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NEUZA RAQUEL DOS SANTOS DUARTE

“Are we what we eat?": The relationship between childhood trauma, emotional distress and emotional motivations of food choices

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Dissertação de Mestrado apresentada à Faculdade de Ciências da Saúde, da Universidade Europeia, para cumprimento dos requisitos necessários à obtenção do grau de Mestre em Psicologia Clínica e da Saúde realizada sob a orientação científica da Doutora Lisa Liliana Nunes Roque, professora assistente da Universidade Europeia e do Doutor Paulo Alexandre da Silva Ferrajão, professor associado da Universidade Europeia.

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Tell me what you eat and I will tell you what you are (Brillat-Savarin, 1826).

The attempt to escape from pain is what creates more pain (Maté, 2022).

Everybody acts not only under external compulsion but also in accordance with inner necessity (Einstein, 1935).

palavras-chave Motivações emocionais das escolhas alimentares; Trauma na Infância; Vinculação; Ansiedade; Depressão

resumo

O presente trabalho tem como objetivo estabelecer uma associação entre a exposição ao trauma infantil e as motivações emocionais das escolhas alimentares, bem como os papéis mediadores da qualidade de vinculação e da perturbação emocional (ou seja, sintomatologia ansiosa e depressiva). O trauma infantil influencia os elementos nutridores do ser humano, seja na sua forma relacional (vinculação), ou na sua forma alimentar (escolhas alimentares). A literatura identifica uma relação bidirecional entre as motivações emocionais das escolhas alimentares e o desenvolvimento de perturbação emocional. Os estados emocionais resultantes do trauma são suprimidos pelo consumo de comida. Neste estudo participaram 500 pessoas que responderam a um conjunto de questionários (Questionário de Trauma na Infância; Escala de Vinculação do Adulto; Escala de Ansiedade e Depressão Hospitalar; Questionário dos Determinantes das Escolhas Alimentares), de forma a perceber a relação entre variáveis. Os resultados demostraram que a relação direta entre o trauma infantil e as motivações emocionais das escolhas alimentares não foi significativa. No entanto, o efeito indireto do trauma infantil nas motivações emocionais nas escolhas alimentares, através da ansiedade vinculativa foi significativo. Níveis mais elevados de trauma infantil estão associados a níveis mais elevados de ansiedade vinculativa, que por sua vez estão associados a níveis mais elevados de motivações emocionais nas escolhas alimentares. Observou-se também que o efeito indireto do trauma infantil nas motivações emocionais das escolhas alimentares, através dos sintomas de ansiedade foi significativo. Níveis mais elevados de trauma na infância estão associados a níveis mais elevados de sintomas de ansiedade, que por sua vez estão associados a níveis mais elevados de motivações emocionais nas escolhas alimentares. Por fim, os resultados indicaram que níveis mais elevados de trauma infantil estão associados a níveis mais elevados de ansiedade de vinculação, que por sua vez estão associados a níveis mais elevados de sintomas de ansiedade, que subsequentemente, estão associados a níveis mais elevados de motivações emocionais nas escolhas alimentares. Os resultados indicaram ainda que uma maior

exposição ao trauma na infância se encontra associada a níveis mais baixos de Conforto com a Proximidade vinculativa, que por sua vez se encontram associados a níveis mais elevados de sintomas de ansiedade, e que subsequentemente estão associados a níveis mais elevados de motivações emocionais nas escolhas alimentares. Futuras investigações devem analisar a relação entre o trauma infantil, a adoção de padrões alimentares saudáveis e biomarcadores inflamatórios, através de uma abordagem multidisciplinar com as áreas da Nutrição e Medicina.

Keywords Emotional Motivations of food choices; Childhood trauma; Attachment; Anxiety; Depression

abstract The present study aims to establish an association between exposure to childhood trauma and the emotional motivations behind food choices, as well as the mediating roles of attachment quality and emotional distress (i.e., anxiety and depressive symptoms). Childhood trauma influences the nourishing elements of human beings, whether in their relational form (attachment) or in their alimentary form (food choices). The literature identifies a bidirectional relationship between the emotional motivations of food choices and the development of emotional distress. The emotional states resulting from trauma are suppressed by food consumption. This study involved 500 people who responded to a set of questionnaires (Childhood Trauma Questionnaire; Adult Attachment Scale; Hospital Anxiety and Depression Scale; Food Choice Determinants Questionnaire) in order to understand the relationship between variables.
The results showed that the direct path from childhood trauma to emotional motivations in food choices was non significant. Meanwhile, the indirect effect from childhood emotional motivations in food choices through Attachment Anxiety was significant. Higher levels of childhood trauma were linked to higher levels of Attachment Anxiety, which in turn were linked to higher levels of emotional motivations in food choices. It was also observed that the indirect effect from childhood trauma to emotional motivations in food choices through anxiety symptoms was significant. Higher levels of childhood trauma were linked to higher levels of anxiety symptoms, which in turn were linked levels of emotional motivations in food choices. Finally, the two-step indirect effects results indicated that higher childhood trauma were linked to higher levels of Attachment Anxiety, which in turn were linked to higher levels of anxiety symptoms, which in turn subsequently were linked to higher levels of emotional motivations in food choices. The findings further indicated that greater exposure to childhood trauma was linked to lower levels of Closeness Attachment, which subsequently were linked to higher levels of anxiety symptoms, ultimately being linked to higher levels of emotional motivations in food choices. Future research should analyze the relationship between childhood trauma, the adoption of healthy eating patterns and inflammatory biomarkers, through a

multidisciplinary approach with the including the areas of Nutrition and Medicine.

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Introduction

Approximately 400 million children across the world suffer abuse that leads to trauma (WHO, 2022). As most of these cases are covered up, few have timely access to health professionals. The consequences of childhood trauma are generalised and remain throughout life, causing poor outcomes in the various areas of the individual's life. Ultimately, the high prevalence of childhood trauma can hold back the country's economic and social development (WHO, 2022). The World Health Organization (WHO) reveals that three out of four children aged 2 to 4 suffer physical punishment or psychological abuse; one out of five girls and one out of thirteen boys aged 0 to 17 have suffered sexual abuse, with a 22.6% chance of each child suffering physical abuse by their main caregivers (WHO, 2022; Ye et al., 2023). Six out of ten children under the age of 5 worldwide frequently suffer physical and psychological punishment from their parents/caregivers (WHO, 2022).

In Portugal, the Associação Portuguesa de Apoio à Vítima (APAV – Portuguese Association for Victims Support), has documented a total of 16,493 offences against children and young people, with 9,085 of the cases recorded in the last three years (APAV, 2025). Caetano & Pereira (2024) concluded that in Portugal, there is an alarming phenomenon of adverse childhood experiences that trigger childhood trauma, with emotional abuse being the most prevalent. This may be related to high parental stress, lack of parenting skills and/or the repetition of dysfunctional family patterns (Greenman et al., 2024; Wen Zeng et al., 2024; Özcan et al., 2016).

In addition to childhood trauma, there is a growing concern about food choices and eating behaviours around the world, given its prevalent association with eating disorders, obesity and several health conditions (Klatzkin et al., 2024; Ljubičić et al., 2023; van Strien, 2018). The main diseases associated with poor nutrition are obesity, diabetes, cardiovascular diseases, chronic

intestinal diseases, non-alcoholic fatty liver disease, tumours, neuropsychiatric diseases and neurodegenerative diseases (Billingsley et al., 2024; Tafuri & Latino, 2025). In 2022, it is estimated that one in eight people worldwide will be living with obesity (WHO, 2025). In Portugal, 67.6% of population is overweight or obese (APDP, 2025). Páscoa and his colleagues (2021) conclude that 61.7% of the Portuguese population has unhealthy food consumption habits, even though they perceive themselves to be healthy.

Taking into consideration the major societal concerns mentioned prior, the main goal of this dissertation is to study the relationship between the exposure to childhood trauma and emotional motivations associated with food choices, as well as the mediating roles of attachment quality and emotional distress (i.e., anxiety and depression symptomatology).

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Literature review

Childhood trauma

Childhood trauma is conceptualised as all physical and psychological harm inflicted on an individual before the age of 18, which compromises the child's safe and/or healthy neurocognitive and socio-emotional development (Clément et al., 2019; Bellehumeur-Béchamp et al., 2024; WHO, 2016; Zhang et al., 2025; Donofry et al., 2021; Liu et al., 2024). This concept refers to the mental consequences of external and unexpected traumatic events (Greenman et al., 2024). Childhood trauma experiences are commonly associated with five categories: emotional abuse, physical abuse, sexual abuse, as well as physical and emotional neglect (Spalletta et al., 2020; Bellehumeur-Béchamp et al., 2024; Larkin & Read, 2008; Quan et al., 2025; Danese & Baldwin, 2017; Zhang et al., 2025; WHO, 2006; Kuzminskaite et al., 2021; Donofry et al., 2021; Liu et al., 2024).

Emotional abuse refers to all actions that compromise the psychological well-being and self-esteem of the child, including ridicule, rejection, minimization, and verbal hostility (Liu et al., 2023; Peng et al., 2025). *Physical abuse* refers to the intentional use of force against a child that may compromise the child's health or development (Ferrara et al., 2019; Peng et al., 2025). *Sexual abuse* is the pursuit of sexual pleasure by an adult toward a child, using their position of superiority to take advantage (Castro et al., 2019; CDC, 2024). *Physical neglect* occurs when parents are unable to meet the physical needs of the child, such as access to medical care, adequate clothing, hygiene, or proper nutrition (Stoltenborgh et al., 2013; Råman et al., 2025). *Emotional neglect* occurs when emotional needs are not met, such as the inability to provide adequate affection and care, consciously allowing inappropriate behavior on the part of the child, or exposure to an environment of domestic violence (Stoltenborgh et al., 2013; Råman et al., 2025).

Exposure to trauma in childhood has been widely associated with physical and mental health (e.g. Quan et al., 2025; Kuzminskaite et al., 2021) and lifelong morbidity and mortality (Chen et al., 2016; Kuzminskaite et al., 2021). Previous work has shown associations between childhood trauma and the presence of negative emotions such as anger (Huang et al., 2020; Quan et al., 2025), emotional dysregulation (Cicchetti & Toth, 2016; Bellehumeur-Béchamp et al., 2024), depression and anxiety disorders (Carr et al., 2020; Klinger-König et al., 2024; Bellis et al., 2019; Greenman et al., 2024; McKay et al., 2021a; Şenyaşar Meterelliyoz & Baş Uluyol, 2024; Huang et al., 2022; Alnassar et al., 2024), cognitive disorders, suicide ideation (Berardelli et al., 2022; Şenyaşar Meterelliyoz & Baş Uluyol, 2024; Angelakis et al, 2019; Medeiros et al., 2020; Hughes et al., 2017; Kuzminskaite et al., 2021; Kuzminskaite et al., 2022), insomnia and hypersomnia (Angelakis et al., 2019; Medeiros et al., 2020; Hughes et al., 2017; Kuzminskaite et al., 2021; Kuzminskaite et al., 2022), as well as post-traumatic stress disorder, personality disorders (Bauer et al., 2022; Jin et al., 2024; Bellis et al., 2019; Greenman et al., 2024) and eating disorders (Bellis et al., 2019; Greenman et al., 2024; Offer et al., 2022).

Physical consequences associated with childhood trauma are several, including risk of obesity, binge eating, diabetes, lung disease (Danese & Tan, 2014; Medeiros et al., 2020; Kuzminskaite et al., 2021; Kuzminskaite et al., 2022; Bellis et al., 2019; Greenman et al., 2024; Klinger-König et al., 2024) respiratory and cardiovascular disorders, as well as cancer (Hughes et al., 2017; Kuzminskaite et al., 2021; Bellis et al., 2019; Greenman et al., 2024).

Importantly, it has been found that childhood trauma results in a decreased volume of grey matter in areas such as the amygdala and hippocampus (Quan et al., 2025; Cai et al., 2023). Childhood trauma has also been found to cause neurobiological changes during crucial stages in brain development, which affect neuronal circuits, particularly those responsible for emotional

control, stress response and brain function (Hye & Chaiyapruk, 2023; Wang, 2024; Offer et al., 2022; Liu et al., 2024; Quan et al., 2025). Ye and colleagues (2023) have identified that childhood trauma is associated with brain alterations in two ways: Affected emotional representation and immature defense mechanisms, which are reflected in episodes of dissociation, dysregulated fantasy and the adoption of risky behaviours, such as substance use, alcohol and tobacco, and risky sexual behaviour (Bauer et al., 2022; Xiao et al., 2023; Jin et al., 2024; Cross et al., 2015; Şenyaşar Meterelliyoz & Baş Uluyol, 2024; Suhail Usmani et al., 2024; Huang et al., 2022; Alnassar et al., 2024).

Childhood trauma can affect cognitive abilities, namely focus, memory, knowledge acquisition and executive function, as well as emotion regulation, through an increased sensitivity to emotions, difficulties managing stress, maintainning or establishing interpersonal relationships (Kuzminskaite et al., 2021; Kuzminskaite et al., 2022; Klinger-König et al., 2024).

Childhood trauma has also been associated with eating behaviors and food choices, namely, an increased consumption of sugar, sugary drinks (Cammack et al., 2020; Costa et al., 2024), fast food (Cammack et al., 2020; Costa et al., 2024), and food choices with high fat content (Abajobir et al., 2017; Costa et al., 2024). Some research also emphasises that childhood trauma precedes emotional dysregulation, which in turn fosters an increase in negative emotions, that can promote emotional eating (Jones et al., 2019; Koçak & Çağatay, 2024; Bellehumeur-Béchamp et al., 2024; Offer et al., 2022).

Attachment

Bowlby (1988) firstly defined the concept of attachment behaviour as carrying a biological function of protection, not exclusive to human beings, which allows individuals to come closer together in the presence of suffering or need. For example, the frightened child who runs into his father's arms to feel protected (Bowlby, 1988).

Attachment behaviours are considered to be of fundamental importance on a similar level to feeding and reproductive behaviours. From an evolutionary perspective, human babies overcame the weaknesses and incapacities inherent to their biological prematurity and guaranteed protection against harm, by exhibiting attachment behaviours, such as crying, thumb sucking, smiling or calling (Ainsworth & Bell, 1970).

When attachment figures are available to meet the child's needs, by responding appropriately to the child’s constant requests for closeness, feelings of security, stability and self-esteem are transmitted to the child. From a cognitive point of view, these feelings and perceptions will form a set of mental representations about the attachment figure(s), oneself and the world. Bowlby defines these mental representations as *dynamic internal models* (Mikulincer & Shaver, 2013; Aliri et al., 2019; Ainsworth & Bell, 1970; Sagone et al., 2023; Rajkumar, 2020; Mikulincer & Florian, 1998 as cited in Nordahl et al., 2020).

Some researchers have found a close relationship between the way bonds are formulated in childhood and the formation of affective bonds with peers in adolescence (Allen, 2008; Delgado et al., 2011; Gorrese & Ruggieri, 2012; Sanchez-Queija & Oliva, 2015; Aliri et al., 2019). The development of new relationships is supported by the previous model of the self and others, which means that secure childhood relationships with attachment figures are highly likely to precede

secure relationships in the future. The way caregivers react to children's emotions indicates how their socio-emotional and cognitive functions will develop later on (Aliri et al., 2019; Chan et al., 2023; Nordahl et al., 2020; Fraley, 2019; Freeman & Simons, 2018; Ye et al., 2023).

When the attachment process is managed by consistent, reliable and sensitive caregivers, children develop a secure attachment style. On the other hand, when caragivers display inconsistent, unreliable or insensitive behaviours, children develop an insecure attachment style: a suboptimal way for individuals to cope with harmful/unresponsive environments (Bosmans & Borelli, 2022). There are two different styles of insecure attachment: Anxious attachment and avoidant attachment (Picardi et al., 2013; Yang et al., 2024; Mikulincer & Shaver, 2013; Rajkumar, 2020). Both secure and insecure attachment styles have an impact on two dimensions of dynamic internal models: Representations about oneself and others. Mary Ainsworth (1985) defined three attachment styles:

Secure attachment, refers to individuals with a healthy self-image, characterized by feelings of worthiness; a positive perception of others, who are seen as receptive and supportive in case of distress; and a sense of autonomy in intimate relationships. Secure attachment is associated with reliable attachment figures who are loving, affectionate, protective and able to meet the child's needs. They represent the good enough mothers as described by Winnicott (Winnicott, 1986; Rose et al., 2023).

Anxious attachment, refers to individuals with a negative self-image, and a positive image of others. This discrepancy can only be resolved with constant external validation, acceptance and dependency from others, in order to guarantee some source of love and relieve from an intense fear of abandonment (Yang et al., 2024; Khan & Moghal, 2021; Nordahl et al., 2020). Children who have an anxious attachment style, have experienced an unstable environment and don't know

when they can count on their attachment figures. With no guarantee of receiving protection and security, these children build up a system of positive feedback - hyperactivated attachment behaviours - in an incessant attempt to feel close, supported and loved. In this way, they try to balance their needs with the lack of availability from their attachment figures (Mikulincer & Shaver, 2013; Sagone et al., 2023).

Avoidant attachment, combines a positive self-image with a negative view of others. This dynamic enables the individual to feel confident to overcome situations (Sagone et al., 2023), but also to avoid contact with others, that are perceived as unsupportive, leading to difficulties in establishing and maintaing intimate relationships (Wang, 2023; Bowlby, 1988; Yang et al., 2024; Nordahl et al., 2020). In the avoidant attachment style, caregivers are perceived as unresponsive and unavailable. The child then internalises that it is irrelevant to seek comfort and protection from attachment figures. In an attempt to shut down their emotions and needs, they disconnect from contact with significant others (Ainsworth & Bell, 1970; Khan & Moghal, 2021; Sagone et al., 2023). Avoidant children deactivate their attachment behaviours by not seeking closeness, denying attachment needs and avoiding closeness, even in stressful situations (Verhees et al., 2021; Ainsworth & Bell, 1970; Bowlby, 1988; Mikulincer & Shaver, 2013).

Main & Solomon (1980), based on the Mary Ainsworth's work (Ainsworth & Bell, 1970; Bowlby, 1988), introduced a new attachment style: *Disorganised attachment*, which represents an individual who have internalised negative ideas about themselves and others, and is characterised by a combination of avoidant and anxious attachment styles. This can lead individuals to develop confused and nonsensical behaviours towards attachment figures (Ye et al., 2023). It develops in children who have been the target of extreme situations of neglect, sexual abuse or violence (Duschinsky, 2015; Rajkumar, 2020). In the case of disorganized attachment, attachment figures

are perceived as incapable of protection, as well as frightening (Mikulincer & Shaver, 2013; Brumariu et al., 2014; Ye et al., 2023; Spruit et al., 2019). There is a high probability that we are dealing with caregivers who carry out negligent, abusive and violent behaviour towards children. The stress that comes from this kind of early environment makes it difficult for the child to organise a behavioural strategy of intimate closeness or avoidance. Instead, hyperactivation and deactivation strategies are mobilized at the same time, in a confusing process that makes interpersonal relationships overwhelming (Brumariu et al., 2014; Ye et al., 2023; Spruit et al., 2019).

Unfortunately, the origin of disorganised attachment relies on situations that, despite being a minority, deserve careful attention and immediate action. It is through this style of attachment that the harmful consequences of physical and emotional violence, sexual abuse, or even coercion are manifested (Spruit et al., 2019).

When situations of neglect, abuse or other adverse experiences occur, there is an additional risk of the child developing an insecure attachment to unpredictable or unreliable caregivers (Rose et al., 2023; Cooke et al., 2019; Ye et al., 2023). The presence of trauma in childhood compromises the child's ability to establish a secure attachment (Lahousen et al., 2019). The emotional suffering caused by trauma inhibits the ability to regulate affection and develop mentalisation (the ability to comprehend and interpret the other person's thoughts), whether due to omitted trauma (physical and psychological neglect) or committed trauma (physical, emotional and sexual abuse) (Fonagy et al., 2002; Lahousen et al., 2019).

It seems that childhood trauma is transmitted from generation to generation through attachment. An insecure attachment in childhood precedes an adult with that same attachment style, who precedes a parent who transmits that same attachment style through their dysregulated

emotions, poor adaptive coping strategies and inadequate parenting strategies, perpetuating a cycle of intergenenerational trauma (Özcan et al., 2016; Greenman et al., 2024).

Exposure to childhood trauma influences the individual's sources and quality of nurturing care, either attachment relationships (Wen Zeng et al., 2024; Lahousen et al., 2019; Özcan et al., 2016; Greenman et al., 2024), or food nourishment, through eating behaviors and food choices (Vanderlinden et al., 2017; Koçak & Çağatay, 2024, Bellehumeur-Béchamp et al., 2024; Greenman et al., 2024). Several studies have established an association between attachment and consumption of unhealthy food, i.e., the more secure the attachment, the healthier the food consumption (e.g. Faber et al., 2018; Gregersen & Gillath, 2020; Santos et al., 2025; Uccula et al., 2022). Faber and colleagues' work (2018) has show that insecure attachment predicts unhealthy food consumption, emotional eating, binge eating, and dieting behaviours.

There are four main mechanisms that explain the relationship between unhealthy food consumption and attachment: 1. *General vulnerability* (i.e., insecure attachment predicts worse physical and mental health, including eating behaviours); 2. *Inability to regulate emotions* (i.e., insecure attachment predicts compensatory emotional choices associated with negative emotions); 3. *Poor self-representation* (i.e., insecure attachment predicts low self-esteem, which is managed by the consumption of unhealthy food) and 4. *Interpersonal difficulties* (i.e., insecure attachment generates difficulties in interpersonal relationships, which are compensated by food consumption) (Zachrisson & Skarderud, 2010; Mikulincer & Shaver, 2013; Santos et al., 2025).

Emotional distress

Emotional distress refers to all negative emotions and feelings triggered by trauma, such as fear, anger, sadness, guilt and shame (Anghele et al., 2023). Throughout the literature, emotional distress has been associated with sadness, low self-esteem, aggression, dissatisfaction with life, loss of interest, excessive fatigue, lack of hope, tension and agitation (Belay et al., 2021; Agbaje et al., 2021; Caetano & Pereira, 2024).

Emotional distress can impact all areas of an individual's life and daily functioning, including interpersonal relationships, recovery from physical damage (Anghele et al., 2023), experience of psychological pain (Anghele et al., 2023) and decline in mental health, specifically through a high prevalence of anxiety and depression symptoms, as well as their comorbidities (Anghele et al., 2023; Guerrini-Usubini et al., 2023; Greenman et al., 2024; Koçak & Çagatay, 2024; Kuzminskaite et al., 2021; Hughes et al., 2017).

It is estimated that between 2009 and 2021, the prevalence of emotional distress increased from 25% to 31% globally. In 2020, there was a significant increase, which coincides with the recently faced global pandemic COVID-19 (Daly & Macchia, 2023). In Portugal, 19.8% of the population suffers from mental health disorders, such as depression and anxiety. One of the highest rates in Europe (Sosa-Cordobés et al., 2024).

Depression

Depression is a mood disorder, characterized by persistent feelings of sadness and loss of interest, which stems from a complex interaction between biological, social and environmental

factors (Chand & Arif, 2023; WHO, 2023). In 2019, it was estimated that 5% of older individuals worldwide experienced depression (WHO, 2023).

The DSM-V-TR (2022) presents several disorders related to depression: Disruptive mood dysregulation disorder; Major depressive disorder; Persistent depressive disorder (dysthymia); Premenstrual dysphoric disorder; Depressive disorder due to another medical condition. Although there are several depressive disorders, they all have in common the presence of depressed, apathetic or irritable mood, and functional changes, namely in sleep or eating habits. Differential diagnosis is established by analyzing the duration of symptoms or presumed etiology (DSM-V-TR, 2022).

Depression can affect all aspects of a person's life, including interpersonal relationships and problems at work (WHO, 2023). The World Health Organization (2023) has identified a variety of physical and psychological symptoms that can result from depression. *Physical symptoms* include physical inactivity, disrupted sleep, changes in appetite or weight, feelings of fatigue and low levels of energy, which can then lead to cardiovascular and respiratory diseases, cancer and diabetes (WHO, 2023). On the other hand, *psychological symptoms* may include lack of concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, and suicide ideation (WHO, 2023).

Individuals exposed to childhood trauma are more likely to develop mental disorders, physical illnesses (Greenman et al., 2024; Cai et al., 2023). Specifically, childhood trauma is associated with sensitivity to stress and the development of depressive disorders (Kuzminskaite et al., 2021; Greenman et al., 2024). Childhood trauma promotes emotional distress, which encourages the development of depressive disorders (Greenman et al., 2024; Wen Zeng et al., 2024). Many researchers have found that the association between trauma and depression is

mediated by attachment (Greenman et al., 2024; Özcan et al., 2016; Lahousen et al., 2019; Spruit et al., 2019; Ye et al., 2023; Yang et al., 2024, Wang, 2023, Herstell et al., 2021).The literature suggests that insecure attachment promotes a maladaptive mental schema, that subjects the individual to constant periods of stress, which can trigger the development of depressive disorders (Spruit et al., 2019; Herstell et al., 2021).

Depression has also been linked to emotional eating, through emotional dysregulation. The guilt arising from emotional eating episodes promotes the increase of depressive symptoms, creating a negative cycle that deepens the depressive disorder (Guerrini-Usubini et al., 2023; Chu et al., 2019; Chwyl et al., 2021; Cecchetto et al., 2021).

Anxiety

Chand & Marwaha (2023) define anxiety as a difficult-to-describe and unpleasant feeling of fear, characterized by discomfort derived from the anticipation of a certain unknown situation considered dangerous. Fear and anxiety are different concepts, since fear is a response to a real danger in the moment, while anxiety is an anticipatory response to a perceived danger (Chand & Marwaha, 2023). Similar to depression, anxiety presents different disorders, all of which share feelings of excessive fear and anxiety, with associated maladaptive behaviors (DSM-V-TR, 2022). These are: Separation anxiety disorder; Selective mutism; Specific phobia; Social anxiety disorder; Panic disorder; Panic attack specifier; Agoraphobia; Generalized anxiety disorder; Substance-Medication-Induced Anxiety Disorder; Anxiety Disorder due to another medical condition; Other specified anxiety disorder; Unspecified anxiety disorder. Differential diagnosis is created in function of duration, time or presumed etiology (DSM-V-TR, 2022). The development of anxiety

disorders arise from a complex interaction between biological, social and environmental factors (WHO, 2023).

Several physical symptoms have been associated with anxiety symptomatology, namely, problems concentrating and making decisions; feeling irritable, tense or restless; experiencing nausea or abdominal distress; having heart palpitations; sweating, trembling or shaking; trouble sleeping; having a sense of impending danger, panic or doom; increased risk of depression and substance abuse; and suicidal ideation (WHO, 2023). The risk of developing an anxiety disorder is higher in women than in men (at an approximate ratio of 2:1) (DSM-V-TR, 2022).

Anxiety disorders develop in childhood/adolescence and tend to persist if left untreated. Individuals who have suffered adverse experiences throughout their lives are particularly vulnerable. Childhood trauma increases the likelihood of developing an anxiety disorder (Zhang et al., 2025; Kascakova et al., 2020; Idsoe et al., 2021; Bellehumeur-Béchamp et al., 2024; Greenman et al., 2024). Childhood trauma generates a vulnerability in the perception of stress, which increases feelings of anxiety, triggering the disorder throughout life. On the other hand, there is a negative association between secure attachment and the development of anxiety disorders (Brumariu et al., 2014; Wang, 2024; Picardi et al., 2013; Brumariu et al., 2014). According to Brumariu and colleagues (2014), attachment plays an essential role in the perception of cues related to fear and anxious states.

There is a strong association between childhood trauma and the severity of psychopathology (e.g. Ravishankar & Sathiyaseelan, 2022). Three out of four individuals who experience childhood trauma have depressive and/or anxiety disorders (Kuzminskaite et al., 2021; Hughes et al., 2017). Several researchers emphasise that childhood trauma can lead to structural psychological and social changes that interfere with the development process, leaving the

individual susceptible to psychiatric disorders, such as anxiety (Fan et al., 2024; Şenyaşar Meterelliyoz & Baş Uluyol, 2024).

High levels of anxiety have also been correlated with excessive food consumption (Slochower, 1983; van Strien, 2018), as a way of compensating for negative emotions (Guiné, 2021). This strategy aims to increase pleasure, through the act of eating, and as consequence, reduce anxiety (Klatzkin et al., 2023). Previous literature has identified a bidirectional relationship between emotional eating and emotional distress (Guerrini-Usubini et al., 2023; Chu et al., 2019; Chwyl et al., 2021; Cecchetto et al., 2021). Emotional distress promotes emotional eating choices, driven by emotional dysregulation and ineffective management of negative feelings and thoughts (Koçak & Çagatay, 2024). This behaviour can be learned and triggered by adverse life experiences or emotional instability, which promotes uncontrollable eating - a compulsion to fill the emotional void (Konttinen, 2020). In turn, these episodes lead to poor self-perception and emotional dysregulation (Koçak & Çagatay, 2024; van Strien, 2018). This cycle generates a persistent feeling of guilt, unhealthy eating behaviours and weight gain (Braun et al., 2021).

Emotional motivations of food choices

Food motivations are defined as central factors underlying the act of eating that identify various aspects of the individual's context, and influence the food choices adopted (Guiné, 2021). There are different types of food motivations: *Healthy motivations,* aimed at reducing the negative consequences associated with the adoption of an unhealthy diet, namely the development of various chronic diseases, such as obesity, coronary heart disease, stroke, general inflammation, increased LDL cholesterol and triglycerides, blood pressure levels, type 2 diabetes and various types of cancer (Guiné, 2021; Ilić et al., 2023); *Economic motivations,* associated with the price of

the product, which has different meanings depending on the socio-economic status of the individual (Guiné, 2021; Ilić et al., 2023); *Emotional motivations,* as a way of compensating for negative emotions or temporary mood states (for example anxiety or irritability, described as emotional eating) (Guiné, 2021; Ljubičić et al., 2023; Ilić et al., 2023) or appetite suppression, particularly present in depressive states (Guiné, 2021); *Cultural motivations,* related with information acquired from tradition, social context and/ or socially acquired eating routines (Guiné, 2021; Ilić et al., 2023); *Marketing and advertising,* associated with repeated exposure to reward mechanisms such as product promotions, or appeals to the authenticity of a given product (Guiné, 2021; Ilić et al., 2023); *Environmental motivations,* which reflect a concern for animal welfare, and the choice of sustainable practices that preserve the ecosystem and biodiversity, as well as having the least possible impact on the planet (Guiné, 2021; Ilić et al., 2023).

Negative emotions can influence food intake in different ways, by promoting food consumption on one hand, or limiting or inhibiting it on the other (Zwierczyk et al., 2022; Ljubičić, et al., 2023; Klatzkin et al., 2023; Betancourt-Núñez et al., 2022).

Emotional eating is a concept that defines the behavioral response of eating or drinking, in function of an emotional stimulus, i.e., without the presence of biological indicators of hunger (Ljubičić, et al., 2023). It is a maladaptive strategy, influenced by mood, to suppress a stressful situation and deal with negative feelings such as sadness, irritability, loneliness and anxiety, for example (van Strien, 2018; Koçak & Çağatay, 2024; Konttinen, 2020; Ljubičić, et al., 2023). Episodes of emotional eating are characterized by the consumption of food high in sugars, such as cakes, cookies, desserts, ice cream, chocolate and its derivatives, sugary cereals, sweets and sugary drinks; high-fat foods, fried foods, fast food and salty snacks. All of these foods are referred in the literature as comfort foods, given that their consumption is used to compensate for negative

emotions that individuals cannot deal with (Ling & Zahry, 2021; Elran Barak et al., 2021; Betancourt-Núñez et al., 2022; Guiné et al., 2020; Lima et al., 2021; Guiné, 2021; McKay et al., 2021b; Finch et al., 2019; Ljubičić, et al., 2023).

Previous work has shown that dysfunctional eating behaviors and emotional food motivations are the main causes of increased overweight and/or obesity around the world (Jackson, et al., 2020; Zwierczyk et al., 2022; Chew et al., 2025). Several researchers point out that emotional states or mood have a high impact on food choices, as a way of filling the emptiness associated with feelings of sadness, loneliness, guilt, depression, caused by interpersonal conflicts and other life situations that cause emotional distress (Ljubičić, et al., 2023).

Recurrent episodes of emotional eating can lead to long-term consequences such as guilt, dysfunctional and unhealthy eating behaviors and weight gain. In addition, there is a positive association between emotional eating and the suppression of basic psychological needs such as security, love, a sense of belonging, self-actualization and self-esteem (Braun et al., 2021; Koçak & Çağatay, 2024; Konttinen, 2020; Ljubičić, et al., 2023). Emotional eating is also associated with various forms of emotional distress, leading to various forms of eating, depression and anxiety disorders (Cecchetto et al., 2021; Squires et al., 2020; Guerrini-Usubini et al., 2023).

Previous literature has identified an association between insecure attachment and emotional motivations of food choices (Gregersen & Gillath, 2020; Santos et al., 2025; Faber et al., 2018), particularly anxious attachment (Devonport et al., 2019; Uccula et al., 2022). Faber and colleagues (2018) have found that individuals with insecure attachment are more likely to consume unhealthy foods compared to the general population. This association can be explained by the emotional distress resulting from attachment, which interferes with the perception of hunger,

promoting the consumption of unhealthy foods (Koçak & Çağatay, 2024; Bellehumeur-Béchamp et al., 2024; van Strien, 2018).

Emotional eating has been widely associated with exposure to childhood trauma, through emotional dysregulation (Koçak & Çağatay, 2024; Cecchetto et al., 2021; Guerrini-Usubini et al., 2023; Bellehumeur-Béchamp et al., 2024; Vanderlinden et al., 2017). Childhood trauma has been identified as the main predictor of emotional eating, especially when the child has suffered emotional abuse (e.g. Burns et al., 2012; Michopoulos et al., 2015). In these scenarios, the child's inability to manage the uncontrolabble and overwhelming experiences associated with trauma can encourage the use of avoidance or emotional coping strategies, including eating comfort food as a way of emotional management (Wallace & Krugman, 2024). In the presence of childhood trauma, there is a greater sensitivity to stress and a decreased ability to return to the body’s normal state, even if the stressful stimulus is no longer present. In the long term, this represents a constant biological and psychological response to a threat that is considered imminent and unpredictable, which can lead to unhealthy food consumption and habits (Wallace & Krugman, 2024; Bellehumeur-Béchamp et al., 2024).

Aims and Research Hypotheses

The overall aim of this research was to analyze the association between the exposure to childhood trauma and emotional motivations associated with food choices, as well as the mediating roles of attachment quality and emotional distress (i.e., anxiety and depression symptomatology).

The specific objectives were: 1) To study the mechanisms associated with food choices and their relationship with mental health; 2) To analyze the indirect effects (i.e., mediating roles) of attachment quality and emotional distress (i.e., anxiety and depression symptomatology), on the relationship between childhood trauma and the emotional motivations of food choices; 3) To increase awareness around the fact that food choices are associated with psychological and developmental factors, and not just survival. With regard to the hypotheses, the following were established:

1) There is a direct effect between exposure to childhood trauma and the emotional motivations of food choices (i.e., higher exposure to childhood trauma is associated with higher levels of emotional motivations associated with food choices);

2) There is an indirect (i.e., mediating) effect of attachment quality in the relationship between childhood trauma and emotional motivations of food choices (i.e., higher levels of childhood trauma are associated with higher insecure attachment, which in turn is associated with higher levels of emotional motivations associated with food choices);

3) There is an indirect effect of emotional distress (i.e., anxiety and depression) in the relationship between childhood trauma and emotional motivations of food choices (i.e., higher levels of childhood trauma are associated with higher levels of emotional distress (i.e., depression

and anxiety), which in turn are associated with higher levels of emotional motivations associated with food choices).

Method

Participants

500 participants took part in this study (390 women, 78%; 110 men, 22%), aged between 18 and 85 (M=32.60; SD=13.83), from different socio-economic backgrounds (3.2% low; 26% medium-low; 56.8% medium; 13.2% medium-high 0.8%; high). Regarding marital status, the majority reported being single (63.2%) with no children (69.8%). With regard to educational qualifications, the majority said they had a Bachelor's degree (45.8%) or completed secondary school (27.4%). With regard to health habits and conditions, 81.8% of the participants reported not having any food allergies or intolerances. The majority of participants reported not doing any physical exercise (30%) or doing it 1-2 times a week (20.6%). With regard to alcohol consumption, the majority reported not consuming alcohol (49.4%), or consuming less than 4 drinks a week (46.2%). 86.4% reported not being smokers. 82.4% reported not having any chronic physical or psychological illness (84.8%) diagnosed by a doctor. With regard to professional clinical support, 75% said they had no psychological support and 90.8% said they were not accompanied by a nutritionist (see Table 1).

Table 1

Socio-demographic and clinical variables

Variável	**Count (%)**
Sex	
Feminine	390 (78%)
Masculine	110 (22%)
Total	500 (100%)
Education	
No education	2 (0.4%)
Less than 12 years of education	7 (1.4%)
12 years of education	137 (27.4%)
Bachelor	229 (45.8%)
Master	95 (19%)
PhD	30 (6%)
Civil status	
Single	316 (63.2%)
Partnership (not married)	62 (12.4%)
Married	97 (19.4%)
Divorced	20 (4%)
Widowed	5 (1%)
Children	
No	349 (69.8%)

Yes	151 (30.2%)
Estatuto sócio-económico	
Lower	16 (3.2%)
Lower middle	130 (26%)
Middle	284 (56.8%)
Upper middle	66 (13.2%)
Upper middle	4 (0.8%)
Allergies / Food intolerances	
No	409 (81.8)
Yes	91 (18.2)
Physical exercise	
I don't exercise	150 (30%)
1 a month	45 (9%)
1-2 a week	148 (29.6%)
3-4 a week	122 (24.4%)
5 or more a week	32 (6.4%)
More than once a day	3 (0.6%)
Alcohol consumption	
I don’t drink	247 (49.4%)
Less than 4 drinks a week	231 (46.2%)
More than 4 drinks a week	22 (4.4%)
Smoker	
No	432 (86.4%)

Yes	68 (13.6%)
Physical chronic illness	
No	412 (82.4%)
Yes	88 (17.6%)
Psychological illness	
No	424 (84.8%)
Yes	76 (15.2%)
Professional psychological support	
No	375 (75%)
Yes	125 (25%)
Professional nutritional support	
No	454 (90.8%)
Yes	46 (9.2%)

Instruments

Childhood Trauma Questionnaire

The Childhood Trauma Questionnaire (Bernstein et al., 1997; Dias et al. 2024) aims to assess issues of abuse and neglect in childhood, analyzing the exposure to traumatic experiences, as well as their frequency and duration. This is a 28-item self-report instrument based on 5 sub-scales, with a response likert scale ranging from 1 (Never) to 5 (Always): *Sexual Abuse* (e.g., item 20: They tried to touch me or forced me to touch someone sexually); *Physical Neglect* (e.g., item

6: I had to wear dirty clothes); *Emotional Abuse* (e.g., item 25: I believe I was emotionally abused); *Emotional Neglect* (e.g., item 2: I knew there was someone to look after and protect me); *Physical Abuse* (e.g., item 11: In my family I was beaten so much that I was left bruised or with bruises on my body). This study analyzed the total score for childhood trauma, which results from the sum of all the items. The reliability of the scale (α=.82) was good.

Adult Attachment Scale

The Adult Attachment Scale (Canavarro et al., 2006; Collins & Read, 1990), was used to assess the quality of attachment. The scale is made up of 18 items, distributed into three sub-scales that analyze different dimensions of attachment: Anxiety, Closeness and Dependence. The subscale *Anxiety* measures the level of anxiety in interpersonal relationships and the fear of rejection or abandonment (e.g., item 3: I often worry that my partners don't really like me; item 9: I often worry that my partners will leave me); *Closeness* assesses the degree of comfort with intimacy and emotional closeness (e.g., item 12: I feel good when I relate closely to other people; item 13: I get uncomfortable when someone gets emotionally close to me); *Dependence* analyzes the trust the individual has in the emotional availability of other people (e.g., item 14: When I need to I feel I can rely on people; item 16: I find it difficult to trust others completely).

The score for each subscale is calculated by averaging the corresponding items. The total score for this scale is obtained by adding up the scores for the three subscales, divided by the total number of items, allowing for an overall assessment of attachment. The three subscales were used in this study. The reliability of the Anxiety scale (α=.88) was good. Closeness (α=.71) and Dependence (α=.62) scales were moderate and acceptable.

Hospital Anxiety and Depression Scale

The Hospital Anxiety and Depression Scale (Pais-Ribeiro et al., 2007), aims to measure the development of emotional distress, in two dimensions (*Anxiety* and *Depression*), in clinical and non-clinical populations. This self-report scale has 14 items and is presented on a Likert-type scale ranging from 0 to 3. The total score of the scale is obtained from the total sum of the items, ranging from 0 to 21: a score between 0 and 7 points identifies that the existence of anxiety or depression is 'unlikely'; a score between 8 and 11 points indicates 'probable, questionable or doubtful', and a score between 12 and 21 points signifies the likelihood of the existence of emotional distress, both in the anxiety and depression dimensions. The reliability of the Anxiety (α=.83) and Depression scales (α=.71) were good and moderate.

Food Choice Determinants Questionnaire

The Food Choice Determinants Questionnaire (Ferrão et al., 2019) aims to understand individuals' food choices, through six independent dimensions: *Healthy motivations; Emotional motivations; Economic and availability motivations; Social and cultural motivations; Environmental motivations and Marketing and commercial motivations*, across 55 items. All the dimensions are assessed on a Likert scale from 1 (Strongly Disagree) to 5 (Strongly Agree). There is no total score for this questionnaire.

In this study, only the Emotional Motivations dimension was used, consisting of 10 items (e.g., item 1: Food helps me deal with stress; item 5: Food makes me feel good). The score results from the average of the 10 items. The reliability of the scale (α=.73) was good.

Procedure

This study was presented and approved by the Ethics Committee of the European University. Participation in the study was voluntary and the anonymity of the participants was guaranteed in accordance with European data privacy and security law [General Data Protection Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016]. The researchers' contact details were made available in case additional information was required.

The protocol was publicised through flyers, social networks, online forums and emails distributed and sent to clinics, hospitals, pharmacies, gyms, universities and influencers in the field of Psychology and Nutrition. This study also had the support of the Portuguese Nutrition Association, which shared the questionnaire with its collaborators, and the Psychology Students' Nucleus (NEPSI) at the University of Algarve.

For this purpose, an appealing message was created, usually accompanied by an illustrative image, with the title "Are we what we eat? The relationship between adverse childhood experiences, food choices and the development of emotional distress". In addition, the questionnaire was shared daily via Instagram and Facebook stories, with images that varied to attract interest and renew participation.

All participants had access to an Informed Consent Form, which provided a description of the research, the processing of personal data, information about the research team, and consent to participate. If the participant refused consent they would be directed to the last page of the questionnaire. With regard to the processing of personal data, it was also made clear to the participants that the data would only be used for the purpose of the study and in the context of scientific publications and that only the researchers would have access to the information.

Results

Data Analysis

Data analysis was conducted using the IBM SPSS Statistics for Windows (version 29). Multiple Pearson correlation analyses were first conducted to test bi-variate relationships between the study variables. If the coefficient value lies between ± 0.50 and ± 1, then it is said to be a strong correlation. If the value lies between ± 0.30 and ± 0.49, then it is said to be a medium correlation. When the value lies below + .29, then it is said to be a small correlation (Cohen, 1988).

A multiple-step mediation methodology, with a bootstrapped confidence interval for indirect effects (Hayes, 2013), was conducted to test our hypotheses of serial mediation. The following was examined: (a) direct association between childhood trauma and emotional motivations in food choices; (b) indirect association between childhood trauma and emotional motivations in food choices through attachment dimensions (Closeness, Dependence, and Anxiety); indirect association between childhood trauma and emotional motivations in food choices through both anxiety and depressive symptoms; and (d) two-step mediation of the association between childhood trauma and emotional motivations in food choices through attachment dimensions (Closeness, Dependence, and Anxiety) and both anxiety and depressive symptoms. All variables were defined as manifest variables. There were no missing cases, as only respondents who completed all questions were able to submit the questionnaire protocol.

To evaluate the proposed model, Structural Equation Modeling (SEM) was conducted in accordance with the guidelines of Hoyle and Smith (1994), utilizing AMOS software (Version 29) and employing the Maximum Likelihood estimation method. Prior to conducting the analyses, data were assessed for normality using the Kolmogorov-Smirnov test, and all requisite assumptions

were satisfactorily met. Model fit was evaluated using the following criteria: (a) a non-significant chi-square (χ^2) statistic; (b) values greater than 0.95 for the Comparative Fit Index (CFI), Normed Fit Index (NFI), and Tucker-Lewis Index (TLI); and (c) values less than 0.08 for both the Root Mean Square Error of Approximation (RMSEA) and the Standardized Root Mean Square Residual (SRMR). Additionally, a bootstrapped confidence interval based on 5,000 resamples was employed to assess the significance of indirect effects.

To evaluate the statistical significance of the indirect effects, the study employed a bootstrapping method following the procedures outlined by Preacher and Hayes (2008). Specifically, 5,000 bootstrap samples were generated to estimate the indirect effects associated with each mediator. Bias-corrected and accelerated (BCa) 95% confidence intervals were calculated for the "ab" paths of each mediator as well as for the overall two-step mediation process. An indirect effect was deemed statistically significant if the corresponding confidence interval did not include zero, thereby indicating the presence of a meaningful mediating relationship.

Table 2

Means and standard deviations for childhood trauma, the 3 dimensions of attachment (Anxiety, Closeness, Dependence), Anxiety and Depression symptoms, and Emotional motivations in food choices.

Variables	M	SD
Childhood Trauma	36,19	11,10
Anxious Attachment	2,52	0,96

Closeness	3,53	0,67
Dependence	3,23	0,65
Anxiety	15,14	3,97
Depression	11,9	3,20
Emotional Motivations for Food Choices	2,96	0,71

Table 3

Pearson correlations between the variables childhood trauma, the 3 dimensions of attachment (Anxiety, Closeness, Dependence), Anxiety and Depression symptoms and Emotional motivations in food choices.

Variables	1	2	3	4	5	6	7
1. Childhood Trauma	-	0.34**	-0.37**	-0.41**	0.37**	0.33**	0.11*
2. Anxiety Attachment		-	-0.42**	-0.53**	0.54**	0.28**	0.26**
3. Closeness			-	0.44**	-0.35**	-0.45**	-0.15**
4. Dependence				-	-0.38**	-0.26**	-0.17**
5. Anxiety					-	0.57**	0.27**
6. Depression						-	0.21**
7. Food Choices Emotion							-

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$

Higher childhood trauma was associated with higher attachment anxiety (r=0.34, $p \leq 0.01$), lower attachment closeness (r=-0.37, $p \leq 0.01$), lower attachment dependence (r=-0.41, $p \leq 0.01$), higher anxiety symptoms (r=0.37, $p \leq 0.01$), higher depression symptoms (r=0.33, $p \leq 0.01$), and higher emotional motivations in food choices (r=0.11, $p \leq 0.05$).

Higher attachment anxiety was associated with lower attachment closeness (r=-0.42, $p \leq 0.01$), lower attachment dependence (r=-0.53, $p \leq 0.01$), higher anxiety symptoms (r=0.54, $p \leq 0.01$), higher depression symptoms (r=0.28, $p \leq 0.01$) and higher emotional motivations in food choices (r=0.26, $p \leq 0.01$). Greater attachment closeness was linked to greater attachment dependence (r=0.44, $p \leq 0.01$), lower anxiety symptoms (r=-0.35, $p \leq 0.01$), lower depression symptoms (r=-0.45, $p \leq 0.01$) and lower emotional motivations in food choices (r=-0.15, $p \leq 0.01$).

Greater attachment dependence was linked to lower anxiety symptoms (r=-0.38, $p \leq 0.01$), lower depression symptoms (r=-0.26, $p \leq 0.01$) and lower emotional motivations in food choices (r=-0.17, $p \leq 0.01$).

Finally, greater anxiety symptoms was associated with higher depression symptoms (r=0.57, $p \leq 0.01$), and higher emotional motivations in food choices (r=0.27, $p \leq 0.01$). Greater depression symptoms were associated with higher emotional motivation in food choices (r=0.21, $p \leq 0.01$).

Serial mediation model

A two-step mediation model was tested in which childhood trauma was directly linked to emotional motivation in food choices; childhood trauma was indirectly linked to emotional motivations in food choices through attachment dimensions (Closeness, Dependence, and

Anxiety); childhood trauma was indirectly linked to emotional motivations in food choices through both anxiety and depressive symptoms; and, a two-step mediation in which childhood trauma was linked to attachment dimensions (Closeness, Dependence, and Anxiety, which in turn were linked to both anxiety and depressive symptoms, which in turn were linked to emotional motivations in food choices. This model provided a good fit to the observed data ($\chi 2$ (1) =0.26, p = .61; NFI= .99; CFI =.99; TLI = .99; RMSEA =.01; SMSR =.01).

After omitting non-significant paths, our final model fit the observed data well ($\chi 2$ (2) = 0.62, p = .73; NFI= .99; CFI = .99; TLI = .99; RMSEA =.01; SMSR =.01). The direct paths from childhood trauma to emotional motivations in food choices were non significant (b = -.03, p =.50, 95% CI, -.09, .03). Meanwhile, the indirect effect from childhood trauma to emotional motivations in food choices through Attachment Anxiety was significant (b = .34, p <.001, 95% CI, .26, .42). Higher levels of childhood trauma were linked to higher levels of Attachment Anxiety, which in turn were linked to higher levels of emotional motivations in food choices. It was also observed that the indirect effect from childhood trauma to emotional motivations in food choices through anxiety symptoms was significant (b = .19, p <.001, 95% CI, .16, .22). Higher levels of childhood trauma were linked to higher levels of anxiety symptoms, which in turn were linked to higher levels of emotional motivations in food choices.

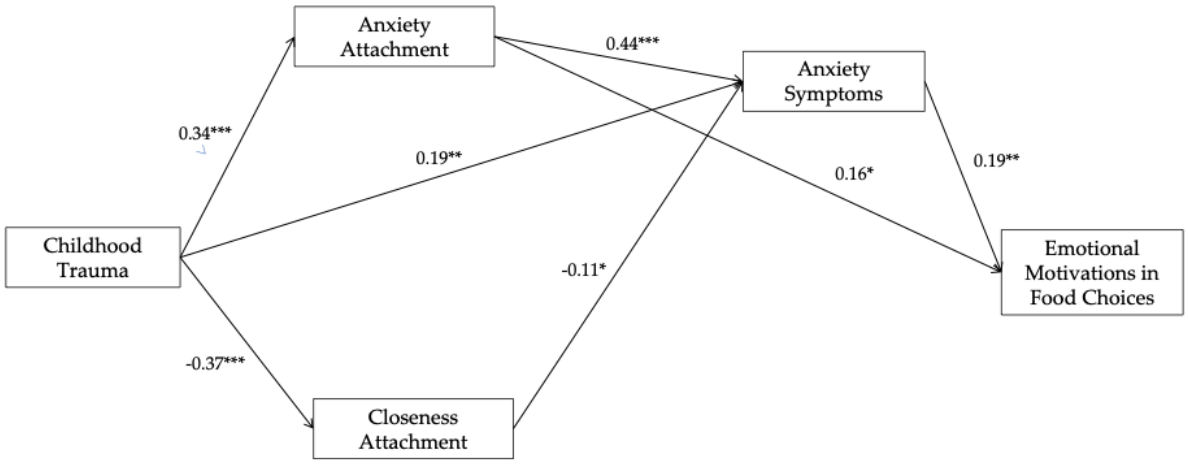
Finally, the two-step indirect effects results indicated that higher levels of childhood trauma were linked to higher levels of Attachment Anxiety, which in turn were linked to higher levels of anxiety symptoms, which in turn subsequently were linked to higher levels of emotional motivations in food choices. The findings further indicated that greater exposure to childhood trauma was linked to lower levels of Closeness Attachment, which subsequently were linked to higher levels of anxiety symptoms, ultimately being linked to higher levels of emotional

motivations in food choices. The remaining paths were non-significant. Standardized results are presented in Figure 1.

Figure 1

Serial Mediational Integrated Model for Emotional Motivations in Food Choices by Childhood Trauma, Attachment and Anxiety.

Note. This figure presents the serial Mediational Integrated Model from the Global Score of Childhood Trauma to Emotional motivations in food choices, through Attachment and Anxiety symptoms. Rectangles indicate measured variables. Standardised maximum likelihood parameters are used. N =500; *p <.05, **p<.01, ***p <.001.



Discussion

The main goal of this study was to analyze the relationship between the exposure to childhood trauma and the emotional motivations in food choices, as well as the mediating roles of attachment quality and emotional distress (i.e., anxiety and depression symptomatology).

The first hypothesis (H1) proposed the existence of a direct effect between childhood trauma exposure and emotional motivations associated to food choices. The results have shown that there isn't a direct effect between childhood trauma and emotional motivations in food choices. These results are consistent with what has been found in the literature, since the relationship between childhood trauma and emotional motivations in food choices is widely reported, through the indirect effects of attachment (Gregersen & Gillath, 2020; Uccula et al., 2022) and emotional distress (Koçak & Çağatay, 2024; Guerrini-Usubini et al., 2023; Bellehumeur-Béchamp et al., 2024). Previous work, has shown that childhood trauma is associated with insecure attachment (Greenman et al., 2024), which promotes the development of anxious and depressive symptoms (Zachrisson & Skarderud, 2010; Mikulincer & Shaver, 2013; Santos et al., 2025). The presence of these negative emotional states creates a change in the perception of hunger (Faber et al., 2018), leading to food intake as a way to compensate for the negative emotions experienced (Koçak & Çağatay, 2024; Bellehumeur-Béchamp et al., 2024; van Strien, 2018).

The second hypothesis (H2) proposed the existence of an indirect effect of attachment quality, in the relationship between childhood trauma and emotional motivations in food choices. The results confirmed this hypothesis. Results showed that higher exposure to childhood trauma was associated with higher attachment anxiety, which in turn was associated with higher emotional motivations in food choices. On the other hand, higher exposure to childhood trauma was associated with lower closeness to others, which in turn was associated with higher anxiety levels,

which then were associated with higher emotional motivations in food choices. Interestingly, the data reveals that only attachment anxiety establishes a direct relationship with emotional motivations associated to food choices. On the other hand, closeness to others establishes a relationship with the emotional motivations in food choices, through the presence of anxiety symptomatology/disorder. These results are aligned with previous literature, with some authors reporting that higher levels of insecure attachment predict higher levels of emotional motivations in food choices (e.g. Faber et al., 2018; Uccula et al., 2022), while other authors report that attachment relationships stemming from childhood trauma, are associated with emotional distress (or emotional negative states), which in turn affect the perception of hunger and the consumption of comfort foods (Koçak & Çağatay, 2024; Bellehumeur-Béchamp et al., 2024; van Strien, 2018). In fact, several authors have suggested that attachment appears as a moderating variable between childhood trauma and the development of emotional distress, through the dynamic internal models formed in childhood (Wang, 2024; Gregersen & Gillath, 2020; Greenman et al., 2024; Özcan et al., 2016; Lahousen et al., 2019). Closeness attachment seems to be associated with emotional motivations in food choices through the presence of anxious symptoms, as a maladaptive form of emotional management (Guiné, 2021; Klatzkin et al., 2023; van Strien, 2018).

Uccula and colleagues (2022) explain that individuals with anxious attachment consider themselves incapable of being loved (Santona et al., 2022), which may promote the regulation of their emotions through food. This data is in line with previous clinical studies (Pace et al., 2022; Roithmeier et al., 2024), which have shown that anxious attachment presents a greater risk of developing emotional eating behaviours and eating disorders, such as binge eating (Pace et al., 2022; Roithmeier et al., 2024; Klein et al., 2022; Tasca & Balfour, 2014).

The third hypothesis (H3) proposed the existence of an indirect effect of emotional distress (i.e., anxiety and depression), in the relationship between childhood trauma and emotional motivations in food choices. The results confirmed this hypothesis in a partial way, given that only anxiety showed a significant indirect effect on this relationship, but not depression. These results are in line with the literature which reveals that childhood trauma is correlated with the presence of negative emotions, emotional dysregulation and the presence of anxious states and disorders, which in turn foster the emotional motivations in food choices (Vanderlinden et al., 2017; Koçak & Çağatay, 2024; Bellehumeur-Béchamp et al., 2024; Greenman et al., 2024; Zhang et al., 2025; Klatzkin et al., 2023). For example, Bekmezci & Çağatay (2024) have already established that there is a vicious cycle between anxious symptomatology and maladaptive eating behaviours, namely binge eating behaviours. Faced with the inability to manage anxiety, individuals use binge eating behaviours to cope with their emotions, which then lead to feelings of guilt and shame, after a false sense of comfort. These feelings generate new anxiety, which is again managed through food consumption.

Unexpectedly, our results show that depression does not have an indirect effect in the relationship between childhood trauma and emotional motivations in food choices. Previous studies have found that anxiety is related to emotional eating (Guiné, 2021; Hambleton et al., 2022; Deroost & Cserjési, 2018) and depression to food inhibition (Guiné, 2021; Guiné et al., 2020; van den Tol et al., 2019; Kroemer et al., 2022). The absence of a significant indirect effect of depression might be associated to the fact that the Emotional Motivations subscale used in this study, targets emotional eating behaviours, opposed to food suppression behaviours.

Implications for clinical practice

This research has practical clinical implications for the general population, but specifically for the population suffering from eating disorders, namely bulimia and binge eating.

Emotional motivations in food choices are present throughout the population (Guiné, 2021). In times of greater stress, emotional eating behaviours can be displayed, but this is should not be considered as some kind of disorder, abnormality or pathology (Guiné, 2021; Ljubičić et al., 2023; Betancourt-Núñez et al., 2022). Therefore, clinical practicioners should pay additional importance to the details of each individual's life, in order to achieve an appropriate diagnosis and individualised intervention. The results of this study have shown that early life experiences, namely childhood trauma and attachment must be taken into account as significant promoters of food choices later in life (e.g. Faber et al., 2018; Tasca & Balfour, 2019; Koçak & Çağatay, 2024, Bellehumeur-Béchamp et al., 2024; Greenman et al., 2024). Collecting information about patients' food consumption and eating motivations can help professionals gain access to clinical details, associated with the quality of their patients' early experiences (Koçak & Çağatay, 2024).

The most commonly used interventions targeting eating behaviours and motivations are Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Interpersonal psychotherapy (IPT) (Smith & Goldschmidt, 2024), Eye Movement Desensitization and Reprocessing (EMDR) (Hatoum & Burton, 2024) and Psychodynamic Intervention (Mirabella et al., 2023; Tasca & Balfour, 2019).

Specifically, the intervention of Friederich and his collaborators (2023), from a current psychodynamic perspective, suggests that the symptomatology of eating disorders (emotional eating, for example), is related to feelings of ineffectiveness, loss of control and difficulty in

differentiating and regulating affect. The individual is unable to deal with these difficulties in interpersonal and intrapsychic terms, and eating behaviour is used as a dysfunctional defense and coping strategy (Friederich et al., 2023).

Modern psychodynamic intervention realises that restrictive diets accompanied by weight loss and/or bulimic eating patterns can maintain psychopathology, which is why the patient's contact with their internal conscious and unconscious psychological conflicts and emotions should be encouraged (Friederich et al., 2023). This approach, allows for an integrated reading of the individual, including their life context, interpersonal relationships, attachment and psychological functioning. This allows the individual to gain a deeper understanding of themselves, resolve conflicts and reduce symptoms (Mirabella et al., 2023; Tasca & Balfour, 2019).

Limitations

Regarding the potential limitations of this study, *first*, its cross-sectional nature does not allow for the establishment of causal relationships between the variables. *Second*, the use of self-report instruments also has its shortcomings for various reasons: 1) social desirability; 2) participants' tiredness when filling in the questionnaires; 3) participants' emotional state when filling the questionnaire, which influences the interpretation and response of each question; 4) reliance on memory of past events, including false memories, identification of family members' accounts as personal stories, for example.

Future investigations

In the future, it would be interesting to collect complementary data, using instruments from other scientific fields such as nutrition or medicine, namely information on food habits or inflammatory biomarkers associated with food patterns. This knowledge will make it possible to draw clearer conclusions about the relationship between childhood trauma, the adoption of a healthy diet and, subsequently, its bidirectional relationship with emotional distress (i.e., anxiety and depression).

On the other hand, it is important to deepen the relationship between depression and the emotional motivations behind food choices. Several questions arise after analysing the results: Is depression related to food inhibition (Guiné, 2021), and not to emotional eating? Is this relationship mediated by other factors? Does this data vary according to the geographical location and cultural background of the participants? Future research should explore these questions, as it is important in the clinical context to understand these issues in order to better assess and intervene.

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Conclusion

Childhood trauma is a worrying factor worldwide (WHO, 2022) and in Portugal (APAV, 2025). On the other hand, diseases related to dietary choices have increased, reaching alarming levels today (WHO, 2025; APDP, 2025). For example, the number of diabetics worldwide has quadrupled since 1990 (OPAS, 2024).

Given this reality, the main objective of this study was to establish a relationship between childhood trauma and the emotional motivations of food choices, and to understand the mediating roles of attachment quality and emotional distress (in the form of anxiety and depressive symptoms).

The literature reveals that childhood trauma negatively influences attachment quality (Wang, 2024) and promotes the severity of psychopathology (Kuzminskaite et al., 2021) and the presence of negative emotional states, such as anxiety and depressive symptoms (Guerrini-Usubini et al., 2023; Koçak & Çagatay, 2024). Several investigations have identified an association between insecure attachment and the emotional motivations of food choices mediated by emotional states (Gregersen & Gillath, 2020), particularly in the face of anxious attachment (Devonport et al., 2019; Uccula et al., 2022).

The results revealed that there is an indirect relationship between childhood trauma and emotional motivations of food choices. This relationship is mediated by attachment quality and anxiety symptoms. Anxious attachment was directly associated with emotional motivations of food choices.

These results have important clinical implications, namely, how food choices can arise from trauma, as well as the importance of analysing the quality of attachment and associated anxiety symptoms.

Future research should analyze and collect additional information (with the help of instruments from other areas such as medicine or nutrition) on the presence of inflammatory biomarkers and eating habits. On the other hand, it is important to understand more deeply the relationship between depression and the emotional motivations behind food choices.

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Annexes

Annexe 1- Data Collection Protocol

Protocolo de Investigação a Disponibilizar ao Participante

1. Título do Projecto

Somos o que comemos? Relação entre a exposição a experiências adversas na infância, stress emocional e escolhas alimentares

2. Breve resumo introdutório aos participantes, sobre os objectivos do estudo.

O presente questionário integra-se no trabalho de investigação, que se realiza no âmbito da dissertação de mestrado em Psicologia Clínica e da Saúde. O principal objetivo estudar as relações entre as experiências de vida precoces, stress emocional e escolhas alimentares. O questionário será aplicado à população geral, prevendo-se que o número de envolvidos seja aproximadamente de 500 pessoas.

3. Inserir Consentimento informado

O presente questionário integra-se no trabalho de investigação, que se realiza no âmbito da dissertação de mestrado em Psicologia Clínica e da Saúde. O principal objetivo estudar as relações entre as experiências de vida precoces, as escolhas alimentares e o stress emocional. O questionário será aplicado à população geral, prevendo-se que o número de envolvidos seja aproximadamente de 500 pessoas.

Caro Participante, nos termos do Regulamento Geral sobre a Proteção de Dados (RGPD) e da Lei n.º 58/2019 informamos que o presente formulário destina-se à recolha dos seus dados para o estudo com o título "*Somos o que comemos? Relação entre a exposição a experiências adversas na infância, escolhas alimentares e stress emocional* e que a entidade responsável pelo tratamento dos seus dados pessoais será a Ensilis, Educação e Formação, Unipessoal, Lda., com o NIPC 504 669 788 e com sede em Quinta do Bom Nome, Estr. da Correia 53, 1500-210 Lisboa, entidade instituidora da Universidade Europeia ("Universidade Europeia").

Ao preencher este formulário, compreende assim que os seus dados pessoais serão tratados para essa finalidade e declara, sob compromisso de honra, que toda a informação disponibilizada no presente formulário é verdadeira.

Em nenhuma situação, os seus dados pessoais serão fornecidos a terceiros, sendo os confidenciais e a sua análise tem como objetivo a obtenção de resultados globais e não individuais. Os dados serão usados apenas com a finalidade a que se refere esta investigação, e no âmbito de publicações e comunicações científicas/académicas, onde os resultados passarão a ser agregados e serão publicados sem individualizar a informação à luz dos direitos, liberdades e garantias.

Em concordância com as Declarações Helsínquia da Associação Médica Mundial, o código deontológico e ético da American Psychological Association e da Ordem dos Psicólogos Portugueses relativamente à investigação realizada, informamos que a sua participação é voluntária e pode recusar-se a participar ou retirar o consentimento a qualquer altura, sem nenhum tipo de prejuízo, ou penalização. Pode também igualmente corrigir os dados durante todo o tempo de preenchimento do questionário.

Ao dar este consentimento, entendo e declaro que:

- Tenho mais de 18 anos.
- Estou a fornecer este consentimento por vontade própria, e não sob coação ou sob qualquer forma de ameaça e que a não aceitação não se traduz em qualquer influência negativa.
- Terão acesso aos meus dados pessoais apenas as pessoas com necessidade de conhecer.
- Reconheço que não tenho direito a qualquer remuneração, royalties ou qualquer pagamento em relação a este consentimento.
- Posso exercer o direito de informação, acesso, rectificação, apagamento, oposição, limitação e portabilidade, ou retirar este consentimento sem que isso afete a legalidade do tratamento efetuado até então, solicitando-o por escrito para os contactos abaixo indicados:
  por e-mail para: direitos.dados@universidadeeuropeia.pt; ou
  por correio com carta registada com aviso de receção para: Quinta do Bom Nome, Estr. da Correia 53, 1500-210, Lisboa.
- A Universidade Europeia esforçar-se-á por responder prontamente ao qualquer pedido, no prazo máximo de 30 dias (prorrogável), da seguinte forma:
  Confirmando a receção do pedido; ou
  O recebimento, pela Universidade Europeia, de qualquer informação adicional que a entidade possa exigir para permitir o cumprimento da solicitação.
- Sem comprometer a minha relação existente com a Universidade Europeia, reservo-me ainda o direito de retirar o consentimento a qualquer momento após a confirmação desta

declaração, aceitando fazê-lo por escrito para os contactos acima indicados.

- A Universidade Europeia a efetuar transferências internacionais, fá-las-á sujeitas a garantias adequadas;
- Existe o direito de apresentar uma reclamação junto da autoridade de controlo competente, a Comissão Nacional de Proteção de Dados.

☐ *Declaro que li e compreendi*

Declaro que ao responder a este questionário, expresso e inequivocamente consinto e autorizo que sejam tratados dados pessoais relativos à saúde física ou mental para fins de investigação científica, relacionados com a presente investigação.

Sim ☐
Não ☐

Consinto em fornecer o meu e-mail à equipa de investigação para assuntos relativos a esta investigação.

Sim ☐ (se sim, indicar: _____)
Não ☐

Consinto em fornecer o meu e-mail à equipa de investigação para participação em estudos futuros.

Sim ☐ (se sim, indicar: _____)
Não ☐

Para qualquer assunto adicional relacionado com o tema proteção de dados, privacidade e segurança da informação, entendo/entendemos que devo/devemos contactar o Encarregado da Proteção de Dados através dos contactos supra indicados comprovando a identidade/tipo de representação legal, descrevendo o assunto do pedido e fornecendo um endereço de e-mail, número de telefone e/ou endereço postal para a resposta. Para mais informações, qualquer dúvida relacionada com questões de proteção de dados pessoais relacionados, poderei/poderemos consultar a política de Privacidade da Universidade Europeia, disponível em:

https://www.europeia.pt/politica-de-privacidade/.

4. Instrumentos/elementos de recolha de dados

Questionário Sociodemográfico

Indique o seu sexo:

☐ Feminino

☐ Masculino

Indique a sua idade:_____ (em anos)

Qual é a sua nacionalidade:

- Português
- brasileiro
- cabo-verdiano
- angolano
- Outra, qual? _____

Habilitações literárias:

☐ Sem Estudos
☐ Ensino secundário incompleto

☐ Ensino secundário completo

☐ Licenciatura

☐ Mestrado

☐ Doutoramento

Qual é o seu estado civil?:

☐ Casado (a)

☐ União de Facto

☐ Solteiro (a)

☐ Divorciado (a)

☐ Viúvo (a)

Qual o seu estatuto socioeconómico?

☐ Baixo

☐ Médio-Baixo

☐Médio

☐Médio-Alto

☐ Alto

II. Estilo de Vida e História Médica

Qual é o seu peso: _____(em kg)

Qual é a sua altura?_____(em cm)

Tem filhos? Se sim, quantos?___

Com que regularidade pratica exercício físico?

☐ Não pratico atividade física

☐ Mensalmente

☐ 1 - 2 vezes por semana

☐ 3 - 4 vezes por semana

☐ 5 ou mais vezes por semana

☐ Mais do que 1 vez por dia

É fumador (a) regular?

☐ Sim

☐ Não

Se sim, quantos cigarros fuma por dia, em média?_____ (Nota: se não for fumador (a) regular pode colocar "0")

Consome álcool com que regularidade?

☐ Não consumo álcool

☐ Menos de 4 bebidas por semana

☐ Mais de 4 bebidas por semana

Tem alguma doença crónica física diagnosticada pelo médico?

☐ Sim
☐ Não

Tem alguma doença psicológica/mental diagnosticada pelo médico?
☐ Sim
☐ Não

Tem acompanhamento psicológico ou psiquiátrico?

☐ Sim

☐ Não

Tem acompanhamento de nutricionista?

☐ Sim

☐ Não

Considera que tem uma alimentação saudável

☐ Nunca

☐ Por vezes

☐ Frequentemente

☐ Sempre

Que benefícios acha que podem existir de uma alimentação saudável (leia atentamente escolha o que mais faz sentido para si

☐ Ficar atraente

☐ Controlo de peso

☐ Prevenir a doença e melhorar a saúde

☐ Melhorar a qualidade de vida

☐ Viver durante mais anos

Apresenta alguma alergia ou intolerância alimentar?

☐ Sim, qual?_____

☐ Não

Para si si, o que é uma alimentação saudável?

_____
_____
_____
_____
_____
_____

CTQ – Questionário de Trauma de Infância

Este questionário tem como objetivo obter dados relativos aos seus traumas de infância, para tal encontram-se abaixo um conjunto de afirmações sobre a sua infância. Por favor, classifique-as de acordo com o que viveu nessa fase da sua vida. Não deixe nenhuma pergunta por responder. As suas respostas são confidenciais e o tratamento de resultados garantirá o seu anonimato.

Instrução:

Encontra abaixo um conjunto de afirmações sobre a sua infância. Por favor, classifique-as de acordo com o que viveu nessa fase da sua vida.

Na minha infância e juventude...		1-NUNCA	2-POUCAS VEZES	3-ÀS VEZES	4-MUITAS VEZES	5-SEMPRE
1.	Eu não tinha comida suficiente.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
2.	Sabia que havia alguém para me cuidar e proteger.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
3.	As pessoas da minha família chamavam-me nomes (estúpido(a), preguiçoso(a), feio(a), etc.).	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
4.	Os meus pais não conseguiam cuidar da família porque se embriagavam ou drogavam.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
5.	Havia alguém na minha família que me ajudava a sentir especial ou importante	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
6.	Tinha que usar roupas sujas.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
7.	Senti-me amado(a).	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
8.	Achava que os meus pais preferiam que eu nunca tivesse nascido.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
9.	Na minha família batiam-me tanto que tinha que ir ao hospital ou ao médico.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
10.	A minha família parecia quase perfeita.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
11.	Na minha família batiam-me tanto que me deixavam pisado ou com nódoas negras no corpo.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
12.	Batiam-me com um cinto, um pau, uma corda ou outras coisas que me magoavam.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre

13.	As pessoas da minha família cuidavam umas das outras.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
14.	Pessoas da minha família diziam coisas que me magoaram ou ofenderam.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
15.	Acredito que fui fisicamente maltratado.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
16.	Tive uma ótima infância.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
17.	Batiam-me tanto que um professor, um vizinho ou um médico chegou a dar-se conta disso.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
18.	Sentia que na minha família alguém me odiava.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
19.	As pessoas da minha família eram unidas.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
20.	Tentaram tocar-me ou obrigaram-me a tocar alguém sexualmente.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
21.	Ameaçaram magoar-me ou contar mentiras sobre mim se eu não fizesse algo sexual.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
22.	Tive a melhor família do mundo.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
23.	Tentaram forçar-me a fazer ou a assistir a algo sexual.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
24.	Alguém me assediou.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
25.	Acredito que fui maltratado(a) emocionalmente.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
26.	Havia alguém para me levar ao médico quando eu precisava.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre

27.	Acredito que fui abusado sexualmente.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre
28.	A minha família foi uma fonte de força e apoio.	Nunca	Poucas vezes	Às vezes	Muitas Vezes	Sempre

EVA-Escala de Vinculação do Adulto

Este questionário pretende avaliar o tipo de vinculação que estabelece nas suas relações. Por favor leia com atenção cada uma das afirmações que se seguem e assinale o grau em que cada uma descreve a forma como se sente em relação às relações afetivas que estabelece. Pense em todas as relações (passadas e presentes) e responda de acordo com o que geralmente sente. Se nunca esteve afetivamente envolvido com um parceiro, responda de acordo com o que pensa que sentiria nesse tipo de situação. Não deixe nenhuma pergunta por responder. As suas respostas são confidenciais e o tratamento de resultados garantirá o seu anonimato.

Escala de resposta:

(1) Nada característico em mim

(2) Pouco característico em mim

(3) Característico em mim

(4) Muito característico em mim

(5) Extremamente característico em mim

1.Estabeleço, com facilidade, relações com as pessoas.

2.Tenho dificuldade em sentir-me dependente dos outros.

3.Costumo preocupar-me com a possibilidade dos meus parceiros não gostarem verdadeiramente de mim.

4.As outras pessoas não se aproximam de mim tanto quanto eu gostaria.

5.Sinto-me bem dependendo dos outros.

6.Não me preocupo pelo facto das pessoas se aproximarem muito de mim.

7.Acho que as pessoas nunca estão presentes quando são necessárias.

8.Sinto-me de alguma forma desconfortável quando me aproximo das pessoas.

9.Preocupo-me frequentemente com a possibilidade dos meus parceiros me deixarem.

10.Quando mostro os meus sentimentos, tenho medo que os outros não sintam o mesmo por mim.

11.Pergunto frequentemente a mim mesmo se os meus parceiros realmente se importam comigo.

12.Sinto-me bem quando me relaciono de forma próxima com outras pessoas.

13.Fico incomodado quando alguém se aproxima emocionalmente de mim.

14.Quando precisar, sinto que posso contar com as pessoas.

15.Quero aproximar-me das pessoas mas tenho medo de ser magoado(a).

16.Acho difícil confiar completamente nos outros.

17.Os meus parceiros desejam frequentemente que eu esteja mais próximo deles do que eu me sinto confortável em estar.

18.Não tenho a certeza de poder contar com as pessoas quando precisar delas.

Questionário dos Determinantes das Escolhas Alimentares

Este questionário pretende avaliar os determinantes das suas escolhas alimentares.

Peço que leia atentamente todas as questões e assinale a opção com a qual se

Identifica mais. Demore o menor tempo possível a responder a cada questão. Não

Existem respostas certas nem erradas e deve responder a cada item com sinceridade.

Não deixe nenhuma pergunta por responder. As suas respostas são confidenciais e o

tratamento de resultados garantirá o seu anonimato.

1.A comida ajuda-me a lidar melhor com o stress;

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

2.Normalmente consumo alimentos que me ajudam a controlar o peso

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

3.Frequentemente consumo alimentos que me façam ficar acordado e alerta (como café, coca-cola, bebidas energéticas)

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

4.Frequentemente consumo alimentos que me ajudem a relaxar (como chás)

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

5.A comida faz-me sentir bem

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

6.Quando me sinto sozinho, consolo-me com a comida

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

7.Eu consumo mais alimentos quando estou sem nada para fazer

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

8.Para mim, a comida serve de consolo emocional

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

9.Eu tenho mais vontade de comer doces quando estou deprimido

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

10. Uma dieta saudável baseia-se na contagem de calorias

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

11. Nunca devemos consumir produtos açucarados

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

12. Frutas e vegetais são muito importantes para a prática de uma alimentação saudável

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

13. Uma dieta saudável deve ser equilibrada, variada e completa

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

14. Podemos comer de tudo, desde que em pequenas quantidades

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

15. Acredito que uma dieta saudável não é barata

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

16. Na minha opinião, acho estranho algumas pessoas terem anseios de doces

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

17. Acredito que a tradição é muito importante para uma dieta saudável

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

18. Acredito que comida produzida de forma biológica é mais saudável

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

12. Nunca devemos consumir produtos com gordura

(1) Discordo Fortemente

(2) Discordo

(3) Não concordo, nem discordo

(4) Concordo

(5) Concordo Fortemente

HADS- Escala de Ansiedade e Depressão Hospitalar

Este questionário foi construído para ajudar a saber como se sente. Pedimos-lhe que leia cada uma das perguntas e escolha a resposta que melhor descreve a forma como se tem sentido na última semana. Demore o menor tempo possível a pensar nas respostas. A sua reação imediata a cada questão será provavelmente mais correta do que uma resposta muito ponderada. As suas respostas são confidenciais e o tratamento de resultados garantirá o seu anonimato. Por favor, escolha apenas a opção de resposta que considera mais apropriada para cada pergunta.

1. Sinto-me tenso/a ou nervoso/a:

( ) Quase sempre

( ) Muitas vezes

( ) Por vezes

( ) Nunca

2. Ainda sinto prazer nas coisas de que costumava gostar:

( ) Tanto como antes

( ) Não tanto agora

( ) Só um pouco

( ) Quase nada

3. Tenho uma sensação de medo, como se algo terrível estivesse para acontecer:

( ) Sim e muito forte

( ) Sim, mas não muito forte

( ) Um pouco, mas não me aflige

( ) De modo algum

4. Sou capaz de rir e ver o lado divertido das coisas:

( ) Tanto como antes

( )Não tanto como antes

( ) Muito menos agora

( ) Nunca

5. Tenho a cabeça cheia de preocupações:

( ) A maior parte do tempo

( ) Muitas vezes

( ) Por vezes

( ) Quase nunca

6. Sinto-me animado/a:

( ) Nunca

( ) Poucas vezes

( ) De vez em quando

( ) Quase sempre

7. Sou capaz de estar descontraidamente sentado/a e sentir-me relaxado/a:

( ) Quase sempre

( ) Muitas vezes

( ) Por vezes

( ) Nunca

8. Sinto-me mais lento/a, como se fizesse as coisas mais devagar:

( ) Quase sempre

( ) Muitas vezes

( ) Por vezes

( ) Nunca

9. Fico de tal forma apreensivo/a (com medo), que até sinto um aperto no estômago:

( ) Nunca

( ) Por vezes

( ) Muitas vezes

( ) Quase sempre

10. Perdi o interesse em cuidar do meu aspeto físico:

( ) Completamente

( ) Não dou a atenção que devia

( ) Talvez cuide menos que antes

( ) Tenho o mesmo interesse de sempre

11. Sinto-me de tal forma inquieto/a que não consigo estar parado/a:

( ) Muito

( ) Bastante

( )Não muito

( ) Nada

12. Penso com prazer nas coisas que podem acontecer no futuro:

( ) Tanto como antes

( ) Não tanto como antes

( ) Bastante menos agora

( ) Quase nunca

13. De repente, tenho sensações de pânico:

( ) Muitas vezes

( ) Bastantes vezes

( ) Por vezes

( ) Nunca

14. Sou capaz de apreciar um bom livro ou um programa de rádio ou televisão:

( ) Muitas vezes

( ) De vez em quando

( ) Poucas vezes

( ) Quase nunca

Annexe 2- Approval by the Ethics Committe

Universidade Europeia

PARECER

DA COMISSÃO DE ÉTICA PARA A INVESTIGAÇÃO

DA UNIVERSIDADE EUROPEIA

Projeto de Investigação em análise: *"Somos os que comemos?" - Relação entre a exposição a experiências adversas precoces, determinantes das escolhas alimentares e stress emocional*
Investigador/a: Neuza Duarte (estudante)
Orientador/a: Lisa Roque
Coorientador/a: Paulo Ferrajão
Área Científica: Psicologia
Âmbito do projecto (Curso e UC ou outro): Dissertação Mestrado Psicologia Clínica e da Saúde F2F

A Comissão de Ética para a Investigação da Universidade Europeia dá o seu parecer favorável ao projeto de investigação em epígrafe, tendo por base as informações a que teve acesso através da sua orientadora e co-orientador, designadamente o acesso a dados pessoais pseudonimizados. A pseudonimização dos dados considerados pessoais, é recomendada por forma a reduzir os riscos de exposição dos titulares de dados e a possibilitar uma segurança adicional para a Universidade Europeia, entidade responsável pelo tratamento. Em caso de vir a ser utilizado dados pessoais, reitera-se que seja cabalmente respeitado o Regulamento (UE) 2016/679 do Parlamento Europeu e do Conselho, de 27 de abril de 2016, relativo à proteção das pessoas singulares no que diz respeito ao tratamento de dados pessoais e à livre circulação desses dados.

Reitera-se que sejam respeitadas, ainda, os Princípios Éticos para a Investigação Médica em Seres Humanos, constantes das Declarações de Helsínquia da Associação Médica Mundial, bem como as recomendações da Organização Mundial de Saúde e da União Europeia, no que se refere à experimentação que envolva seres humanos.

Lisboa, 17 de Fevereiro de 2025

Susana Antas Videira
Presidente da Comissão de Ética

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