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Steps toward understanding the impact of early emotional experiences on disordered eating: The role of self-criticism, shame, and body image shame

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ABSTRACT

In research, it has been suggested that early threatening emotional experiences, characterized by abuse, rejection, neglect or absence of affiliative signals may activate maladaptive defensive responses. Further, several studies have emphasised the association between the recall of early emotional experiences and eating psychopathology. However, this relationship does not seem to be direct. Thus, the current study explored the mediator roles of self-criticism and shame (general and body image-focused shame) in the link between early emotional experiences and the engagement in disordered eating, while controlling for the effect of body mass index. The sample of this study included 552 female participants, aged between 18 and 40 years old.

The path analysis indicated that the absence of early positive emotional experiences was associated with disordered eating behaviours, through an increased perception of being negatively perceived as inferior or unattractive by others, self-critical attitudes, and body image-focused shame. The tested model accounted for 63% of body image shame and for 67% of disordered eating's variance, and showed an excellent model fit. These findings suggest that shame and self-criticism are defensive mechanisms associated with early threatening emotional experiences, which may trigger disordered eating behaviours.

These data appear to offer important research and clinical implications supporting the development of intervention community programs for body and eating difficulties, that specifically target shame (general and body image-focused shame) and self-criticism, through the development of more adaptive emotional regulation strategies.

1. Introduction

Literature has consistently demonstrated the important role of early experiences with attachment figures on one's subsequent psychological and social development (Gilbert & Perris, 2000; Schore, 1998) and physical and mental well-being throughout life (e.g., Baumeister & Leary, 1995; Bowlby, 1969, 1973). In particular, the exposure to threatening experiences during childhood (of rejection, abuse, shame, criticism, neglect, or absence of affiliative signals) have been widely associated with a higher vulnerability to mental health problems (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006), namely disordered eating (Ferreira, Marta-Simões, & Trindade, 2016; Oliveira, Ferreira, & Mendes, 2016; Vartanian, Smyth, Zawadzki, Heron, & Coleman, 2014).

In contrast, positive rearing experiences, related to feelings of warmth and safeness, have been linked with a series of well-being and psychosocial adjustment indicators (such as happiness, self-esteem, social safeness, connectedness, and a sense of belonging; Cheng & Furnham, 2004; DeHart, Peham, & Tennen, 2006; Ferreira et al., 2016; Gilbert et al., 2009; Mikulincer & Shaver, 2004).

Positive early experiences of warmth, safeness, and acceptance seem to promote the development of more adaptive emotional regulation strategies (Richter, Gilbert, & McEwan, 2009) and, specifically, seem to associate with the use of self-reassurance and self-soothing abilities when facing stressful setbacks and personal failures (Baldwin & Dandeneau, 2005; Gilbert, Baldwin, et al.,

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2006). Furthermore, empirical accounts suggested that positive emotional rearing experiences are associated with higher resilience towards adverse life events (Richter et al., 2009). On the other hand, adverse rearing experiences can be recorded as conditioned negative or traumatic emotional memories (Gilbert & Irons, 2008; Matos, Pinto-Gouveia, & Duarte, 2012), which may have a crucial impact on the development of negative internal working models of self and others (Baldwin & Dandeneau, 2005; Matos, Pinto, Gouveia, & Costa, 2013; Mikulincer & Shaver, 2005; Pinto-Gouveia & Matos, 2011). Prior studies have suggested that adverse rearing experiences and the absence of warmth and safeness affiliative early experiences seem to activate maladaptive defensive behaviours and processes (such as shame, submission and self-criticism; Cunha, Matos, Faria, & Zagalo, 2012; Ferreira et al., 2016; Gilbert, 2003; Gilbert & Procter, 2006).

Self-criticism refers to a maladaptive emotional regulation process, characterized by a negative and punitive self-to-self relationship in face of one's faults, errors or attributes which may cause social negative scrutiny or rejection (Gilbert, Clarke, Hempel, Miles, & Irons, 2004). In fact, this process may be understood as a maladaptive defensive self-monitoring strategy to cope with failures or deficits perceived by the self, enacted to assure self-correction and self-enhancement (Gilbert et al., 2004). However, self-criticism has been highly linked to psychopathology, such as depressive symptomatology (Gilbert et al., 2004; Gilbert, Durrant, & McEwan, 2006) and disordered eating symptoms (Ferreira, Pinto-Gouveia, & Duarte, 2014; Pinto-Gouveia, Ferreira, & Duarte, 2014; Kelly & Carter, 2013; Steele, O'Shea, Murdock, & Wade, 2011). Indeed, this strategy is known to paradoxically feed the sense of the self as flawed, and thus associate with increased sense of inferiority, unfavourable social comparison and shame (Gilbert et al., 2004, 2010).

Shame is a painful self-conscious emotion that emerges from the human need of seeking social acceptance and positive attention (e.g., Gilbert & Miles, 2002). In this context, shame can be conceptualized as a response to the social threat of being perceived negatively in the minds of others, which puts the self at risk of being rejected or criticized (Gilbert & Miles, 2002; Tangney & Dearing, 2002). This self-focused emotion is a multifaceted experience which includes a complex set of feelings (anxiety, disgust, anger), cognitions (automatic thoughts about the self being inferior, inadequate and flawed) and actions (automatic defensive behaviours) (Gilbert & Miles, 2002; Tangney & Dearing, 2002; Tangney & Fischer, 1995). Shame is often conceptualized as comprising two distinct components: external shame and internal shame (Gilbert & Miles, 2002). Specifically, external shame can be defined as the perception that others see the self as flawed, inferior, worthless, defective, unlovable, unattractive or undesirable, which relates to the probability of exposure of one's failures, flaws and deficits (Gilbert & Miles, 2002; Lewis, 1992; Tangney & Dearing, 2002). This negative view of the self may become internalized, emerging as a self-devaluing judgment of the self, characterized as internal shame.

Both internal and external shame have been related to a higher vulnerability to psychopathology, namely eating disorders. Specifically, research has reported positive associations between higher levels of shame and disordered eating symptoms (Gilbert & Miles, 2002; Troop, Allan, Serpall, & Treasure, 2008). Empirical evidences, both in clinical and general population samples, have documented that general shame has a major influence on body image and eating difficulties (Ferreira, Pinto-Gouveia, & Duarte, 2013a, 2013b; Goss & Allan, 2009; Kelly & Carter, 2013; Pinto-Gouveia et al., 2014). In fact, several authors converge on the notion that maladaptive body image and eating-related behaviours may be conceptualized as dysfunctional responses to avoid shame and enhance acceptance and support of others (Gilbert & Miles, 2002; Goss & Allan, 2009; Pinto-Gouveia et al., 2014).

According to the biopsychosocial approach, the focus of shame may vary (e.g., personal characteristics, body image or certain behaviours). Particularly, body image-related shame can be conceptualized as involving negative social and self-evaluation about one's physical attributes (such as weight, size, and body shape) that are perceived as unattractive, defective, or inferior by others (Gilbert, 2003; 2007; Gilbert & Miles, 2002), which may put oneself in an unwanted social position and lead to social rejection and criticism (Gilbert & McGuire, 1998; Gilbert & Miles, 2002).

Data from both clinical and community-based studies offered evidence that body shame is a strong predictor of body image and eating-related psychopathology (Bessenoff & Snow, 2006; Doran & Lewis, 2012; Swan & Andrews, 2003; Troop & Redshaw, 2012). Recently, Duarte, Pinto-Gouveia, Ferreira, and Batista (2015), developed a scale specifically designed to assess body image shame (Body Image Shame Scale; BISS), which includes two dimensions: external and internal body shame. There is consistent evidence demonstrating that body image shame, as measured by BISS, is associated with higher levels of depressive, anxiety, and stress symptoms and with body image problems and disordered eating severity (Duarte & Pinto-Gouveia, 2016, 2017; Duarte, Pinto-Gouveia, & Ferreira, 2014; Duarte et al., 2015). Overall, these findings suggest that body image-focused shame is a harmful emotion that may have a negative effect on women's well-being. In fact, body image-shame experiences may lead to the activation of disordered body and eating-related attitudes and behaviours, which emerge as maladaptive strategies to control or change perceived unattractive attributes or characteristics of body image (Duarte et al., 2015; Gilbert & Miles, 2002; Goss & Gilbert, 2002).

Family can provide children with either body-accepting or body-shaming experiences. It is consensual that parental attitudes and behaviours related to their children's appearance may have a significant impact on how they experience their body and its functions as acceptable or unacceptable (Gilbert & Miles, 2002). Literature also emphasizes that parental criticism (about weight or body shape) associates with unhealthy eating attitudes and weight concerns (Shisslak et al., 1998; Thompson & Sargent, 2000) and is positively associated with body dissatisfaction, body shame, and disordered eating (Gilbert & Miles, 2002).

Considering this background, the current study intended to expand the knowledge about body image shame and disordered eating. An integrative model was tested to clarify the roles of self-criticism and shame experiences (external shame and body image shame) as mediators on the link between the early experiences of warmth and safeness and eating psychopathology. The tested model hypothesized that the relationship between the absence of early positive memories and higher levels of disordered eating would be carried by higher levels of self-criticism, external shame (i.e., negative perception of one's rank position within the social world), and body image-related shame experiences. To make this model more robust, the effect of body mass index (BMI) was controlled, given its high association with body shame and eating psychopathology (Duarte et al., 2015). This model may be an important contribution to understand the link between early emotional experiences and disordered eating symptoms and of the mechanisms involved in this relationship. The examination of these associations may be key to guide the development and refinement of preventive and intervention programs for body image and eating-related difficulties at a community level.

2. Material and methods

2.1. Participants

The research was conducted in a sample that aimed to represent