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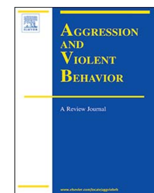

Developmental pathways between peer victimization, psychological functioning, disordered eating behavior, and body mass index: A review and theoretical model

Kirsty S. Lee[a], Tracy Vaillancourt[a,b,*]

[a] Counselling Psychology, University of Ottawa, Canada
[b] School of Psychology, University of Ottawa, Canada

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ABSTRACT

Peer victimization, a high body mass index (BMI), and disordered eating behavior are all considered to be major health concerns afflicting today's youth. We bring together evidence from epidemiological, longitudinal, and meta-analytic research to propose a theoretical model of how peer victimization relates to psychopathology, which in turn, leads to misguided attempts to alter physical appearance through disordered eating behavior, and highlight how the pathway may vary as a function of BMI and gender. Specifically, we argue that, as a result of being victimized by peers: (1) overweight adolescents will be at high risk of psychological dysfunction and disordered eating behavior (particularly binge eating), and the effect will be stronger in girls; (2) average weight adolescents will be at high risk of psychological dysfunction and disordered eating behavior (particularly binge eating and bulimic symptoms), and the effect will be stronger in girls; and (3) underweight adolescents will be at high risk of psychological dysfunction and disordered eating behavior (particularly to increase muscle mass), and the effect will be stronger in boys. The identification and testing of comprehensive theoretical models may be beneficial for the targeting of interventions for children and adolescents affected by repeated aggressive behavior.

Peer victimization (i.e., being the target of intentional and repeated aggression by peers where an imbalance of power exists; being bullied) is highly pervasive and has been acknowledged as a major public health concern (Feder, 2007). Decades of research show that peer victimization adversely affects psychological functioning and adjustment (see McDougall & Vaillancourt, 2015 and Wolke & Lereya, 2015, for reviews) at the time of victimization and over 40 years later (Takizawa, Maughan, & Arseneault, 2014). Although peer victimization is most prevalent in children aged around 8–10 years old (Analitis et al., 2009; Tippett, Wolke, & Platt, 2013), among adults, peer victimization appears to be most memorable between the ages of 11 and 13, suggesting that peer victimization during early adolescence may be particularly severe and noteworthy (Eslea & Rees, 2001). Adolescence is a critical period of development and negative experiences during this time have the potential to influence psychological and physical health in a myriad of ways.

1. The influence of peer victimization on psychological functioning

Being victimized by peers during adolescence, whether through direct (e.g., being hit, kicked, name called) or indirect acts (e.g., being socially excluded or the target of malicious rumors), has been associated with numerous psychological difficulties, like depression and emotional problems, as well as psychotic experiences, self-harm, and suicide ideation and attempt (Copeland, Wolke, Angold, & Costello, 2013; Fox & Farrow, 2009; Lereya et al., 2013; Lereya, Copeland, Costello, & Wolke, 2015; Stapinski et al., 2014; Vaillancourt, Brittain, McDougall, & Duku, 2013; Vaillancourt & Sunderani, 2011; Winsper, Lereya, Zanarini, & Wolke, 2012; Zwierzynska, Wolke, & Lereya, 2013). Peer victimization has consistently been associated with low self-esteem and internalizing disorders in the immediate (Wolke, Lee, & Guy, 2017) and long-term (Haltigan & Vaillancourt, 2014, 2017; Vaillancourt et al., 2013). In one study of nearly 3000 adolescents aged 11- to 16-years from UK, targets of bullying were found to have significantly lower self-esteem than non-targets, with self-esteem being lowest among adolescents who were victimized by multiple means (i.e., direct, relational,

* Corresponding author at: Counselling Psychology, Faculty of Education and School of Psychology, Faculty of Social Sciences, University of Ottawa, K1N 6N5, Canada.
E-mail address: tracy.vailancourt@uottawa.ca (T. Vaillancourt).

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cyber) (Wolke et al., 2017). Combining the results of multiple longitudinal studies in a meta-analysis, Reijntjes, Kamphuis, Prinzie, and Telch (2010) found reciprocal associations between peer victimization and internalizing disorders over time, with the effect being strongest when peer victimization predicted future internalizing disorders (r = .18), rather than the reverse (r = .08). Internalization is essentially the integration of others attitudes or opinions into one's own self-image, and internalizing symptoms like anxiety, depression, and emotional dysregulation have been associated with self-blame among targets of bullying (Graham & Juvonen, 1998). This suggests that the experience of peer victimization can lead young people to blame themselves for the abuse and come to believe they are fundamentally flawed (Miller & Vaillancourt, 2011).

A perception of being flawed is probably most evident in the way peer victimized children and adolescents feel about their bodies. There is much evidence that body-esteem, (i.e., the subjective evaluation of one's appearance; Smolak & Thomson, 2009), is significantly lower than average among children and adolescence who get teased or bullied (Farrow & Fox, 2011; Lereya, Eryigit-Madzwamuse, Patra, Smith, & Wolke, 2014; Paxton, Neumark-Sztainer, Hannan, & Eisenberg, 2006; Van den Berg, Wertheim, Thompson, & Paxton, 2002), and the effect may be long-lasting. In a longitudinal study based in Sweden, Lunde, Frisén, and Hwang (2007) found that peer victimization at age 10 resulted in poorer weight-esteem in girls and poorer appearance attributions (i.e., evaluations attributed to others about one's body and appearance) in boys at age 13. In a retrospective study of young adults in European universities, Lereya et al. (2014) found that a history of relational peer victimization at school was associated with low body-esteem in women and men. Body-esteem is generally lower among girls and women in comparison to boys and men (Morin, Maïano, Scalas, Janosz, & Litalien, 2017), yet there appear to be few gender differences in the extent to which poor body-esteem affects quality of life (Griffiths et al., 2017) or the desire to change the body, even in extreme ways like via cosmetic surgery, among girls and boys who are victimized by their peers (Lee, Guy, Dale, & Wolke, 2017a; Pertschuk, Sarwer, Wadden, & Whitaker, 1998).

Numerous studies have reported that the psychological constructs of body-esteem, self-esteem, and emotional problems are closely related (Brunet, Sabiston, Dorsch, & McCreary, 2010; Cohane & Pope, 2001; McCreary & Sasse, 2000; Van den Berg et al., 2002). Early research showed that adolescent body image was related to internalizing dimensions of psychopathology (Attie & Brooks-Gunn, 1989), and more recently, longitudinal research showed that adolescent body dissatisfaction predicted low self-esteem and depressive symptoms five years later (Paxton et al., 2006). Similar findings were found in a population based sample of Norwegian adolescents, which showed a strong bi-directional relation between self-esteem and body satisfaction in girls and boys over a 13-year period (Wichstrøm & von Soest, 2016). As such, previous researchers have combined measures of self-esteem, body-esteem, and emotional problems into an indicator of psychological functioning (Lee et al., 2017a; Lee, Guy, Dale, & Wolke, 2017b; McCreary & Sasse, 2000; Van den Berg et al., 2002). Taken together, there appears to be a direct pathway between peer victimization during childhood and adolescence and future psychological dysfunction (McDougall & Vaillancourt, 2015).

1.1. The influence of peer victimization on disordered eating behavior

Disordered eating behavior can manifest as any predetermined strategy to maintain, lose, or gain weight, and can include extreme behavior like binging, purging, and consuming diet pills, powders or supplements. These types of behavior are associated with clinical eating disorders as diagnosed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). For example, a diagnosis of anorexia nervosa requires a person to present with emaciation, persistent restriction of calories, persistent behavior that prevents weight gain, an intense fear of gaining weight, and body image disturbance. A diagnosis of bulimia nervosa requires a person to be preoccupied with their body or weight, engage in recurrent episodes of uncontrolled binge eating, and use compensatory behavior to avoid weight gain like self-induced vomiting, abusing laxatives or diuretics, fasting (specifically to lose weight), or engaging in excessive exercise. The DSM-5 also contains a diagnosis for Binge Eating Disorder, in which recurrent episodes of binge eating accompanied by distress are present, but are not associated with the compensatory behavior typically seen in bulimia. The prevalence of clinical eating disorders are relatively rare in the general population: estimates for anorexia nervosa range between 0.3% to 2.2% in girls and women and 0% to 0.3% in boys and men; estimates of bulimia range between 0.5% to 1.6% in girls and women and 0.1% to 0.7% in boys and men; estimates of binge eating disorder range between 1.9% to 3.5% in girls and women and 0.3% to 2% in boys and men (Ricciardelli & Yager, 2015). Despite the rarity of clinical diagnoses, sub-threshold symptoms are highly prevalent in community samples, particularly among older adolescents (Ricciardelli & Yager, 2015), and are associated with significant impairment and morbidity (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). In a large study of more than eighty thousand American adolescents, Croll, Neumark-Sztainer, Story, and Ireland (2002) found that 56% of girls and 28% of boys in grade 9 and 57% of girls and 31% of boys in grade 12 reported engaging in one or more disordered eating behavior. In a sample of over 7000 adolescents in the UK, Micali et al. (2017) found that at age 16 and 18, around 12.5% of girls had symptoms of disordered eating behavior, in comparison to 5.7% at age 14.

It is well documented that teasing about appearance can lead to disordered eating behavior and weight control strategies (Brown, Skelton, Perrin, & Skinner, 2016; Menzel et al., 2010). Weight and shape teasing by peers has been shown to predict frequent dieting among girls (Haines, Neumark-Sztainer, Eisenberg, & Hannan, 2006) and binge eating among girls and boys (Agras, Bryson, Hammer, & Kraemer, 2007). It may seem intuitive that appearance-based teasing is associated with a subsequent desire to alter the size or shape of the body, but there is emerging evidence that any type of victimization by peers (e.g., being the target of repeated physical aggression or social exclusion) is associated with disordered eating behavior. In the UK, Lee et al. (2017b) found that adolescents aged 11–16 years who experienced direct, relational, or cyber victimization by their peers were more preoccupied with losing weight, regardless of their actual weight, compared to adolescents who were not victimized by their peers, while Farrow and Fox (2011) found that experiences of direct, relational, or cyber victimization by peers was associated with restrained eating in 11–14-year-olds. In an American longitudinal study spanning 16 years, Copeland et al. (2015) found that targets of peer mockery, physical attacks, or threats were at increased risk of anorexic and bulimic symptoms.

Disordered eating behavior has been typically associated with weight loss, but there is increasing evidence that disordered eating behavior is similarly associated with a desire to gain weight or muscle. Special diets, like the use of food supplements (e.g., protein powders), are now commonly used as a strategy to increase weight and muscle mass among adolescent girls and boys (Field et al., 2005). The use of such supplements is normally combined with exercise, and just as healthy behavior clusters together, so too does unhealthy behavior (Berrigan, Dodd, Troiano, Krebs-Smith, & Barbash, 2003; Busch, Van Stel, Schrijvers, & de Leeuw, 2013). Among late adolescents and adults, compulsive exercise (e.g., “when I don't exercise I feel guilty”) has been associated with disordered eating attitudes and behavior (Adkins & Keel, 2005; Holland, Brown, & Keel, 2014). In western societies, both girls and boys experience sociocultural pressure to gain muscle (McCabe & Ricciardelli, 2003) and there appear to be few gender differences in the extent to which adolescent girls and boys use protein supplements and weight management products (e.g., diet pills, fat absorbers, appetite suppressants; Bell, Dorsch, McCreary, & Hovey, 2004;

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