

Disordered Eating, Self-Reported Nutrition Knowledge, and Online Nutrition Information Seeking Among an International Sample of Adults

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ABSTRACT

Objective: Examine relationships between self-reported nutrition knowledge, seeking nutrition information online, and disordered eating.

Methods: Cross-sectional data were drawn from online surveys in 2021 among adults from Australia, Canada, Mexico, the United Kingdom, and the United States (N = 21,138). Adjusted logistic models generated odds ratios to assess relationships between self-reported nutrition knowledge (ordinal) and online sources of nutrition information (dichotomous) with disordered eating.

Results: Higher self-reported nutrition knowledge was associated with elevated odds of binge eating, preoccupation with thinness, and self-induced vomiting. Seeking nutrition information online was associated with higher odds of binge eating in Australia and Mexico; lower odds of self-induced vomiting in Australia, Canada, Mexico, and the United States; and higher odds of preoccupation with thinness in Canada, the United Kingdom, and the United States.

Conclusions and Implications: Disordered eating is cross-sectionally associated with self-reported nutrition knowledge and seeking nutrition information from online sources. Results indicate a greater need for public health nutrition research and education.

Key Words: disordered eating, nutrition knowledge, social media, nutrition information seeking, adults (*J Nutr Educ Behav.* 2026;000:1–8.)

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INTRODUCTION

Disordered eating behaviors are unhealthy behaviors intended to control weight and/or appearance, such as severely restricting caloric intake, binge eating, and compulsively exercising.¹ In a recent systematic review and meta-analysis of 32 studies from 16 countries, the

authors found that 22% of children and adolescents screened positive for disordered eating.² Among adults, the prevalence of disordered eating is estimated at around 12% to 19%, which varies depending on the sample composition, country, and time frame (e.g., past week vs year).^{3–7} Most studies have focused on adults less than 30 years old, and

research on the prevalence of disordered eating in older adult populations is limited. Many biological, psychological, developmental, and sociocultural risk factors contribute to engagement in disordered eating behaviors,⁸ leading to known disparities by age, gender identity, and racial and ethnic identity.^{3,4}

One underexplored potential contributor to disordered eating is perceived nutrition knowledge. Nutrition knowledge, defined as an understanding of nutrients, the association between diet and disease, and dietary guidelines, may influence diet-related behaviors and consumers' abilities to identify nutrient-dense foods.^{9,10} Studies in the United States (US), Australia, Canada, and several European countries have demonstrated that nutrition knowledge tends to be higher among those whose sex is female, are older in age, and have a higher education level and income.^{9,11,12}

There has been limited research on connections between nutrition

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knowledge and disordered eating.^{13,14} One study comparing levels of nutrition knowledge among health professionals, patients with eating disorders, and individuals without an eating disorder found that participants with eating disorders had lower levels of nutrition knowledge than dietitians (who are assumed to have high levels of nutrition knowledge), equivalent levels to all other health professionals, and higher levels of nutrition knowledge than control participants who did not have an eating disorder.¹³ Studies have also found that dietitians and dietetic students may have a higher risk for disordered eating compared with those not in the fields of nutrition and dietetics,^{15–17} though the directionality of this relationship has not been established.

Relatedly, the source through which one seeks out nutrition knowledge and information can influence food choices, diet quality, and potentially, disordered eating risk.¹⁸ Social media and the internet are among the most common sources for seeking nutrition information among adolescents and adults.^{19–22} It is also well-documented that social media use is associated with an elevated risk of disordered eating among young people.^{23–25} It is likely that the relationships between nutrition knowledge, online nutrition information seeking, and disordered eating are complex, bidirectional, and differ across the lifespan. Individuals who seek nutrition information online may have an increased risk for developing disordered eating because of the pervasive promotion of diets, supplements and health foods, and other weight loss methods online.^{26,27} At the same time, individuals engaged in disordered eating may be more likely to seek out nutrition content online as a means to achieve a change in body weight or appearance, and as such report having high nutrition knowledge.

Given the current state of the research, there is a gap in knowledge of the relationships between sources of nutrition information, nutrition knowledge, and disordered eating. The objectives of this study were to examine cross-sectional relationships among the use of online sources to obtain

nutrition information, nutrition knowledge, and disordered eating.

METHODS

Data Collection

This study solely drew on data from the 2021 wave of the International Food Policy Study (IFPS), conducted online among adults aged 18–100 years in Australia, Canada, Mexico, the United Kingdom (UK), and the US. The IFPS aims to evaluate the impact of national-level nutrition policies and examine dietary patterns and policy-relevant behaviors across countries. Participants were recruited by Nielsen Consumer Insights Global and partner panels using probability and non-probability sampling methods and quotas for age and sex that approximated known proportions in each country for male and female individuals across 4 age groups (18–29, 30–44, 45–64, ≥ 65 years). Participants completed online surveys in November–December 2021 and provided written consent online. Surveys were conducted in English in Australia and the UK; Spanish in Mexico; English or French in Canada; and English or Spanish in the US. The study underwent a full board review and received ethics clearance through the University of Waterloo Research Ethics Committee (Office Research Ethics no. 30829). Additional details about the IFPS are available elsewhere.²⁸

Measures

One item assessing self-reported nutrition knowledge was adapted from the 2015 Canadian Foundation for Dietetic Research Tracking Nutrition Trends survey²⁹ and asked the following: “How would you rate your nutrition knowledge?” (with response options: not at all knowledgeable, a little knowledgeable, somewhat knowledgeable, very knowledgeable, and extremely knowledgeable). This variable was treated as ordinal (range 1–5) and was assumed to follow a log-linear trend. Those who responded “don’t know” or refused to answer were categorized as missing ($n = 296$). Although a single item of self-reported nutrition knowledge likely does not reflect

objective or functional nutrition knowledge,¹¹ its widespread use in research and clinical nutrition settings warrants exploration as a possible correlate of disordered eating risk. Further, self-reported nutrition knowledge may be indicative of behavioral confidence, such as through the Dunning-Kruger Effect (DKE), a phenomenon which suggests that those with less knowledge in a particular area tend to overestimate their knowledge in that area, thereby influencing their behavioral patterns.³⁰

To assess seeking nutrition information online, the survey drew on an item that was adapted from the Canadian Community Health Survey Food Guide module³¹ and Tracking Nutrition Trends.²⁹ The question asked the following: “In the past 12 months, did you get information on food or nutrition from any of the following sources? (select all that apply).” Using the response options from the survey, we created a dichotomous variable to indicate whether participants reported seeking nutrition information from no online sources or any online source (i.e., general research on the internet, social media, blogs, or celebrities). Participants who indicated using another source could specify using an open-text prompt. Open-ended responses were assessed, and any that aligned with online sources (e.g., YouTube) were reclassified accordingly.

Disordered eating was assessed using 3 brief and validated items from Haines et al.,³² developed and validated among English-speaking students in the US, that addressed binge eating, self-induced vomiting, and preoccupation with thinness. Participants were asked the following: (1) “In the past 3 months, how often have you gone on eating binges (eating a large amount of food while feeling out of control)?” and (2) “In the past 3 months, how often have you made yourself sick (vomited) to control your weight?” Response options for both items included: never, less than 1 time a month, 1–3 times a month, once a week, 2–6 times a week, once a day, and more than once a day. Each construct was operationalized as a binary variable. Participants who responded 1–3 times a

month or more for binge eating and less than 1 time a month or more for self-induced vomiting met the cutoff for each respective behavior. Preoccupation with thinness was assessed using the following prompt: "I am preoccupied with a desire to be thinner," and response options included: always, usually, often, sometimes, rarely, and never. Participants who indicated they were always, usually, or often preoccupied were coded as 1. Although the original item suggests different cutoffs for female and male respondents, we used the same cutoff because of the growing literature surrounding preoccupation with thinness among boys and men.³³ For each item, participants who responded "don't know" or refused to answer were categorized as missing (binge eating $n = 361$, self-induced vomiting $n = 193$, preoccupation with thinness $n = 197$).

Several potential confounders of the relationships between self-reported nutrition knowledge, sources of nutrition information, and disordered eating risk were incorporated in the analyses, including age group (18–29, 30–44, 45–59, ≥ 60 years), country (Australia, Canada, Mexico, UK, US), gender identity, perceived income adequacy, level of education, and racial/ethnic identity. Gender identity was assessed using a measure that queried participants' identity and provided the following response options: man, woman, trans male/trans man, trans female/trans woman, gender queer/gender conforming, different identity, don't know, and refuse to answer. Given the small proportion of participants who indicated a gender identity other than man or woman, all other participants were collapsed into a gender minority category ($n = 156$, [0.7%]). To assess perceived income adequacy, participants were asked the following: "Thinking about your total monthly income, how difficult or easy is it for you to make ends meet?" with response options ranging from very easy to very difficult,³⁴ which were operationalized as a continuous variable (range 1–5), as well as missing for those who reported "don't know" or refused to answer ($n = 274$).

Level of education and racial/ethnic identity were queried using

national country-specific measures.³⁵ To allow for cross-country comparisons, the national measures were then standardized across the 5 countries, which vary widely in educational systems and racial/ethnic composition. Level of education was categorized according to country-specific criteria as low, medium, high, or missing if participants did not respond to the corresponding items ($n = 105$). Ethnic identity was classified as 'majority' in each country if participants identified as non-indigenous (in Mexico), White, and/or English-speaking (in Australia); participants who did not identify as any of the above were categorized as belonging to a 'minority' racial or ethnic group or categorized as missing if they selected 'don't know,' refused to answer, or did not respond to respective items ($n = 279$). Details about the standardized variables are available in the [Supplementary Data](#).

Statistical Analysis

Poststratification sample weights were applied to all analyses and constructed using a raking algorithm with population estimates for each country based on age group, ethnicity (except in Canada), education (except in Mexico), region, and sex assigned at birth.³⁵ The sample weights were used to more closely align the sample with the general composition of the population in each country, but are not intended to make the sample population-representative.

Cross-sectional descriptive statistics (n [%]) were performed for each of the outcome variables (binge eating, self-induced vomiting, and preoccupation with thinness) and covariates by country and overall. A bivariate analysis was conducted to examine the relationship between online sources of nutrition information and self-reported nutrition knowledge. Separate multivariate logistic models were used to identify the relationships between each of the online sources of nutrition information and self-reported nutrition knowledge with each of the outcome variables, adjusting for age, gender identity, perceived income adequacy, level of education, and racial/ethnic identity. Because the prevalence of

each outcome measure varied across countries, models were stratified by country, adjusting for covariates to generate adjusted odds ratios (AOR).

The total sample consisted of 21,138 participants, and participants with missing data were excluded listwise from each respective model. The response was low across models, and the sample size ranged from 20,284 to 20,577, depending on the outcome variable (96.0% to 97.3% of the eligible sample). We also conducted a chi-square test (test of independence) of association to examine potential differences in disordered eating risk by response versus non-response to the self-reported nutrition knowledge item.

RESULTS

The sample characteristics, stratified by country, are presented in [Table 1](#). Overall, the sample was evenly split across countries. Most participants belonged to a racial/ethnic majority group (76.8%). The prevalence of binge eating in the past 3-months ranged from 18.6% (Canada) to 41.3% (Mexico), with an overall prevalence of 25.7%. The prevalence of self-induced vomiting in the past 3-months ranged from 5.3% (Mexico) to 15.4% (UK), or 10.1% overall. Across the sample, the prevalence of preoccupation with thinness ranged from 24.6% (US) to 28.6% (Mexico), or 25.6% overall.

The results of the adjusted models examining country-specific associations between self-reported nutrition knowledge, seeking nutrition information from online sources, and each disordered eating outcome are presented in [Table 2](#). In Australia and Mexico, participants who sought nutrition information online had elevated odds of engaging in binge eating in the past 3 months compared with those who did not seek nutrition information online (AOR range 1.28–1.30). Seeking nutrition information from online sources was associated with significantly elevated odds of preoccupation with thinness in Canada, the UK, and the US (AOR range 1.30–1.71). In contrast, compared with participants who did not seek nutrition information from online sources, those who did had

Table 1. Sample characteristics of adult participants from the International Food Policy Study, 2021, Weighted (N = 21,138)

Characteristics	Australia (n = 4,105)	Canada (n = 4,572)	Mexico (n = 4,172)	United Kingdom (n = 4,196)	US (n = 4,093)
	% (n)				
Age, y					
18–29	825 (20.1)	871 (19.1)	1,179 (28.3)	806 (19.2)	841 (20.6)
30–44	1,111 (27.1)	1,164 (25.5)	1,285 (30.8)	1,026 (24.5)	1,047 (25.6)
45–59	986 (24.0)	1,108 (24.2)	1,180 (28.3)	1,058 (25.2)	1,004 (24.5)
≥ 60	1,184 (28.8)	1,430 (31.3)	528 (12.7)	1,306 (31.1)	1,201 (29.3)
Gender identity (n = 21 non-response)					
Man	1,996 (48.7)	2,236 (48.9)	1,989 (47.8)	2,032 (48.4)	1,997 (48.8)
Woman	2,074 (50.6)	2,286 (50.0)	2,154 (51.7)	2,131 (50.8)	2,072 (50.7)
Gender minority (transgender, genderqueer, another identity)	31 (0.8)	49 (1.1)	22 (0.5)	34 (0.8)	21 (0.5)
Ethnic identity ^a (n = 279 non-response)					
Minority	1,103 (27.0)	1,015 (22.5)	783 (19.2)	470 (11.3)	1,461 (36.3)
Majority	2,983 (73.0)	3,487 (77.5)	3,299 (80.8)	3,702 (88.7)	2,559 (64.0)
Education ^b					
Low	1,720 (42.1)	1,934 (42.5)	837 (20.1)	2,089 (50.2)	2,236 (55.0)
Medium	1,317 (32.2)	1,514 (33.3)	611 (14.7)	888 (21.4)	406 (10.0)
High	1,050 (25.7)	1,105 (24.3)	2,719 (65.3)	1,182 (28.4)	1,426 (35.1)
Perceived income adequacy (n = 274 non-response)					
Very easy	585 (14.4)	656 (14.5)	187 (4.5)	699 (16.9)	807 (20.1)
Easy	1,076 (26.6)	1,019 (22.5)	603 (14.6)	1,051 (25.4)	901 (22.4)
Neither easy nor difficult	1,466 (36.2)	1,589 (35.2)	1,696 (41.1)	1,494 (36.1)	1,319 (32.8)
Difficult	667 (16.5)	886 (19.6)	1,242 (30.1)	650 (15.7)	661 (16.4)
Very difficult	257 (6.4)	372 (8.2)	402 (9.7)	248 (6.0)	332 (8.3)
Self-reported nutrition knowledge (n = 296 non-response)					
Not at all knowledgeable	294 (7.3)	271 (6.0)	159 (3.8)	363 (8.8)	277 (6.9)
A little knowledgeable	1,387 (34.3)	1,517 (33.7)	1,277 (30.7)	1,595 (38.9)	1,248 (31.0)
Somewhat knowledgeable	1,590 (39.3)	1,815 (40.3)	2,100 (50.6)	1,475 (35.9)	1,660 (41.2)
Very knowledgeable	601 (14.9)	756 (16.8)	515 (12.4)	497 (12.1)	629 (15.6)
Extremely knowledgeable	174 (4.3)	147 (3.3)	103 (2.5)	176 (4.3)	219 (5.4)
Seeks nutrition information from online sources ^c	835 (20.4)	1,002 (21.9)	1,594 (38.2)	693 (16.5)	908 (22.2)
Binge eating ^d (n = 361 non-response)	930 (23.2)	830 (18.6)	1,713 (41.3)	983 (23.8)	957 (23.8)
Self-induced vomiting ^d (n = 193 non-response)	491 (12.1)	358 (7.9)	221 (5.3)	638 (15.4)	444 (11.0)
Preoccupation with thinness ^d (n = 197 non-response)	1,106 (27.2)	1,116 (24.7)	1,191 (28.6)	1,088 (26.4)	998 (24.6)

^aCountry-specific criteria were used to categorize participants as being part of a majority or minority racial/ethnic group; ^bCountry-specific criteria were used to designate education level category; ^cIncludes participants who self-reported using at least one of the following sources for nutrition information: social media or blogs, celebrities, and/or general research on the internet; ^dFor binge eating and self-induced vomiting, the thresholds were going on a binge at least 1–3 times a month and ever having vomited over the past 3 months. For preoccupation with thinness, the threshold indicated always, usually, or often being preoccupied with a desire to be thinner.

Note: The values are presented as n (%).

Table 2. Associations Among Self-Reported Nutrition Knowledge, Seeking Nutrition Information From Online Sources, and Disordered Eating by Country Among Adult Participants From the International Food Policy Study, 2021, Weighted (N = 21,138)

Variables	Disordered Eating Outcome, AOR (95% CI) ^a					
	Binge Eating ^b	P	Self-induced Vomiting ^b	P	Preoccupation With Thinness ²	P
Seeks nutrition information from online sources ^c						
Australia	1.30 (1.08–1.56)	0.005	0.58 (0.45–0.76)	< 0.001	1.17 (0.98–1.40)	0.07
Canada	0.91 (0.75–1.10)	0.31	0.65 (0.49–0.86)	0.003	1.30 (1.11–1.54)	0.002
Mexico	1.28 (1.12–1.46)	< 0.001	0.72 (0.53–0.97)	0.03	1.13 (0.98–1.30)	0.09
UK	1.18 (0.96–1.45)	0.11	0.87 (0.68–1.12)	0.28	1.71 (1.42–2.06)	< 0.001
US	1.20 (1.00–1.43)	0.05	0.72 (0.55–0.93)	0.012	1.30 (1.10–1.55)	0.003
Self-reported nutrition knowledge ^d						
Australia	1.27 (1.16–1.38)	< 0.001	1.51 (1.35–1.69)	< 0.001	1.19 (1.10–1.29)	< 0.001
Canada	1.14 (1.04–1.24)	0.005	1.38 (1.22–1.57)	< 0.001	1.04 (0.96–1.13)	0.33
Mexico	1.06 (0.97–1.15)	0.18	1.47 (1.24–1.76)	< 0.001	0.99 (0.90–1.08)	0.79
UK	1.33 (1.22–1.45)	< 0.001	1.61 (1.45–1.78)	< 0.001	1.25 (1.15–1.35)	< 0.001
US	1.32 (1.21–1.43)	< 0.001	1.69 (1.51–1.90)	< 0.001	1.22 (1.13–1.33)	< 0.001

AOR indicates adjusted odds ratio; CI, confidence interval.

^aAll models adjusted for age, gender identity, perceived income adequacy, level of education, and race/ethnicity. Participants with missing data were excluded from their respective models. The number of participants excluded from each model ranged from 2.7% to 4.0% of the total sample.; ^bFor binge eating and self-induced vomiting, the thresholds were going on a binge at least 1–3 times a month and ever having vomited over the past 3 months. For preoccupation with thinness, the threshold indicated always, usually, or often being preoccupied with a desire to be thinner.; ^cBinomial logistic regression. Seeking nutrition information from online sources was defined as reporting any online source (i.e., general research on the internet, social media, blogs, or celebrities).; ^dMultivariate logistic regression. An item inquiring self-reported nutrition knowledge included 5 response options. AORs reflect a per 1-category increase (1–5).

significantly lower odds of self-induced vomiting in the past 3 months in Australia (AOR = 0.58 [95% confidence interval (CI), 0.45–0.76]), Canada (AOR = 0.65 [95% CI, 0.49–0.86]), Mexico (AOR = 0.72 [95% CI, 0.53–0.97]), and the US (AOR = 0.72 [95% CI, 0.55–0.93]).

Participants from Australia, Canada, the UK, and the US who self-reported greater levels of nutrition knowledge had a per-category elevated odds of binge eating and preoccupation with thinness (except for Canada) (Table 2). The adjusted odds of self-induced vomiting were elevated for participants with greater self-reported nutrition knowledge across all countries (AOR range 1.38–1.69).

There were no significant differences in binge eating and self-induced vomiting in the past 3 months between those with missing data on self-reported nutrition knowledge or seeking nutrition information from online sources. However, participants with missing data on self-reported nutrition knowledge were significantly less likely to report a preoccupation with thinness than those without missing data ($\chi^2 = 7.58$, $P = 0.01$).

DISCUSSION

Disordered eating is a growing public health concern, and increasing social media use may lead individuals to use online platforms as a primary source of nutrition information. We found that, among adult survey respondents from Australia, Canada, Mexico, the UK, and the US, higher self-reported nutrition knowledge and getting nutrition information from online sources were separately and cross-sectionally associated with varying odds of engagement in disordered eating behaviors and attitudes. Across all countries, higher odds of self-induced vomiting in the past 3 months were observed for participants with greater self-reported nutrition knowledge, while in most countries, participants with higher self-reported nutrition knowledge had significantly elevated odds of binge eating, whereas participants in Australia, the UK, and the US also had elevated odds of preoccupation with thinness.

Our findings contribute to the dearth of literature examining associations between perceived nutrition knowledge and disordered eating.^{13,14} One study among US college women found that although objective nutrition knowledge was not directly associated with disordered eating, it did moderate the association between perfectionism, an established risk factor for eating disorders, and shape/weight concerns.³⁶ The authors suggested that it may be possible that individuals with greater nutrition knowledge are vulnerable to the connection between perfectionism and shape/weight concerns, which may prompt them to actively seek out nutrition information for weight modification. Qualitative research among dietetics students has similarly identified the ways in which increased nutritional knowledge can lead to overthinking about food and weight.¹⁸ However, in the broader literature and in this study, it is unclear whether those susceptible to disordered eating are more likely to seek out and remember nutrition information or if seeking out nutrition information increases the risk of disordered eating.

It is important to note that self-reported measurements of nutrition knowledge, such as the measure used in this study, have been weakly associated with objective health and nutrition knowledge; for example, a 2018 international study found that those who rated themselves as extremely knowledgeable had lower health literacy and functional nutrition knowledge scores than those who rated themselves somewhat knowledgeable.¹¹ This suggests that many individuals, regardless of disordered eating risk, tend to overestimate their nutrition knowledge, a phenomenon that may be related to the DKE, whereby those with less knowledge in an area tend to overestimate their knowledge.³⁰ The DKE is common in food and media literacy, and individuals who overestimate their knowledge may be especially vulnerable to misleading health and nutrition advertising on social media.³⁷ As such, overconfidence in self-reported versus objective nutrition knowledge may uniquely contribute to disordered eating risk.

Interestingly, compared with individuals who did not get nutrition information from online sources, those who did had significantly lower odds of self-induced vomiting. One recent study found that exposure to social media weight loss content was positively associated with psychological factors related to disordered eating and binge eating, but not self-induced vomiting,³⁸ which suggests that the pathway between internet use and this behavior is different from that for other facets of disordered eating. This may be due to social media content moderation policies; while the promotion of other purging methods may be prevalent (e.g., overexercise), vomiting-related content may be restricted for its graphic nature or accompanied by a health warning, and thus, high online users are not exposed to it as a purging method.

This study has several limitations to consider. The use of a self-reported measure of nutrition knowledge does not reflect objective or functional nutrition knowledge, and differences in what nutrition knowledge might mean across countries that have different dietary guidelines and cultural practices regarding food may lead to cross-cultural differences. Furthermore, it is possible that seeking nutrition information online may be highly correlated with high social media use, which is associated with elevated risks of disordered eating engagement^{23–25}; as such, future research may consider examining the potentially mediating role of social media use on this relationship. The brief 3-item measure of disordered eating was developed for and validated among English-speaking students in the US,³² which could have potentially impacted results from Spanish- and French-speaking participants in Mexico, the US, and Canada. In particular, the relatively high prevalence of binge eating in Mexico may be indicative of a language or validation issue among these participants, and the assessment of measurement invariance is encouraged in future studies. Other disordered eating behaviors, such as diet pill and laxative misuse and overexercise, were not measured. Although this study is strengthened by a large

international sample of adults, participants were recruited using non-probability sampling, which may limit the generalizability of the findings. Our study drew on results from previously collected data; therefore, we were unable to analyze additional information that may confound associations, such as previously diagnosed mental health conditions. Finally, the snapshot nature of this study did not allow for an exploration of the directionality of this association (i.e., whether high nutrition knowledge and seeking nutrition information online lead to disordered eating).

IMPLICATIONS FOR RESEARCH, PRACTICE, AND POLICY

This study has several implications for research, including a novel contribution to scant literature examining relationships between perceived nutrition knowledge, sources of nutrition information, and disordered eating, each of which is of public health nutrition significance. We found increased odds of binge eating and preoccupation with thinness among participants who reported getting nutrition information from online sources compared with those who did not. Many studies have identified associations between social media use, body image dissatisfaction, and disordered eating behaviors.³⁹ Unhealthy fad diets and nutrition misinformation are common online,⁴⁰ which might be a contributing factor to the relationship between social media exposure and disordered eating. Because the use of online sources for nutrition information is prevalent,^{19–21} the identified cross-sectional associations warrant prospective exploration into the directionality of the relationship between unreliable nutrition information and disordered eating. Future research may also consider including measures of objective nutrition knowledge and platform-specific exposures to examine how information sources may differ online and the differing pathways through which some disordered eating behaviors differently interact with nutrition

knowledge. Our study contributes to broader calls for policies aimed at filtering misinformation online, as well as the need for improving media literacy among the public.

This study's findings also highlight the potential importance of integrating online media literacy skills into clinicians' provision of nutrition education, as improving individuals' abilities to assess the credibility of online content may help translate nutrition information into healthier attitudes and behaviors. Nutrition counseling and education may benefit from the incorporation of structured reflection on perceived versus objective knowledge, as well as considering approaches to care that do not promote stigma. Furthermore, clinicians and dietitians may consider screening for online information-seeking patterns and perceived nutrition expertise, particularly in relation to overconfidence, in their assessment of disordered eating risk.

CONFLICT OF INTEREST DISCLOSURE

The authors have not stated any conflicts of interest.

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SUPPLEMENTARY DATA

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