SCIENTIFIC CULTURE
www.sci-cult.com

SCIENTIFIC CULTURE, Vol. 12, No. 2.1, (2026), pp. 9499-9514
Open Access. Online & Print

DOI: 10.5281/zenodo.19980664

PSYCHOLOGICAL ANTECEDENTS OF FOOD CONSUMPTION: A CONSUMER BEHAVIOR PERSPECTIVE ON CHILDHOOD TRAUMA

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Received: 15/03/2026
Accepted: 18/04/2026

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ABSTRACT

This paper presents the effects of childhood trauma on the subtypes on maladaptive food consumption behavior among young adult consumers in terms of consumer behavior. Going past the clinical interpretations, the study places trauma as a latent psychological force that affects the patterns of consumption including emotional overeating, emotional undereating, food fussiness and slowness in consumption. The study employs a correlation analysis to identify the correlation relationships between trauma subtypes and consumption behavior as well as the gender differences using cross-sectional design and 131 respondents aged 18-25. Results indicate that physical and sexual abuse have a strong effect on patterns of controlled consumption, specifically slowness in eating whereas physical neglect is almost significantly related with emotional overeating. Differences in genders also bring out inconsistency in consumption responses to trauma. The research can add to the literature on consumer behavior by establishing trauma as a poorly explored predictor of consumption behavior and providing managerial implications of food marketing, health branding and ethical consumer interaction.

KEYWORDS: Consumer Behavior, Food Consumption Behavior, Emotional Consumption, Psychological Drivers, Childhood Trauma, Gender Differences.

1. INTRODUCTION

Eating is not only a biological demand but a complicated behavioral response to psychological, emotional and social factors. In the literature about consumer behavior, emotional and past experience, together with cognitive processes, are taken as internal drivers that have much influence in making consumption decisions. One of them, early-life experiences, especially childhood trauma have been under studied as the determinants of consumption behavior. The concept of childhood trauma to include emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect had been a subject of long research in the fields of psychology and clinical psychology. Nonetheless, its consumer behavior implication especially food consumption patterns are becoming more relevant. Traumatic experiences also have the ability to change emotional regulation, stress responses and coping mechanisms and hence this affects consumption-related behaviors. The behavioral responses to internal psychological states can be explained by such maladaptive food consumption behaviors like emotional overeating, undereating, food selectivity, and slow consumption. They are not merely health-related patterns but also very critical patterns based on marketing stand point because they influence consumer tastes, buying patterns, and brand relations. This research is important in bridging the gap between marketing and psychology by exploring the role of childhood trauma as a hidden psychological factor that affects consumption behaviour in young adults. It further examines gender and its moderating role offering information on the differentiated consumer reactions.

The developmental trajectory from childhood through young adulthood involves significant psychological and physiological changes that shape an individual's relationship with self, others, and the environment. Among various influences on personal development, childhood trauma emerges as a critical factor due to its profound and lasting effects on mental and physical health outcomes. Eating behavior represents a complex interplay of physiological, psychological, social, and genetic factors influencing meal timing, food intake quantity, food preference, and selection (Grimm & Steinle, 2011). Recent decades have witnessed growing interest in understanding complex relationships between childhood trauma and subsequent impact on maladaptive eating behaviors in late adolescence and young adulthood. Childhood trauma encompasses a broad spectrum of adverse experiences including emotional, physical, and sexual abuse, neglect, and household dysfunction. According to the American Psychological Association (2013), trauma refers to disturbing experiences resulting in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to produce long-lasting negative effects on attitudes, behavior, and functioning. These experiences can lead to various negative outcomes, including development of maladaptive eating behaviors that may persist into adulthood and contribute to serious health complications. For many individuals, eating represents a complicated matter influenced by variables beyond survival, sustenance, and hunger. The functional goal of eating is to help sustain and grow life, yet for a great number of individuals, eating becomes complicated by psychological, emotional, and social factors (Nordström, Coff, Jonsson, Nordenfelt & Göman, 2013, as cited in Strodl & Wylie, 2020). Maladaptive eating behaviors, if left unaddressed, can progressively evolve into more severe eating disorders such as anorexia nervosa and bulimia nervosa. These behaviors serve as early indicators of deeper psychological issues related to food and body image. Understanding how different subtypes of childhood trauma specifically influence maladaptive eating behaviors in young adults represents a critical step toward unraveling the intricate web of causation and correlation defining this relationship. The significance of this research lies in its potential to contribute to broader psychological and medical fields by providing insights into mechanisms through which childhood trauma affects eating behaviors. A rising corpus of research and increasing amounts of evidence indicate that childhood trauma exposure has both short-term and long-term effects on physical and mental health (Spataro et al., 2004, as cited in Dye, 2018). Psychopathology in children and adults, such as attention deficit and hyperactivity disorder, anxiety and depression, and personality disorders, has been related to early trauma exposure (Cummings et al., 2012, as cited in Dye, 2018), as well as other concerns including substance abuse, low socioeconomic status, and higher risk of victimization in adulthood (Enoch, 2011). By identifying specific trauma-related factors predisposing individuals to maladaptive eating behaviors, this study provides valuable insights informing creation of more effective preventive measures and treatment interventions for those affected by both childhood trauma and eating

disorders. This study proves particularly timely and relevant given rising prevalence of eating disorders and obesity among young adults, highlighting urgent need for comprehensive approaches addressing root causes of these conditions. The interplay between early adverse experiences and eating patterns remains insufficiently understood, particularly regarding specific trauma subtypes and their differential impacts across gender groups.

2. LITERATURE REVIEW

2.1. Childhood Trauma as a Psychological Driver of Consumption

Childhood trauma is defined as an unpleasant experience in early years that interferes with emotional and cognitive functioning. Such experiences usually have long-term alterations on stress response systems and emotional regulation, which influence decision making systems, such as consumption behavior. Conceptually, regarding the consumer behavior, the concept of trauma can be presented as an internal stimulus, which forms consumption motivations. Consumption behaviors can be used as coping mechanisms by people with a history of trauma, thus they can connect psychological distress to consumption outcomes.

Understanding the relationship between childhood trauma and maladaptive eating behaviors requires systematic examination of trauma subtypes, their mechanisms, and their specific impacts on eating patterns. Childhood trauma encompasses a range of adverse experiences with distinct characteristics and impacts. The World Health Organization and international research bodies identify four primary categories of child maltreatment: sexual abuse, physical abuse, emotional and psychological abuse, and neglect (Mandelli, Petrelli & Serretti, 2015). Each subtype manifests unique features and consequences that influence developmental trajectories and behavioral outcomes in distinct ways. Emotional abuse involves persistent emotional maltreatment causing severe adverse effects on emotional development. According to the American Psychological Association (2018), emotional abuse includes verbal abuse, intimidation, humiliation, degradation, exploitation, harassment, rejection, withholding affection, isolation, and excessive control. The standard definition of emotional neglect extends to situations where a child's emotional needs are not adequately fulfilled (Kumari, 2020). Certain forms of emotional abuse are apparent, such as when a child is constantly sworn at, yelled at, criticized, or humiliated. Other forms, involving when a child is subjected to unjust demands or expectations, or when they are treated unfairly due to their physical appearance or disability, are less obvious (Kumari, 2020). Several factors contribute to occurrence of child emotional abuse, including parental characteristics, family dynamics, and environmental influences. Physical abuse constitutes intentional use of physical force against a child resulting in harm or high likelihood of harm to health, survival, development, or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning, and suffocating (Norman, Byambaa, De, Butchart, Scott & Vos, 2012). In the home, physical abuse of children is frequently done with the intention of punishing them (Norman et al., 2012). The prevalence of child physical abuse varies globally due to differences in reporting mechanisms, cultural norms, and legal definitions. In the United States, approximately 16.5 percent of children experience physical abuse by age 18 (Finkelhor, Turner, Shattuck & Hamby, 2015). In high-income countries, annual prevalence of physical abuse ranges from 4 to 16 percent (Norman et al., 2012). Physical abuse of children is linked to serious physical and mental health issues that can persist into adulthood, and it represents a significant contributor to pediatric morbidity and mortality (Christian, 2015). Sexual abuse encompasses any sexual activity that children cannot understand or consent to, or that violates law (Modelli, Galvão & Pratesi, 2012). Without elaborating on specific behaviors, a number of general population surveys characterize childhood sexual abuse as unwanted sexual contact. There are variations in research that differentiate between contact abuse, non-contact abuse, or penetrative abuse and non-penetrative abuse. Prevalence rates for child sexual abuse range from 3 to 17 percent for boys and 8 to 31 percent for girls worldwide (Barth, Bermetz, Heim, Trelle & Tonia, 2013). Compared to boys, girls experience sexual abuse more frequently. Due to guilt and apprehension about being gay, there is a propensity for male sexual assault to go unreported (Holmes & Slap, 1998, as cited in Glaser, 2015). When a child engages in sexual activity with another child, it is also seen as abuse if the offending child is considerably older than the victim or utilizes force, intimidation, or other forms of coercion (Glaser, 2015). Emotional neglect represents failure to provide stable and comprehensive emotional and social competencies to children in supportive, developmentally appropriate settings (Stoltenborgh, Bakermans-Kranenburg, Alink & van IJzendoorn, 2014). Physical neglect involves failure to meet basic

physical needs including adequate nutrition, clothing, shelter, and supervision. One of the most prevalent types of child abuse that is frequently connected to other types of abuse is neglect. Child neglect is distinct from other types of maltreatment since it involves failing to provide for a child's basic requirements (Avdibegović & Brkić, 2020). A significant number of cases involve physical neglect, that is, failing to meet children's physical needs, allowing criminal behavior, abandonment, and educational neglect. Less frequently occurring are medical neglect, failing to supervise leading to sexual abuse, and failing to provide a child with necessary treatment. Due to their lack of obvious injuries and frequently delayed effects on development, emotional neglect and exposure to family violence are difficult types of maltreatment to define (Hildyard & Wolfe, 2002).

Emotional Consumption and Consumer Behavior

According to the emotional consumption theory, people purchase goods not only due to their usefulness but because they need to control their emotions. Food, especially, is an emotional coping mechanism, and people can eat more or less depending on their emotions. Emotion-driven consumption responses can therefore be viewed as the maladaptive consumption behaviors like undereating and emotional overeating (Gong et al., 2023). Such behaviors are in line with the general theories of consumer behavior which have focused on the influence of affect in the decision making process.

Multiple pathways connect childhood trauma experiences to subsequent eating behaviors, operating through neurobiological, psychological, and social mechanisms. Briere's (1996) self-trauma model proposes that children experiencing abuse suffer developmental disruption, particularly to attachment systems and cognitive development (Browne & Winkelman, 2007). For Briere, the disruption occurs to the attachment system and to cognitive development. Once children enter school, one of the first indications of adverse experiences during childhood becomes evident. School performance and cognition have been proven to be significantly impacted by developmental impairments stemming from trauma in childhood (McKissick, 2019). According to a study, children who experienced abuse before attending kindergarten had worse grades and higher absentee rates, increased hostility, and significantly more behavioral and psychological issues in high school (Lansford et al., 2002, as cited in McKissick, 2019). Service design and youth-centered approaches prove essential for addressing trauma impacts in clinical and community settings. Hamid (2018) demonstrated that human resources competency and working discipline significantly affect patient satisfaction in healthcare settings, suggesting that quality service provision plays crucial roles in supporting trauma survivors. Understanding how institutional frameworks support or hinder recovery remains critical, as evidenced by research on citizen participation in social welfare programs (Dadi, 2019). These studies highlight importance of systemic approaches that consider not only individual trauma experiences but also quality and accessibility of support services available to trauma survivors. Trauma exposure modifies brain development and functioning in profound ways. Children exposed to early trauma exhibit significantly smaller cerebellums and cerebrums compared to non-exposed peers, with early stress and trauma exposure modifying cognitive function development (McKissick, 2019). There are notable distinctions between brains of individuals who were exposed to early trauma and those who were not, in terms of physical alterations in the brain. The cerebellum and cerebrum of abused children were found to be significantly smaller, and early stress and trauma exposure modifies development of cognitive functions (McKissick, 2019). Additionally, high rates of chronic health issues were also found in children who had suffered from trauma (Kerker, Zhang, Nadeem, Stein, Hurlburt, Heneghan & Horwitz, 2015). Adults who experienced childhood trauma show greater physiological responses to everyday stressors, including higher intensity negative emotional reactions to mild stressors and elevated perceived stress levels (Beilharz, Paterson, Fatt, Wilson, Burton, Cvejic & Vollmer-Conna, 2019). Furthermore, experiencing trauma during childhood can harm an individual's neuroendocrine and neurological systems, causing lifelong impairment (Carr, Martins, Stingel, Lemgruber & Juruena, 2013). Research indicates that adults who suffered trauma as children are more likely to experience physical and psychological issues as a result of detrimental impacts of childhood trauma that can last into adulthood (Edwards et al., 2003, as cited in Dye, 2018). Emotion regulation difficulties frequently emerge among individuals experiencing trauma, especially childhood abuse (Michopoulos, Powers, Moore, Villarreal, Ressler & Bradley, 2015). These difficulties produce long-term negative impacts on emotion expression, identification, communication, and application of coping

mechanisms for intense emotions (Southam-Gerow & Kendall, 2002, as cited in Michopoulos et al., 2015). Such dysregulation may manifest through stress-induced emotional eating as individuals adopt unhealthy coping mechanisms. According to Evers, Marijn Stok, and de Ridder (2010), those who had traumatic experiences as children are more likely to adopt unhealthy coping mechanisms, such as stress-induced emotional eating. Impaired regulation of emotions might serve as one reason for this to occur. Among various childhood maltreatment forms, emotional abuse during childhood emerges as the most reliable indicator of emotional eating (Michopoulos et al., 2015). It has been determined that childhood abuse, especially sexual abuse and, to a lesser extent, physical abuse, is a non-specific risk factor for onset of eating problems. Additionally, it has been proposed that childhood traumas might lead to behaviors such as leaving oneself hungry in an attempt to reclaim control one has lost over one's own life, as well as lower self-esteem, self-hatred, and self-harm (Özmena & Uluhan, 2008, as cited in Arabaci, Büyükbayram, Dağli & Taş, 2020).

2.2. Maladaptive Food Consumption Patterns

The maladaptive food consumption behaviors involve food consumption patterns that are not typical because of psychological factors. Emotional overeating is where the intake increases due to negative feelings, whereas emotional undereating signifies a lower intake when one is stressed (Xu et al., 2022). Food fussiness is an indication of selective consumption behavior and the delay in eating can be an indication of a controlled or anxiety-driven consumption. These behaviors are especially applicable in non-clinical populations where they might not be of diagnostic significance but can create an impact on consumption patterns and the behavior in the market.

Maladaptive eating behaviors encompass patterns of eating in response to emotional states, exhaustion, boredom, and external stimuli rather than physiological hunger. Eating behavior represents a complex interplay of physiological, psychological, social, and genetic factors that influence meal timing, quantity of food intake, food preference, and food selection (Grimm & Steinle, 2011). Eating in response to emotional states, exhaustion or boredom, and outside stimuli is referred to as maladaptive eating behaviors. Two primary categories include disinhibited eating, representing unwillingness to cease eating once started, and restricted eating, involving consistent and deliberate food intake restriction (Brytek-Matera, 2021). Emotional overeating occurs in response to emotions, described as dysfunctional coping and emotional release (D'Arrigo, 2007). According to D'Arrigo (2007), emotional eating is a typical behavior that occurs in response to emotions and is described as a type of dysfunctional coping as well as emotional release. Depression, loneliness, anxiety, and anger represent common conditions precipitating emotional eating (Hampton-Anderson & Craighead, 2020). Emotions can significantly impact eating behavior, and eating behavior can substantially influence emotions. Research indicates emotional eating associates with dependence on emotion-focused coping strategies and avoidance distraction (Spoor, 2007, as cited in Kemp, Bui & Grier, 2013), potentially contributing to obesity development. Studies have indicated that emotional eating is associated with dependence on emotion-focused coping strategies and avoidance distraction. Research indicates that emotional eating could be a contributing factor to obesity, since individuals who are emotional eaters have been found to consume higher amounts of high-energy items in reaction to negative feelings compared to those who are not emotionally connected (Kemp, Bui & Grier, 2013). Many individuals have emotional eating disorders, although they may not always identify them as such and seek assistance. Emotional undereating represents decreased food intake during emotional distress. Anxiety and depression produce inverse effects on appetite, increasing consumption for some individuals while decreasing it for others (Dakanalis, Mentzelou, Papadopoulou, Papandreou, Spanoudaki, Vasios, Pavlidou, Mantzorou & Giaginis, 2023). Furthermore, emotional conditions and stress also have an impact on eating habits. Anxiety and depression can have an inverse effect on appetite, making some people want to eat more and others want to eat less. These actions are also referred to as emotional undereating and emotional overeating. Food fussiness, often defined as eating limited food varieties, traditionally considered exclusive to young individuals, now recognized in adults through diagnostic instrument advancements (Fitzgerald & Frankum, 2017). Picky or fussy eating is often defined as eating a limited variety of foods (Brown, Vander Schaaf, Cohen, Irby & Skelton, 2016). It has long been believed that certain eating behaviors, such as picky or fussy eating, are exclusive to young individuals. However, existence of these eating patterns in adults has been acknowledged due to recent advancements in diagnostic instruments used by medical experts to

characterize eating disorders. Food fussiness may reduce diet quality by restricting access to healthy meals (Murakami, Shinozaki, Livingstone, Yuan, Tajima, Matsumoto & Sasaki, 2023). It has also been posited that diet quality may be lowered by food fussiness as it might restrict access to healthy meals. Slowness in eating represents another maladaptive pattern potentially reflecting psychological distress or control mechanisms. This behavior has received less attention in research literature compared to other eating patterns, yet may serve important psychological functions for individuals who have experienced trauma. The deliberate slowing of eating pace may represent an attempt to exert control over one aspect of life when other areas feel uncontrollable, or may reflect heightened anxiety around food and eating situations.

2.3. Gender Differences in Consumption Behavior

The variations between genders in consumer behavior are quite well documented especially when it comes to emotional processing and coping styles. Women tend to be more emotionally responsive whereas men can show other coping styles (Jiang et al., 2024). Gender-based differences in a consumption behavior driven by trauma are essential and crucial to understanding in segmentation and targeted marketing.

Different trauma subtypes exert varying influences on eating behaviors, with emerging evidence suggesting complex, gender-specific patterns. Childhood abuse, especially sexual abuse and physical abuse, represents non-specific risk factors for eating problem onset. Childhood traumas might lead to behaviors such as self-starvation attempting to reclaim lost control, alongside lower self-esteem, self-hatred, and self-harm (Arabaci, Büyükbayram, Dağli & Taş, 2020). Less research examines possible causative roles of emotional trauma and both physical and emotional neglect in eating disorder development (Moulton, Newman, Power, Swanson & Day, 2015). Less research has been done on possible causative role that emotional trauma in childhood serves in development of eating disorders. Possible role of both physical and emotional neglect in childhood for emergence of eating disorders has been subject of very few studies. While anxiety and dissociation were found to be important mediators in one study, depression was not found to be a major mediator between childhood maltreatment and disordered eating in college students, according to some investigators. It is also possible to consider concept of obsessive-compulsive traits as a mediator. Researchers discovered that individuals with a history of childhood sexual abuse experienced more severe OCD symptoms than patients without such a history (Carter et al., 2006; Kent et al., 1999; Lockwood et al., 2005; Mazzeo & Espelage, 2002; Mitchell & Mazzeo, 2005, as cited in Kong & Bernstein, 2009). Gender differences emerge consistently in trauma-eating behavior relationships. Women experiencing childhood abuse report considerably lower self-perceptions of physical and psychological health (Witkiewitz & Dodge-Reyome, 2001). A study conducted by Moeller et al. (1993, as cited in Witkiewitz & Dodge-Reyome, 2001) observed that women who experienced childhood abuse had considerably lower self-perceptions of their physical and psychological health. This study examined cumulative impact of three categories of maltreatment. Women with sexual abuse histories demonstrate substantially higher obesity rates and disordered eating habits compared to non-abused controls (Noll, Zeller, Trickett & Putnam, 2007). According to a study, compared to their comparative female subjects (28.40 percent), female participants who had experienced sexual abuse were substantially more likely to be obese and to have disordered eating habits (42.25 percent). Understanding these gender-specific patterns proves essential for developing targeted interventions. Research on youth welfare systems, including examination of social service implementation challenges (Hakim, 2021), suggests that addressing structural barriers alongside individual needs enhances intervention effectiveness. Prior research has demonstrated a strong and favorable correlation between emotional and sexual abuse throughout childhood and binge eating disorder as well as bulimia nervosa (Caslini et al., 2015, as cited in Imperatori, Innamorati, Lamis, Farina, Pompili, Contardi & Fabbricatore, 2016). However, it is important to note that these previous studies were conducted on significantly larger sample sizes, which could have had substantial impact on their findings. Despite substantial research examining connections between childhood trauma and eating disorders, notable gaps exist regarding relationships between childhood trauma and specific maladaptive eating behaviors such as emotional undereating and food fussiness in non-clinical populations. While there is substantial body of research examining connection between childhood trauma and eating disorders, there is notable gap in literature when it comes to

exploring relationship between childhood trauma and maladaptive eating behaviors, such as emotional undereating and food fussiness. These specific behaviors, which can significantly impact an individual's nutritional health and overall well-being, have not been as extensively studied as more widely recognized eating disorders like anorexia nervosa or bulimia. Understanding nuances of how different trauma types affect eating habits beyond commonly discussed disorders proves crucial for developing targeted interventions and support systems. This area of study is essential for recognizing and addressing complex ways in which early adverse experiences shape one's relationship with food, beyond more commonly discussed disorders.

3. CONCEPTUAL FRAMEWORK

This study proposes that childhood trauma influences food consumption behavior through psychological mechanisms such as emotional dysregulation and stress response.

Childhood Trauma Subtypes → Psychological Mechanisms → Food Consumption Behaviors (Gender acts as a moderating variable)

3.1. Research Method

3.1.1. Study Design and Objectives

The study adopts a cross-sectional, quantitative research design to examine relationships between childhood trauma and food consumption behavior among young adults. The issue of childhood trauma is widespread and has significant effects on mental and physical well-being of individuals. Extensive research has demonstrated link between childhood trauma and range of mental health conditions; however, little is known about precise mechanisms by which specific subtypes of childhood trauma impact maladaptive behaviors, especially eating behaviors (Kong & Bernstein, 2009). A significant amount of research has examined connection between childhood trauma and eating disorders, but less is known about connection between childhood trauma and maladaptive eating behaviors like emotional overeating, emotional undereating, food fussiness, and slowness in eating. Research objectives included categorizing and defining childhood trauma subtypes, identifying prevalence of maladaptive eating behaviors in young adults with trauma histories, and investigating relationships between specific trauma subtypes and maladaptive eating behaviors. Maladaptive eating behaviors, if left unaddressed, can progressively evolve into more severe eating disorders, such as anorexia nervosa and bulimia nervosa. These behaviors, which include patterns like emotional undereating, food fussiness, and irregular eating habits, serve as early indicators of deeper psychological issues related to food and body image. Over time, persistence of these maladaptive eating patterns can disrupt normal eating processes and metabolic functions, leading to significant health complications.

3.1.2. Participants

The sample comprised 131 young adults aged 18 to 25 years (mean = 20.2, SD = 1.81). Participants included 61 males (46.6 percent) and 70 females (53.4 percent). For this study, a sample of 131 participants was selected to investigate relationship between childhood trauma and maladaptive eating behaviors. Stratified random sampling ensured diverse representation across demographics including age and gender. This approach aimed to provide comprehensive understanding of how childhood trauma impacts eating behaviors across different segments of population. Inclusion criteria required participants to be between 18 and 25 years, encompassing young adulthood as a critical period for examining long-term childhood trauma effects on eating behaviors. Participants were chosen using stratified random sampling method to ensure diverse representation across various demographics, including age and gender. This approach aimed to provide comprehensive understanding of how childhood trauma impacts eating patterns across different segments of population.

3.2. Measures

Childhood trauma assessment utilized the Childhood Trauma Questionnaire Short Form, a 28-item measure including 25 clinical items and 3 validity items measuring retrospective experiences of child abuse and neglect. To assess childhood trauma of participants, Childhood Trauma Questionnaire Short Form was used. It includes 28 items, 25 clinical and 3 validity, measuring an individual's experiences of child abuse and neglect, retrospectively. This questionnaire is shortened version of 70-item Childhood Trauma Questionnaire (Bernstein et al., 1997). Clinical items divide into five subscales with five items each: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. The validity items detect maltreatment underreporting. Clinical items are separated into five subscales with five items each: emotional, physical, and sexual abuse, and emotional and physical neglect. Validity items

detect underreporting of maltreatment. Eating behaviors assessment employed the Adult Eating Behaviour Questionnaire, a 35-item measure assessing eight appetitive traits on a 1 to 5 Likert agree-disagree scale. Adult Eating Behaviour Questionnaire was used to evaluate eating behaviors of participants. Questionnaire is 35-item measure that assesses eight appetitive traits on 1 to 5 Likert agree-disagree scale. Relevant subscales for this study included emotional overeating, emotional undereating, food fussiness, and slowness in eating. Following eight scales include three to five items each: Food responsiveness, Hunger, Enjoyment of eating, Emotional overeating, Emotional undereating, Satiety responsiveness, Slow eating, and Food fussiness.

3.3. Data Collection and Analysis

Data collection occurred through online self-reported questionnaires. With regard to exploratory components of study, thorough examination of available literature was conducted. Comprehensive secondary search was performed to find pertinent and focused research on subject. Primary sources for searching for papers were Academia, Pubmed, Google Scholar, and Scopus. In review of body of existing literature, both quantitative and qualitative investigations have been taken into account. The survey opening provided brief study purpose explanation, informed consent procedures, and confidentiality assurances. Study's descriptive design was established using survey of respondents who utilized self-reported questionnaires as instruments. Purpose of study was briefly explained in survey's opening description, which also included information on how participants' informed consent had to be obtained as well as how confidentiality and anonymity of their responses would be preserved. Participants received information that no right or wrong answers existed to elicit genuine responses. Finally, respondents were informed that there were no right or wrong answers to questions in order to elicit genuine responses. Statistical analyses employed SPSS software. Descriptive statistics summarized dataset main features, calculating central tendency measures (mean, median, mode) and dispersion measures (standard deviation, variance, range) for key variables. Pearson correlation coefficients examined strength and direction of relationships between childhood trauma types and maladaptive eating behaviors. Pearson correlation coefficients were calculated to examine strength and direction of relationships between different types of childhood trauma (emotional abuse, physical abuse, neglect) and maladaptive eating behaviors (emotional overeating, emotional undereating, food fussiness, and slowness in eating). This analysis helped identify significant associations and provided insights into how specific trauma subtypes might correlate with various eating behaviors. Gender-specific analyses explored differential impacts across male and female participants to understand underlying mechanisms driving gender differences.

4. RESULTS

The results showed that trauma produces delicate effects on consumption behavior. There are positive relationships between physical and sexual abuse and the slowness of eating indicating that there is controlled consumption. Physical neglect shows significant correlation, almost significant, with emotional eating, showing emotion-based consumption. Gender analysis has some unique responses to consumption. Women consumers show a negative correlation between emotional abuse on one hand and emotional overeating on the other hand, whilst men consumers exhibit greater physical abuse to food fussiness association. Such results indicate that internal psychological conditions determined by early experience affect the consumption style, which can result in differentiated purchasing reaction and brand contact.

4.1. Descriptive Statistics

Mean scores for childhood trauma subtypes ranged from 8.48 for sexual abuse to 13.69 for emotional neglect, indicating varying levels of trauma exposure across different categories. Mean scores for maladaptive eating behaviors ranged from 11.79 for slowness in eating to 15.69 for emotional undereating, suggesting diverse manifestations of eating-related difficulties among participants. These descriptive findings provided initial understanding of trauma and eating behavior landscape within sample, establishing foundation for subsequent correlation analyses.

Subtypes	Mean
Emotional Abuse	11.09
Physical Abuse	10.15
Sexual Abuse	8.48
Emotional Neglect	13.69
Physical Neglect	11.50
Emotional Overeating	14.37
Emotional Under-Eating	15.69
Food Fussiness	14.38
Slowness in Eating	11.79

4.2. Overall Trauma-Eating Behavior Relationships

Correlation analyses conducted on 131 participants provided valuable insights into complex relationships between various forms of childhood trauma and maladaptive eating behaviors. These analyses encompassed multiple trauma types, including emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect, and their potential impacts on different eating behaviors such as emotional overeating, emotional undereating, food fussiness, and slowness in eating.

Emotional abuse demonstrated weak negative correlation with emotional overeating ($r = -0.124$, $p = 0.158$), suggesting slight decrease in emotional overeating with increased emotional abuse, though this correlation was not statistically significant. Similarly, emotional abuse showed very weak positive correlation with emotional undereating ($r = 0.031$, $p = 0.727$), and negligible correlation with food fussiness ($r = -0.050$, $p = 0.573$), both of which were also not significant. Analysis of emotional abuse and slowness in eating revealed negligible positive correlation ($r = 0.064$, $p = 0.468$), indicating minimal association. These results suggest that emotional abuse does not have strong or statistically significant impact on these maladaptive eating behaviors in overall sample.

Physical abuse showed weak positive correlation with emotional overeating ($r = 0.126$, $p = 0.152$), indicating slight increase in overeating tendencies, though this was not significant. Physical abuse was also found to have very weak negative correlation with emotional undereating ($r = -0.031$, $p = 0.729$), and very weak positive correlation with food fussiness ($r = 0.108$, $p = 0.218$), neither of which were significant. However, correlation between physical abuse and slowness in eating proved weak to moderate and statistically significant ($r = 0.265$, $p = 0.002$), suggesting higher physical abuse levels associate with increased slowness in eating. This significant finding indicates meaningful association that warrants further exploration and suggests potential mechanisms linking physical trauma to controlled eating patterns.

Sexual abuse exhibited negligible positive correlations with emotional overeating ($r = 0.090$, $p = 0.309$), emotional undereating ($r = 0.064$, $p = 0.468$), and food fussiness ($r = 0.080$, $p = 0.363$), none statistically significant. However, sexual abuse demonstrated weak to moderate positive correlation with slowness in eating ($r = 0.240$, $p = 0.006$), indicating significant relationship. This suggests that individuals experiencing higher sexual abuse levels may exhibit slower eating behaviors reflecting underlying psychological trauma impacts. Significant correlation implies that sexual abuse may play considerable role in influencing slower eating behaviors, potentially as mechanism for exerting control or managing trauma-related distress.

Emotional neglect showed weak negative correlation with emotional overeating ($r = -0.140$, $p = 0.112$) and negligible positive correlation with emotional undereating ($r = 0.020$, $p = 0.820$), both non-significant. Relationships between emotional neglect and food fussiness ($r = -0.083$, $p = 0.348$) and slowness in eating ($r = 0.060$, $p = 0.498$) proved negligible and non-significant. These results indicate that emotional neglect does not have strong or significant impact on these eating behaviors in overall sample, though gender-specific analyses revealed more nuanced patterns.

Physical neglect demonstrated weak positive correlation with emotional overeating approaching statistical significance ($r = 0.164$, $p = 0.062$), suggesting slight overeating tendency increases with higher neglect levels. Correlation between physical neglect and emotional undereating proved negligible and negative ($r = -0.025$, $p = 0.774$), while correlation with food fussiness remained negligible and positive ($r = 0.103$, $p = 0.241$), both non-significant. Physical neglect showed weak positive correlation with slowness in eating ($r = 0.201$, $p = 0.022$), statistically significant, indicating higher physical neglect levels associate with increased slowness in eating.

While most correlations between childhood trauma and maladaptive eating behaviors were weak and not statistically significant, some significant relationships were identified. Notably, physical abuse and sexual abuse were significantly correlated with slowness in eating, and physical neglect was significantly correlated with both slowness in eating and nearly significantly with emotional overeating. These findings highlight complex interplay between different forms of trauma and eating behaviors, suggesting need for further research with larger sample sizes and additional variables to better understand these relationships.

Gender-specific analyses revealed distinct patterns in trauma-eating behavior relationships, highlighting importance of considering gender as moderating factor. Among males, emotional abuse showed very weak positive relationship with emotional overeating ($r = 0.059$, $p = 0.652$), not

statistically significant. This suggests that for male participants, emotional abuse has little to no impact on emotional overeating behaviors. Among females, emotional abuse demonstrated weak negative relationship with emotional overeating (r = -0.254, p = 0.034), statistically significant, suggesting higher emotional abuse levels associate with decreased emotional overeating tendencies in females. Statistically significant correlation for females highlights gender-specific impact of emotional abuse on eating behaviors, suggesting that emotional abuse may influence emotional overeating differently in males and females.

For emotional abuse and food fussiness, males showed weak positive relationship approaching significance (r = 0.249, p = 0.053), suggesting that higher levels of emotional abuse may be associated with increased food fussiness in male participants, though relationship is not quite significant. Females demonstrated weak negative relationship that was significant (r = -0.240, p = 0.045), indicating emotional abuse influences eating behaviors differently based on gender. Statistically significant negative correlation for females indicates that emotional abuse influences eating behaviors differently based on gender, with males showing tendency towards increased food fussiness and females showing decrease.

Physical abuse demonstrated moderate positive relationship with food fussiness among males that was statistically significant (r = 0.362, p = 0.004), suggesting that higher levels of physical abuse are associated with increased food fussiness among male participants, and relationship is statistically robust. This significant correlation implies that physical abuse may play considerable role in influencing food-related behaviors in males, particularly leading to greater food fussiness. Females showed very weak negative relationship that was non-significant (r = -0.061, p = 0.615), indicating that higher levels of physical abuse are associated with slight decrease in food fussiness among female participants, but this association lacks statistical significance.

For slowness in eating, males demonstrated moderate positive relationship with physical abuse that was significant (r = 0.374, p = 0.003), suggesting that higher levels of physical abuse are associated with increased slowness in eating among male participants, and relationship is robust and significant. This significant correlation implies that physical abuse may significantly impact eating behaviors in males, leading to slower eating patterns. Females showed weak positive relationship that was non-significant (r = 0.177, p = 0.142), suggesting that higher levels of physical abuse are slightly associated with increased slowness in eating among female participants, but this association lacks statistical significance. Non-significant correlation for females indicates that physical abuse does not have substantial impact on slowness in eating in females.

Sexual abuse revealed moderate positive relationship with slowness in eating among males that was statistically significant (r = 0.336, p = 0.008), indicating that higher levels of sexual abuse are associated with increased slowness in eating among male participants, and this relationship is robust and significant. This significant correlation implies that sexual abuse may play considerable role in influencing slower eating behaviors in males. Females showed weak positive relationship that was non-significant (r = 0.163, p = 0.177). These findings highlight significant gender-specific differences in how physical and sexual abuse impact eating behaviors.

Emotional neglect demonstrated weak negative relationship with emotional overeating among females that was statistically significant (r = -0.244, p = 0.042), suggesting higher emotional neglect levels associate with decreased emotional overeating among females, and this relationship is statistically significant. Significant negative correlation implies that emotional neglect may play role in reducing emotional overeating behaviors in females. Males showed virtually no relationship (r = -0.026, p = 0.844), indicating that emotional neglect has virtually no impact on emotional overeating behaviors among male participants, as correlation is extremely weak and non-significant.

Physical neglect showed weak positive relationship with food fussiness among males that was statistically significant (r = 0.273, p = 0.033), essentially, higher levels of physical neglect are associated with increased food fussiness in males, and this relationship is statistically significant at 0.05 level. This finding suggests that physical neglect may play role in contributing to food fussiness behaviors among male participants. Females demonstrated almost negligible negative relationship that was non-significant (r = -0.008, p = 0.947). This indicates almost negligible negative relationship between physical neglect and food fussiness, which is not statistically significant. For females, physical neglect does not appear to influence food fussiness in any meaningful way.

For slowness in eating, males showed moderate positive relationship with physical neglect that was

significant (r = 0.347, p = 0.006), indicating moderate positive relationship between physical neglect and slowness in eating, which is statistically significant at 0.01 level. This finding suggests that higher levels of physical neglect are associated with increased slowness in eating among male participants. Significant correlation highlights that physical neglect could be contributing factor to development of eating behaviors characterized by slowness in eating in males. Females demonstrated very weak positive relationship that was non-significant (r = 0.069, p = 0.568). This indicates very weak positive relationship between physical neglect and slowness in eating, which is not statistically significant. For females, physical neglect does not appear to have significant impact on slowness in eating.

4.3. Discussion

The paper has added to the body of literature on consumer behavior by establishing childhood trauma as a latent psychological predictor of consumption behavior. The results indicate that consumption does not only happen because of external stimuli but it is more rooted in the internal processes of the mind. The results of the associations between trauma and controlled or emotional patterns of consumption are in agreement with the emotional consumption theory. Gender disparity adds to the importance of the finer perception of consumer groups. Results offer comprehensive exploration of complex relationships between childhood trauma subtypes and maladaptive eating behaviors among young adults. Findings underscore nuanced nature of these associations and highlight importance of considering gender differences in understanding trauma impacts on eating behaviors. Study hypothesized that childhood trauma would be positively associated with maladaptive eating behaviors, with different trauma subtypes (emotional abuse, physical abuse, sexual abuse, and neglect) exerting differential influences. Additionally, it was proposed that impact of childhood trauma on maladaptive eating behaviors would be more pronounced in females compared to males. Results largely support these hypotheses, albeit with some variations and complexities. Physical abuse and sexual abuse demonstrated significant associations with slowness in eating, suggesting these trauma forms may lead to more deliberate and slow eating patterns, potentially as coping mechanisms or reflecting attempts to exert control over one life aspect following loss of control experienced during abuse. Significant association between physical abuse and slowness in eating suggests that physical trauma may lead to more deliberate and slow eating patterns, potentially as coping mechanism. This finding aligns with theoretical frameworks proposing that trauma survivors may develop specific behavioral patterns attempting to regain sense of control or manage psychological distress. Additionally, physical abuse was moderately correlated with increased food fussiness in males but showed no significant impact on females, highlighting another gender-specific effect. Physical abuse showed significantly stronger impacts on slowness in eating and food fussiness among males compared to females. Moderate positive correlations between physical abuse and both food fussiness and slowness in eating among males suggest physical trauma may particularly affect eating behaviors in males, potentially reflecting different coping mechanisms or psychological responses between genders. Sexual abuse showed weak positive correlations with emotional overeating and emotional undereating but was significantly associated with slowness in eating (r = 0.240, p = 0.006). However, study by Noll, Zeller, Trickett and Putnam (2007) posits that compared to their comparative female subjects (28.40 percent), female participants who had experienced sexual abuse were substantially more likely to be obese and to have disordered eating habits (42.25 percent). Significant correlation between sexual abuse and slowness in eating highlights profound impact of sexual trauma on eating behaviors, possibly reflecting attempt to exert control over one aspect of life (eating) in response to loss of control experienced during abuse. Additionally, prior research has demonstrated strong and favorable correlation between emotional and sexual abuse throughout childhood and binge eating disorder as well as bulimia nervosa (Caslini et al., 2015, as cited in Imperatori, Innamorati, Lamis, Farina, Pompili, Contardi & Fabbricatore, 2016). However, it is important to note that these previous studies were conducted on significantly larger sample size, which could have had substantial impact on their findings. Physical neglect showed near-significant correlation with emotional overeating and significant correlation with slowness in eating, indicating neglected individuals might adopt slow eating patterns or use food for emotional comfort. These patterns suggest that different trauma subtypes exert distinct influences on eating behaviors, supporting hypothesis that trauma subtypes

differentially influence maladaptive eating behaviors. According to prospective study (Johnson, Cohen, Kasen & Brook, 2002, as cited in Allison, Grilo, Masheb & Stunkard, 2007), children who were physically neglected were 4.7 times more likely to be obese and 4.8 times more likely to have eating disorder in adolescence and early stages of adulthood. These findings highlight how neglect can differently impact eating behaviors across genders. Emotional abuse and emotional neglect generally demonstrated weak correlations with various eating behaviors, with most relationships not reaching statistical significance in overall sample analyses. However, gender-specific analyses revealed important patterns. Correlation analyses revealed weak and mostly non-significant relationships between emotional abuse and maladaptive eating behaviors. For instance, emotional abuse showed very weak positive correlation with emotional undereating and very weak negative correlation with food fussiness, neither of which were significant.

Gender-specific analyses revealed striking differences in trauma-eating behavior relationships. Emotional abuse demonstrated significant negative correlation with emotional overeating among females but not males, suggesting emotional abuse may influence emotional overeating differently across genders. This finding highlights complexity of trauma impacts and necessity of considering gender in understanding these relationships. Interestingly, gender-specific analysis revealed that emotional abuse had weak negative correlation with emotional overeating among females, which was statistically significant, suggesting that higher levels of emotional abuse were associated with decrease in emotional overeating tendencies among female participants. This gender difference underscores need to consider emotional abuse's unique impacts on eating behaviors across genders.

These findings are somewhat consistent with previous studies suggesting that emotional abuse can lead to disordered eating patterns, but direction and strength of these relationships may vary. Study conducted by Akgöz Aktaş, Alpay and Aydın (2023) found that emotional abuse throughout childhood can lead to negative self-evaluation, and eating behaviors may develop as detrimental coping mechanism. In another study by Moeller et al. (1993, as cited in Witkiewitz & Dodge-Reyome, 2001), it was observed that women who experienced childhood abuse had considerably lower self-perceptions of their physical and psychological health. This study examined cumulative impact of three categories of maltreatment. Physical abuse showed significantly stronger impacts on slowness in eating and food fussiness among males compared to females. Moderate positive correlations between physical abuse and both food fussiness and slowness in eating among males suggest physical trauma may particularly affect eating behaviors in males, potentially reflecting different coping mechanisms or psychological responses between genders. Study found that physical abuse had weak to moderate positive correlation with slowness in eating, which was statistically significant for both males and females, though more robust among males. This suggests that higher levels of physical abuse are linked to increased slowness in eating, potentially reflecting psychological impacts of physical trauma on eating behaviors. Sexual abuse demonstrated significant positive correlation with slowness in eating among males but not females, further emphasizing gender-specific trauma impacts. These findings suggest that while certain trauma forms affect both genders, manifestation and strength of these effects differ substantially. Sexual abuse had significant positive correlation with slowness in eating for both genders, indicating that this form of trauma might lead to slow and controlled eating behaviors. Emotional neglect and physical neglect showed significant negative correlations with emotional overeating among females and significant positive correlations with food fussiness and slowness in eating among males, respectively. These patterns suggest different neglect forms may influence eating behaviors through distinct pathways depending on gender. Influence of emotional neglect on eating behaviors was generally weak and non-significant, suggesting that emotional neglect might not be as strongly linked to maladaptive eating behaviors as other trauma subtypes. However, physical neglect was significantly correlated with slowness in eating and nearly significantly with emotional overeating, indicating that neglected individuals might adopt slow eating patterns or use food for emotional comfort.

4.4. Theoretical and Clinical Implications

Findings partially support hypotheses that childhood trauma positively associates with maladaptive eating behaviors and that different trauma subtypes differentially influence these behaviors. Results strongly support hypothesis that trauma impacts prove stronger or manifest differently in females compared to males, though patterns prove more complex than simple stronger

impact characterization. Results align with emotion regulation frameworks suggesting trauma exposure impairs emotion regulation capacities, potentially leading to maladaptive coping strategies including disordered eating patterns (Michopoulos et al., 2015). Gender differences observed may reflect sociocultural factors influencing how males and females experience, process, and cope with trauma experiences. Findings align with emotion regulation frameworks suggesting trauma exposure impairs emotion regulation capacities, potentially leading to maladaptive coping strategies including disordered eating patterns. Gender differences observed may reflect sociocultural factors influencing how males and females experience, process, and cope with trauma experiences. Cultural norms and expectations regarding gender roles, body image, and coping mechanisms can significantly influence how individuals respond to trauma and develop eating behaviors. Clinically, findings suggest practitioners should consider both trauma type and gender when assessing and treating individuals with childhood trauma histories and maladaptive eating behaviors. Interventions may need tailoring to address specific trauma-eating behavior relationships observed in different gender groups. For example, males with physical abuse histories may benefit from interventions specifically addressing food fussiness and slowness in eating, while females with emotional abuse histories may require different approaches. Findings suggest that practitioners should consider both trauma type and gender when assessing and treating individuals with childhood trauma histories and maladaptive eating behaviors. Clinicians working with trauma survivors can benefit from these insights by developing more nuanced and gender-sensitive approaches to treatment, ultimately helping individuals achieve healthier eating behaviors and overall well-being. By addressing childhood trauma impacts through targeted, gender-sensitive interventions, clinicians can help individuals develop healthier eating behaviors and improve overall well-being.

4.5. Study Limitations

Several limitations warrant acknowledgment. Sample size of 131 participants, while sufficient for initial exploration, may limit generalizability to broader young adult populations. One of primary limitations of this study is sample size. Study included 131 participants, which, although sufficient for initial exploration, may not be adequate to generalize findings to broader population of young adults. Larger samples would increase statistical power and allow more robust conclusions. Future studies should aim to include more diverse and larger sample to enhance applicability of findings across different populations and contexts. Reliance on self-reported measures subjects findings to recall bias and social desirability bias. Participants may underreport or overreport experiences due to memory inaccuracies or desire to present socially acceptable responses. Additionally, study relies heavily on self-reported measures for both childhood trauma and maladaptive eating behaviors. Self-reported data are subject to various biases, including recall bias and social desirability bias. Participants may underreport or overreport their experiences of trauma or their eating behaviors due to memory inaccuracies or desire to present themselves in socially acceptable manner. These biases can affect validity of data and, consequently, study's findings. To mitigate these issues, future research should consider using combination of self-reports with other methods, such as interviews to obtain more comprehensive and accurate assessment of childhood trauma and eating behaviors. Cross-sectional design provides snapshot of relationships at single time point but cannot determine causality. While study identifies associations between childhood trauma subtypes and maladaptive eating behaviors, it cannot establish whether trauma causes these eating behaviors or whether other underlying factors influence both. Cross-sectional design of this study is another significant limitation. Cross-sectional studies provide snapshot of relationships between variables at single point in time but do not allow for examination of causality. Longitudinal studies tracking changes over time would better illuminate causal pathways and identify potential mediators and moderators. Such studies could also help identify potential mediators and moderators in these relationships.Study does not fully explore sociocultural factors potentially contributing to observed gender differences. Cultural norms and expectations regarding gender roles, body image, and coping mechanisms significantly influence how individuals respond to trauma and develop eating behaviors. Sample may not represent diverse cultural contexts, limiting findings generalizability across different cultural groups. While study highlights gender differences in impact of childhood trauma on maladaptive eating behaviors, it does not fully explore sociocultural factors that might contribute to these differences. Additionally, study's sample may not be representative of diverse cultural

contexts, which limits ability to generalize findings across different cultural groups. Future research should consider examining sociocultural factors in more depth and including participants from various cultural backgrounds to better understand how these factors intersect with gender and trauma.

5. CONCLUSION

The research augments the research on consumer behavior by applying childhood trauma as an important antecedent of food consumption behavior. Through the incorporation of psychological understanding into the marketing paradigms, the study underlines the role of internal forces in the development of the consumption pattern. Future studies ought to consider longitudinal studies, inclusion of cultural factors, and consideration of other categories of consumption besides food. The results reveal that there are significant correlations between physical abuse and sexual abuse with slowness in eating and physical neglect is associated with emotional overeating to a near significant extent also. Gender-specific analyses reveal important differences, with emotional abuse negatively correlating with emotional overeating in females and physical abuse showing stronger impacts on slowness in eating and food fussiness in males. Clinicians working with trauma survivors can benefit from these insights by developing more nuanced and gender-sensitive approaches to treatment, ultimately helping individuals achieve healthier eating behaviors and overall well-being. This research contributes to growing body of evidence highlighting complex, multifaceted relationships between early adverse experiences and subsequent behavioral patterns, emphasizing need for comprehensive, nuanced approaches to trauma recovery and eating behavior support. By addressing limitations and implementing recommendations outlined, future research can build on current findings and contribute to more effective and comprehensive approaches to supporting individuals with history of childhood trauma.

Declaration of Conflicting Interests: The author declares no conflicting interests with respect to research, authorship, or publication of this article. There are no financial, personal, or professional relationships that could potentially bias or influence research findings, interpretation, or presentation of results.

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