The influence of childhood polyvictimization on disordered eating symptoms in emerging adulthood

Amanda J. Hassellea,⁎, Kathryn H. Howella, Madeline Dormoisb, Laura E. Miller-Graffb

a Department of Psychology, University of Memphis, 202 Psychology Building, Memphis, TN 38152-3230, United States
b Psychology and Peace Studies, University of Notre Dame, 107 Haggar Hall, Notre Dame, IN 46556, United States

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ABSTRACT

Children who endure multiple victimization experiences, or “polyvictims,” are vulnerable to maladaptive outcomes. Yet, little research exists evaluating the relationship between childhood polyvictimization and disordered eating symptoms (DES) in emerging adulthood. The current study examines the relationship between childhood polyvictimization and DES in emerging adults. Data were collected from 288 participants across two universities using online self-report measures. Hierarchical regression analyses revealed a significant positive relationship between number of childhood victimization experiences and DES in young adulthood (β = 0.14; p = 0.016). Female participants were more likely to demonstrate DES (β = 0.14; p = 0.008). Further, high levels of emotion dysregulation during young adulthood were associated with more DES (β = 0.33; p < 0.001). Findings suggest that exposure to victimization experiences in childhood increases individuals’ risk for exhibiting DES in young adulthood. Results also highlight the strong relationship between individuals’ emotion regulation abilities and the presence of DES. Findings align with the theory that children who have endured high levels of victimization often feel overwhelmed by their emotions and circumstances, demonstrate emotion regulation difficulties, and may rely on maladaptive coping strategies, including disordered eating, to manage adversities. Study results emphasize the importance of considering victimization history when working with emerging adults displaying disordered eating symptomatology.

1. Introduction

Childhood victimization can encompass a wide range of direct and indirect experiences, including exposure to violence, child abuse, maltreatment, and bullying (Finkelhor, 2011). These forms of victimization are risk factors for a range of problematic mental health consequences among emerging adults, including disordered eating symptoms (DES) (Brown et al., 2014; Briggs-Gowan et al., 2010; Copeland, Keeler, Angold, & Costello, 2007; Dvir, Ford, Hill, & Frazier, 2014; Lejonclou, Nilsson, & Holmqvist, 2014). DES include behaviors (e.g., binging, purging) and attitudes (e.g., belief that one is fat when others believe they are thin, preoccupation with food) consistent with the DSM-5 criteria for eating disorders (American Psychiatric Association, 2013). DES exist along a continuum: some individuals are asymptomatic, others have subclinical levels of symptomatology, and a much smaller portion of the population meet clinical criteria for an eating disorder (American Dietetic Association, 2006; American Psychiatric Association, 2013). Unhealthy eating behaviors and attitudes, from dieting to sporadic binging or purging to body dissatisfaction, are more prevalent than clinically significant eating disorders, and these subclinical DES may contribute to physical and psychological
problems, including increased risk for eventually developing an eating disorder (American Dietetic Association, 2006; Mintz & Betz, 1988; Shriver, Wollenberg, & Gates, 2016). Thus, it is critically important to understand not only factors that contribute to full eating disorder diagnoses, but also variables associated with subclinical symptomatology.

Previous work has revealed both direct and indirect relationships between various forms of childhood adversity and DES among emerging adults (Burns, Fischer, Jackson, & Harding, 2012; Hund & Espelage, 2005; Kent & Waller, 2000; Miskinyte, Perminas, & Sinkariova, 2006; Smolak & Murnen, 2002), while other studies have not found significant relationships between particular forms of adversity and disordered eating (Burns, Fischer, Jackson, & Harding, 2012; Fischer, Stojek, & Hartzell, 2010; Kent, Waller, & Dagnan, 1999; Miskinyte et al., 2006; Smolak & Murnen, 2002). All of these studies have largely focused on the effects of specific types of childhood victimization (e.g., sexual abuse, physical abuse) on DES, but have failed to consider how cumulative childhood victimization experiences relate to disordered eating attitudes and behaviors. Polytomization refers to experiencing multiple types of violence (e.g., physical abuse and bullying) rather than multiple victimizations of a single type (e.g., multiple instances of bullying; Hamby & Grych, 2013), thus it assesses breadth rather than depth of adversity. Current research indicates that the consideration of polytomization is critical. In actuality, youth are more likely to experience multiple forms of victimization rather than any one type in isolation (Lejonclou et al., 2014). Further, exposure to multiple instances of victimization appears to have a compounding effect, as polytomization has been associated with increased risk for negative consequences, beyond the effects of exposure to a single traumatic event (Finkelhor, Ommrod, & Turner, 2007). The current study aims to address gaps in existing literature by examining the relationship between childhood polytomization and emerging adults’ current DES, controlling for demographic and mental health variables.

2. Disordered eating during emerging adulthood

DES may be especially relevant to examine in emerging adulthood as these symptoms are highly prevalent during this developmental stage, which typically encompasses individuals aged 18–24 (Hudson, Hiripi, Pope, & Kessler, 2007; White, Reynolds-Malear, & Cordero, 2011). Anorexia commonly begins during adolescence or young adulthood and is often associated with stressful events, like leaving home for college (American Psychological Association, 2013). Similarly, bulimia commonly begins in adolescence or young adulthood, with peak prevalence rates observed among this population (American Psychological Association, 2013). While less is known about the development of binge-eating, it is common among adolescent and college-age samples and typically begins in this developmental period as well (American Psychological Association, 2013). In a nationally representative, in-person survey of United States households, participants indicated that the average age of onset for anorexia, bulimia, binge eating disorder, subthreshold binge eating disorder, and “any binge eating” was 18–22. Furthermore, the majority of college women report either “intense” dieting or dieting that put them “at risk” for an eating disorder (Krah, Kurth, Gomberg, & Drewnowski, 2005). Finally, college enrollment status is associated with more disordered eating, when comparing college students to same-aged women not currently enrolled in college (Rand & Kulda, 1991). Such findings suggest that the emerging adulthood years are a key time to examine factors contributing to DES.

3. Disordered eating and childhood polytomization

Another advantage of examining DES during the critical period of emerging adulthood is that it provides a comprehensive picture of participants’ childhood victimization histories, which facilitates an understanding of the prevalence of DES in the context of a transitional period following potentially traumatic childhood experiences. Childhood victimization experiences represent an important etiological consideration when evaluating disordered eating among emerging adults, as the negative emotions associated with polytomization may result in the use of avoidance or escape strategies, including disordered eating (Cooper, Wells, & Todd, 2004; Corstorphine, 2006; Dansky et al., 1997; Hund & Espelage, 2005; Root & Fallon, 1988).

Under the “avoidance/escape” framework, DES are conceptualized as distraction techniques that enable traumatized individuals to avoid processing their emotions (Molinari, 2001; Serpell & Treasure, 2002). Consistent findings linking childhood victimization experiences to deficits in emotional intelligence bolster this interpretation, suggesting that victimized children may not be equipped to adaptively cope with negative emotions (Dvir et al., 2014; Kim & Cicchetti, 2010; Mills, Newman, Cossar, & Murray, 2015). While this theoretical model provides a foundation to understand the relationship between victimization and DES, it has not yet been explored among youth who have experienced polytomization. Because polytomization appears to have especially pernicious effects on mental health (Finkelhor et al., 2007), its influence in the development of disordered eating, along with consideration of emotion regulation difficulties, merits further attention.

Although the literature is still nascent, a few studies point to polytomization as a relevant risk factor for understanding disordered eating during emerging adulthood. Smyth, Heron, Wonderlich, Crosby, and Thompson (2008) found that the number of reported childhood traumas predicted restricted eating among students entering their first year of college. Similarly, Lejonclou et al. (2014) compared victimization experiences between a Swedish female outpatient sample of adolescents/young adults meeting criteria for an eating disorder diagnosis and a nonclinical sample of young women. Using The Linkoping Youth Life Experiences Scale (LYLES), which assessed for a range of potentially traumatizing events, researchers found that frequency of repeated exposure to specific types of trauma, frequency of exposure to different types of adverse childhood circumstances, and number of potentially traumatic interpersonal experiences were associated with the presence of eating disorders. However, questions about the effects of polytomization remain because both studies were limited in their assessment or conceptualization of potentially traumatic events during childhood. Smyth et al. (2008) assessed childhood trauma history using only six items, asking participants to indicate whether
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