

Invalidating childhood environments in anorexia and bulimia nervosa

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Abstract

Objective: This study examined the relationship between an invalidating childhood environment and eating pathology, including diagnoses, eating attitudes and eating behaviours.

Method: Fifty-eight eating-disordered patients completed a measure of invalidating childhood environments, and a standardised measure of eating pathology.

Results: Patients with bulimia nervosa scored higher on levels of paternal invalidation than those with anorexia nervosa. There were no associations at the attitudinal level, but some behaviours were related to perceived parental style. Self-induced vomiting was associated with paternal invalidation, while those who experienced an invalidating mother were less likely to report binge-eating. Those who exercised excessively were more likely to have experienced a family style in which the focus is on remaining in control of one's emotions, success and achievement.

Discussion: Invalidating childhood environment was related to eating psychopathology in a clinical population — particularly the presence or absence of some behaviours. Implications for treatment are considered.

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There is considerable evidence of links between family environment and eating pathology, although the direction of causality remains to be established (Schmidt et al., 1998). A central element appears to be the family's contribution to the child's development of negative emotional states. However, such states are most likely to have an impact where the individual has learned that it is not acceptable or safe to experience such states. In such circumstances, the individual responds by using 'blocking' mechanisms to reduce awareness of the emotions that are regarded as unacceptable (e.g., Root & Fallon, 1989; Waller, Kennerley & Ohanian, 2007). Such mechanisms involve impulsivity (such as binge-eating and purging, as well as behaviours such as self-harm) and compulsivity (such as dietary restriction and compulsive exercise, as well as obsessive–compulsive features).

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There are many factors that can drive the individual's experience of negative emotions, such as poor experiences of parental care in childhood (Parker, 1983), teasing and bullying (Sweetingham & Waller, *in press*), and childhood abuse and neglect (Kent & Waller, 2000). However, there is less understanding of why the individual develops the belief that such emotions are unacceptable. Linehan (1993) has proposed one candidate for this mediating role — the experience in childhood of living in an invalidating environment. Such an environment can be defined as one where there is a poor fit between the environment and the child's temperament, where the child's personal experiences are not validated by caregivers, and where communication of emotions is either ignored or punished. Linehan (1993) suggests that growing up in an invalidating environment tells the child that his or her view and experience of emotions is incorrect. Such an experience can lead to the development of emotional dysregulation, as the child may not have been taught how to label his or her feelings appropriately or how to tolerate emotional distress. This pattern becomes self-maintaining, as the child learns to invalidate his or her own emotional experiences.

Such emotional dysregulation is relevant to the eating disorders, as patients with eating disorders often report difficulty in tolerating strong emotions (Corstorphine, Mountford, Tomlinson, Waller & Meyer, 2007; Wisner & Telch, 1999; Waller, Corstorphine & Mountford, 2007), and will often try to avoid potential triggers of these states (Serpell, Treasure, Teasdale, & Sullivan, 1999), or will use impulsive behaviours to cope with them (e.g., Root & Fallon, 1989; van der Kolk & Fessler, 1994). Therefore, Mountford, Corstorphine, Tomlinson and Waller (2007) have proposed that Linehan's concept of emotional invalidation might provide a framework within which to understand the emotional difficulties that patients with eating disorders often experience. They have carried out preliminary validation of this concept, showing that emotional invalidation is associated with poor distress tolerance, which in turn is associated with eating psychopathology. However, that study was focused on the validation of a measure, and did not distinguish clinical groups. It remains unclear whether the emotional invalidation model applies equally to both anorexic and bulimic cases.

This study extends the work of Mountford et al. (2007), determining whether an invalidating childhood environment is associated with a specific diagnosis or with a pattern of eating attitudes and behaviours. Given the higher level of impulsivity and emotional dysregulation that are reported among bulimic women than anorexics, it can be hypothesised that the reported level of childhood invalidation will be higher among those who have bulimic disorders and who demonstrate bulimic behaviours. Reports of perceived family functioning among women with eating disorders suggest that both maternal and paternal behaviours are relevant to all eating disorders. However, the level of perceived pathogenic parenting tends to be greater among bulimics than anorexics, with higher levels of overprotection by fathers reported by patients with bulimia nervosa (Leung, Thomas & Waller, 2000). Calam, Waller, Slade and Newton (1990) suggest that the presence of paternal overprotection might result in a greater tendency for their daughters to attempt to regain control over their lives, resulting in eating disorder symptoms that serve this control function. Therefore, it is hypothesised that paternal invalidation will be more strongly associated than maternal invalidation with bulimic disorders and symptoms. In contrast, as core eating attitudes tend to be common across all eating disorders (e.g., Fairburn, Cooper & Shafran, 2003), no hypothesis can be developed regarding associations with beliefs about eating, weight and shape.

1. Method

1.1. Participants

The participants were 58 adult patients who were assessed at one of two eating disorder services in London. The sample consisted of fifty-five female and three male patients, with a mean age of 27.0 years ($SD=6.10$). Participants were diagnosed at assessment with either bulimia nervosa (including atypical bulimia nervosa) or anorexia nervosa (including atypical anorexia nervosa), using DSM-IV criteria (American Psychiatric Association, 1994). Each was weighed and their height was measured objectively, to yield a body mass index ($BMI = \text{weight}(\text{kg}) / \text{height}(\text{m})^2$). Those with anorexia nervosa had a mean BMI of 16.6 ($SD=1.82$), and those with bulimia nervosa had a mean BMI of 22.6 ($SD=3.30$). The sample did not overlap with that of Mountford et al. (2007).

1.2. Measures and procedure

The study was granted ethical approval by the relevant research committees (equivalent to Institutional Review Board). Participants were all given information sheets and the opportunity to discuss the study. All participants gave informed written consent.

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