



The role of trait emotional intelligence in body dissatisfaction and eating disorder symptoms in preadolescents and adolescents



Cristina Cuesta-Zamora^{a,*}, Irene González-Martí^b, Luis Miguel García-López^a

^a University of Castilla-La Mancha, Faculty of Education, Music, Arts Education and Physical Education Department, Edificio Simón Abril, Plaza de la Universidad 3, 02071 Albacete, Spain

^b University of Castilla-La Mancha, Faculty of Education, Music, Arts Education and Physical Education Department, Edificio Fray Luis de León, Avenida de los Alfares 42, 16071 Cuenca, Spain

ARTICLE INFO

Keywords:

Trait emotional intelligence
Eating disorder symptoms
Body dissatisfaction
Drive for thinness
Bulimic symptoms
Adolescents
Preadolescents

ABSTRACT

Although the literature indicates that eating disorders (EDs) are associated with emotional problems and difficulties, there is scant research on the role of trait emotional intelligence (EI) in general preadolescent and adolescent populations. For these reasons, the main aim of this study was to analyze the relationships between trait EI, body dissatisfaction, bulimic symptoms and drive for thinness in preadolescents ($N = 382$) and adolescents ($N = 380$). Participants completed the Trait Emotional Intelligence Questionnaire-Adolescent Short Form, the Eating Disorder Inventory-3 and were weighed and measured to calculate their body mass index (BMI). Trait EI significantly predicted body dissatisfaction and ED symptoms in both samples, even after controlling for the effects of BMI. Indeed, in preadolescent and adolescent girls and in preadolescent boys, trait EI predicted bulimic symptoms over and above body dissatisfaction. Results suggest that perceptions and beliefs about emotional abilities may have an important role in ED symptoms in preadolescents and adolescents.

1. Introduction

Eating disorders (EDs) are persistent disturbances of eating or eating-related behaviors that result in significant impairments in physical health and psychosocial functioning (American Psychiatric Association [APA], 2013). Although adolescence is the period of greatest vulnerability to the development of eating disorders (APA, 2013), the age of onset of EDs is decreasing (Campbell & Peebles, 2014; Nicholls, Lynn, & Viner, 2011). The incidence rate for early onset of eating disorders (EOED) in children aged between 5 and 12 years ranges from 1.4 to 3.01 per 100,000 (Madden, Morris, Zurynski, Kohn, & Elliot, 2009; Nicholls et al., 2011; Pinhas, Morris, Crosby, & Katzman, 2011). In addition, EOED in children is associated with physical instability in 35% of cases (Hudson, Nicholls, Lynn, & Viner, 2012), and with at least one psychiatric comorbidity in 47.1% to 62% of cases (Madden et al., 2009; Pinhas et al., 2017). Hence, greater efforts are needed in the prevention and early detection of EDs (Campbell & Peebles, 2014; Nicholls et al., 2011).

Recent literature underscores the critical role of difficulties in emotion regulation (Fairburn, Cooper, & Shafran, 2003; Haynos & Fruzzetti, 2011; Lavender et al., 2015; Oldershaw, Lavender, Sallis, Stahl, & Schmidt, 2015; Pisetsky, Haynos, Lavender, Crow, & Peterson,

2017), and emotional processing (e.g., Sfarlea et al., 2016) in ED symptomatology. In this sense, eating-disordered behaviors (e.g., self-starvation, purging and excessive exercise) might be used as a dysfunctional way to regulate and provide an escape from aversive emotional arousal (Fairburn et al., 2003; Haynos & Fruzzetti, 2011). However, despite the growing research highlighting the role of emotion dysregulation in EDs, and although emotion regulation and emotional intelligence (EI) are important aspects of emotional management (Peña-Sarrionandia, Mikolajczak, & Gross, 2015), very few studies have addressed the role of EI. In essence, in contrast to the research tradition in emotion regulation, which focuses on the basic emotion regulation processes, the EI tradition addresses the impact of individual differences in emotion regulation on the social, health, educational and occupational domains (Peña-Sarrionandia et al., 2015).

1.1. Trait EI

Since the first definition of EI proposed by Salovey and Mayer (1990), varying approaches have emerged, giving rise to two models: ability EI (or cognitive-emotional ability) and trait EI (or trait emotional self-efficacy). Ability EI concerns emotion-related cognitive abilities evaluated through performance-based tests (Salovey & Mayer,

* Corresponding author at: Department of Didactic in Musical, Plastic and Physical Expression, Faculty of Education, University of Castilla-La Mancha, Edificio Simón Abril, Plaza de la Universidad 3, 02071 Albacete, Spain.

E-mail addresses: Cristina.Cuesta@uclm.es (C. Cuesta-Zamora), Irene.GMartí@uclm.es (I. González-Martí), LuisMiguel.Garcia@uclm.es (L.M. García-López).

<https://doi.org/10.1016/j.paid.2017.12.021>

Received 18 October 2017; Received in revised form 13 December 2017; Accepted 14 December 2017

0191-8869/© 2017 Elsevier Ltd. All rights reserved.

1990), whereas trait EI refers to a constellation of emotional self-perceptions located at the lower levels of personality hierarchies assessed through questionnaires and rating scales (Petrides, Pita, & Kokkinaki, 2007). In essence, trait EI defines how good individuals believe they are in terms of understanding, regulating and expressing emotions in order to adapt to their environment and maintain well-being (Petrides et al., 2016). In this study, we focus on trait EI for two reasons: firstly because adolescents' perceptions are an important aspect of their psychological adjustment (Poulou, 2014). Secondly, because not all the components of the ability model of EI seem to be consistently associated with robust tests of emotional understanding (e.g., Austin, 2010; Farrelly & Austin, 2007).

In adults, the literature consistently reflects that beliefs concerning one's own emotional abilities may play a key role in the development of body image and ED symptomatology (Swami, Begum, & Petrides, 2010). In this sense, findings show that low trait EI is associated with body appreciation (Swami et al., 2010), bulimic symptomatology (Gardner, Quinton, & Qualter, 2014; Markey & Vander Wal, 2007; Pettit, Jacobs, Page, & Porras, 2010), and ED symptoms (Costarelli, Demerzi, & Stamou, 2009; Zysberg, 2014; Zysberg & Tell, 2013). However, in adolescents, the relationships between trait EI and ED symptoms remain unclear. To the best of our knowledge, only two studies have been conducted in this regard, and with contrasting results. In this line, while Zavala and López (2012) observed negative associations between trait EI and ED symptoms, Wong, Lin, and Chang (2014), found that a higher trait EI score was associated with a greater tendency to develop EDs. Hence, although the relationships between trait EI and ED symptoms in adults are consistent, further research is required with adolescents, as the symptoms and severity of EDs differ significantly between adolescents and adults (e.g., Fisher, Schneider, Burns, Symons, & Mandel, 2001). A possible explanation for the discrepancy of findings in the relationships between trait EI and EDs may lie in the fact that both studies analyzed the results for boys and girls in conjunction. The associations between EDs and trait EI may vary by gender because, in adolescence, not only is body dissatisfaction higher in girls than boys but it also tends to increase with age in girls and decrease with age in boys (Smolak, Levine, & Thompson, 2001). Moreover, the role of trait EI in ED symptoms in males as a single group has not yet been analyzed either in adolescents or adults. Another possible explanation for the differences found in adolescents may be the use of different instruments to measure trait EI. In this sense, the study by Swami et al. (2010) is the only work to analyze the relationships between EI and body dissatisfaction (BD) from the perspective of trait EI theory, which provides a scientific basis for the interpretation of the findings (Swami et al., 2010). Thus, the study of the relationships between ED symptoms and trait EI from the perspective of trait EI theory by gender might help clarify these associations in adolescents.

Furthermore, despite the significant differences in the clinical presentation of psychological, behavioral and physical symptoms between children with EOED and adolescents with EDs (Bravender et al., 2007; Nicholls & Bryant-Waugh, 2009; Walker et al., 2014), the link between trait EI and ED symptomatology among preadolescents (10–12 years) remains under-researched. Given that previous research in preadolescents has found that high trait EI scores are related to lower levels of psychopathological symptoms (Frederickson, Petrides, & Simmonds, 2012; Williams, Daley, Burnside, & Hammond-Rowley, 2010a, 2010b), emotional and behavioral difficulties (Poulou, 2014) and attempted self-harm (Mikolajczak, Petrides, & Hury, 2009), trait EI might be associated with ED symptoms. Indeed, in this line Sim and Zeman (2005, 2006) have also found relationships between emotion dysregulation, BD and ED symptoms in preadolescents.

Thus, the first aim is to examine whether trait EI is related to BD and ED symptoms over and above body mass index (BMI) in preadolescents and adolescents. In adolescents, the predisposition toward elevated premorbid BMI during childhood could be a risk factor for the onset of body dissatisfaction and ED symptomatology (e.g., Allen, Byrne,

Crosby, & Stice, 2016; Berkowitz et al., 2016; Stice, Gau, Rohde, & Shaw, 2017). Drawing on models of emotion dysregulation and the previously cited research, the first hypothesis is that relationships will be found between trait EI, body dissatisfaction and ED symptoms even after controlling for BMI. The second aim is to determine whether trait EI is a predictor of drive for thinness and bulimic symptoms over and above BD. Body dissatisfaction is recognized as a robust risk factor for EDs (Stice, 2002). As Sim and Zeman (2005) found that emotion dysregulation predicted bulimic symptoms over and above BD, trait EI is also expected to predict drive for thinness and bulimic symptoms even after controlling for BD. The third aim is to examine whether significant differences exist between levels of ED symptoms in preadolescents and adolescents and in girls and boys. Drawing on the previous literature (Smolak et al., 2001), we expect to find significant differences in gender and age. If differences are found between preadolescents and adolescents, the analyses will be conducted separately.

2. Method

2.1. Participants

The sample comprised 382 preadolescents (51.8% females, $M = 10.55$, $SD = 0.60$ years, range = 10–12 years) and 380 adolescents (47% females, $M = 13.53$, $SD = 1.25$ years, range = 12–17 years) from various primary and secondary schools in the provinces of Albacete, Cuenca, Ciudad Real and Toledo in the autonomous community of Castilla-La Mancha (Spain). To ensure both samples were representative of the complete region of Castilla-La Mancha, we took into account the following parameters: a confidence level of 95% ($p < 0.05$), a confidence interval of 6.2, and the size of the entire preadolescent and adolescent population of the region (42,750 preadolescents and 86,168 adolescents) (Junta de Comunidades de Castilla-La Mancha, 2017).

2.2. Measures

2.2.1. Trait emotional intelligence questionnaire-adolescent short form

The Spanish version of the Trait Emotional Intelligence Questionnaire-Adolescent Short Form (TEIQue-ASF; Petrides, Sangareau, Furnham, & Frederickson, 2006) was used to measure trait EI. The TEIQue-ASF is a 30-item self-report instrument that yields a global EI trait score. The items are scored on a 7-point Likert-type scale (1 = *Completely disagree*; 7 = *Completely agree*) and incorporate the 15 subscales of the trait EI model: adaptability, assertiveness, emotion appraisal (self and others), emotion expression, emotion management (others), emotion control, impulsiveness (low), relationships, self-esteem, self-motivation, social awareness, stress management, trait empathy, trait happiness and trait optimism. The TEIQue-ASF has shown solid incremental validity in the presence of other constructs such as cognitive ability (e.g., Ferrando et al., 2011; Siegling, Vesely, Saklofske, Frederickson, & Petrides, 2017), personality, self-concept (Ferrando et al., 2011) and coping strategies (Siegling et al., 2017). In Spanish preadolescents and adolescents, the test has exhibited an internal consistency of 0.82 (Ferrández, Hernández, Bermejo, Ferrando, & Sáinz, 2012; Ferrando et al., 2011). In the present study, the internal consistency for the entire sample was 0.80.

2.2.2. Eating disorder inventory-3

To measure the total score for ED symptoms, we used the subscales of drive for thinness (DT-EDI-3), bulimia (B-EDI-3) and body dissatisfaction (BD-EDI-3) from the Eating Disorder Inventory-3 (EDI-3; Garner, 2004), in the Spanish version by Elosua, López-Jáuregui, and Sánchez-Sánchez (2010). The drive for thinness subscale comprises seven items measuring participants' extreme desire to be thinner, concern for dieting, preoccupation with weight and intense fear of weight gain. The 8-item bulimia subscale assesses aspects related to binge

Download English Version:

<https://daneshyari.com/en/article/7248929>

Download Persian Version:

<https://daneshyari.com/article/7248929>

[Daneshyari.com](https://daneshyari.com)