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Finding the link between internalized weight-stigma and binge eating behaviors in Portuguese adult women with overweight and obesity: The mediator role of self-criticism and self-reassurance

Lara Palmeira [a,*], José Pinto-Gouveia [a], Marina Cunha [a,b], Sérgio Carvalho [a]

[a] Cognitive and Behavioral Research Centre, University of Coimbra, Portugal
[b] Miguel Torga Superior Institute (ISMT), Coimbra, Portugal

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1. Introduction

Weight stigma refers to discriminatory attitudes towards people with overweight and obesity, and has a negative impact on the life of individuals with overweight and obesity (e.g. Puhl & Heuer, 2010). Even in the absence of perceived discrimination, the perception of being a target of stigma is related to poorer health (e.g., Ratner, Halim, & Amodio, 2013). Moreover, weight stigma is associated with disordered eating behaviors (O'Brien et al., 2016; Vartanian & Porter, 2016), particularly binge eating (Ashmore, Friedman, Reichmann, & Musante, 2008; Lillis, Hayes, & Levin, 2011). Additionally, this weight bias discrimination tends to be internalized by individuals with overweight and obesity reflecting negative self-evaluations of one's weight and physical appearance and perceived discrimination (Durso & Latner, 2008; Lillis, Luoma, Levin, & Hayes, 2010). In turn, this is linked with negative health outcomes not exclusively attributed to obesity itself (Latner, Durso, & Mond, 2013). Weight self-stigma is correlated with psychological distress and disordered eating (e.g. Durso et al., 2012; Pearl & Puhl, 2014; Schvey & White, 2015) and affects the quality-of-life of individuals with overweight and obesity (Farhangi, Emam-Alizadeh, Hamedi, & Jahangiry, 2016; Latner, Barile, Durso, & O'Brien, 2014; Palmeira, Pinto-Gouveia, & Cunha, 2016a).

Empirical evidence suggests that individuals who internalize weight-based stereotypes are prone to engage in binge eating (Puhl, Moss-Racusin, & Schwartz, 2007). In fact, eating is a common way for individuals with overweight and obesity to cope with weight-related discrimination and stigmatization experiences (Puhl & Brownell, 2006). Additionally, individuals with overweight and obesity with binge eating present poorer health outcomes and quality-of-life than those without binge eating (see Baiano et al., 2014 for a meta-analysis). Specifically, individuals with overweight and obesity who binge eat have higher levels of eating psychopathology, greater medical and psychiatric morbidity (e.g. Bulik, Sullivan, & Kendler, 2002; Herbozo, Schaefer, & Thompson, 2015), and present more ineffective strategies of emotional regulation (e.g. Gianini, White, & Masheb, 2013).

As a result of weight self-stigma, individuals may engage in critical and punitive internal dialogues towards the self, i.e., self-criticism (Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Gilbert & Irons, 2005). Self-criticism has been conceptualized as a harsh and punitive way of self-to-self relating, particularly in the face of setbacks or when things go wrong (Gilbert et al., 2004). Although it may be rooted in a desire to self-improve and self-correct, this strategy usually backfires, given that self-criticism focuses on and emphasizes one's flaws and feelings of inferiority (Gilbert et al., 2004; Gilbert & Irons, 2005). Unintentionally, this may lead to increased negative affect, which is a well-known predictor of binge eating episodes (Gianini et al., 2013). On the other hand, the more toxic and harsh form of self-criticism involves feelings of aversion and contempt towards the self (Gilbert et al., 2004; Gilbert & Irons, 2005). This desire to persecute and punish the self and has been consistently related to more severe forms of psychological suffering (e.g., Castilho, Pinto-Gouveia, & Duarte, 2015). A recent study showed that harsh self-criticism mediates the relationship between body-image shame and binge eating in a sample of 329 non-overweight women (general population and college students) (Duarte, Pinto-Gouveia, & Ferreira, 2014). In fact, although a few studies have shed some light on how self-criticism and binge eating are related, little is known about the impact of self-criticism, specifically in individuals with overweight and obesity. A study conducted in a sample of patients with eating disorders found that self-criticism predicted depressive symptoms and shape and weight over-evaluation (Dunkley & Grilo, 2007). Another study, in a sample of 170 patients with binge eating disorder, found that self-criticism was an important mediator between emotional abuse and body dissatisfaction and depression (Dunkley, Masheb, & Grilo, 2010). Nevertheless, although the role of self-criticism in eating disorders has been growingly unveiled (Goss & Allan, 2014), little is known about its contribution to the impact of weight self-stigma in binge eating symptoms in people with obesity and overweight.

* Corresponding author at: CINEICC, Faculdade de Psicologia e Ciências da Educação, Universidade de Coimbra, Rua do Colégio Novo, Apartado 6153, 3001-802 Coimbra, Portugal.
E-mail address: larapalmeira@gmail.com (L. Palmeira).

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In contrast to self-criticism, being self-kind, self-compassionate and able to reassure the self when things go wrong seem to be crucial psychological processes that protect against disordered eating (see Braun, Park, & Gorin, 2016, for a review). Some evidence suggests that self-compassion negatively predicts eating disorders symptoms (Geller, Srikameswaran, & Zelichowska, 2015; Kelly, Vimalakanthan, & Carter, 2014; Taylor, Daiss, & Krietsch, 2015). Nevertheless, it is noteworthy that these studies were conducted in samples from the general population or college students, and not individuals with overweight or obesity.

Compassion-based approaches to eating disorders have been recently developed (Goss & Allan, 2014) and seem to be effective in reducing binge eating (Kelly & Carter, 2015). These approaches specifically aim to promote the development of a self-to-self- relationship characterized by a kind, caring and supportive attitude, instead of being critical, punitive and harsh towards oneself (Gilbert et al., 2014; Neff, 2003). In fact, some evidence points out that when people with overweight and obesity experience setbacks, they tend to become self-critical and have difficulty in being self-compassionate. In turn, this is linked with struggles in maintaining healthy behaviors (e.g., Gilbert et al., 2014). Thus, this calls for the importance of exploring the role of self-reassurance in binge eating in patients with overweight and obesity. Additionally, studies about how self-compassion relates to weight self-stigma and binge eating are still scant, with only one study showing that self-compassion mediated the impact of weight self-stigma on mental and physical health outcomes (Hilbert et al., 2015).

The current study has three aims: 1) to study the associations between weight self-stigma, self-criticism, self-reassurance and binge-eating in a sample of women with overweight or obesity with and without Binge Eating Disorder (BED). We expect positive and moderate to strong correlations between weight self-stigma, hated and inadequate-self and binge eating symptoms. Conversely, moderate to strong negative associations are expected between the above mentioned variables and reassured-self; 2) to explore differences between binge-eaters and non-binge-eaters in weight self-stigma, self-criticism and self-reassurance. We expect that women with BED present higher levels of weight self-stigma and self-criticism and lower self-reassuring abilities than those without BED. The third goal was to test whether self-criticism and self-reassurance mediate the relationship between weight self-stigma and binge eating symptoms.

2. Methods

2.1. Participants

From the 134 Portuguese women with overweight or obesity seeking nutritional treatment in Coimbra invited to participate, nine declined. A sample of 125 participants were interviewed by experienced clinical psychologists using the Portuguese versions of Eating Disorder Examination Interview (Ferreira, Pinto-Gouveia, & Duarte, in preparation) and the appendix H from Structured Clinical Interview for DSM-IV TR (SCID; translated by Maia, 2006) to determine the existence of Binge Eating Disorder. BED diagnosis was established following the criteria from DSM-V. According to DSM-V, 54 participants (43.2%) presented BED and 73 participants did not. Participants' mean age was 41.14 ($SD = 8.72$), with an average of 14.96 ($SD = 3.15$) years of education. Sample's average Body Mass Index (BMI) was 34.44 ($SD = 5.51$). Concerning marital status, 62.4% were married and 20.8% were single. The majority came from low to medium socio-economic status (87.21%).

2.2. Procedures

Prior to data collection, the current study was approved by the ethics committee of Coimbra's University Hospital (CHUC) and by the scientific committee of the Psychology Faculty of University of Coimbra, Portugal. Participants were invited to participate by a research team member on the day of their nutritional appointment. Participants were informed about the voluntary and confidential nature of the collaboration, as well as the main study's goals. After signing a written informed consent, participants were screened for BED individually and completed the self-report measures. The questionnaires took approximately 20 min to be completed.

2.3. Measures

2.3.1. Demographic data

Participants' age, years of education and current height were self-reported.

2.3.2. BMI

Participants were weighted with their clothes (without shoes) using the same Body Composition Analyzer (Tanita TBF-300) accurate to 0.1 kg.

Weight self-stigma Questionnaire (WSSQ; Lillis et al., 2010; Palmeira, Cunha, & Pinto-Gouveia, 2016b) includes 12 items that assess weight self-stigma in people with overweight and obesity. It measures negative thoughts and emotions about being overweight and fear of enacted stigma. Participants are asked to rate each item in a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). Higher scores indicate higher levels of weight self-stigma. Both the original ($\alpha = 0.88$) and Portuguese ($\alpha = 0.85$) versions presented good psychometric properties (Lillis et al., 2010; Palmeira et al., 2016b).

Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Gilbert et al., 2004; Castilho et al., 2015) is 22-item self-report measure with three subscales: inadequate-self (focused on personal inadequacies and feelings of inferiority, "*There is a part of me that feels I am not good enough*"), hated-self (focused on condemning and attacking the self; "*I have a sense of disgust with myself*") and reassured-self (focused on being warm and in comforting the self; "*I am gentle and supportive with myself*"). It measures the tendency to criticize or reassure the self when facing failures or errors. Items are rated on a 5-point scale (0 = "Not at all like me" to 4 = "Extremely like me"). Both the original and Portuguese versions revealed good internal consistencies in clinical and non-clinical samples ranging from 0.83 to 0.91 (Castilho et al., 2015; Gilbert et al., 2004).

Binge Eating Scale (BES; Gormally, Black, Daston, & Rardin, 1982; Duarte, Pinto-Gouveia, & Ferreira, 2015) consists of 16 items. Participants are asked to choose which of the given statements best describes their experience concerning binge-eating symptoms. Scale's scores range from 0 to 46, with higher scores reflecting higher severity of binge eating symptoms. Both the original and Portuguese versions showed high internal consistency ($\alpha = 0.88$).

Table 1 displays the internal consistency for all variables in study.

2.4. Data analysis

Data analyses were performed using IBM SPSS Statistics 20 and AMOS software. Preliminary data analyses were performed to explore the adequacy of the data. Pearson correlation coefficients were conducted to examine the associations between BMI, WSSQ, hated, inadequate and reassured-self and BES (Cohen, Cohen, West, & Aiken, 2013). To explore differences between binge eaters and non-binge eaters in all variables, independent sample *t*-tests and Cohen's d effect size were calculated (Field, 2013). Cohen's cutoff values were followed: Cohen's d between 0.2 and 0.4 - small effects; between 0.5 and 0.7 - medium effects and above 0.8 - large effects (1988 cited in Tabachnick & Fidell, 2007). Finally, to test whether self-criticism and self-reassurance mediated the relationship between weight self-stigma (WSSQ) and binge eating symptomatology (BES), while controlling for BMI, a path analysis was used. Path analysis allows the simultaneous examination of structural relationships, as well as the examination of direct and indirect paths (e.g., Schumacker & Lomax, 2004). The Maximum Likelihood

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