



The unique associations of self-criticism and shame-proneness to symptoms of disordered eating and depression[☆]

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ARTICLE INFO

Keywords:

Depression
Disordered eating
Shame
Self-criticism
Transdiagnostic

ABSTRACT

This study examined the unique associations of shame-proneness and self-criticism to symptoms of disordered eating and depression among 186 undergraduate students. The study also tested the degree to which self-criticism and shame-proneness accounted for the association between disordered eating and depressive symptoms. Both shame-proneness and self-criticism were significantly related to disordered eating and depressive symptoms. Self-criticism was significantly associated with disordered eating and depressive symptoms, over-and-above shame-proneness, but the reverse was not true. Controlling for shame-proneness, self-criticism also accounted for a significant proportion of the covariance between disordered eating and depressive symptoms, suggesting that self-criticism could account for some of the comorbidity between depression and eating disorders. Findings suggest that self-criticism may have incremental utility above-and-beyond shame-proneness as part of a transdiagnostic underlying cognitive substrate for depression and disordered eating. Implications emerge for future research and clinical practice.

1. Introduction

Identifying transdiagnostic processes may explain comorbidity among different disorders, clarify basic processes that contribute to psychological impairment, and identify targets for prevention and intervention (Insel, 2014). Research on two highly comorbid forms of psychopathology, depression and disordered eating, could benefit from a transdiagnostic approach involving self-criticism and shame-proneness (Green et al., 2009). Self-criticism and shame-proneness are significantly related to symptoms of depression and disordered eating (e.g., Dunkley & Grilo, 2007; Gee & Troop, 2003); however, the degree to which they (individually and jointly) account for the high correlation between these disorders remains unclear. The current study examined the unique and combined associations of shame-proneness and self-criticism to symptoms of depression and disordered eating.

Shame-proneness (SP) refers to a tendency to experience shame across a variety of situations (Tangney & Dearing, 2002). *Self-criticism* (SC) consists of negative self-evaluations triggered by perceived discrepancies between the actual and ideal self (e.g., Beck, 1963; Blatt, 1974). Despite these differences in definitions, the two constructs share considerable conceptual overlap. Namely, SP and SC both involve negative self-evaluation, feelings of inadequacy and incompetence, and

self-consciousness (Tangney & Dearing, 2002; Blatt, Rounsaville, Eyre, & Wilber, 1984). These characteristics also typify individuals with depression and disordered eating (e.g., Fairburn, Cooper, & Shafran, 2003; Jacobi, Paul, de Zwaan, Nutzinger, & Dahme, 2004; Orth, Berking, & Burkhardt, 2006). Previous research shows that SP and SC are both strongly associated with depression and disordered eating (Cesare et al., 2016; Dunkley & Grilo, 2007; Tangney & Dearing, 2002). Surprisingly, SP and SC have never been simultaneously examined in relation to these psychopathologies, making it difficult to distinguish their unique contributions to the comorbidity between these outcomes.

Although SC and SP share considerable conceptual overlap, their correlation is modest (Shahar, Doron, & Szepeswol, 2015), suggesting each may have attributes that are uniquely associated with disordered eating and depressive symptoms. For example, although both SC and SP are self-evaluative constructs, the nature and form of self-evaluation differs between SC and SP.

In shame, negative self-evaluation manifests through negative affect in reaction to specific experiences – typically, a perceived or actual social transgression (Tangney & Dearing, 2002; Wolf, Cohen, Panter, & Insko, 2010). Individuals who are highly shame-prone have a propensity for such reactions. Research shows that elevated affective reactivity (Booij, Snippe, Jeronimus, Wichers, & Wigman, 2018) and

[☆] The results contained in this paper have not been presented elsewhere in any form. This research was supported in part by the following grant. R. L. Zekowitz: NIMH training grant: T32MH018921-26.

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cognitive reactivity (reacting with negative affect and negative self-evaluation; Cole et al., 2014) to unpleasant interpersonal experiences predict depressive symptoms. In addition, disordered eating behaviors are often seen as methods of coping with states of negative affect (Smyth et al., 2007) and fluctuations in shame are associated with fluctuations in disordered eating (Goss & Allen, 2009).

SC, conversely, reflects negative self-focused cognitions and accompanying affect that may be internally generated or triggered by external situations (e.g., perceived failure).¹ SC thus has both trait-like and state-like characteristics (Zuroff, Sadikaj, Kelly, & Leybman, 2016). Evidence supports SC as a predictor of both depressive symptoms and disordered eating symptoms (Dunkley, Stanislow, Grilo, & McGlashan, 2009; Fennig et al., 2008).

The current study had two hypotheses. First, we hypothesized that SC and SP would each uniquely relate to depressive symptoms and disordered eating. Second, we hypothesized that SC and SP would account for a significant proportion of the covariance between these constructs.

2. Methods

2.1. Participants

Participants included 186 students recruited from the research subject pool at a mid-sized southern private university. Average age of the participants was 19.21 ($SD = 1.89$), and 79% of participants were female. The sample was 63% White, 22% Asian or American-Asian, 12% Black, 10% Hispanic, and 3% other.

2.2. Measures

The *Test of Self-Conscious Affect-3* (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000) was used to measure SP. The TOSCA-3 is a 16-item measure that examines the degree to which respondents would experience shame in response to hypothetical scenarios. The *Self-Rating Scale* (SRS; Hooley, Ho, Slater, & Lockshin, 2002) was used to measure SC. The SRS is an 8-item measure that examines the degree to which participants generally think self-critically. The global scale of the *Eating Disorder Examination-Questionnaire* (EDE-Q; Fairburn & Beglin, 1994) was used to measure disordered eating. The EDE-Q measures the frequency of maladaptive eating behaviors and attitudes over the past 28 days using both free-response and 7-point Likert scale responses. The *Beck Depression Inventory-II* (BDI-II; Beck, Steer, & Brown, 1996) was used to assess depressive symptoms. The BDI-II measures the severity of 21 depressive symptoms on 4-point scales. We removed the items assessing suicidality (due to safety concerns) and SC (to avoid artificially inflating the correlation between SC and depression due to that item), resulting in 19 remaining items.² Coefficient alphas for each measure are presented in Table 1.

2.3. Procedure

Participants independently completed measures of SC, SP, depressive symptoms, and disordered eating via the Qualtrics online survey system. Graduate research assistants contacted participants who reported elevated depressive or disordered eating symptoms to provide information about online and campus resources.

¹ Theorists also suggest that individuals high in SC show a particular susceptibility to criticism of others (e.g., Blatt, 1974; Zuroff, Mongrain, & Santor, 2004)

² The suicide ideation item was not administered to participants. The SC item was administered, and results did not differ with it included or excluded from the total BDI-II.

Table 1
Pearson correlations, means, standard deviations.

Variable	1	2	3	α	M	SD	Skew	Kurtosis
1. Depressive symptoms				0.91	9.23	7.75	1.13	1.26
2. Disordered eating symptoms	0.48			0.93	1.66	1.42	0.91	-0.01
3. Self-criticism	0.55	0.44		0.90	23.54	11.06	0.66	-0.23
4. Shame-proneness	0.30	0.28	0.46	0.80	48.81	11.36	-0.08	-0.52

All correlations significant, $ps < .001$.

2.4. Data analysis

All analyses were conducted via Mplus (version 8.0; Muthén & Muthén, 2017) using maximum likelihood estimation. Hypotheses were tested via path analysis. Fig. 1 is a path diagram in which SC and SP predict depressive and disordered eating symptoms. Using Wright's tracing rules (Loehlin & Beaujean, 2016), we calculated the covariance between disordered eating and depressive symptoms explained by SC, by SP, and by both predictors jointly. Because parameters for such statistics do not have a known sampling distribution, we used bias-corrected bootstrapping to generate an empirical sampling distribution, derive 95% confidence intervals, and test significance of estimates.

3. Results

3.1. Descriptive statistics

Table 1 reports descriptive statistics for SC, SP, disordered eating, and depressive symptoms. All correlations were statistically significant. Skewness and kurtosis values fell within acceptable ranges. Roughly 9.1% of participants (2.6% of males, 10.8% of females) scored at or above the cutoff for clinically significant disordered eating pathology (i.e., global EDE-Q scores ≥ 4.0 ; Luce, Crowther, & Pole, 2008); 28.9% of participants scored at or above the cutoff for mild depressive symptoms (i.e., BDI-II scores ≥ 14 ; Dozois, Dobson, & Ahnberg, 1998).³

3.2. Testing the unique associations of SC and SP to symptoms of disordered eating and depression

The following parameter estimates are unstandardized (standardized estimates are shown in Fig. 1). Results showed that SC accounted for 28% of the variance in depressive symptoms (path a = 0.37, $SE = 0.07$, $p < .001$) and 16% of the variance in disordered eating symptoms (path d = 0.05, $SE = 0.01$, $p < .001$), after controlling for SP. SP accounted for a nonsignificant 0.2% of the variance in depressive symptoms (path e = 0.04, $SE = 0.05$, $p = .46$) and 0.8% of the variance in disordered eating symptoms (path c = 0.01, $SE = 0.01$, $p = .19$) after controlling for SC. SC accounted for 82% of the covariance between SP and depressive symptoms (paths $b * a = 21.34$, $p < .001$) and 68% of the covariance between SP and disordered eating (paths $b * d = 2.99$, $p < .001$).

3.3. Testing the degree to which SP and SC account for the covariance between symptoms of depression and disordered eating

The total covariance between depressive symptoms and disordered eating symptoms was 5.29 ($p < .001$) and can be represented as the sum of the following tracings in Fig. 1: $cov(Dep, DE) = abc + ebd + a(s_{sc}^2)d + c(s_{sp}^2)e + f$.⁴ The covariance between disordered eating and

³ Because the item on the BDI-II assessing suicidal ideation was removed, these proportions were computed using the remaining 20 items.

⁴ s_{sc}^2 and s_{sp}^2 represent the variances of SC and SP, respectively.

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