AN INVESTIGATION INTO THE RELATIONSHIP BETWEEN ADVERSE CHILDHOOD EXPERIENCES, BODY IMAGE DISSATISFACTION AND BINGE EATING AMONG YOUNG ADULTS

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submitted in partial fulfillment of the requirements for the award of the Degree of Master of Psychology (Clinical and Counselling) to MIER College of Education (Autonomous), is an authentic record of my own research work carried out under the supervision of Dr. Priya Choudhary, Assistant Professor.

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TABLE OF CONTENTS

Contents **Page No.**

Supervisor Certificate i

Declaration of the candidate ii

Acknowledgement iii

Table of Content ..... iv-vi

List of Tables viii

List of Figures ix

List of Abbreviations x

List of Appendices xi

Abstract xii

CHAPTER-I

INTRODUCTION

1.1 Adverse Childhood Experiences 1

1.1.1 Theoretical Framework: Adverse Childhood Experiences and Trauma Theory 6

1.2 Body Image Dissatisfaction 6

1.2.1 Theoretical Framework: Development of Body Image Dissatisfaction – Objectification and Schema Theories 11

1.3 Binge Eating 12

1.3.1 Theoretical Framework: Binge Eating Behaviour – Emotion Regulation and Cognitive–Behavioural Models 14

1.4 Statement of the Problem 14

1.5 Need and Significance of the Study 14

1.6 Operational Definitions.....15

1.7 Objectives of the Study.....16

1.8 Hypotheses of the Study.....16

1.9 Delimitations of the Study.....17

CHAPTER-II

REVIEW OF LITERATURE

2.1 Introduction.....18

2.2 Review of Related Studies.....18

2.3 Research Gap.....28

CHAPTER-III

RESEARCH METHOD

3.1 Introduction.....30

3.2 Research Design.....30

3.2.1 Variables of the Study.....31

3.2.2 Population and Sample.....31

3.2.3 Inclusion/Exclusion Criteria.....31

3.3 Research Tools and Their Description.....31

3.4 Statistical Analysis Techniques.....32

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF DATA

4.1 Introduction.....33

4.2 Results and Findings.....33

4.2.1 Objective 1 – To Explore the Relationship Between Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating Behaviour.....34

4.2.2 Objective 2 – To Assess the Effect of Adverse Childhood Experiences on Body Image Dissatisfaction.....36

4.2.3 Objective 3 – To Examine the Effect of Binge Eating Behaviour on Body Image Dissatisfaction.....338

CHAPTER-V

FINDINGS, CONCLUSION, FUTURE IMPLICATIONS AND SUGGESTIONS

5.1 Introduction.....40

5.2 Major Findings of the Study.....40

5.3 Conclusion and Discussion.....43

5.4 Implications for Future Research.....45

5.5 Suggestion for Future Research.....46

5.6 Conclusion.....47

SUMMARY.....**49-56**

REFERENCES.....**57-63**

APPENDIX.....**64-68**

Appendix – I: Adverse Childhood Experience Questionnaire (ACE-Q).....64

Appendix – II: Body Dissatisfaction Scale.....65

Appendix – III: Binge Eating Scale (BES).....67

LIST OF TABLES

Table No. & Title	Page No.
Table 4.1 Descriptive Statistics for Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating	33
Table 4.2 Pearson Correlations Among Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating	34
Table 4.3(A) Summary Simple Linear Regression of Body Image Dissatisfaction on Adverse Childhood Experiences	36
Table 4.3(B) Regression Coefficients for Adverse Childhood Experiences Predicting Body Image Dissatisfaction	37
Table 4.4(A) Model Summary for Simple Linear Regression of Body Image Dissatisfaction on Binge Eating	38
Table 4.4(B) Regression Coefficients for Binge Eating Predicting Body Image Dissatisfaction	39

LIST OF FIGURES

Figure No. & Title	Page No.
Figure 1.1 Biological Impacts of Childhood Chronic Stress	3
Figure 1.2 Understanding Body Image Disturbance	7
Figure 1.3 Understanding Binge Eating	12
Figure 4.1 Demographics of Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating	34
Figure 4.2 Relationship Between Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating Among Young Adults	35
Figure 4.3 Scatterplot with Regression Line for the Association Between Adverse Childhood Experiences and Body Image Dissatisfaction	37

LIST OF ABBREVIATIONS

Abbreviation	Full Form
ACEs	Adverse Childhood Experiences
ACE-Q	Adverse Childhood Experiences Questionnaire
BED	Binge Eating Disorder
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
PROCESS	PROCESS Macro (Hayes's Mediation/Moderation Tool for SPSS)
SPSS	Statistical Package for the Social Sciences

LIST OF APPENDICES

Appendix I Adverse Childhood Experience Questionnaire (ACE-Q)

Appendix II Body Dissatisfaction Scale

Appendix III Binge Eating Scale (BES)

ABSTRACT

Adverse childhood experiences (ACEs) have been widely recognised as early life stressors that can shape an individual's psychological development and well-being. The present study aimed to explore how these early experiences are linked to body image dissatisfaction and binge eating behaviour among young adults, with a particular focus on understanding the underlying psychological pathway connecting these variables. Grounded in trauma-informed and cognitive-behavioural perspectives, the study proposed that negative perceptions about one's body may act as a key mechanism through which early adversity influences maladaptive eating patterns.

A cross-sectional correlational research design was employed, and data were collected from 200 college-going young adults in Jammu district using standardized self-report measures, including the Adverse Childhood Experiences Questionnaire (ACE-Q), Body Dissatisfaction Scale, and Binge Eating Scale (BES). Statistical analyses, including Pearson's correlation and regression analysis, were conducted using SPSS.

The findings revealed significant positive relationships among all three variables. Higher levels of adverse childhood experiences were associated with greater body image dissatisfaction and increased binge eating behaviour. Additionally, body image dissatisfaction was found to significantly predict binge eating, suggesting its role as a proximal psychological factor. Regression analyses further indicated that ACEs significantly predicted body image dissatisfaction, while binge eating also emerged as a significant predictor of body image concerns.

Overall, the results support a developmental pathway in which early adverse experiences contribute to negative self-perceptions, particularly related to the body, which in turn increase vulnerability to maladaptive coping strategies such as binge eating. These findings highlight the importance of addressing both early trauma and body image concerns in interventions aimed at reducing disordered eating behaviours.

The study contributes to the growing body of trauma-informed research within the Indian context and underscores the need for early identification, prevention strategies, and therapeutic approaches that focus on self-concept, emotional regulation, and body acceptance among young adults.

CHAPTER-I

INTRODUCTION

1.1 ADVERSE CHILDHOOD EXPERIENCES

Adverse Childhood Experiences (ACEs) represent a critical area of inquiry in contemporary psychological and medical research, fundamentally altering our understanding of how early life trauma shapes lifelong health trajectories. The systematic investigation of adverse childhood experiences emerged from the groundbreaking CDC-Kaiser Permanente Adverse Childhood Experiences Study conducted in the mid-1990s, which revolutionized the field by establishing empirical connections between childhood adversity and adult health outcomes (Felitti et al., 1998). This seminal research introduced a standardized framework for measuring childhood trauma that has since become one of the most widely utilized assessment tools in public health, clinical psychology, and preventive medicine.

The adverse childhood experiences framework encompasses a broad spectrum of potentially traumatic experiences occurring before the age of 18, systematically categorized into three primary domains: abuse (emotional, physical, and sexual), neglect (emotional and physical), and household dysfunction (including parental separation or divorce, domestic violence, household substance abuse, mental illness in the household, and incarceration of household members). This categorization reflects not only the direct harms inflicted upon children but also the environmental conditions that compromise healthy development. Each category was carefully selected based on substantial prior research demonstrating significant negative health or social implications, and for which considerable efforts were already underway in public and private sectors to reduce their occurrence (Felitti et al., 1998).

The conceptual architecture of the adverse childhood experiences framework rests on the understanding that these experiences are not merely isolated incidents but rather represent chronic stressors that fundamentally alter developmental trajectories. Unlike discrete traumatic events, many adverse childhood experiences involve ongoing exposure to adverse conditions living with a parent who struggles with addiction, witnessing repeated domestic violence, or experiencing persistent emotional neglect.

This chronic nature distinguishes adverse childhood experiences from other forms of trauma and helps explain their profound and enduring impact on physical and mental health across the lifespan (Anda et al., 2006).

What makes the adverse childhood experiences framework particularly powerful is its cumulative nature. Research consistently demonstrates a dose-response relationship between the number of adverse childhood experiences experienced and the severity of negative outcomes in adulthood. Individuals with higher ACE scores indicating exposure to multiple types of adversity face exponentially greater risks for numerous health problems, including depression, substance use disorders, chronic diseases such as heart disease and diabetes, and significantly increased premature mortality (Anda et al., 2006; Bethell et al., 2014). This cumulative effect suggests that childhood adversities do not simply add to one another but interact in complex ways to compound developmental disruption.

Understanding why adverse childhood experiences exert such profound and lasting effects requires examining the neurobiological and psychological mechanisms through which early adversity becomes biologically embedded. When children experience chronic stress without adequate buffering from supportive caregivers, their developing stress response systems undergo fundamental alterations. This phenomenon, termed "toxic stress," represents a pathological adaptation to overwhelming adversity (Danese & McEwen, 2012). Unlike normative stress responses that activate temporarily and then return to baseline, toxic stress involves prolonged activation of the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system, leading to wear and tear on multiple biological systems.

Physiological and biomolecular studies have increasingly established the precise mechanisms through which childhood exposure to chronic stress leads to changes in the development of nervous, endocrine, and immune systems. The developing brain is particularly vulnerable to the effects of toxic stress during sensitive periods of growth. Chronic cortisol exposure can impair the development of the prefrontal cortex the region responsible for executive functions, emotional regulation, and decision-making while simultaneously enhancing the reactivity of the amygdala, the brain's fear and threat detection center (Danese & McEwen, 2012). This neurological reconfiguration

creates a lasting vulnerability to anxiety, depression, and difficulties with impulse control and emotional regulation.

Beyond the central nervous system, adverse childhood experiences influence the development of the body's stress response systems more broadly. The concept of allostatic load the cumulative physiological toll of chronic stress provides a framework for understanding how early adversity translates into physical disease decades later (Danese & McEwen, 2012). Allostatic load encompasses dysregulation across multiple systems: elevated inflammatory markers, altered immune function, metabolic disturbances, and cardiovascular changes. Children exposed to adverse childhood experiences show evidence of increased allostatic load even in childhood, and this burden tends to accumulate across the lifespan, ultimately manifesting as chronic diseases in adulthood.

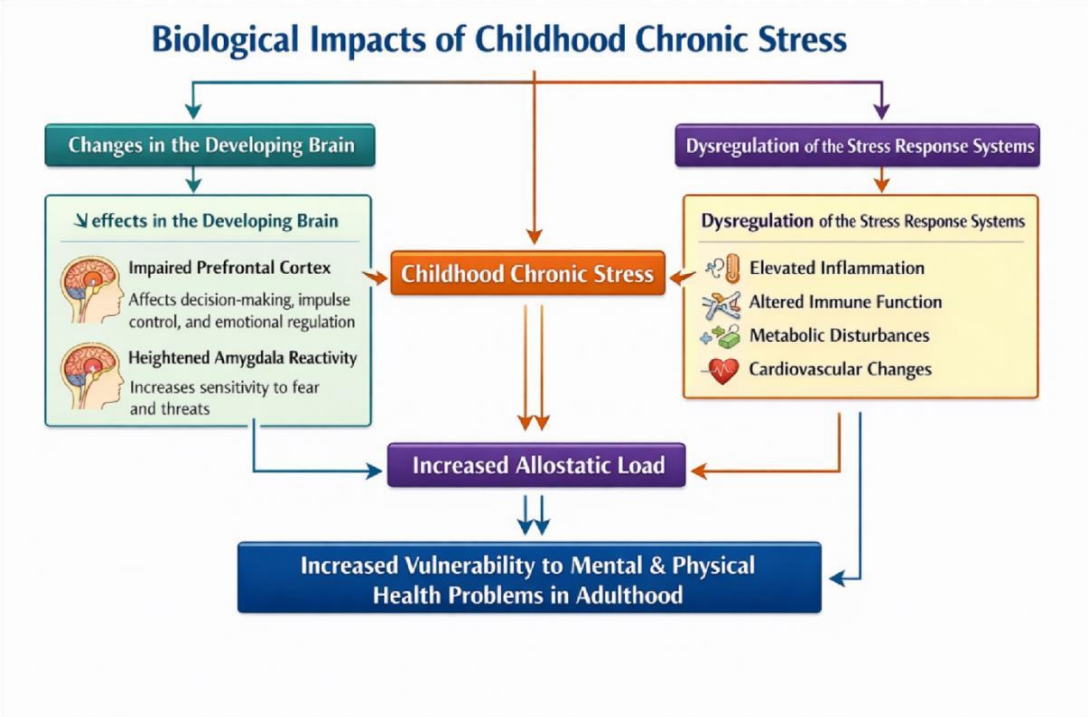


Figure-1.1 *Biological Impacts of Childhood Chronic Stress*

The psychological consequences of adverse childhood experiences are equally profound and multifaceted. Early adversity disrupts the development of core psychological capacities essential for healthy functioning. Secure attachment the foundation for healthy relationships and emotional regulation is frequently compromised when caregivers are unavailable, unpredictable, or frightening. Children

who experience abuse or neglect often develop insecure or disorganized attachment patterns, which predispose them to difficulties in forming trusting relationships, managing emotions, and developing a coherent sense of self (Anda et al., 2006).

Adverse Childhood Experiences also interfere with the development of adaptive emotion regulation strategies. Children learn to manage their emotions primarily through co-regulation with caregivers who provide comfort, modeling, and guidance. When caregivers are absent, inconsistent, or themselves a source of distress, children must develop alternative strategies for managing overwhelming emotions. These strategies which may include dissociation, emotional numbing, hypervigilance, or behavioral acting out represent adaptive responses to adverse environments but become maladaptive when carried into different contexts. Many individuals with adverse childhood experiences histories struggle throughout their lives with emotion regulation difficulties, contributing to increased risk for anxiety disorders, depression, substance abuse, and behavioral problems (Burke Harris, 2018).

The impact of adverse childhood experiences on self-concept and identity formation represents another critical psychological mechanism. Children develop their sense of self largely through the reflected appraisals of significant others, particularly caregivers. When children are abused, neglected, or exposed to chaotic home environments, they often internalize messages of worthlessness, unlovability, or dangerousness. These negative self-beliefs become deeply ingrained cognitive schemas that shape how individuals perceive themselves, interpret others' behaviors, and navigate social situations throughout their lives (Majid et al., 2023).

The public health significance of adverse childhood experiences cannot be overstated. Epidemiological research reveals that childhood adversity is disturbingly common, affecting a substantial proportion of the population across diverse geographical, cultural, and socioeconomic contexts. The original adverse childhood experiences Study found that approximately two-thirds of participants reported experiencing at least one category of adverse childhood experiences, while more than one in five reported three or more adverse childhood experiences (Felitti et al., 1998). Subsequent research in various populations has confirmed that adverse childhood experiences are not isolated occurrences affecting only the most vulnerable children but rather represent a widespread public health concern touching families across all demographic groups.

The social and economic costs associated with adverse childhood experiences are staggering. Individuals with high adverse childhood experiences scores experience greater utilization of healthcare services throughout their lives, higher rates of disability and unemployment, increased involvement with criminal justice systems, and shortened life expectancy (Anda et al., 2006). When these individual-level impacts are aggregated across populations, the societal burden becomes enormous—estimated in the billions of dollars annually in healthcare costs, lost productivity, and social services expenditures. This economic analysis underscores that adverse childhood experiences are not merely individual tragedies but collective challenges requiring comprehensive public health responses.

The intergenerational transmission of adverse childhood experiences represents a particularly concerning aspect of their public health impact. Parents who experienced childhood adversity face increased risks of mental health problems, substance abuse, and difficulties with parenting, which in turn elevate the risk that their own children will experience adverse childhood experiences (Brown et al., 2020). This intergenerational cycle can perpetuate patterns of adversity across multiple generations unless interrupted through effective interventions. Breaking these cycles requires not only treating the consequences of adverse childhood experiences in affected individuals but also preventing the transmission of trauma to subsequent generations through family-focused interventions and community-level supports.

Recognition of adverse childhood experiences profound impact has catalyzed significant efforts toward prevention and early intervention. The adverse childhood experiences framework has been adopted by healthcare systems, schools, social service agencies, and policymakers as a tool for identifying at-risk individuals and targeting resources effectively. Trauma-informed care approachesm which recognize the prevalence and impact of trauma and seek to avoid retraumatization while promoting healing—have proliferated across service sectors (Center for Youth Wellness, 2019). These approaches represent a paradigm shift from asking "What's wrong with you?" to "What happened to you?"—a subtle but profound reframing that acknowledges the role of life experiences in shaping behavior and functioning.

1.1.1 Theoretical framework: Adverse Childhood Experiences and Trauma Theory

The foundation of the present framework lies in Trauma Theory, which posits that early exposure to abuse, neglect, and household dysfunction disrupts normative psychological and neurobiological development. The seminal ACE framework proposed by Felitti et al. conceptualizes childhood adversity as cumulative stressors that exert long-lasting effects on mental and physical health . According to this model, repeated or chronic exposure to stress during sensitive developmental periods leads to toxic stress, resulting in dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis and impaired emotional regulation capacities.

Developmental trauma theorists argue that children exposed to ACEs often experience disruptions in attachment security, self-worth, and emotional processing, which persist into adulthood. These disruptions contribute to heightened vulnerability to maladaptive coping strategies, including disordered eating behaviours (Anda et al., 2006; Danese & McEwen, 2012). Thus, ACEs are conceptualized in the present study as a distal risk factor that sets the stage for later psychological difficulties.

1.2 BODY IMAGE DISSATISFACTION

Body image dissatisfaction (BID) represents a complex psychological phenomenon involving negative thoughts, feelings, and perceptions about one's physical appearance. Far from being a superficial concern, body image dissatisfaction reflects fundamental aspects of how individuals perceive themselves and their place in the world. The construct of body image is inherently multidimensional, encompassing perceptual, cognitive, affective, and behavioral components that interact in complex ways (Thompson et al., 1999; Cash, 2004).

The perceptual component involves how individuals literally see their bodies—the mental representation of body size, shape, and appearance. This is not merely an objective assessment but rather a subjective perception that can be systematically distorted. Individuals with body image disturbance often misperceive their body size, seeing themselves as larger or differently proportioned than they objectively are. This perceptual distortion appears to involve alterations in body schema—the neural

representation of the body maintained by the brain—rather than simple errors in visual processing (Vocks et al., 2018).

The cognitive-affective component encompasses the thoughts, beliefs, attitudes, and emotions individuals hold about their bodies. This includes evaluative judgments (e.g., "My body is unattractive"), importance placed on appearance (e.g., "My worth depends on how I look"), and emotional reactions to one's body (e.g., disgust, shame, anxiety). These cognitive and emotional responses are often more distressing and functionally impairing than perceptual distortions themselves. Individuals may experience intense negative emotions when viewing their bodies, trying on clothing, or being in situations where their appearance is visible to others (TuschenCaffier, 2015).

The behavioral component involves body-related actions, which can be broadly categorized into body checking and body avoidance behaviors. Body checking includes repetitive behaviors aimed at evaluating appearance, such as frequent weighing, mirror checking, comparing one's body to others, or seeking reassurance about appearance. While these behaviors are intended to reduce uncertainty and anxiety, they typically maintain or exacerbate body dissatisfaction by directing attention repeatedly to perceived flaws. Body avoidance, conversely, involves efforts to avoid confronting one's appearance through behaviors such as avoiding mirrors, wearing baggy clothing, or withdrawing from social situations where the body is visible. Both patterns of behavior interfere with normal functioning and maintain distorted body perceptions (Cash, 2004).

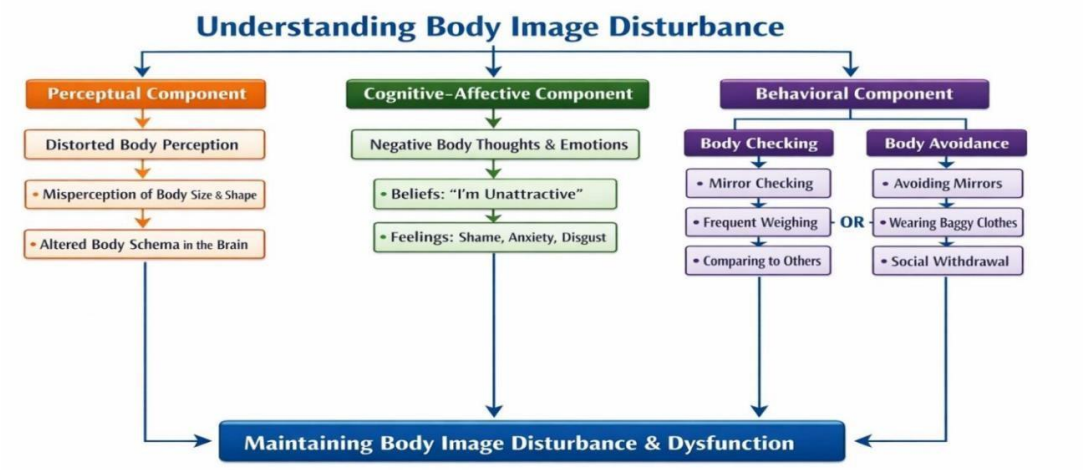


Figure-1.2 *Understanding Body Image Disturbance*

Body image is not formed in isolation but rather develops through complex interactions between individual factors (genetics, personality, developmental experiences) and sociocultural influences (media exposure, peer relationships, family attitudes, cultural beauty ideals). From early childhood, individuals receive messages about the importance of appearance and the standards against which bodies are judged. These messages come from multiple sources: media representations that predominantly feature idealized and often digitally altered bodies, comments from family members and peers about appearance and weight, and broader cultural narratives linking appearance to moral worth, success, and social acceptance (Bordo, 2023).

The sociocultural context of body image has evolved dramatically throughout history, reflecting changing values, economic conditions, and social structures. In ancient civilizations, body ideals emphasized fertility, strength, and health. The ancient Greeks celebrated athletic, muscular male bodies as symbols of discipline and civic virtue, while fuller female forms represented fertility and abundance. During the Renaissance, prosperity was reflected in rounder, more voluptuous bodies depicted in art, with corpulence signifying wealth and high social status (Burychka et al., 2021).

The 20th century witnessed a dramatic shift in Western body ideals, particularly for women, as thinness became increasingly valued. This transformation accelerated in the post-World War II era with the rise of mass media, fashion industries, and consumer culture. By the 1960s and 1970s, extremely thin bodies—epitomized by models like Twiggy—became the feminine ideal, a standard that has persisted and intensified through the present day despite brief periods celebrating more diverse body types. This cultural emphasis on thinness has been linked to dramatic increases in eating disorders, body dissatisfaction, and weight-control behaviors across Western societies (Bordo, 2023).

Contemporary body image concerns reflect the influence of digital media and social networking platforms, which expose individuals to unprecedented volumes of appearance focused content. Social media creates new pressures through constant comparison with carefully curated images, the proliferation of appearance-focused feedback (likes, comments), and exposure to idealized and often digitally manipulated representations of bodies. Research consistently demonstrates associations between social media use and body dissatisfaction, particularly among adolescents and young

adults who are both heavy users of these platforms and in developmental stages marked by heightened appearance concerns (Burychka et al., 2021).

Recent years have witnessed the emergence of body positivity and body acceptance movements challenging narrow beauty standards and promoting appreciation for diverse body types. These movements advocate for expanding definitions of beauty, reducing weight stigma, and cultivating body respect rather than requiring body love. While these efforts have increased visibility of diverse bodies and sparked important conversations about beauty standards, research suggests that body dissatisfaction remains highly prevalent, indicating that cultural shifts occur slowly and unevenly (Burychka et al., 2021).

Body image concerns manifest differently across gender and developmental stages, reflecting the intersection of biological changes, social experiences, and cultural expectations. While body dissatisfaction was historically conceptualized primarily as a female concern, contemporary research recognizes that body image disturbance affects individuals across the gender spectrum, albeit with different patterns and foci.

For girls and women, body dissatisfaction typically centers on weight and body size, with pressure toward thinness beginning in childhood and intensifying during adolescence. Puberty represents a particularly vulnerable period, as the normative increases in body fat associated with female sexual maturation move girls' bodies away from cultural ideals emphasizing thinness. Research consistently documents sharp increases in body dissatisfaction during early adolescence among girls, with many internalizing thin-ideal beliefs and engaging in weight control behaviors by middle school (Ricciardelli et al., 2010).

Boys and men also experience body dissatisfaction, though often manifesting differently than in females. While some males desire to be thinner, many express dissatisfaction with muscularity and wish to be larger and more muscular. This drive for muscularity reflects masculine ideals emphasizing strength, power, and physical dominance. Contemporary media increasingly present idealized male bodies that are simultaneously lean and muscular—a physique difficult to achieve without intensive exercise and, in some cases, performance enhancing substances. Research indicates increasing rates of body dissatisfaction and muscle oriented disordered eating among males across recent decades (Ricciardelli et al., 2010).

Gender-diverse individuals face unique body image challenges related to gender dysphoria— distress arising from incongruence between one's gender identity and assigned sex—as well as societal pressures and discrimination. For many transgender and nonbinary individuals, body dissatisfaction relates specifically to physical characteristics perceived as incongruent with gender identity. Additionally, these individuals often face stigma, discrimination, and pressure to conform to binary gender presentations, all of which can exacerbate body image concerns.

The relationship between childhood adversity and body image disturbance has been increasingly recognized in recent years, though the mechanisms underlying this connection remain an active area of investigation. Several theoretical frameworks help explain how early trauma may contribute to the development of body dissatisfaction.

From a developmental perspective, adverse childhood experiences disrupt the normal formation of self-concept, of which body image is a central component. Children develop their sense of self including how they perceive and feel about their bodies largely through interactions with caregivers and other significant figures. When these interactions are characterized by abuse, neglect, or emotional unavailability, children may develop distorted or negative selfperceptions. Sexual abuse, in particular, has been consistently linked to body image disturbance, potentially because it involves violation of physical boundaries and may lead survivors to develop feelings of disgust, shame, or disconnection from their bodies (Anderson et al., 2023).

Objectification theory provides another lens for understanding the trauma-body image connection. This framework suggests that experiencing objectification being treated as a body valued primarily for its use or appearance leads individuals to internalize an observer's perspective on their own bodies, a process termed self-objectification. Sexual abuse and other forms of trauma can induce self-objectification by positioning the individual's body as an object for others' use. This objectified relationship with one's own body manifests as body surveillance (chronic monitoring of appearance), body shame, and difficulty recognizing internal bodily sensations all of which contribute to eating disorder risk (Smith et al., 2023).

Emotion regulation theories posit that body-focused concerns and behaviors may serve emotion regulation functions for trauma survivors. Individuals who experienced childhood adversity often lack adaptive emotion regulation skills and may turn to

maladaptive strategies including intense focus on appearance and weight-control behaviors—as means of managing overwhelming emotions. The sense of control achieved through regulating eating or appearance may provide relief from feelings of powerlessness stemming from trauma experiences. However, these strategies ultimately maintain psychological distress and interfere with developing more adaptive coping mechanisms (Miller et al., 2022).

Schema theory suggests that adverse childhood experiences contribute to the formation of negative core beliefs about the self, others, and the world. These schemas—deeply held beliefs such as "I am worthless," "My body is disgusting," or "I am unlovable"—develop in response to adverse experiences and subsequently filter how individuals interpret experiences and perceive themselves. Body dissatisfaction may represent one manifestation of these broader negative self-schemas. Furthermore, body-focused concerns may serve as a concrete, tangible focus for diffuse feelings of inadequacy or self-loathing stemming from trauma (Brown et al., 2020).

1.2.1 Theoretical framework: Development of Body Image Dissatisfaction: Objectification and

Schema Theories

Body Image Dissatisfaction is understood within this framework as a maladaptive outcome of disrupted self-concept formation following childhood adversity. Schema theory suggests that adverse interpersonal experiences contribute to the development of negative core beliefs about the self, including perceptions of worthlessness, shame, and defectiveness. These schemas often become embodied, manifesting as dissatisfaction with one's physical appearance (Brown et al., 2020).

Additionally, Objectification Theory provides a critical lens for understanding how trauma— particularly emotional and sexual abuse—can lead individuals to internalize an observer's perspective of their body. This process of self-objectification results in chronic body surveillance, body shame, and appearance-based self-worth (Cash, 2004). Empirical evidence consistently shows that individuals with higher ACE exposure report significantly greater body dissatisfaction, even after controlling for body mass index and demographic variables (Bödicker et al., 2022). Within the present framework, body image dissatisfaction is conceptualized as a proximal psychological

consequence of early adversity and a key mechanism linking trauma to eating pathology.

1.3 BINGE EATING

Binge eating represents a pattern of disordered eating characterized by episodes of consuming objectively large amounts of food accompanied by a sense of loss of control. The phenomenology of binge eating extends beyond simply overeating to encompass specific cognitive, emotional, and behavioral features that distinguish it from normative eating patterns. Understanding binge eating requires attention to both its behavioral manifestations and its subjective psychological experience (Felitti et al., 1998).

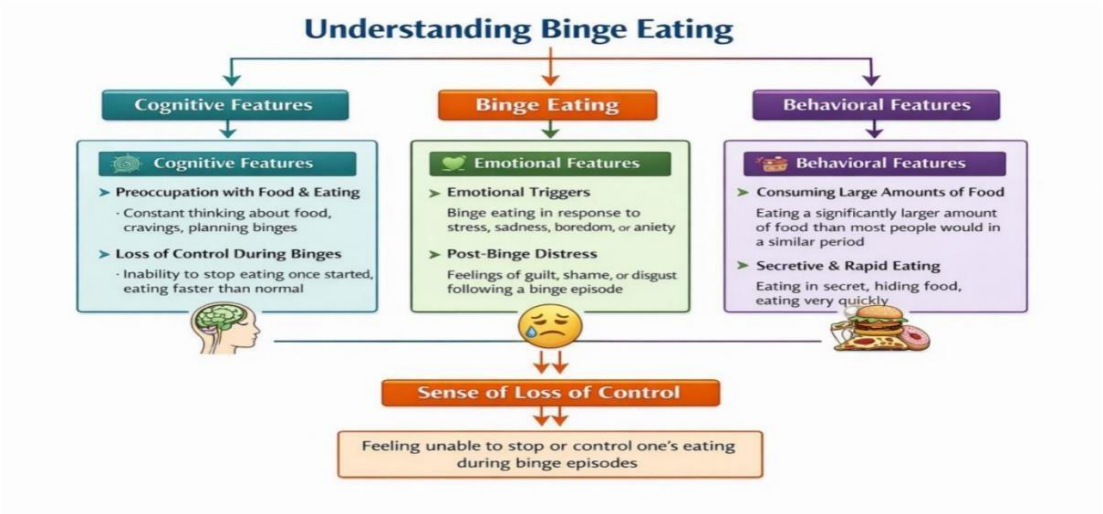


Figure-1.3 *Understanding Binge Eating*

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines a binge eating episode as consuming, within a discrete period (typically two hours or less), an amount of food that is definitively larger than what most individuals would consume under similar circumstances, while experiencing a sense of lack of control over eating during the episode. This loss of control—the feeling that one cannot stop eating or control what or how much one eats—represents the core subjective feature distinguishing binge eating from simple overeating. Individuals describe feeling driven to continue eating despite physical discomfort, feeling disconnected or in a trance-like state during binges, or being unable to resist urges to eat even when not physically hungry (Mitchell et al., 2007).

Binge episodes are typically associated with additional features that reflect their dysregulated nature: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts when not physically hungry, eating alone due to embarrassment about the quantity consumed, and feeling disgusted with oneself, depressed, or guilty afterward. These associated features highlight that binge eating involves not only loss of behavioral control but also significant emotional distress before, during, and after episodes (Mitchell et al., 2007).

When binge eating occurs regularly—at least once weekly for three months—without regular compensatory behaviors (such as purging, fasting, or excessive exercise), it may meet criteria for Binge Eating Disorder (BED), now recognized as a distinct eating disorder diagnosis in DSM-5. BED represents the most common eating disorder, with prevalence estimates of approximately 1-3% in the general population and substantially higher rates in weight-loss treatment-seeking populations. Unlike bulimia nervosa, which also involves binge eating, individuals with BED do not regularly engage in compensatory behaviors, leading many to experience weight gain and obesity-related health complications (NICE, 2017).

The functional aspects of binge eating—what psychological purposes it serves for individuals—are crucial for understanding its maintenance and treatment. Research identifies multiple functions that binge eating may serve: emotional regulation (numbing, soothing, or distracting from negative emotions), self-punishment (expressing self-directed anger or confirming negative self-beliefs), filling emotional emptiness, providing comfort or nurturing, or dissociating from painful awareness. For many individuals, binge eating represents a maladaptive coping strategy that provides temporary relief from psychological distress but ultimately maintains or exacerbates the underlying problems it temporarily ameliorates (Wu et al., 2014).

The neurobiological underpinnings of binge eating have been increasingly elucidated through neuroimaging and neurochemical research. Studies reveal alterations in reward processing, impulse control, and emotional regulation circuits among individuals with binge eating patterns. Specifically, research documents heightened reward sensitivity to food cues, diminished inhibitory control, and altered stress response systems—patterns that overlap substantially with those observed in substance use disorders,

leading some researchers to conceptualize binge eating within an addiction framework (Wu et al., 2014).

1.3.1 Theoretical framework: Binge Eating Behaviour

Binge eating behaviour is conceptualized as a maladaptive coping strategy that emerges from deficits in emotion regulation and self-control, which are commonly observed among individuals with histories of childhood adversity. According to emotion regulation models, binge eating serves as a temporary means of alleviating negative affect, shame, and stress through distraction or emotional numbing (Mitchell et al., 2007).

From a cognitive–behavioural perspective, binge eating is maintained by dysfunctional beliefs related to food, body image, and self-worth. Individuals with high body dissatisfaction often engage in binge eating following perceived failures to meet appearance ideals, reinforcing a cycle of guilt, shame, and loss of control (Dunkley et al., 2010). Neurobiological research further supports this framework, demonstrating altered reward sensitivity and impulse control among individuals with binge eating patterns (Wu et al., 2014).

1.4 STATEMENT OF THE PROBLEM

“An investigation into the relationship between Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating among young adults”.

1.5 NEED AND SIGNIFICANCE OF THE STUDY

The present study is important as it explores a meaningful yet often overlooked aspect of mental health among young adults—how early life experiences continue to shape self-perception and coping behaviours. It focuses on the relationship between adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating behaviour, highlighting how these factors are interconnected rather than separate. Many individuals carry the emotional impact of childhood adversity without fully understanding its long-term effects. Experiences such as abuse, neglect, or household dysfunction often influence self-esteem, emotional regulation, and coping patterns into adulthood. One way this impact appears is through negative body image, where

individuals internalize feelings of shame or inadequacy and reflect them onto their physical appearance.

Body image dissatisfaction goes beyond appearance concerns and reflects deeper psychological struggles. When individuals feel unhappy with their bodies, they may engage in maladaptive coping behaviours like binge eating to manage emotional distress. In this sense, binge eating often represents an attempt to deal with unresolved emotions rather than just food-related behaviour. The need for this study arises from the limited research examining these three variables together, especially in the Indian context. While past studies have explored childhood adversity and eating behaviours separately, fewer have focused on how body image dissatisfaction may act as a link between them. Understanding this connection provides a clearer view of how psychological distress develops. This study is significant as it integrates trauma, cognitive, and sociocultural perspectives, offering a more comprehensive understanding of these issues. Practically, it helps identify body image dissatisfaction as a modifiable factor, which can guide interventions aimed at promoting healthier coping strategies and reducing binge eating.

Additionally, the study is relevant in the Indian context, where social pressures, appearance ideals, and stigma around mental health may intensify these concerns. By addressing these factors, the study contributes to more culturally sensitive and effective approaches to mental health. Thus, this study adds to existing knowledge while also offering practical insights. By highlighting the link between early adversity, body image, and coping behaviours, it supports better understanding and intervention for young adult's mental well-being.

1.6 OPERATIONAL DEFINITIONS

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) refer to stressful or traumatic events that occur during childhood (before the age of 18), including different forms of abuse, neglect, and household dysfunction such as parental conflict, substance abuse, or loss. These experiences often shape an individual's emotional and psychological development in lasting ways. In the present study, ACEs are operationally defined as the level of childhood adversity reported by participants, as measured through their responses on

the standardized Adverse Childhood Experiences Questionnaire (ACE-Q). Higher scores indicate greater exposure to adverse experiences during childhood.

Body Image Dissatisfaction

Body image dissatisfaction refers to negative thoughts, feelings, or attitudes an individual holds about their physical appearance, including concerns about body size, shape, or overall attractiveness. It reflects the extent to which a person feels unhappy or uncomfortable with their body. In the present study, body image dissatisfaction is operationally defined as the degree of dissatisfaction participants report regarding their body, as assessed through the Body Dissatisfaction Scale used in the research.

Higher scores indicate greater dissatisfaction with one's body image.

Binge Eating Behaviour

Binge eating behaviour refers to episodes of consuming large amounts of food within a short period of time, accompanied by a sense of loss of control over eating. These episodes are often followed by feelings of guilt, shame, or distress. In the present study, binge eating behaviour is operationally defined as the severity of binge eating patterns reported by participants, as measured through the standardized Binge Eating Scale (BES). Higher scores indicate greater levels of binge eating behaviour.

1.7 OBJECTIVES OF THE STUDY

The objectives of the present study are as follows:

1. To explore the relationship between Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating behaviour.
2. To assess the effect of Adverse Childhood Experiences (ACEs) on Body Image Dissatisfaction among young adults.
3. To examine the effect of Binge Eating behaviour on Body Image Dissatisfaction.

1.8 HYPOTHESES OF THE STUDY

H1- There will be a significant positive correlation between Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating behaviour.

H2- There will be a significant effect of Adverse Childhood Experiences on Body Image Dissatisfaction.

H3- There will be a significant effect of Binge Eating behaviour on Body Image Dissatisfaction.

1.9 DELIMITATIONS OF THE STUDY

- This study was limited to young adult college students from Jammu district, which means the findings may not represent individuals from other age groups.
- The research focused only on three specific variables—Adverse Childhood Experiences (ACEs), Body Image Dissatisfaction, and Binge Eating behaviour. Other relevant factors such as self-esteem, depression, anxiety, peer influence, and social media exposure were not included.
- This study used a cross-sectional research design, where data were collected at a single point in time. As a result, the study examines relationships between variables but does not establish cause-and-effect relationships.
- Data were collected using self-report questionnaires.
- This study employed quantitative methods only, and did not include qualitative insights (such as interviews), which could have provided deeper understanding of participant's lived experiences.

CHAPTER-II

REVIEW OF LITERATURE

2.1 INTRODUCTION

The review of literature constitutes a fundamental aspect of the research process, as it provides a comprehensive understanding of existing theoretical frameworks and empirical findings related to the research variables adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating. This chapter synthesizes relevant research conducted in both Western and Indian contexts

2.2 REVIEW OF RELARED STUDIES

Lu et al. (2025) conducted a systematic investigation into the role of childhood trauma in the development of disordered eating behaviors among adolescents and young adults. Using quantitative analyses to examine trauma exposure and eating-related pathology, the study found that emotional abuse was a significant predictor of both restrictive eating and binge– purging behaviors, while physical abuse was uniquely associated with binge–purging symptomatology. The findings further demonstrated a dose–response relationship, such that greater frequency and severity of traumatic experiences corresponded with increased risk of disordered eating. Latent profile analyses identified distinct trauma patterns, revealing that individuals exposed to high and multifaceted trauma were at the greatest risk for eating-related pathology. This study provides robust evidence that childhood trauma contributes to disordered eating in a nuanced and cumulative manner, underscoring the importance of multidimensional trauma assessment in research and clinical interventions targeting eating disorders.

Abdoli et al. (2024) reviewed psychological factors associated with eating disorders in adults, emphasizing body image disturbance, emotion regulation, and self-esteem. Individuals with eating disorders consistently reported greater body dissatisfaction than non-clinical populations, closely linked to emotion regulation difficulties and lower self-esteem. Body dissatisfaction also exerted indirect effects on disordered eating through reduced self-esteem and increased depressive symptoms, with women showing heightened vulnerability across these pathways. Findings highlight the interplay of multiple psychological processes in eating pathology, supporting integrated treatment

approaches that simultaneously address body image concerns, emotion regulation deficits, and self-esteem.

Lagan et al. (2024) investigated psychological and neurobiological pathways linking ACEs to eating disorders. Higher ACE exposure was significantly associated with increased body dissatisfaction and drive for thinness in individuals with anorexia nervosa and bulimia nervosa. Low self-esteem emerged as a central mediator, accounting for a substantial proportion of the ACE–eating disorder relationship. Neurobiological analyses additionally revealed altered reward-related neural responses across multiple brain regions, indicating trauma-linked disruptions in reward processing. Findings provide robust evidence that ACEs influence eating disorders through interconnected psychological and neural mechanisms, supporting interventions that address both self-esteem deficits and neurobiological alterations associated with early adversity.

Nelson et al. (2023) examined perceived discrimination as a sociocultural risk factor for eating disorder symptomatology beyond ACE exposure. More frequent discrimination was significantly associated with elevated body dissatisfaction, increased cognitive restraint, and greater purging behaviors. Weight- and gender-based discrimination emerged as particularly salient predictors of disordered eating, even after controlling for early life adversity. Findings position perceived discrimination as a potent, independent psychosocial stressor contributing to eating disorder risk, underscoring the importance of incorporating broader sociocultural contexts alongside trauma-based frameworks in etiological models of eating disorders.

Royer et al. (2023) examined mindfulness as a mediator between ACEs and disordered eating in young adults. Greater ACE exposure was significantly associated with lower mindfulness, which in turn predicted higher disordered eating behaviors. These findings suggest childhood adversity undermines present-moment awareness and impairs emotion regulation, thereby contributing to eating-related difficulties. The study identifies mindfulness as a key psychological mechanism in the ACE–disordered eating pathway, supporting mindfulness-based interventions within trauma-informed prevention and treatment approaches for young adults with elevated ACE exposure.

Smith et al. (2023) conducted an empirical examination of the impact of adverse childhood experiences on body image dissatisfaction and maladaptive eating behaviors

among adolescents. Drawing on developmental and psychosocial frameworks, the study found that higher exposure to ACEs was significantly associated with increased body dissatisfaction, which in turn was linked to maladaptive coping strategies such as binge eating. These findings indicate that early adversity contributes to negative body image and disordered eating patterns during a critical developmental period. Importantly, the authors highlighted limitations in the existing literature, noting a lack of longitudinal designs and culturally diverse samples. By identifying these gaps, the study underscores the need for more rigorous and inclusive research to clarify the long-term pathways linking childhood adversity to body image disturbance and eating behaviors in adolescence.

Anderson et al. (2023) conducted a comprehensive investigation into the mechanisms through which adverse childhood experiences contribute to the development of eating disorders, focusing on both psychological and neurobiological pathways. The study assessed ACE exposure alongside measures of self-esteem and neural responses to salient stimuli, revealing that higher levels of childhood adversity were associated with lower self-esteem and altered brain activity in response to reward- and threat-related cues. These psychological and neurobiological alterations, in turn, predicted greater eating-disorder symptomatology. By demonstrating that ACEs exert effects through interconnected self-concept and neural mechanisms, the study underscores the importance of routinely assessing childhood adversity in both clinical and biological evaluations. Moreover, the findings highlight interventions targeting self-esteem as a promising avenue for reducing eating-disorder risk among individuals with trauma histories.

Williams et al. (2023) conducted an empirical investigation into the impact of adverse childhood experiences on the development of binge-eating disorder in adolescents. Using standardized measures of ACE exposure and eating-disorder symptoms, the study found that higher levels of childhood adversity were significantly associated with an increased risk of binge-eating behaviors. These findings indicate that early trauma constitutes a robust predictor of disordered eating during adolescence, highlighting critical developmental vulnerabilities. The authors emphasized the importance of early screening for ACEs and the implementation of trauma-focused interventions as preventative measures. This work reinforces the necessity of integrating trauma history

into clinical assessments and intervention strategies aimed at reducing the onset of binge-eating disorder among youth.

Brown et al. (2023) identified perceived discrimination as a powerful and independent contributor to eating-disorder symptoms, exceeding the predictive influence of adverse childhood experiences. Discrimination functions as a chronic social stressor that reinforces body surveillance, shame, and feelings of marginalization. Unlike early adversity, which may be temporally distant, discrimination represents an ongoing threat to identity and belonging.

This role closely mirrors the stigmatizing marriage norms in Akram et al. (2024), where persistent social judgment fosters psychological distress through internalized devaluation.

Kovács-Tóth et al. (2022) conducted an empirical investigation to examine the association between adverse childhood experiences and the risk of eating disorders among adolescents. These results suggest that adverse childhood experiences influence eating disorder risk through multiple developmental and psychological pathways. The study underscores the importance of routine screening for childhood adversity and supports the integration of trauma informed approaches in the early identification and prevention of eating disorders during adolescence.

Ghaffari et al. (2022) examined the association between ACEs and disordered eating in early and middle adolescents. A dose–response relationship was found, with even moderate ACE exposure significantly predicting behaviors such as fasting, reduced food interest, and binge eating. Multiple adversity categories—including parental separation, household incarceration, exposure to violence, and household mental illness or substance use—independently elevated risk. Findings suggest childhood adversity contributes to disordered eating through multiple developmental pathways, supporting comprehensive ACE screening and trauma-informed assessment in adolescent eating disorder evaluation.

Chu et al. (2022) conducted a population-based investigation to examine the relationship between adverse childhood experiences and the development of binge-eating disorder in early adolescence. Using standardized assessments of childhood adversity and binge-eating pathology, the study evaluated the cumulative impact of

multiple ACEs on the likelihood of BED onset. The findings demonstrated a clear dose–response relationship, whereby increasing numbers of adverse childhood experiences were associated with progressively higher odds of developing binge-eating disorder. Notably, household-level adversities—including exposure to mental illness, domestic violence, and criminal involvement within the family—emerged as the strongest predictors of BED risk. These results suggest that childhood adversity contributes to binge-eating vulnerability through multiple environmental and psychological pathways. The study highlights the importance of routine screening for ACEs and supports the implementation of trauma-focused prevention and early intervention strategies for adolescents at risk of bingeeating disorder.

Rienecke et al. (2022) examined ACE prevalence and patterns among adults seeking eating disorder treatment. ACEs were significantly more prevalent in the clinical sample than in the general population, with distinct ACE profiles varying across diagnoses. Individuals with OSFED showed stronger links to household-related adversities, while those with binge eating disorder were more associated with abuse-related ACEs. These findings indicate that childhood adversity contributes to eating disorders in diagnosis-specific ways, highlighting the importance of assessing both severity and qualitative ACE patterns to inform individualized, trauma-informed treatment.

Rosenberg et al. (2022) examined identification with the aggressor as a mediator between childhood abuse and eating disorder symptoms in adulthood. Greater abuse severity was associated with increased shape and weight concerns, body dissatisfaction, and binge eating behaviors. Higher abuse levels also predicted stronger tendencies to internalize the perpetrator's attitudes and aggression. Mediation analyses confirmed that identification with the aggressor significantly accounted for the abuse–eating disorder relationship. Findings highlight complex intrapsychic processes linking childhood adversity to eating pathology, supporting trauma-informed interventions that directly address identification with the aggressor in therapeutic contexts.

Bödicker et al. (2022) conducted a meta-analysis examining childhood maltreatment as a distal risk factor for adult body image disturbance. Results revealed a small but significant association between early maltreatment and negative body-related thoughts and emotions, with stronger effects observed among individuals with PTSD. Subtype

differences were not evident in non-clinical samples, yet the overall pattern indicated lasting effects of early adversity on body perception and evaluation. The meta-analysis provides robust support for the long-term impact of childhood maltreatment on body image, underscoring the need for trauma-informed interventions targeting body image disturbance in adulthood.

Yan et al. (2022) examined mechanisms linking body dissatisfaction to binge eating in young adults, testing a mediation-moderation model. Perceived stress significantly mediated the body dissatisfaction–binge eating relationship, suggesting negative body evaluations elevate binge eating vulnerability by increasing psychological strain. Self-acceptance and cognitive reappraisal weakened this stress-mediated pathway, while expressive suppression offered no protective effect. Findings indicate binge eating vulnerability involves an interaction of maladaptive and adaptive psychological processes, supporting interventions that address body dissatisfaction, reduce stress, and promote adaptive emotion regulation skills in young adult populations.

Johnson et al. (2022) conducted an empirical investigation into the role of adverse childhood experiences in the development of body image disturbance and maladaptive exercise behaviors. Using measures assessing multiple dimensions of body dissatisfaction and exercise-related coping strategies, the study found that higher exposure to ACEs significantly predicted various forms of body dissatisfaction, which were in turn associated with unhealthy exercise behaviors. These findings indicate that childhood adversity contributes not only to negative body image but also to maladaptive behavioral responses aimed at regulating distress. By demonstrating that ACEs are a salient risk factor across distinct dimensions of body image disturbance, this study reinforces the importance of incorporating early adversity into models of body image pathology and highlights maladaptive exercise as a key outcome of trauma-related coping processes.

Miller et al. (2022) conducted an empirical investigation into the psychological mechanisms linking adverse childhood experiences to disordered eating behaviors among adolescents. Using validated measures of ACE exposure, emotion regulation difficulties, self-compassion, body image dissatisfaction, and eating-related pathology, the study found that impairments in emotion regulation, low levels of self-compassion, and heightened body image dissatisfaction functioned as key mediating factors between

childhood adversity and disordered eating. These mediators accounted for a substantial proportion of the association between ACEs and maladaptive eating behaviors, highlighting their central role in trauma-related risk pathways. By identifying modifiable emotional and self-related processes, this study provides a mechanistic framework that supports the integration of emotion regulation and self-compassion–based strategies into trauma-informed interventions aimed at reducing eating disorder risk among adolescents with histories of early adversity.

O'Loghlen (2022) highlighted shame as a central psychological mechanism through which adverse childhood experiences translate into binge-eating symptoms. The findings demonstrated that individuals with higher exposure to early adversity reported elevated levels of shame, which in turn significantly predicted binge-eating behaviors. In this model, shame functions as an internalized emotional response to early maltreatment, fostering negative self evaluation and emotional distress. Binge eating emerges as a maladaptive strategy to regulate or escape these shame-laden emotional states. Similar to self-silencing in Akram et al. (2024), shame represents an inward-directed coping response that mediates the impact of external harm on psychological and behavioral outcomes.

Túry et al. (2022) focused on childhood maltreatment as a risk-amplifying factor in the development of eating disorders among adolescents. The study demonstrated that higher exposure to abuse and neglect significantly increased the likelihood of disordered eating behaviors. Maltreatment operates by undermining emotional security, body trust, and self worth during critical developmental periods. This role is comparable to how social devaluation in Akram et al. (2024) fosters internal vulnerability, with early trauma laying the psychological groundwork upon which later eating pathology develops.

Cuzzocrea et al. (2022) identified maladaptive coping strategies as a key mediator between body image dissatisfaction and binge-eating behaviors in adolescents. The findings showed that appearance-related distress led to disordered eating primarily when adolescents relied on avoidance-based or emotion-focused coping styles. Coping mechanisms thus determine whether body dissatisfaction translates into pathology. This mediating role closely aligns with self-silencing in Akram et al. (2024), as both

involve suppression or mismanagement of emotional distress in response to social pressure.

Monteleone et al. (2021) examined psychological pathways linking childhood maltreatment to eating disorder psychopathology in individuals with bulimia nervosa and binge eating disorder. Emotional abuse emerged as a central connecting factor across both diagnoses. However, distinct mediating pathways were identified: feelings of ineffectiveness were primary in bulimia nervosa, while impulsivity was more prominent in binge eating disorder. Deficits in interoceptive awareness served as a shared pathway across both diagnoses, reflecting broader emotion regulation difficulties. Findings highlight that childhood adversity influences eating pathology through both shared and diagnosis-specific mechanisms, supporting trauma-informed interventions targeting emotional abuse and regulatory deficits.

Brown et al. (2020) conducted an empirical examination of the role of adverse childhood experiences in the onset and maintenance of eating disorders. Drawing on clinical and developmental evidence, the study demonstrated that exposure to multiple forms of childhood abuse was significantly associated with increased vulnerability to eating-disorder pathology across the lifespan. The authors emphasized that early traumatic experiences contribute not only to the emergence of disordered eating behaviors but also to their persistence over time. By highlighting the cumulative impact of diverse forms of childhood abuse, this study reinforces the importance of comprehensive trauma assessment in clinical settings. These findings support the inclusion of adverse childhood experiences as a core consideration in etiological models of eating disorders and underscore their relevance for early intervention and prevention efforts among trauma-exposed populations.

Imperatori et al. (2020) emphasized the role of cumulative adverse life experiences as a foundational vulnerability for both obesity and binge-eating disorder. Rather than identifying a single mediator, the study positioned trauma exposure as a broad etiological factor that disrupts emotional regulation, stress responsivity, and self-care behaviors. Life adversity increases susceptibility to eating-related pathology by shaping long-term psychological and physiological stress responses. This role parallels the stigmatizing social environment described by Akram et al. (2024), in which

persistent external stressors create conditions that erode psychological resilience and promote maladaptive outcomes.

Lins et al. (2020) highlighted gender as a moderating factor in the relationship between body image dissatisfaction and binge-eating behaviors. While body image concerns were associated with binge eating across participants, female students exhibited significantly greater vulnerability. Gender functions here as a sociocultural lens through which appearance pressures are internalized more intensely. This role parallels the gender-specific stigma examined by Akram et al. (2024), underscoring how socially constructed expectations heighten psychological risk for women.

Lewer et al. (2017) conducted a comprehensive review of body image disturbance in individuals with binge eating disorder, examining its cognitive, affective, and behavioral dimensions across developmental stages. Synthesizing evidence from clinical and developmental studies, the authors identified that body image disturbance in BED is characterized by pronounced overconcern with weight and shape, body dissatisfaction, body related checking and avoidance behaviors, and maladaptive cognitive biases. Importantly, the review indicated that although individuals with BED generally demonstrate accurate perception of body size, disturbances are predominantly cognitive and emotional in nature and often emerge early in childhood and adolescence, where they are closely linked to the onset and maintenance of binge-eating behaviors. These findings establish body image disturbance as a multidimensional and developmentally embedded construct within BED, underscoring the necessity of comprehensive assessment and targeted interventions that address cognitive, affective, and behavioral components of body image to improve treatment outcomes across the lifespan.

Guillaume et al. (2016) examined the effects of childhood trauma subtypes on eating disorder severity in a clinical sample. Emotional abuse was the strongest predictor, uniquely linked to heightened eating concerns, shape/weight dissatisfaction, and poorer functioning. Physical and sexual abuse independently predicted eating-related concerns, indicating differential trauma pathways. A clear dose–response relationship was found—greater trauma exposure corresponded with more severe symptoms. The study underscores the need for trauma-informed approaches addressing both specific and cumulative childhood adversity in eating disorder assessment and intervention.

Vartanian et al. (2014) examined mechanisms linking early adverse experiences to disordered eating in young women. Adverse exposure was associated with reduced personal resources—including lower self-esteem and diminished personal growth initiative—which in turn predicted heightened body dissatisfaction, a key proximal predictor of disordered eating, particularly weight-loss-driven exercise. This sequential model suggests early adversity undermines intrapersonal resources and fosters negative body evaluations, ultimately contributing to disordered eating. Findings support interventions targeting personal resource-building and body dissatisfaction to prevent eating-related difficulties in individuals with early adversity exposure.

Vartanian et al. (2014) conducted an empirical examination of the mechanisms through which early adverse experiences contribute to disordered eating among young women, with a particular focus on personal and social resources. Using measures of childhood adversity, intrapersonal resources (including self-esteem and personal growth initiative), interpersonal supports (such as gratitude and social connectedness), body dissatisfaction, and eating-related behaviors, the study found that early adversity was associated with depleted psychological and social resources. Lower levels of these resources predicted heightened body dissatisfaction, which in turn was linked to disordered eating behaviors, including compulsive exercise for weight control. These findings support a sequential resource-depletion model, indicating that childhood adversity indirectly influences eating pathology by undermining protective intrapersonal and interpersonal capacities. This study contributes to etiological models of disordered eating by identifying modifiable psychosocial resources as key intervention targets for preventing body dissatisfaction and subsequent eating-disorder behaviors.

Dunkley et al. (2010) conducted an empirical investigation into the cognitive mechanisms linking childhood maltreatment to eating-disorder pathology, focusing specifically on patients diagnosed with binge eating disorder. Using validated measures of childhood abuse, self criticism, depressive symptoms, and body dissatisfaction, the study found that self-criticism functioned as a key mediating variable between experiences of emotional and sexual abuse and body dissatisfaction. Notably, self-critical thinking fully accounted for the relationship between emotional abuse and both depressive symptoms and body dissatisfaction, even when controlling for global self-esteem. These findings identify self-criticism as a distinct and robust cognitive-

affective process through which early adversity contributes to binge eating disorder symptomatology. This work extends trauma-informed models of eating disorders by establishing self-criticism as an empirically grounded target for psychological intervention in individuals with histories of childhood maltreatment.

Alvarenga et al. (2010) emphasized body image dissatisfaction as a widespread and normative risk condition among university students. The study found high prevalence rates of both body dissatisfaction and binge-eating behaviors, suggesting that appearance-related distress often precedes clinical pathology. Body dissatisfaction functions as an early warning marker, increasing susceptibility to disordered eating when combined with stress or emotional dysregulation. This role is comparable to the normalization of stigmatizing narratives in Akram et al. (2024), where socially reinforced beliefs silently shape psychological outcomes.

Grilo et al. (2005) demonstrated that body image dissatisfaction serves as a psychological conduit linking early interpersonal adversity and current emotional distress to binge-eating disorder. Childhood teasing, depression, and low self-esteem contributed to heightened body dissatisfaction, which intensified vulnerability to binge eating. Body image concerns function by anchoring negative self-beliefs to physical appearance, making the body a focal point of shame and control struggles. This mechanism resembles self-silencing in that it redirects distress inward, transforming relational harm into self-directed criticism and maladaptive behavior.

Lakkis et al. (1999) underscored sociocultural context as a shaping force in the relationship between body esteem, self-esteem, and disordered eating. While lesbians and heterosexual women showed similar levels of disordered eating, body esteem was more strongly linked to self-esteem among lesbians. This suggests that cultural identity influences how body image concerns are psychologically processed. Much like cultural marriage norms in Akram et al. (2024), sociocultural context determines whether body-related concerns manifest as eating pathology or broader self-concept issues.

2.3 RESEARCH GAP

Although substantial research has examined adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating independently, limited studies have investigated these variables within a single framework, particularly the mediating role

of body image dissatisfaction in the relationship between ACEs and binge eating. Existing research has largely been conducted in Western countries and clinical populations, with little attention given to non-clinical young adults in the Indian context. Furthermore, studies exploring these relationships among college-going young adults in Jammu district are scarce. Therefore, there is a need to examine the interplay between ACEs, body image dissatisfaction, and binge eating on young adults to better understand trauma-related risk pathways and contribute to culturally relevant, trauma-informed research and interventions.

CHAPTER- III

RESEARCH METHOD

3.1 INTRODUCTION

Research is a systematic and scientific process that involves the collection, analysis, and interpretation of data in order to develop knowledge and understanding of complex psychological phenomena (Creswell, 2008). In line with this approach, the present chapter outlines the research methodology adopted to investigate the relationship between Adverse Childhood Experiences (ACEs), Body Image Dissatisfaction, and Binge Eating behaviour among young adults. The study conceptualizes Adverse Childhood Experiences as early traumatic stressors that may have long-lasting psychological consequences, Body Image Dissatisfaction as a maladaptive self-perceptual outcome, and Binge Eating behaviour as a dysfunctional coping mechanism. Drawing on trauma-informed and cognitive-behavioural perspectives, the research seeks to examine whether exposure to early adversity is associated with negative body perceptions and disordered eating patterns in young adulthood.

3.2 RESEARCH DESIGN

The present study adopted a cross-sectional research design, which is appropriate for examining relationships among psychological variables as they naturally occur within a population (Polit & Hungler, 1999). In this design, Adverse Childhood Experiences were treated as the independent variable, Body Image Dissatisfaction as both an outcome and mediator, and Binge Eating behaviour as the dependent variable.

The design allows for the simultaneous assessment of associations among ACEs, body image dissatisfaction, and binge eating, as well as the testing of mediation effects using regression-based procedures. Since all variables were measured at a single point in time using standardized questionnaires, the design emphasizes explanatory modelling and relationship analysis rather than causal inference.

3.2.1 Variables of the Study

The present study included three main variables:

Independent variable: Adverse Childhood Experiences (ACEs)

Dependent variable: Binge Eating Behaviour

3.2.2 Population and Sample

Population: The population of the study consisted of young adults (18–25 years), representing a group that is particularly vulnerable to body image concerns and eating-related issues.

Sample: The sample comprised 202 participants, who were selected using random sampling technique. Participants were recruited through 4 different colleges of Jammu district.

3.2.3 Inclusion /Exclusion Criteria

Inclusion Criteria: The inclusion criteria as follows:

- Young adults aged between 18–25 years
- People were English/Hindi literate
- Voluntary informed consent was taken from people.

Exclusion Criteria: The exclusion criteria as follows:

- Individuals with a diagnosed severe psychiatric condition.
- Those currently undergoing treatment for eating disorders
- Participants unwilling to provide informed consent.

3.3 RESEARCH TOOLS

The following standardized tools were used for data collection:

1. **Adverse Childhood Experiences Questionnaire (ACE-Q) -** Number of Items: 10, The ACE-Q assesses exposure to childhood abuse, neglect, and household dysfunction before the age of 18. The test-retest reliability

coefficient is reported to be 0.64, indicating moderate reliability. Higher scores reflect greater exposure to adverse childhood experiences.

2. **Body Dissatisfaction Scale -** This scale measures the level of dissatisfaction individuals experience with their body size, shape, and physical appearance. Higher scores indicate greater body image dissatisfaction.

3. **Binge Eating Scale (BES) -** The BES assesses the severity of binge eating behaviours and associated emotional and cognitive features.Higher scores indicate greater severity of binge eating symptoms.

3.4 STATISTICAL ANALYSIS TECHNIQUES

The collected data were analysed using SPSS software. The following statistical techniques were employed:

1. **Descriptive Statistics:** Mean and standard deviation were calculated for all variables.

2. **Pearson's Correlation Coefficient:** It is used to examine the relationships among Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating behaviour.

3. **Regression analysis:** It was conducted to assess the predictive relationships among the variables. This allowed for understanding how well the independent variable (ACEs) predict the dependent variable binge eating behaviour.

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

This chapter presents the findings of this study. It focuses on understanding how adverse childhood experiences, body image dissatisfaction, and binge eating are related among young adults. The aim is to explore how early life experiences can influence how individuals feel about their bodies and how they behave in terms of eating using descriptive statistics, correlation analysis and regression analysis.

4.2 RESULTS AND FINDINGS

Table 4.1 *Descriptive Statistics of Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating among young adults*

Variable	***N***	***M***	***SD***
Adverse Childhood Experiences	202	2.08	2.33
Body Image Dissatisfaction	202	74.55	18.30
Binge Eating	202	11.67	10.17

Descriptive statistics is computed for the three study variables: adverse childhood experiences (ACEs), body image dissatisfaction and binge eating as shown in Table 1. The mean ACE score is $M = 2.08$ ($SD = 2.33$), suggesting relatively low to moderate endorsement of adverse childhood experiences across the sample. Body image dissatisfaction has $M = 74.55$ ($SD = 18.30$), indicating moderate levels of body image concern. Binge eating scores averaged $M = 11.67$ ($SD = 10.17$), with notable variability in binge eating behaviors across participants ($N = 202$).

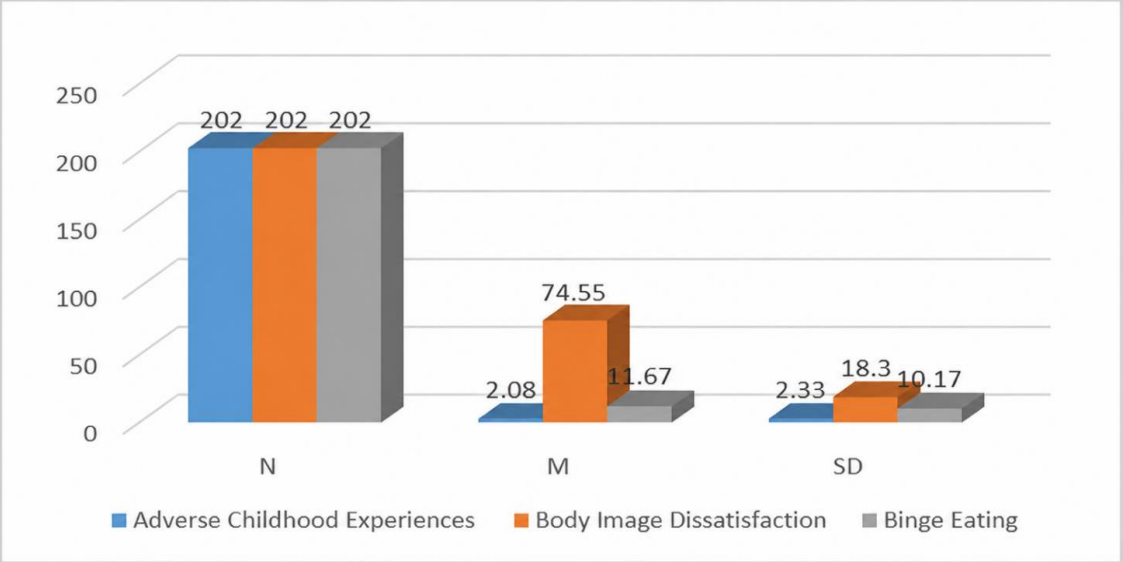


Figure 4.1- *Demographics of Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating*

4.2.1 OBJECTIVE 1 - TO EXPLORE THE RELATIONSHIP BETWEEN ADVERSE CHILDHOOD EXPERIENCES, BODY IMAGE DISSATISFACTION AND BINGE EATING.

Table 4.2 *Pearson Correlations Among Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating*

Variables	Adverse Childhood Experiences	Body Image Dissatisfaction	Binge Eating
Adverse Childhood Experiences	1	.254**	.299**
Body Image Dissatisfaction	.254**	1	.313**
Binge Eating	.299**	.313**	1

***Correlation is significant at the 0.01 level (2-tailed).*

Pearson's correlation analysis was conducted to examine the relationships among adverse childhood experiences (ACE), body image dissatisfaction, and binge eating. The results revealed a significant positive correlation between adverse childhood

experiences and body image dissatisfaction, r(200) = .254, p < .001, indicating that higher levels of adverse childhood experiences are associated with greater body image dissatisfaction.

Similarly, Adverse Childhood Experiences positively and significantly correlated with binge eating, r(200) = .299,p < .001, suggesting that individuals with more adverse childhood experiences tend to report higher levels of binge eating behaviour. Furthermore, a significant positive relationship was found between body image dissatisfaction and binge eating, r(200) =.313, p < .001, indicating that greater dissatisfaction with body image is associated with increased binge eating.

Overall, all variables were positively interrelated, supporting the hypothesized relationships among adverse childhood experiences, body image dissatisfaction and binge eating among young adults.

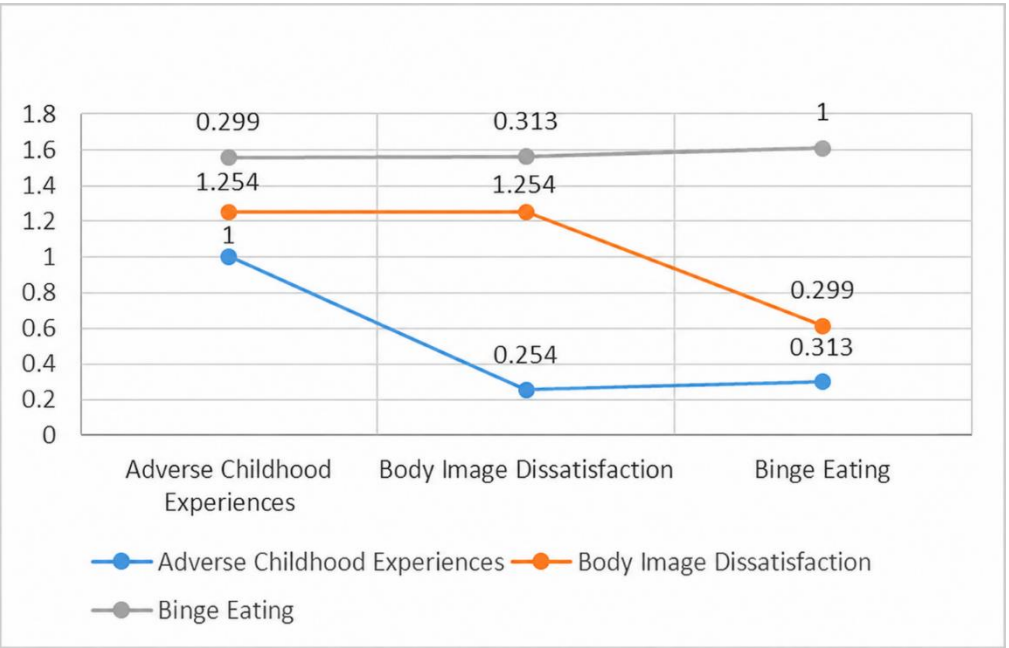


Figure-4.2 *Relationship between Adverse Childhood Experiences, Body Image Dissatisfaction and Eating Eating among Young Adults*

4.2.2 OBJECTIVE 2- TO ASSESS THE EFFECT OF ADVERSE CHILDHOOD EXPERIENCES (ACEs) ON BODY IMAGE DISSATISFACTION AMONG YOUNG ADULTS.

Table 4.3(A) *Summary Simple Linear Regression of Body Image Dissatisfaction on Adverse Childhood Experiences.*

Model	*R*	R^2	Adjusted R^2	SE	F Change
1	.25	.065	.060	17.74	13.79

Predictors: *(Constant), Adverse Childhood Experiences*. *Dependent Variable*: *Body Image Dissatisfaction*.

A simple linear regression was conducted to examine whether adverse childhood experiences predict body image dissatisfaction. The results indicated a positive association between adverse childhood experiences and body image dissatisfaction, $R = .25$. The regression model explained 6.5% of the variance in body image dissatisfaction, $R^2 = .065$, Adjusted $R^2 = .060$. The overall model was statistically significant, $F(1, 198) = 13.79$, indicating that adverse childhood experiences significantly predicted body image dissatisfaction. The standard error of the estimate was 17.74. These findings suggest that individuals reporting higher levels of adverse childhood experiences tend to experience greater body image dissatisfaction.

Table 4.3(B) *Regression Coefficients for Adverse Childhood Experiences Predicting Body Image Dissatisfaction*

Predictor	***B***	**SE B**	**β**	***t***	***p***
Constant	70.40	1.68		41.99	<.001
Adverse Childhood Experiences	1.99	0.54	.25	3.71	< .001

Note. Dependent Variable: Body Image Dissatisfaction. $R^2 = .065$, Adjusted $R^2 = .060$, $F(1, 200) = 13.79$, $p < .001$.

A simple linear regression was conducted to examine whether adverse childhood experiences predicted body image dissatisfaction. The model was significant, $F(1, 200) = 13.79$, $p < .001$, explaining 6.5% of the variance in body image dissatisfaction ($R^2 = .065$, adjusted $R^2 = .060$). Adverse childhood experiences significantly and positively predicted body image dissatisfaction, $\beta = .25$, $B = 1.99$, $SE = 0.54$, $t = 3.71$, $p < .001$, indicating that higher levels of adverse childhood experiences were associated with greater body image dissatisfaction.

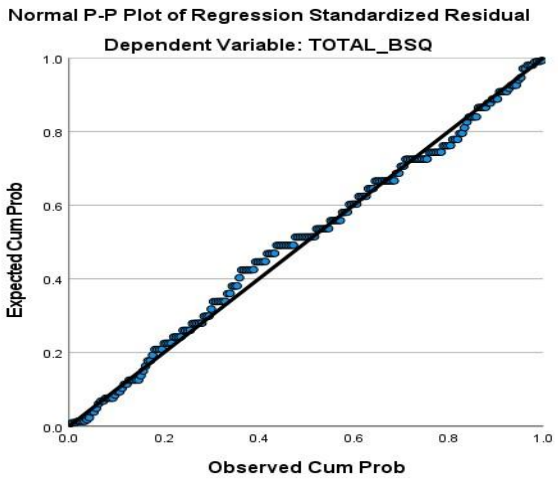


Figure 4.3 *Scatterplot with regression line for the association between adverse childhood experiences and body image dissatisfaction*

4.2.3 OBJECTIVE 3- TO EXAMINE THE EFFECT OF BINGE EATING BEHAVIOUR ON BODY IMAGE DISSATISFACTION.

Table 4.4(A) ***Model Summary for Simple Linear Regression of Body Image Dissatisfaction on Binge Eating***

Model	*R*	R^2	Adjusted R^2	SE	F Change
1	.31	.098	.094	17.42	21.74

Note. Predictors: (Constant), Binge Eating. Dependent Variable: Body Image Dissatisfaction.

The regression model examining the relationship between the predictor(s) and the dependent variable demonstrated a statistically meaningful fit. The model explained 9.8% of the variance in the outcome variable, as indicated by R2 = .098 (Adjusted R2 = .094), reflecting a modest effect size. The correlation coefficient (R = .31) suggests a weak to moderate positive relationship between the variables. Additionally, the change in explained variance was significant (ΔR2 = .098), with an F change of 21.74, indicating that the predictor(s) significantly improved the model. The standard error of the estimate was 17.42, indicating the average deviation of observed values from the predicted values.

Table 4.4(B) *Regression Coefficients for Binge Eating Predicting Body Image Dissatisfaction*

Predictor	***B***	**SE**	**β**	***t***	***p***
Constant	67.98	1.87		36.39**	< .001
Binge Eating	0.56	0.12	.31	4.66**	< .001

Note. Dependent Variable: Body Image Dissatisfaction. $R^2 = .098$, Adjusted $R^2 = .094$, $F(1, 200) = 21.74$, $p < .001$.

A simple linear regression was conducted to examine whether binge eating predicted body image dissatisfaction. The regression model was significant, $F(1, 200) = 21.74$, $p < .001$, accounting for 9.8% of the variance in body image dissatisfaction ($R^2 = .098$, adjusted $R^2 = .094$). Binge eating significantly and positively predicted body image dissatisfaction, $\beta = .31$, $B = 0.56$, $SE = 0.12$, $t = 4.66$, $p < .001$, indicating that higher levels of binge eating were associated with greater body image dissatisfaction.

CHAPTER-V

FINDINGS, CONCLUSION, FUTURE IMPLICATIONS AND SUGGESTIONS

5.1 INTRODUCTION

This study examined the relationships between Adverse Childhood Experiences (ACEs), Body Image Dissatisfaction, and Binge Eating among young adults in Jammu district. Drawing on trauma-informed and cognitive-behavioural frameworks, it explored how early-life adversity connects to negative body perceptions and disordered eating in a college-going sample.

5.2 MAJOR FINDINGS OF THE STUDY

The present study examined the relationship among adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating behaviour among young adults, and also investigated whether body image dissatisfaction mediated the relationship between ACEs and binge eating behaviour. The results indicated that adverse childhood experiences were significantly associated with body image dissatisfaction, suggesting that individuals with higher exposure to childhood adversity tend to report more negative perceptions of their bodies. Further, body image dissatisfaction was found to be significantly related to binge eating behaviour, indicating that individuals who feel dissatisfied with their bodies are more likely to engage in maladaptive eating patterns. However, the direct relationship between adverse childhood experiences and binge eating behaviour was found to be weaker or not consistently significant across analyses. This suggests that the influence of childhood adversity on binge eating behaviour primarily operates through body image dissatisfaction. Overall, the findings highlight that body image dissatisfaction plays a crucial mediating role in linking early adverse experiences to later disordered eating behaviours among young adults.

OBJECTIVE 1: TO EXPLORE THE RELATIONSHIP AMONG ADVERSE CHILDHOOD EXPERIENCES, BODY IMAGE DISSATISFACTION AND BINGE EATING BEHAVIOUR

The findings supported the first hypothesis, demonstrating significant positive correlations among adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating. ACEs were positively associated with both body image dissatisfaction ($r = .25$, $p < .001$) and binge eating ($r = .30$, $p < .001$), while body image dissatisfaction was also positively related to binge eating ($r = .31$, $p < .001$). These results are consistent with previous research indicating that childhood adversity contributes to negative body image and disordered eating behaviors.

The observed relationships suggest that individuals with greater exposure to childhood adversity are more likely to experience dissatisfaction with their bodies and engage in binge eating behaviors. Furthermore, body image dissatisfaction appears to play an important role in increasing vulnerability to binge eating. Collectively, these findings support the proposed theoretical model in which ACEs function as a distal risk factor that contributes to body image dissatisfaction, which in turn elevates the risk of binge eating. The results also highlight the relevance of these psychological processes within the Indian context, suggesting that the associations among childhood adversity, body image concerns, and binge eating extend across different sociocultural settings.

Additionally, the significant interrelationships among the variables emphasize the enduring psychological impact of early adverse experiences and underscore the importance of early identification and intervention efforts aimed at reducing body image concerns and preventing maladaptive eating behaviors among young adults.

OBJECTIVE 2: TO ASSESS THE EFFECT OF ADVERSE CHILDHOOD EXPERIENCES ON BODY IMAGE DISSATISFACTION AMONG YOUNG ADULTS

The findings supported the second hypothesis, demonstrating that adverse childhood experiences (ACEs) significantly predicted body image dissatisfaction. The regression analysis revealed that ACEs were a significant positive predictor of body image dissatisfaction ($B = 1.99$, $SE = 0.54$, $\beta = .25$, $t = 3.71$, $p < .001$), explaining 6.5% of the variance in body image dissatisfaction scores.

This indicates that higher levels of childhood adversity are associated with greater dissatisfaction with one's body image. These results are consistent with previous research and suggest that adverse childhood experiences contribute to the development of negative self-perceptions and body-related concerns. The relationship may be explained through cognitive mechanisms, whereby early adverse experiences foster negative self-schemas that become reflected in body image evaluations. Additionally, experiences of abuse or neglect may increase feelings of shame, self-objectification, and appearance-based self-criticism. Neurobiological changes associated with chronic childhood stress may further intensify emotional vulnerability and self-critical thinking, thereby contributing to body image dissatisfaction.

Overall, the findings highlight adverse childhood experiences as an important risk factor for body image dissatisfaction and extend existing evidence to an Indian young adult population. The results emphasize the lasting psychological impact of childhood adversity on self-perception and body-related well-being.

These results are consistent with previous research and suggest that adverse childhood experiences contribute to the development of negative self-perceptions and body-related concerns. The relationship may be explained through cognitive mechanisms, whereby early adverse experiences foster negative self-schemas that become reflected in body image evaluations. Additionally, experiences of abuse or neglect may increase feelings of shame, self-objectification, and appearance-based self-criticism. Neurobiological changes associated with chronic childhood stress may further intensify emotional vulnerability and self-critical thinking, thereby contributing to body image dissatisfaction.

Overall, the findings highlight adverse childhood experiences as an important risk factor for body image dissatisfaction and extend existing evidence to an Indian young adult population. The results emphasize the lasting psychological impact of childhood adversity on self-perception and body-related well-being.

OBJECTIVE 3: TO EXAMINE THE EFFECT OF BINGE EATING BEHAVIOUR ON BODY IMAGE DISSATISFACTION

The findings supported the third hypothesis, demonstrating that binge eating significantly predicted body image dissatisfaction. The regression analysis showed that binge eating was a significant positive predictor ($B = 0.56$, $SE = 0.12$, $\beta = .31$, $t(200) = 4.66$, $p < .001$), accounting for approximately 9.8% of the variance in body image dissatisfaction. The stronger beta coefficient compared to the ACE model suggests that binge eating may be a more immediate or proximal factor influencing body image dissatisfaction.

These results are consistent with previous research indicating a close relationship between binge eating behaviors and negative body image. Individuals who engage in binge eating often experience greater concerns about body shape, weight, and appearance, which contribute to increased body dissatisfaction. Cognitive-behavioural perspectives suggest that negative beliefs about one's body and excessive emphasis on appearance can increase vulnerability to binge eating, particularly following perceived failures or dietary lapses. In turn, binge eating episodes may evoke feelings of guilt, shame, and self-criticism, further worsening body image dissatisfaction and creating a cyclical pattern.

Overall, the findings highlight the strong association between binge eating and body image dissatisfaction, emphasizing the importance of addressing both constructs simultaneously in prevention and intervention efforts. Strategies that promote self-acceptance, adaptive emotion regulation, and healthier body perceptions may help reduce the negative cycle linking binge eating and body dissatisfaction.

5.3 CONCLUSION AND DISCUSSION

From the findings of the present research, it can be concluded that:

1. There is a significant positive relationship between adverse childhood experiences (ACEs) and body image dissatisfaction among young adult women. **Accepted**
2. There is a significant positive relationship between body image dissatisfaction and binge eating behaviour. **Accepted**

3. The direct relationship between adverse childhood experiences (ACEs) and binge eating behaviour is weak or not consistently significant. **Partially Supported**

The findings of the present study highlight an important psychological pathway through which early life adversity continues to influence behaviour in later stages of life. The results suggest that childhood experiences do not affect eating behaviour directly in most cases; rather, their impact is carried forward through how individuals perceive and relate to their own bodies. A clear pattern emerges from the findings: early adverse experiences → development of negative self-perception and body dissatisfaction → engagement in maladaptive coping behaviours such as binge eating. This suggests that binge eating is not merely about food or lack of control, but often reflects deeper emotional struggles rooted in past experiences.

The mediating role of body image dissatisfaction is particularly important. It shows that individuals who have experienced adversity in childhood may internalize feelings of shame, low self-worth, or inadequacy, which then become expressed through dissatisfaction with their physical appearance. Over time, this dissatisfaction can lead to unhealthy coping strategies, including binge eating, as a way to manage emotional distress.

The study also contributes to existing literature by integrating trauma-related perspectives with body image and eating behaviour research. It supports the idea that psychological outcomes are shaped by interconnected processes rather than isolated factors. By identifying body image dissatisfaction as a key link, the study provides a more nuanced understanding of how early adversity translates into behavioural outcomes.

From a practical perspective, these findings carry meaningful implications. They suggest that interventions should not only focus on controlling eating behaviour but also address deeper issues such as self-perception, emotional regulation, and unresolved childhood experiences. Helping individuals develop a healthier relationship with their bodies and more adaptive coping strategies may reduce the likelihood of binge eating behaviours.

In the Indian context, where discussions around mental health, trauma, and body image are still growing, these findings are particularly relevant. Social pressures, beauty standards, and limited awareness may intensify body dissatisfaction and prevent individuals from seeking help. Therefore, promoting awareness and creating supportive environments becomes essential. In conclusion, the study emphasizes that early life experiences continue to shape emotional and behavioural outcomes in subtle yet powerful ways. By understanding the role of body image dissatisfaction as a mediating factor, the study opens pathways for more sensitive, informed, and effective approaches to improving mental health and well-being among young adults.

5.4 IMPLICATIONS FOR FUTURE RESEARCH

The findings of the present study, particularly the mediating role of body image dissatisfaction between adverse childhood experiences (ACEs) and binge eating behaviour, suggest several important directions for future research. The results highlight that it is not only early adversity itself, but also the way individuals internalize and interpret these experiences through their body image, that shapes later behavioural outcomes. Therefore, future research should move beyond direct relationships and focus more on the underlying psychological processes that connect early experiences to later behaviours. One important implication is the need for intervention-based research that targets body image dissatisfaction. Programs that promote positive body image, self-acceptance, and emotional awareness may help reduce the likelihood of binge eating, especially among individuals with a history of childhood adversity. Future studies can examine the effectiveness of such interventions in improving both self-perception and eating behaviours over time. Another key area for future research is the role of support systems. Family, peer, and social support may act as protective factors that reduce the negative impact of adverse childhood experiences. Research can explore how supportive environments help individuals develop healthier body image and coping strategies, thereby preventing maladaptive behaviours like binge eating.

Educational and awareness-based interventions also hold strong potential. Future studies can focus on introducing body image education and emotional coping skills at school and college levels. Early awareness may help individuals recognize unhealthy thought patterns and develop healthier relationships with their bodies before dissatisfaction becomes deeply ingrained. The use of technology-based interventions

offers another promising direction. Mobile applications and online platforms can be developed to help individuals track their emotions, body image concerns, and eating patterns. Digital tools may also provide accessible support through guided exercises, self-reflection activities, and cognitive-behavioral strategies, especially for those who may not have easy access to professional help. A more holistic and culturally sensitive approach is also needed in future research. In the Indian context, social expectations, beauty standards, and stigma around mental health may intensify body dissatisfaction and discourage help-seeking. Future studies should consider these cultural factors while designing interventions and aim to create awareness at both individual and societal levels. Additionally, clinical research can focus on early screening and identification. Mental health professionals may benefit from assessing adverse childhood experiences, body image concerns, and eating behaviours together, rather than in isolation. This integrated approach can help in developing more targeted and effective treatment plans.

In conclusion, future research should adopt a multidimensional perspective that combines psychological, social, and cultural factors. By focusing on body image dissatisfaction as a key mechanism, researchers can develop more meaningful interventions that not only address symptoms like binge eating but also the deeper emotional processes underlying them.

5.5 SUGGESTION FOR FUTURE RESEARCH

1. Longitudinal Studies

- Track young adults from childhood through emerging adulthood
- Establish causal pathways and developmental trajectories rather than relying on cross-sectional data

2. Exploring Additional Mediators

- Investigate emotion dysregulation, internalized shame, and self-compassion as potential mediators
- Examine how these variables operate alongside body image dissatisfaction in the ACE–binge eating pathway (Miller et al., 2022; O'Loghlen, 2022)

3. Diverse and Representative Populations

- Extend findings beyond student samples to non-students, rural residents, and varied socioeconomic groups
- Include participants from different Indian regions to improve generalizability

4. Cross-Cultural Comparisons

- Compare Indian and Western samples to yield theoretically and clinically informative insights
- Identify culture-specific versus universal patterns in the ACE–eating pathology relationship

5. Gender-Specific Analyses

- Conduct targeted analyses accounting for differential patterns of body image concerns and eating pathology across genders
- Develop gender-sensitive frameworks for understanding ACE-related outcomes

6. Intervention Research

- Design randomized controlled trials (RCTs) in college settings
- Evaluate combined trauma-focused and body image intervention programs
- Build an evidence base to translate research findings into actionable mental health resources for young adults with elevated ACE exposure.

5.6 CONCLUSION

This study investigated the relationships among Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating in 202 young adults from Jammu district. ACEs significantly predicted body image dissatisfaction, binge eating significantly predicted body image dissatisfaction, and all three variables were meaningfully intercorrelated. These findings support the theoretical model that early adversity disrupts positive self-concept formation including body image and that resulting dissatisfaction increases binge eating vulnerability as a maladaptive coping mechanism.

By documenting these associations in an Indian young adult sample, the study contributes to trauma-informed eating disorder research and reinforces the need to address childhood adversity in prevention and clinical frameworks. Binge eating, these findings suggest, is often not simply a behavioural problem—it is frequently a psychologically meaningful response to early trauma and the body shame that follows. Effective intervention needs to address not just the eating behaviour itself, but the traumatic history and body image disturbance underlying it. In sum, this investigation provides empirical support for the ACE → Body Image Dissatisfaction → Binge Eating pathway and underscores the clinical and public health importance of identifying childhood adversity early. It calls for greater integration of traumainformed perspectives in eating disorder research and practice in the Indian context, and lays groundwork for the longitudinal and intervention studies needed to deepen our understanding of these relationships.

SUMMARY

TOPIC: AN INVESTIGATION INTO THE RELATIONSHIP BETWEEN ADVERSE CHILDHOOD EXPERIENCES, BODY IMAGE DISSATISFACTION AND BINGE EATING AMONG YOUNG ADULTS

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INTRODUCTION

Young adulthood represents a pivotal developmental stage during which individuals navigate significant psychological, social, and physiological changes. This period is marked by heightened vulnerability to mental health concerns, including difficulties related to self-perception, emotional regulation, and coping behaviour. Among the psychological constructs increasingly recognised as relevant to young adult wellbeing are adverse childhood experiences (ACEs), body image dissatisfaction, and binge eating behaviour.

Adverse childhood experiences refer to traumatic or stressful events that occur before the age of 18, encompassing various forms of abuse, neglect, and household dysfunction. The groundbreaking CDC-Kaiser Permanente ACE Study (Felitti et al., 1998) established empirical connections between childhood adversity and wide-ranging adult health outcomes. The ACE framework categorises childhood trauma into three domains: abuse (emotional, physical, and sexual), neglect (emotional and physical), and household dysfunction (parental separation, domestic violence, substance abuse, mental illness, and incarceration of household members). Research consistently demonstrates a dose-response relationship: individuals with higher ACE scores face exponentially greater risks for mental health problems, including

depression, anxiety, substance use disorders, and disordered eating (Anda et al., 2006; Bethell et al., 2014).

The neurobiological and psychological mechanisms through which ACEs exert lasting effects are well documented. Chronic adversity during sensitive developmental periods produces toxic stress, leading to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, impaired prefrontal cortex development, and heightened amygdala reactivity (Danese & McEwen, 2012). These neurobiological changes increase vulnerability to anxiety, depression, and difficulties with emotional regulation and impulse control. Psychologically, ACEs disrupt the development of secure attachment, positive self-concept, and adaptive emotion regulation strategies, contributing to negative self-schemas and maladaptive coping behaviours in adulthood.

BODY IMAGE DISSATISFACTION

Body image dissatisfaction (BID) is a complex psychological phenomenon involving negative perceptions, cognitions, and emotions related to one's physical appearance. As a multidimensional construct, it encompasses perceptual, cognitive-affective, and behavioural components. Perceptual distortions involve misperceptions of body size and shape; cognitive-affective components include negative beliefs, appearance-based self-worth, and emotional reactions such as shame, disgust, and anxiety; and behavioural components involve body checking or body avoidance patterns (Cash, 2004; Thompson et al., 1999).

The development of body image is shaped by complex interactions between individual factors and sociocultural influences, including media exposure, peer relationships, family attitudes, and cultural beauty ideals. The 20th century saw dramatic shifts in Western ideals, particularly the cultural valorisation of thinness, linked to significant increases in eating disorders and body dissatisfaction. Contemporary digital and social media amplify these pressures through constant social comparison and exposure to idealised and often digitally manipulated images, particularly affecting adolescents and young adults (Bordo, 2023; Burychka et al., 2021).

The relationship between childhood adversity and body image disturbance is increasingly recognised. Schema theory posits that adverse childhood experiences foster negative core beliefs about the self that become embodied as body dissatisfaction

(Brown et al., 2020). Objectification theory further explains how trauma, particularly sexual and emotional abuse, leads individuals to internalise an observer's perspective of their own bodies, resulting in self-objectification, body surveillance, and body shame (Cash, 2004). A meta-analysis by Bödicker et al. (2022) confirmed a small but significant association between childhood maltreatment and adult body image disturbance.

BINGE EATING

Binge eating is characterised by episodes of consuming objectively large amounts of food accompanied by a subjective sense of loss of control. The DSM-5 defines a binge eating episode as consuming, within approximately two hours, an amount of food definitively larger than what most individuals would eat under similar circumstances, while experiencing loss of control. Associated features include eating rapidly, eating until uncomfortably full, eating alone due to embarrassment, and subsequent feelings of guilt, shame, and disgust (Mitchell et al., 2007).

When binge eating occurs at least once weekly for three months without regular compensatory behaviours, it may meet criteria for Binge Eating Disorder (BED), the most prevalent eating disorder, affecting approximately 1-3% of the general population. Neurobiologically, binge eating involves altered reward processing, diminished inhibitory control, and dysregulated stress response systems, patterns overlapping substantially with substance use disorders (Wu et al., 2014). Functionally, binge eating commonly serves as a maladaptive coping strategy for managing negative affect, providing temporary relief from emotional distress stemming from trauma, shame, or powerlessness.

Extensive research links childhood adversity to binge eating through multiple pathways. Chu et al. (2022) demonstrated a clear dose-response relationship between ACEs and binge eating disorder in early adolescence. Friedman et al. (2018) found that different trauma subtypes contributed to binge behaviours through distinct psychological pathways. Monteleone et al. (2021) identified emotion regulation deficits, impulsivity, and impaired interoceptive awareness as shared mediating mechanisms. Theoretical frameworks including cognitive-behavioural models posit that negative beliefs about body and self-worth increase vulnerability to binge eating, particularly following perceived failures or dietary lapses.

NEED AND SIGNIFICANCE

This study addresses an important yet underexplored area of mental health among young adults — how early life experiences continue to shape self-perception and coping behaviours in adulthood. Many individuals carry the emotional impact of childhood adversity without fully understanding its long-term consequences. Experiences of abuse, neglect, or household dysfunction commonly influence self-esteem, emotional regulation, and coping patterns, which may manifest as negative body image and disordered eating in young adulthood.

While past studies have explored childhood adversity and eating behaviours separately, fewer have investigated how body image dissatisfaction may function as a psychological link between them. This study is particularly significant in the Indian context, where social pressures, appearance ideals, cultural beauty standards, and stigma around mental health may intensify body dissatisfaction and discourage help-seeking. By addressing these culturally specific factors, the study contributes to more sensitive and effective approaches to mental health intervention.

Despite growing research on ACEs and eating pathology, empirical studies examining all three variables together — ACEs, body image dissatisfaction, and binge eating — remain limited, especially within Indian populations. Understanding the interconnections among these variables provides a more comprehensive view of how psychological distress develops and is maintained, with practical implications for prevention and clinical intervention.

STATEMENT OF THE PROBLEM

The present study is entitled: “An Investigation into the Relationship Between Adverse Childhood Experiences, Body Image Dissatisfaction and Binge Eating Among Young Adult”.

OPERATIONAL DEFINITIONS

ADVERSE CHILDHOOD EXPERIENCES (ACEs): Stressful or traumatic events occurring before the age of 18, including abuse, neglect, and household dysfunction. In this study, ACEs are operationally defined as the level of childhood adversity reported

by participants, as measured by the Adverse Childhood Experiences Questionnaire (ACE-Q). Higher scores indicate greater exposure.

BODY IMAGE DISSATISFACTION: Negative thoughts, feelings, and attitudes an individual holds about their physical appearance, including concerns about body size, shape, or overall attractiveness. In this study, it is operationally defined as the degree of dissatisfaction reported by participants on the Body Dissatisfaction Scale. Higher scores indicate greater dissatisfaction.

BINGE EATING BEHAVIOUR: Episodes of consuming large amounts of food within a short period accompanied by a sense of loss of control, often followed by guilt, shame, or distress. In this study, it is operationally defined as the severity of binge eating patterns reported by participants on the Binge Eating Scale (BES). Higher scores indicate greater severity.

OBJECTIVES OF THE STUDY

1. To explore the relationship between Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating behaviour among young adults.
2. To assess the effect of Adverse Childhood Experiences (ACEs) on Body Image Dissatisfaction among young adults.
3. To examine the effect of Binge Eating behaviour on Body Image Dissatisfaction among young adults.

HYPOTHESES OF THE STUDY

H1 There will be a significant positive correlation between Adverse Childhood Experiences, Body Image Dissatisfaction, and Binge Eating behaviour.

H2 There will be a significant effect of Adverse Childhood Experiences on Body Image Dissatisfaction.

H3 There will be a significant effect of Binge Eating behaviour on Body Image Dissatisfaction.

POPULATION OF THE STUDY

The population for the present study consists of all young adults (aged 18–25 years) in the Jammu district.

SAMPLE FOR THE STUDY

The sample comprised 202 young adult participants selected using random sampling from four colleges in Jammu district. A sample of this size was selected to ensure adequate statistical power and representation of the target population, keeping in view practical constraints of time and resources. Participants were required to be between 18 and 25 years of age, English or Hindi literate, and willing to provide voluntary informed consent. Individuals with a diagnosed severe psychiatric condition or those currently undergoing treatment for eating disorders were excluded.

TOOLS USED

Adverse Childhood Experiences Questionnaire (ACE-Q): A 10-item standardised instrument assessing exposure to childhood abuse, neglect, and household dysfunction before the age of 18. Test-retest reliability is reported at 0.64. Higher scores reflect greater exposure to adverse childhood experiences.

Body Dissatisfaction Scale: A self-report scale measuring the degree of dissatisfaction individuals experience with their body size, shape, and physical appearance. Higher scores indicate greater body image dissatisfaction.

Binge Eating Scale (BES): A standardised questionnaire assessing the severity of binge eating behaviours and associated emotional and cognitive features. Higher scores indicate greater severity of binge eating symptoms.

RESULTS OF THE STUDY

Descriptive statistics revealed that the mean ACE score was 2.08 (SD = 2.33), indicating relatively low to moderate endorsement of adverse childhood experiences across the sample. Body image dissatisfaction had a mean score of 74.55 (SD = 18.30), reflecting moderate levels of body image concern. Binge eating scores averaged 11.67 (SD = 10.17), with notable variability across participants (N = 202).

The first objective examined the relationships among all three variables using Pearson's Product Moment Correlation. Results revealed significant positive correlations: ACEs and body image dissatisfaction ($r = .254$, $p < .001$), ACEs and binge eating ($r = .299$, $p < .001$), and body image dissatisfaction and binge eating ($r = .313$, $p < .001$). All three variables were positively interrelated, supporting the first hypothesis.

The second objective assessed the predictive effect of ACEs on body image dissatisfaction using simple linear regression. Results indicated that ACEs significantly predicted body image dissatisfaction ($B = 1.99$, $SE = 0.54$, $\beta = .25$, $t = 3.71$, $p < .001$), explaining 6.5% of the variance ($R^2 = .065$, $F(1, 198) = 13.79$, $p < .001$). For every one-unit increase in ACE score, body image dissatisfaction increased by approximately 1.99 units. The second hypothesis was therefore accepted.

The third objective examined the effect of binge eating on body image dissatisfaction. Simple linear regression revealed that binge eating significantly predicted body image dissatisfaction ($B = 0.56$, $SE = 0.12$, $\beta = .31$, $t = 4.66$, $p < .001$), accounting for 9.8% of the variance ($R^2 = .098$, $F(1, 200) = 21.74$, $p < .001$). The stronger beta coefficient compared to the ACE model suggests binge eating is a more proximal predictor of body dissatisfaction. The third hypothesis was therefore accepted.

Overall, the findings supported the proposed theoretical model in which ACEs function as a distal risk factor contributing to body image dissatisfaction, which in turn elevates the risk of binge eating as a maladaptive coping response. The direct relationship between ACEs and binge eating was weaker and not consistently significant across analyses, suggesting that the influence of childhood adversity on binge eating primarily operates through body image dissatisfaction. This underscores body image dissatisfaction as a key mediating variable in the ACE–binge eating pathway.

SUGGESTIONS FOR FUTURE RESEARCH

- Longitudinal studies may be conducted to track young adults from childhood through emerging adulthood to establish causal pathways and developmental trajectories.
- Future studies should explore additional mediating variables such as emotion dysregulation, internalized shame, self-compassion, and self-esteem alongside body image dissatisfaction in the ACE-binge eating pathway.
- Similar studies can be extended beyond student samples to non-students, rural populations, and varied socioeconomic groups for greater generalizability.
- Cross-cultural comparisons between Indian and Western samples would yield theoretically and clinically informative insights into culture-specific versus universal patterns.

- Gender-specific analyses should be conducted to account for differential patterns of body image concerns and eating pathology across genders.
- Future research may examine additional psychological variables such as anxiety, depression, self-esteem, social support, and coping strategies alongside ACEs and body image.
- Qualitative or mixed-method designs can be used to gain deeper understanding of participants' lived experiences of trauma, body image concerns, and eating behaviours.
- Randomised controlled trials in college settings should evaluate the effectiveness of combined trauma-focused and body image intervention programmes for young adults with elevated ACE exposure.

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APPENDIX I

ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE FOR ADULTS

California Surgeon General's Clinical Advisory Committee

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
2. Did you lose a parent through divorce, abandonment, death, or other reason?
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?
4. Did you live with anyone who had a problem with drinking or using drugs, includingprescription drugs?
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?
6. Did you live with anyone who went to jail or prison?
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
9. Did you feel that no one in your family loved you or thought you were special?

Do you believe that these experiences have affected your health?

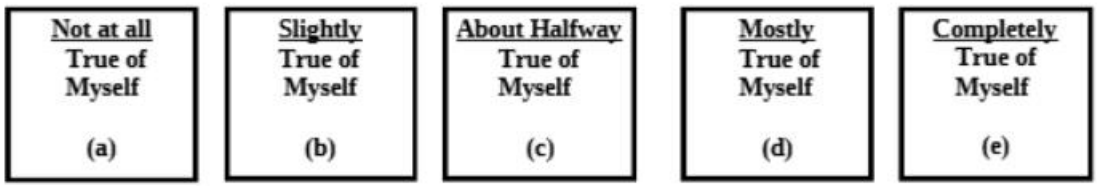
Not much Some Alot

Experiences in childhood are just one part of a person's life story.

There are many ways to heal throughout one's life.

APPENDIX -II

BODY SELF-IMAGE QUESTIONNAIRE



Instructions for Statement 1 through Statement 27

Statements 1 through 27 are all related to you and your body. Read each statement carefully, and decide how true the statement is for you. Use the rating scale below to indicate how true the statement is for you. Pencil in the bubble for the letter that indicates your response:

Response Format

STATEMENTS

1) I think my body is unattractive. (OAE)

2) How well my body is functioning influences the way I feel about my body. (HFI)

3) Having a well-proportioned body is important to me. (II)

4) My overall fitness level is high. (HFE)

5) I compare my body to people I'm close to (friends, relatives, etc.). (SD)

6) I've often wanted to be taller. (HD)

7) I think my body looks fat in clothes. (FE)

8) My naked body makes me feel sad. (NA)

9) I pay careful attention to my face and hair, so that I will look good. (AG)

10) I look good in clothes. (OAE)

11) I feel better about my body when I'm fitter. (HFI)

12) Body size matters to me. (II)

13) My body is healthy. (HFE)

14) Being around good-looking people makes me feel bad about my body. (SD)

15) I wish I were a different height. (HD)

16) My body is overweight. (FE)

17) I feel depressed about my body. (NA)

18) I'm usually well-dressed. (AG)

19) My body looks good. (OAE)

20) The way I feel about my body improves when I exercise regularly. (HFI)

21) I care about how well-shaped my legs are. (II)

22) My body is in shape. (HFE)

23) I'm more aware of my body when I'm in social situations. (SD)

24) If I were a different height, I'd like my body better. (HD)

25) I wish I were thinner. (FE)

26) Most days I feel bad about my body. (NA)

27) I spend time making my appearance more attractive. (AG)

APPENDIX - III

BINGE-EATING SCALE (BES)

Instructions:

Below are groups of statements. Read all of the statements in each group and select the one that best

describes the way you feel about the problems you have controlling your eating behavior.

1 Question 1

0 I don’t feel self-conscious about my weight or body size when I’m with others.

0 I feel concerned about how I look to others, but it normally does not make me feel disappointed with myself.

1 I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.

3 I feel very self-conscious about my weight and frequently, I feel intense shame and disgust for myself. I try to avoid social contacts

because of my self consciousness.

2 Question 2

0 I don’t have any difficulty eating slowly in the proper manner.

1 Although I seem to “gobble down” foods, I don’t end up feeling stuffed because of eating too much.

2 At times, I tend to eat quickly and then, I feel uncomfortably full afterwards.

3 I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because

I’ve eaten too much.

3 Question 3

0 I feel capable to control my eating urges when I want to.

1 I feel like I have failed to control my eating more than the average person.

3 I feel utterly helpless when it comes to feeling in control of my eating urges.

3 Because I feel so helpless about controlling my eating I have become very desperate about trying to get in control.

4 Question 4

0 I don't have the habit of eating when I'm bored.

0 I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.

0 I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.

2 I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.

5 Question 5

0 I'm usually physically hungry when I eat something.

1 Occasionally, I eat something on impulse even though I really am not hungry.

2 I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need

the food.

3 Even though I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a

sandwich, that fills my mouth. Sometimes, when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain

6 Question 6

0 I don't feel any guilt or self-hate after I overeat.

1 After I overeat, occasionally I feel guilt or self-hate.

3 Almost all the time I experience strong guilt or self-hate after I overeat.