body types and meaning behind different body types (86,95).

The different motivations in body image construct in this study were peer influences through bullying, social appreciation for certain body types, and intrinsic view of body type. While bullying and intrinsic views were related to emotions of disgust and shame,

positive appreciation was related to positive emotions which served as means of reinforcing current body types. The participants who struggled with body image structured their diet mainly through skipping meals while participants wishing to gain weight appeared not to engage in any specific actions. This may be due to the high external pressure of being overweight rather than underweight. South African studies similarly identified meal skipping as means to facilitate weight loss, however, additional interventions such as smoking to suppress hunger, using unofficial medications to facilitate weight loss and purging behaviors; the absence of these interventions in our settings may be due to difference in cultural acceptability of inducing vomiting, stigma related to medication intake as weight loss method and due to lack of knowledge of some of these methods in the adolescent population (86,95).

While the wish to maintain a thin body was described in relation to maintaining health in some participants, the major motivation appeared to be the recognition and avoidance of negative social perception of overweight individuals. This was similarly noted in other studies which described the influence of teasing and humiliation as a strong factor for losing weight in adolescents who recognized experiences of prejudice towards their overweight status (86).

Concerns regarding body image and identity extend beyond physical health in these participants can be understood through Eric Erickson's psychosocial theory, which elaborates the developmental staging of adolescents to be filled with self-exploration and identity formation. The link between eating behavior and body appearance expressed by participants can be understood as an attempt of identity construction through sense of belongingness in their peer group or society (96).

A study done amongst participants with severe mental illness explored the experiences of derogatory comments such as being called a "pig" while adolescents in this study noted their wish to avoid being labeled "fatso (ዶጮ)" with other participants describing being subject to discriminatory comments…"you who eats everything", "Lucy in skin" (24).

It is crucial to understand external comments not only trigger certain emotional states in these individuals but also alter their identity and internalized assumptions about being a

certain weight to eventually disrupt their eating behaviors. This highlights the compounding impact of psychosocial stressors on mental illness and perception of self and reflects the implications of social acceptance in internalized meaning making. Thus, the contribution of external environment to emotional distress may further lead to maladaptive eating patterns as a coping mechanism (92,94).

According to World Bank, Ethiopia, a developing country, still struggles with affordability and availability of food with majority of the population being under the poverty line. Thus, studies note socioeconomic factors and cultural norms to be influencing factors to dietary choices (88). This may explain the descriptions of social responsibility as causes to dysregulated eating patterns that were observed in this study with few participants noting the burden of responsibility in taking care of family members. A study from South Africa indicates food insecurity to have minimal impact on dietary behaviors validating that structural economical differences to be an important influencing factor (97).

Most participants in this study described changes with appetite related to their mood; with the most predominant descriptions being lack of interest in diet and lack of cognitive awareness of the need to eat during distressing emotions. Most participants implied these changes in eating habits as unintentional and further clarified preferences to distract themselves with peer engagement or sitting with the emotions/expressing them. This contrasts with other studies which found descriptions of disordered eating with mood shifts and this may be due to cultural differences in coping strategies amongst western and developing countries (24,81).

However, a few individuals in this study still described the use of food as means of coping with emotions with a participant expressing using food as means of harming self when feeling misunderstood and another stating using sugary diet to suppress appetite in times of lowered mood. These results are supported by a study done on participants with trauma and those with severe mental illness with participants describing use of food as an emotion regulator with engagement in disordered eating decreasing negative affect in the short term, restrictive behaviors to be related with apathy and salty/sweet food choices during emotional states (81,82).

Although clinicians often conceptualize disordered eating behaviors as the consequence of pursuit towards an ideal shape, the above results indicate emotional eating theory to have an additional relationship with disordered eating patterns as motivations arising from a desire for emotional eating maybe a means of self-medicating through the physiological achievement of serotonin when eating contents of food with high carbohydrates (34).

A few of the participants who were taking medications expressed appetite changes with their medication intake; with side effects leading to both weight gain and dyspepsia symptoms. The effect on physical health was described as a concern for these participants, as comments on their eating habits by others were described as the reason for subjective distress and the need to make specific food choices as to prevent dyspeptic symptoms was expressed as a reason for daily inconvenience. This results are similar to another study, which noted dietary behaviors could not be ascribed exclusively to medications (24).

While other studies described the impact of academic pressure as a dietary influence, this study found a reverse relationship with dietary influences over academic experiences with most participants explaining their eating patterns impacted cognitive capacity to focus on schoolwork. This contrast may be due to majority of participants in this study having diagnosis of functional neurological disorder where nutritional deficits exacerbate somatic weakness, which in turn hinders the mental energy required for schoolwork (91).

Participants' narratives suggest that eating behaviors are the construction of various mechanisms rather than being defined by simple nutritional variations. In this study, an interaction between individuals' cognitive vulnerability and environmental stressors is described as the initial trigger to mental health conditions or disrupted eating patterns. The underlying stressors have a complicated network between common mental disorders and eating and weight related descriptions with bidirectional experiences. This is described to be further affected by the emotional dysregulation commonly apparent in adolescence due to their developmental stage. While mental health disorders further intensify these challenges, it can be observed from the study participants that the

influence of social circles, peer groups, social background need not be underestimated. Thus, clinicians should scrutinize a one illness approach and broaden their perspective to individual focused approach.

9) STRENGTHS AND LIMITATIONS

To my knowledge, this is the first qualitative study in Ethiopia to focus on the subjective views of adolescents regarding eating, moving beyond the usual biological and quantitative data. However, as a qualitative approach, it only provides insight into a relatively small group and may not reflect a nuanced socio-economical and geographical difference between urban and rural areas as well as between patients from private and public hospital practice.

A major advantage was that most participants were not on psychotropic medication. This allowed the assess the unaltered impact of mental illness on eating habits without the confounding effects of drugs.

Potential for social desirability bias in interviews and internal bias for positive findings must be considered as a possible limitation of this study. The inclusion of only one participant within the overweight category identifies a gap in certain populations who may have different experiences in eating habits.

10) CONCLUSIONS

This study identified the subjective experiences of adolescents with common mental disorders, a group that is usually not a scope of study. The findings from this study indicated that the significance of understanding eating behaviors in these populations isn't to be undermined as risk to disordered eating is observed.

This study identifies that eating habits are shaped by various internal and external explanations rather than simple biological needs; epistemic knowledge of healthy eating is not protective of poor dietary choices in adolescents. As taste preferences, mood alterations, societal comments drive eating habits, internal drives and body image perception further promote subjective decisions in healthy dietary choices.

Adolescents explained that the impact of unhealthy eating habits extended from physical to social negative experiences. With some participants, impact on academic work was described as a major source of concern due to difficulty in maintaining focus in schoolwork that was attributed to undereating and missing schoolwork due to excessive sleepiness. They described this led to poor interaction with their teachers and resulted in the wrong impression of their actions as a behavioral problem rather than an effect of dysregulated eating. The impact further spread to social engagement with playtime being decreased and becoming a source of teasing comments from peers. In some of these adolescents, medical complications resulted due to chronic eating dysregulation with fainting episodes and electrolyte imbalances leading to medical care.

Thus, these findings indicate the significant clinical implications of dysregulated eating patterns and highlight the need to utilize high index of suspicion in these age groups and to look beyond the assumption that dysregulated eating patterns are driven only through pursuit of an ideal shape without taking into consideration the societal and emotional correlations.

11) RECOMMENDATIONS

Screening for eating patterns in depth in adolescents presenting to our clinical OPDs could help reflect the true significance of disordered eating behaviors as comorbid diagnosis and would aid in making individualized formulations. Additionally, based on the results of this study, it is noted that patients will benefit from individualized intervention plans integrating specific regulating techniques that include eating behaviors. The knowledge from this study will be valuable in conducting quantitative research to determine the prevalence of comorbid disordered eating behaviors in risk age groups and will also serve as a guide in future qualitative studies including substance users, higher economic status adolescents and adolescents from rural areas.

12) ETHICAL CONSIDERATIONS

Study was reviewed and approved by Addis Ababa University ethical review committee after formal letter from school was acquired. Verbal consent was obtained from the participants prior to progressing to the interview. Confidentiality and privacy of information will be ensured. Transcripts and audios were stored on password protected servers. Interviewees that had high distress and risk were communicated to their primary physician for emergency psychological support

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14) ANNEXES

14.1 Information sheet and consent form

Good morning/Good afternoon. My name is _____. I am a data collector for the study undertaken by Dr Mahider Molla, a final year psychiatry resident in Tikur Anbessa Specialized hospital.

The purpose of this study is to explore the lived experiences of appetite among adolescents with common mental disorders. The findings of this study will hopefully provide knowledge on the subjective relationship between appetite and mental health and eating attitudes and behaviors among clinical adolescent population.

Procedure: The choice of participants is made conveniently.

Confidentiality: The information that you give us will be kept confidential and will be used for this study purpose only. Your name and other personal identity will not be recorded on data collection form. We will never tell anyone else any piece of information about your response. If there are any concerning issues about your current health status, your primary clinician may be contacted to aid in your treatment process. All study documents will be kept in a password protected online platform and will be destroyed at the end of the study.

Voluntariness of the study and Right as a participant: Anyone who will not be willing to participate in the study will have the right to discontinue at any time in the process.

Possible risks and benefits: There is no direct benefit that you will get from this study right now.. Do you agree to participate in this study? Yes, _____ continue. No_____

Thank you for volunteering to participate in the study.

Investigator Name _____

Signature_____

Date _____

Time started _____ end_____

Person to contact: If you want to know more information you can contact Mobile:+251913643306; mahidermolla@hotmail.com

አባሪ 1 . የመጥይቅ እና የፍቃደኝነት ማረጋገጫ ፎርም

ጤና ይስጥልኝ እንደምን አደራችሁ/ዋላችሁ

የእኔ ስም ዶ/ር ማህደር ሞላ ይባላል፡፡ ስራዬም በጥቁር አንበሳ ሆስፒታል የአእምሮ ህክምና ክፍል፤ የመጨረሻ አመት ሰልጣኝ ሃኪም ነኝ፡፡

የጥናቱ ዓላማ የጉርምስና እድሜ ክልል ላይ ያሉ ተመላላሽ ታካሚዎችን የአመጋገብ ሁነታ እና ከአእምሮ ህመም ጋር ያለውን ግንኙነት መረዳት ነው፡፡ በተጨማሪም የታካሚው/ዋን የግል ልምድ በሰፊው በመገንዘብ እና በመረዳት የተሻለ ህክምና ለመስጠት የሚያግዙ ስልቶችን በመንደፍ የታካሚዎችን ጤና ማሻሻል ነዉ፡፡
የጥናቱ ሂደት ፤ በጥናቱ የሚካተቱ ሰዎች የሚመረጡት ለተመላላሽ ህክምና ሲመጡ ይሆናል፡፡

ሚስጥራዊነት: በዚህ መጠይቅ የሚገኙ ማንኛውም የጽሁፍም ሆነ የድምጽ ቅጂ መረጃዎች በሙሉ ለማንም ተላልፈዉ የማይሰጡ ፤ በአጥኝዉ ብቻ በሚስጥር የሚያያዙ እና ጥናቱ ሲጠናቀቅ የሚወገዱ ናቸዉ፡፡ ከዚህም በተጨማሪ የእርስዎን ማንነት የሚገልጡ ስምም ሆነ ሌላ መገለጫ አይካተትም፡፡.ነገር ግን፣ አሁን ስላላው የጤና ሁኔታዎ አሳሳቢ የሆኑ ጉዳዮች ካሉ የህክምና ሂደትዎን ለማገዝ ዋናው ሃኪምዎን ማሳወቅ አስፈላጊ ሊሆን ይችላል፡፡

የተጠያቂዉ ፍቃደኝነት እና መብት፤ ተጠያቂዉ በማንኛዉም ሰዓት መጠይቁን በማንኛዉም ሰዓት እና ሁኔታ ማቋረጥም ሆነ አለመሳተፍ ይችላል፡፡

ሊያጋጥሙ የሚችሉ ጉዳቶች ወይም ጥቅሞች፤ በዚህ መጠይቅ በቀጥታ የሚያገኙት ጥቅም ሆነ ጉዳት የለም፡፡ በዚህ ጥናት ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን በመመለስ ተሳታፊ ይሆናሉ፡፡ ስለዚህ በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት ወይ? አዎ ከሆነ ፊርማዎትን እዚህ ላይ ያስፍሩ
የወላጅ ስምና ፊርማ_____

ለፍቀደኝነትዎ አመሰግናለሁ፡፡

የአጥኝዉ ስም _____ፊርማ _____ ቀን _____

መጥይቁ የተጀመረበት ሰዓት _____ መጠይቁ ያለቀበት ሰዓት _____

ተጨማሪ መረጃ ከፈለጉ የጠያቂው አድራሻ፡ Mahidermolla@hotmail.com +251913643306

14.2 Questionnaire

- **Unique no. identifier of respondent _____**

Dear respondent, thank you for your collaboration in responding to this questionnaire.

I am _____. This questionnaire will be used to explore the experiences in appetite among adolescents with common mental disorders in Addis Ababa, Ethiopia.

Interviewer's name----------

Signature----------

Date of interview----------

1) **Socio demographic characteristics of respondents;**

I. **Age ----------**

II. **Sex ----------**

III. **Educational level**

IV. **Weight and height…….**

Topic guide

Annex I: Interview Guide (English Version)

Section A: Socio-demographic Variables

1. Age
2. Gender
3. Place of residence
4. Educational status
5. Do both of your parents alive? Do they live together?
6. Family educational status

Section B: Main Topic Guide

1. Could you please introduce yourself?
2. Could you describe what healthy eating is for you?
3. Could you tell me about your eating patterns?
4. How has your dietary behavior changed since you began having mental disorder symptoms?

Probe: What factors caused these changes? (pressure in appearances, weight)

5. How did this impact your life (school, sleep, body weight)?
6. Could you describe what enables you to have healthy eating behavior?
7. Could you elaborate on the barriers to healthy eating behavior?

Probe: How about in terms of food availability?

8. Could you describe how your appetite has been affected by your mental health condition?
9. Could you describe how your eating patterns are related to your mood?

Probe: How about during anxiety, depression, somatic patterns, stress..?

10. Could you also elaborate on how your mood affects your eating behavior?
11. What strategies do you use to solve these changes?

Probe: How about in terms of skipping meals?

12. Could you describe how your eating patterns impacted the way you perceive your body?
13. Could you describe how your eating pattern could help as a coping factor?
14. Could you describe how your dietary choices have changed since starting medication/ clinical visits?
15. Could you tell me the support you would have preferred to be offered concerning dietary behaviors during mental health conditions?
16. Do you have any additional remarks or suggestions on eating behavior and mental health conditions?

አባሪ ፪፡ የመጠይቅ መመሪያ (በአማርኛ)

ክፍል ፩፡ የማህበራዊ እና ስነ-ህዝባዊ መረጃዎች

1. እድሜ
2. ጾታ
3. አድራሻ
4. የትምህርት ደረጃ
5. ሁለቱም ወላጆችሽ/ህ በህይወት አሉ? አብረው ይኖራሉ?
6. የቤተሰብ የትምህርት ደረጃ?

ክፍል ፪፡ ዋና ዋና የውይይት ነጥቦች

1. እባክሽን/ህን እራሥሽን/ህን አስተዋውቂ/ቅ?
2. ጤናማ አመጋገብን እንደት ትገልጪዋለሽ/ህ?
3. ስለአመጋገብ ስርዓትሽ/ህ ልትነግረኝ ትችላለህ?
4. የአመጋገብ ባህሪሽ/ህ የአእምሮ ህመም ምልክቶች ከጀመሩሽ/ህ በኋላ በምን መልኩ ተቀየሩ?
   ተጨማሪ ጥያቄ፡ ምን ምክንያቶች እነዚህን ለውጦች ያመጡ ይመስልሻል? (ውጫዊ ወበት ላይ ያሉ ጫናዎች፣ ክብደት)
5. ይህ ህይወትሽ/ህ ላይ ምን አይነት ተጽእኖ አመጣ? (ትምህርት፡ እንቅልፍ፡ የሰውነት ክብደት)
6. ጤናማ የመብል ባህሪ እንዲኖርሽ/ህ የሚያስችል ነገርን መግለጽ ትችያለሽ/ላለህ?
7. ጤናማ የመብል ባህሪን ለማክበር የሚከለክሉ እንቅፋቶችን መግለጽ ትችያለሽ/ላለህ?
   ተጨማሪ ጥያቄ፡ ከምግብ ተደራሽነት አንጻርስ?
8. የአእምሮ ጤናሽ/ህ ሁኔታ የምግብ ፍላጎትሽ/ህ ላይ እንዴት ተጽእኖ እንዳረገው መግለጽ ትችያለሽ?ላለህ
9. የመብል ስራአትሽ/ህ ከውስጣዊ ስሜቶችሽ ጋር እንዴት እንደሚያያዙ መግለጽ ትችያለሽ/ህ?
   ተጨማሪ ጥያቄ፡ በድበተ፡ በጭንቀት፡ አሳላዊ ምልክቶች፡ በመረበሽ ጊዜስ?
10. ውስጣዊ ስሜትህ በመብል ባህሪህ ላይ እንዴት ተጽእኖ እንደሚያረግ ማብራራት ትችያለሽ/ህ?
11. እነዚህን ለውጦች ለመፍታት የምትጠቀሚው/ቀመው የመፍትሔ መንገዶች ምንድናቸው?
    ተጨማሪ ጥያቄ፡ ምግብ (ቁርስ፤ ምሳ፤ እራት ከመዝለል አንጻርስ?)
12. የመብል ስርአትሽ/ህ እንዴት በሰውነትሽ/ህ ላይ ያለሽ/ህ አመለካከት ላይ ጫና እንዳመጣ መግለጽ ትችያለሽ?
13. የመብል ስርአትሽ/ህ እንዴት እንደ ችግር መቋቋሚያ አካል ሊረዳ እንደሚችል መግለጽ ትችያለሽ?
14. መድሃኒት መውሰድ ወይም የሕክምና ክትትል ከጀመርሽ/ህ ጀምሮ የምግብ ምርጫዎችሽ/ህ እንዴት እንደተለወጡ መግለጽ ትችያለሽ/ላለህ?
15. የአእምሮ ጤና ሁኔታ እና በምግብ ባህሪዎች ዙሪያ በተያያዘ ምን አይነት ድጋፍ ቢቀርብልሽ/ህ እንደምትመርጪ መናገር ትችያለሽ/ላለህ?
16. በመብል ባህሪ እና በአእምሮ ጤና ሁኔታዎች ላይ በተያያዘ ተጨማሪ አስተያየት ወይም ምክር አለሽ/ህ?

(91)

14.3 Assurance of principal investigators

I, the undersigned, declare that this thesis proposal is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

If proven otherwise, I understand that appropriate actions will be taken based on the Senate Legislation of Addis Ababa University and the Guidelines provided by the Ministry of Education.

Name of Investigator: Mahider Molla Mengistu

Signature: _____

Date of submission: May, 2026

This proposal has been submitted to DOP with my approval as a supervisor.

- ✓ Name and Signature of the first Supervisor _____
- ✓ Name and Signature of the second supervisor _____