Supplemental Material

Method

Participants

Data for the current study were extracted from five surveys conducted in 2011-2014: two surveys on childhood adversity (July 2011 and July 2012), one survey on physical health (November-December 2012), one survey on BMI (January 2011- January 2014), and one survey on background variables (March 2012). Educational level did not differ significantly between the BMI subsample and the total sample (p = .72). Age was significantly lower in the BMI subsample (p = .04).

ACEs

ACEs were measured using two surveys. The categories emotional, physical, and sexual abuse were assessed in a survey on response to traumatization. The categories household dysfunction, severe parental conflict, and poor quality relationship with parents were assessed in a survey that contained detailed retrospective questions on family background (Oudejans, 2013).

Severe parental conflict was measured with four items that were evaluated on a Likert Scale ranging from 1 to 3 (‘never’, ‘once or twice’, ‘several times’) or ‘I don’t know’. Data of participants who indicated that they did not know the answer were treated as missing values. Percentages of participants with missing values for the four items were 9.4%, 12%, 11%, and 7.7% respectively. In contrast to the original ACE study that showed an association between four

ACEs and mental and physical illness (Felliti et al., 1998), we examined effects of three or more ACEs because of the low number of participants reporting four ACEs in the present study.

BMI and fat percentage.

See (Kooreman and Scherpenzeel, 2014) for more information about BIA with data from the LISS panel weighing project. Each person was recognized by his or her typical combination of weight and impedance. Therefore, other members of the same household were allowed to use the scale. For other study purposes, participants were randomly assigned to one of nine experimental conditions. Depending on the experimental condition, they received instructions to weigh themselves with a certain frequency and received different types of feedback after weighing (only their own measurement, the norm range or their own goal weight). For the current study we selected each participants' first weighing measurement in order to control for effects in the experimental condition. Findings on the effects of frequency of weighing and feedback after weighing on BMI and fat percentage are presented elsewhere (Kooreman and Scherpenzeel, 2014).

Statistical analysis. Skewness and kurtosis of physical problems, BMI, and fat percentage were examined and outliers (n = 13) were substituted by the maximum value. Participants with BMI lower than 11 and higher than 50 or a fat percentage lower than 8% were excluded from data analysis (N = 7). These values were considered incorrect measurements.

References

Burke, N. J., Hellman, J. L., Scott, B. G., Weems, C. F. & Carrion, V. G. (2011). The impact of adverse childhood experiences on an urban pediatric population. *Child abuse & neglect, 35***,** 408-413.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J. & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of affective disorders, 82***,** 217-225.

Felitti, V. J. (2002). [The relationship of adverse childhood experiences to adult health: Turning gold into lead]. *Zeitschrift für Psychosomatische Medizin und Psychotherapie, 48***,** 359-69.

Kooreman, P. & Scherpenzeel, A. (2014). High frequency body mass measurement, feedback, and health behaviors. *Economics & Human Biology, 14***,** 141-153.

Oudejans, M., & Kalmijn, M. (2013). Life History Questionnaire. Tilburg, the Netherlands: Centerdata. (2013).