



Loss of control eating in adolescents: Associations with adaptive and maladaptive emotion regulation strategies



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ABSTRACT

Objective: To examine differences in the use of emotion regulation strategies in adolescents with and without loss of control over eating (LOC).

Method: A community-based sample of 524 adolescents from 12 to 18 years old (70.6% girls; $M_{age} = 15.08$; $SD = 1.59$) reported on LOC and the use of several maladaptive and adaptive emotion regulation strategies.

Results: Adolescents who experience LOC (28%) report more use of maladaptive strategies. With regard to adaptive strategies a significant group X gender interaction effect was found with girls who report LOC using less adaptive strategies. More specifically, based on the FEEL-KJ less problem-oriented action, distraction, humor enhancement, acceptance and cognitive problem solving were observed in girls who report LOC compared to those who do not report LOC. Boys with LOC report more use of adaptive strategies compared to those who do not report LOC.

Discussion: LOC in adolescents is associated with increased use of maladaptive emotion regulation strategies as well as a decreased use of adaptive strategies although the latter is only specific for girls. These results may inform prevention and treatment of emotion regulation problems in adolescents with LOC.

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1. Introduction

Binge eating is characterized by the consumption of an objectively large amount of food accompanied by the experience of loss of control over eating (LOC) (APA, 2013). Binge eating, even at a subthreshold frequency, appears to be common among adolescents with prevalence estimates ranging from approximately 2–20% in community samples up to 40% in overweight youth (Glasofer et al., 2007; Goossens, Soenens, & Braet, 2009; Sonnevile et al., 2013). Also common are reports of eating episodes during which adolescents experience LOC without consuming an unambiguously large amount of food. Studies demonstrate that youth who report LOC are characterized by elevated levels of psychopathology and maladjustment irrespective of whether or not a large amount of food is eaten. For example, LOC appears to be associated with greater eating-related emotional distress, anxiety, and depressive symptomatology and poorer self-esteem (Decaluwe & Braet, 2003; Tanofsky-Kraff, Faden, Yanovski, Wilfley, & Yanovski, 2005). Moreover, longitudinal studies indicate that LOC eating is predictive of exacerbated general and eating disorder psychopathology (Hilbert, Hartmann, Czaja, & Schoebi, 2013; Tanofsky-Kraff et al., 2011), excessive weight and fat gain (Tanofsky-Kraff et al., 2009) and metabolic dysfunction (Tanofsky-Kraff et al., 2012) and may be a precursor of binge eating disorder (Tanofsky-Kraff et al., 2011). Therefore, investigating which

factors are implicated in LOC eating is still important to inform both developmental risk models of eating and weight pathology as well as to refine prevention, screening, and early intervention strategies for eating and weight disorders in youth (Goldschmidt, Wall, Loth, Bucchianeri, & Neumark-Sztainer, 2014).

When examining the development and maintenance of psychopathology, emotion regulation (ER) appears to be an important transdiagnostic process (Berking & Wupperman, 2012; Gross & Thompson, 2007). ER can be conceptualized as the process by which individuals modify their emotions or the situations eliciting the emotions (Gross, 1998). According to Aldao and Nolen-Hoeksema (2012) ER strategies can be classified as ineffective (maladaptive) versus effective (adaptive) based on both their immediate and long-term effects on affect, behavior and cognition. In their meta-analysis, Aldao, Nolen-Hoeksema, and Schweizer (2010) found that maladaptive ER strategies such as rumination, avoidance, and suppression are more strongly related to psychopathology (i.e. depression, anxiety, substance abuse, and eating disorders) than adaptive strategies like acceptance, problem-solving, and reappraisal. However, most of the studies that were included in this meta-analysis were conducted in adult samples. From a developmental view, the ability to regulate emotions already starts at very young ages and further increases through childhood and adolescence (Zeman, Cassano, Perry-Parrish, & Stegall, 2006). Research shows that a more frequent use of maladaptive ER strategies is already in youngsters characterized by a worse psychological outcome in terms of

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more rejection by peers (Kim & Cicchetti, 2010), more depressive, and anxiety symptoms (e.g. Carthy, Horesh, Apter, & Gross, 2010; Silk, Steinberg, & Morris, 2003). With regard to the use of adaptive strategies, research shows that a higher presence of adaptive strategies in children is related to better coping with stress whereas more emotional and behavioral problems such as symptoms of anxiety, depression, conduct, and oppositional problems are reported in community-based samples when children and adolescents have less adaptive strategies at their disposal (Braet et al., 2014). Unfortunately this latter study did not examine associations with eating pathology.

Theoretically it has already been suggested that LOC eating occurs in response to negative emotional states (Heatherton & Baumeister, 1991; Leon, Fulkerson, Perry, & Early-Zald, 1995) and some adult models of eating disorders (Fairburn, Cooper, & Shafran, 2003; Schmidt & Treasure, 2006) suggest that individuals with poorly regulated emotions often turn to food to escape from or down-regulate their emotions thereby increasing the risk for the development of an eating disorder. Empirically, negative affect has found to be a robust risk factor and causal risk factor for LOC in adults (Stice, 2002). Over the past years there have been studies in children and adolescents as well that found evidence for the cross-sectional and longitudinal association between negative affect and LOC eating (Goldschmidt et al., 2014; Hilbert et al., 2013; Ranzenhofer et al., 2014; Tanofsky-Kraff et al., 2007) However, most evidence comes from studies questioning about youngsters' levels of negative affect (mainly using scales that assess symptoms of depression and anxiety) or emotional eating but less evidence is available on which specific ER strategies are associated with LOC in adolescents.

In female adolescents, researchers (Fryer, Waller, & Kroese, 1997) found a role of emotion-focused coping, but not problem-focused coping, for explaining a general measure of disturbed eating attitudes. In another female adolescent population, researchers (Norwood et al., 2011) found that those girls with eating pathology, in terms of restrained and emotional eating, reported more use of expression and suppression strategies. Although these few results support the assumption that disordered eating is associated with more maladaptive emotion regulation, no conclusions can be drawn concerning the specific association with LOC, neither is it possible to conclude whether these associations between ER and disordered eating are also present in adolescent boys. To our knowledge, Czaja, Rief, and Hilbert (2009) were the first to investigate the association between a broad range of ER strategies and LOC in a sample of 8 to 13-year old children (of both genders) and concluded that children with LOC used significantly more maladaptive ER strategies (especially giving up and rumination) compared to children without LOC. Interestingly, both groups did not differ in their use of adaptive ER strategies. Furthermore, past evidence has shown that the use of ER strategies varies by age (Zeman et al., 2006), and more specifically that with increasing maturation children may learn to make more use of adaptive ER strategies and less use of maladaptive ER strategies (Gullone, Hughes, King, & Tonge, 2010; John & Gross, 2004). Therefore, it remains to be investigated whether the conclusions that were drawn by Czaja et al. (2009) can be generalized to an adolescent population.

It was the aim of the present study to examine differences in the use of adaptive and maladaptive emotion regulation strategies in adolescents with and without LOC. In line with previous studies in children (Czaja et al., 2009), it was hypothesized that adolescents who report LOC use more maladaptive ER strategies in general, as well as more of several specific maladaptive ER strategies (giving up, aggressive action, withdrawal, self-devaluation, and rumination). Although in the study of Czaja et al. (2009) no differences were found with regard of the use of adaptive ER strategies, based on transdiagnostic research (Braet et al., 2014), we hypothesized that adolescents who report LOC will also use less adaptive strategies, again both on general level as well as with regard to some specific adaptive ER strategies (i.e. acceptance, problem-oriented action, cognitive problem solving, distraction, neglect, reevaluation, and put into good humor).

2. Materials and methods

2.1. Participants and procedure

Participants were recruited from the community through information letters which were passed around in nine high schools (grades 7–12) and via the University's psychology students as part of a practical course. Every participant received the same information letter explaining that this study was part of a larger project on behavior and emotions of adolescents from 12 to 18 years old. Participants either completed the questionnaires in the class room (paper version) or at home (paper or online version). Completion of the entire set of questionnaires took approximately 45 min. In the sample who filled out the questionnaires in the class room, school principals and adolescents gave their active consent while parents gave their passive consent. In the sample who filled out the questionnaires at home, both adolescents and parents gave their active consent. Every adolescent got a unique code to maintain anonymity and confidentiality. Ethics approval was obtained from the University's Ethics Committee.

2.2. Measures

2.2.1. Loss of control over eating (LOC)

To assess LOC, we used the Children's Eating Disorder Examination Questionnaire (ChEDE-Q) (Decaluwé & Braet, 1999), which is a Dutch adaptation of Fairburn and Beglin's (1994) EDE-Q. The ChEDE-Q was designed for use in youngsters from 8 to 18 years old (see Decaluwe and Braet (2004) for more information regarding this modification). Concordant with the EDE-Q, the ChEDE-Q is the only self-report questionnaire available that differentiates between the various forms of binge eating and provides the determination of binge eating as defined in DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013). It measures objective bulimic episodes (OBE; a sense of loss of control accompanied by eating a large amount of food that other people would also qualify as large) and subjective bulimic episodes (SBE; a sense of loss of control accompanied by eating a large amount of food according to the subject, but that other people would not qualify as unambiguously large). Both OBE and SBE fall under the coordinating term of LOC (Marcus & Kalarchian, 2003). In the present study youngsters were categorized as experiencing LOC when they reported at least one episode of OBE or SBE during the last month (LOC+ group). Youngsters who did not report SBE or OBE were categorized in the NoLOC (LOC-) group (see also Tanofsky-Kraff et al. (2004) for this procedure). Research demonstrated the reliability and validity of the ChEDE-Q for examining eating pathology in youngsters from the general population (Goossens & Braet, 2010; Van Durme, Craeynest, Braet, & Goossens, 2015) and in clinical samples of treatment seeking obese youngsters (Decaluwe & Braet, 2003; Decaluwe, Braet, & Fairburn, 2003).

2.2.2. Emotion regulation

The Questionnaire to Assess Children's and Adolescents' Emotion Regulation strategies (FEEL-KJ; Cracco, Van Durme, & Braet, 2015; Grob & Smolenski, 2005) is a 90-item self-report questionnaire measuring 15 emotion regulation strategies in response to three emotions, i.e. anger, anxiety, and sadness in children and adolescents between the age of 10 and 20. Each ER strategy is assessed by two items for each of the three emotions, and items are rated on a five-point scale from 1 = almost never to 5 = almost always. The FEEL-KJ encompasses 15 primary emotion regulation strategies and two secondary emotion regulation scales conformed through factor analyses, i.e. an adaptive emotion regulation scale and a maladaptive emotion regulation scale (Cracco et al., 2015). The Adaptive ER scale consists of seven primary strategies (acceptance, problem-oriented action, cognitive problem solving, distraction, neglect, reevaluation, and put into good humor) and the Maladaptive ER scale consists of five primary strategies (giving up, aggressive action, withdrawal, self-devaluation, and rumination).

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