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'Not good enough:' Exploring self-criticism's role as a mediator between childhood emotional abuse & adult binge eating☆

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ABSTRACT

Empirical studies have identified emotional abuse in childhood (CEA) as a risk factor with long-term implications for psychological problems. Indeed, recent studies indicate it is more prevalent than behavioral forms of abuse, (i.e. childhood sexual and physical abuse) and the childhood trauma most clearly associated with subsequent eating pathology in adulthood. However, relatively little is understood about the mechanisms linking these distal experiences. This study explores three psychological mechanisms – self-criticism (SC), depression and anxiety symptoms – as plausible mediators that may account for the relationship between CEA and binge eating (BE) among adult women. Detailed telephone interviews conducted with a community-based sample of 498 adult women (mean age 44) assess BE, CEA and SC along with the most frequently researched psychological variables, anxiety and depression. Regression analyses reveal that BE is partially explained by CEA along with the three mediators. Bootstrapping analysis, which compares multiple mediators within a single model using thousands of repeated random sampling observations from the data set, reveals a striking finding: SC is the only psychological variable that makes a significant contribution to explaining BE severity. The unique role of punitive self-evaluations vis-à-vis binge eating warrants additional research and, in the interim, that clinicians consider broadening treatment interventions accordingly.

1. Introduction

Empirical studies have identified emotional abuse in childhood (CEA) as a risk factor with long-term implications for psychological problems in adulthood, including eating pathology. Indeed, recent studies indicate it is more prevalent than behavioral forms of abuse, (i.e. childhood sexual and physical abuse) and the childhood trauma most clearly associated with subsequent eating pathology (Hund & Espelage, 2006; Kennedy, Ip, Samra, & Gorzalka, 2007; Racine & Wildes, 2015; Waller, Corstorphine, & Mountford, 2007).

Among the earliest researchers to explore the relationship between emotionally abusive childhood experiences and later eating psychopathology, Rorty and her colleagues (Rorty, Yager, & Rossotto, 1994) compared women with and without lifetime histories of bulimia nervosa. Higher rates of psychological abuse[1] (i.e. parental emotional abuse) were found among those reporting bulimic histories compared to others. In contrast, no group differences were found regarding childhood sexual abuse. The researchers caution against viewing the connection "simplistically in an 'if child abuse, then eating disorder' model" (Rorty et al., 1994 p. 1126). This suggests the possibility of intervening mechanisms which may link childhood traumas to adult eating pathology, although the links are not clear. Studies of the two most frequently researched psychological mediators, anxiety and depression, offer inconsistent findings e.g., (Groleau et al., 2012; Hund & Espelage, 2006; Kennedy et al., 2007; Kent, Waller, & Dagnan, 1999; Mazzeo & Espelage, 2002; Mazzeo, Mitchell, & Williams, 2008).

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[1] The term 'emotional abuse,' is often used interchangeably with 'psychological abuse' and generally refers to "verbal assaults on a child's sense of worth or well-being, or any humiliating, demeaning, or threatening behavior directed toward a child by an older person" (Kong & Bernstein, 2009).

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1.1. The role of self-criticism

Emotional or verbal abuse includes belittling, attacking, demeaning, insulting and humiliating and likely contribute to a child's sense of being flawed (Dunkley, Masheb, & Grilo, 2010). In contrast to behavioral forms of abuse, CEA, construed as a personal attack on the self, may influence the development of a self-critical style (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006). As Kent and Waller (2000) acknowledge: "Sustained verbal attacks, particularly by a significant other and at a crucial development stage, are likely to lead to the development of negative core beliefs about oneself … [which] increases the likelihood of development a range of psychological difficulties, including eating disorders" (Kent & Waller, 2000 p. 894).

Considering that CEA is the form of abuse most frequently associated with subsequent eating pathology (e.g., Groleau et al., 2012; Racine & Wildes, 2015), self-criticism's mediating role may be especially important vis-à-vis serious eating problems in adulthood. Support for this possibility comes from an early study by Steiger, Goldstein, Mongrain, and Van der Feen (1990) which revealed elevated levels of negative self-judgments (even controlling for depression) in patients with anorexia nervosa and bulimia nervosa compared to control groups. In the wake of harsh and chronic negative self-evaluations, binge eating behaviors might arise to self-soothe or relieve these painful emotions, at least in the short term (Burns, Fischer, Jackson, & Harding, 2012). This perspective is consistent with an affect regulation model which proposes that binge eating is not only triggered by, but also alleviates high levels of negative affect (Berg et al., 2015). The current study examines a pivotal role for self-criticism with a relatively large, community based study of women across the life-span.

1.2. Goals of analysis

Although self-criticism has been theoretically and empirically linked with childhood trauma (e.g., Glassman, Weierich, Hooley, Deliberto, & Nock, 2007; Sachs-Ericsson et al., 2006) and eating psychopathology (e.g., Fennig et al., 2008; Kelly, Carter, Zuroff, & Borairi, 2013), its role as a potential mediator in the relationship between CEA and eating pathology has not been firmly established. Therefore, a primary analytic goal is to explore the mediational role of SC in the relationship between CEA & binge eating behaviors (BE). In view of previous research regarding depression and anxiety, a secondary goal is to include them as simultaneous mediators. A unique mediational role for SC is strengthened if depression and anxiety are ruled our as plausible alternatives (Dunkley et al., 2010).

Accordingly, we expect to find more severe BE among women with CEA experiences and higher levels of SC. Moreover, we expect that when SC is included in the model, depression and anxiety will not be significant contributors to BE severity. Bootstrapping, a recommended analytic procedure, is used to test the model and provide a more accurate estimate of the effects of the hypothesized mediators. Additional clarity concerning psychological mediators is likely to shed light on complex processes that sustain BE while providing empirical evidence for more targeted intervention strategies.

2. Methods

2.1. Participants and procedures

A community-based sample of 498 adult women (mean age 44) was randomly recruited from primary health care clinics in Jerusalem metropolitan areas and surrounding suburban neighborhoods. Specific neighborhood clinics were selected to achieve a demographically diverse sample. Under Israel's universal health care system, clinics provide services to all residents without charge. Primary care utilization rates are frequent although not attributable to poorer health status (Rosen, Nakar, Cohen, & Vinker, 2014). Since many women's visits include medical treatment for children or other family members, respondents recruited in clinics are more broadly reflective of a sample drawn from the wider community than a treated patient population. This was substantiated by a majority of interviewees reporting no medical treatment for any health conditions during the previous year (see 12 for full demographic details of sample). All field work protocols and instruments were approved by the appropriate institutional review boards. The 22 Medical Directors from participating clinics also reviewed and approved the recruitment protocols and instruments prior to granting access to the clinics.

2.2. Measures

2.2.1. Childhood abuse variables (independent)

Consistent with other population studies (e.g., McLaughlin et al., 2010), a history of physical, sexual and emotional abuse during childhood was assessed with three straightforward, dichotomous questions. Each question elicits a yes/no response or don't know/don't remember and is similarly phrased: As a child, do you remember being physically abused/sexually abused/verbally abused? None of the abuse terms were defined; rather, the format was designed to obtain responses that represent interviewees' perceptions and interpretations of what they considered abusive events and experiences (Levitt, 2007). Only unequivocal yes answers are included (Feinson & Meir, 2014).

2.2.2. Psychological variables (mediators)

A significant relationship between psychological problems and disordered eating symptoms has been well documented (e.g., Bulik, Sullivan, & Kendler, 2002; Grilo & Masheb, 2001; Grucza, Przybeck, & Cloninger, 2007; Javaras et al., 2008). Three aspects of emotional well-being are measured: self-criticism, depression and anxiety symptoms. The Rosenberg Self-Esteem scale is a well-established and widely-used 10-item measure of global self-esteem (Rosenberg, 1979). A modified version adapted for this study reflects a more nuanced dimension, namely, self-criticism (e.g., feeling critical of yourself, not good enough, much of what you do is inadequate, etc.) with three response categories: most of the time, sometimes, rarely. Higher scores reflect more self-criticism (SC). *Alpha* reliability for the sample was an acceptable 0.74. Two six-item sub-scales from the Brief Symptom Inventory (BSI), an 18-item questionnaire with well-established reliability and validity, were used to assess symptoms of depression and anxiety (Derogatis, 2000). *Alpha* reliabilities for the BSI depression and BSI anxiety sub-scales were 0.80 and 0.79 respectively.

2.2.3. Binge eating behaviors (dependent)

Self-report screening questionnaires (SRQs) are considered effective research instruments when clinical diagnoses are not required (Keski-Rahkonen et al., 2006; Wilfley, Schwartz, Spurrell, & Fairburn, 1997) and may be particularly appropriate for assessing secretive or shameful behaviors, such as out-of-control eating behaviors (Fairburn & Beglin, 1990; Wilfley et al., 1997). However, in the absence of adequately standardized instruments that have been used with multicultural, non-clinical samples of adult women across the life span (Kuba & Harris, 2001; Marcus, Bromberger, Wei, Brown, & Kravitz, 2007), an easily administered 16 item screening questionnaire (SQ) with clinically relevant symptoms was developed for this study by a clinical research group with mental health expertise. To increase the validity of the scale, the SQ was designed to incorporate DSM symptoms (Appendix A). It was developed in English, translated into Hebrew and Russian and back translated into English, according to standard translation protocols. To minimize the potential for recall bias, all SQ items are phrased in the present tense and answered with a