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Childhood Experiences of Being Bullied and Teased in the Eating Disorders

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Empirical studies have found associations between eating pathology and childhood experiences of being bullied and teased about appearance. However, the nature of these links is not clear. This study investigated the possible links between such experiences and eating disorders, focusing on the potential mediating role of two socially oriented emotions–shame and social anxiety. Ninety-two eating-disordered women completed measures of social anxiety, shame, eating pathology and childhood experiences of being bullied and teased about their appearance (by peers and family). There was a specific relationship between teasing by peers about appearance and body dissatisfaction, which was mediated by shame. These findings support existing evidence regarding the associations between trauma and eating pathology. They suggest that clinicians need to consider the potential role of teasing by peers about appearance and shame when understanding body dissatisfaction. Further research is needed to determine if the model proposed here reflects true causal links. Copyright © 2007 John Wiley & Sons, Ltd and Eating Disorders Association.

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There is a substantial literature on the impact of childhood trauma upon the development of the eating disorders (e.g. Anderson, LaPorte, & Crawford, 2000; Kent & Waller, 2000; Kent, Waller, & Dagnan, 1999; Pope & Hudson, 1992; Root & Fallon, 1988; Welch & Fairburn, 1996). However, the research to date has focused almost exclusively on sexual, physical and emotional abuse, usually with an older perpetrator. There is less understanding of the roles of being bullied (verbally or physically) and being teased (about weight, shape and appearance) by peers, even though such experiences have frequently been identified in the aetiology of the eating disorders (e.g. Slade, 1982). Bullying is a subjective experience, which has been defined in different ways (e.g. Craig, 1998; Farrington, 1993). Olweus's (1991) definition includes the most important elements of bullying, involving: an aggressive act; a behaviour that occurs frequently; an imbalance of power and a verbal, physical or indirect attack. Recent research has shown an association between childhood experiences of being bullied and eating-disordered behaviours (Engstrom & Norring, 2002; Kaltiala-Heino, Rissanen, Rimpela, & Rantanen, 2003). Childhood experiences of being teased about weight and shape are also associated with eating and related

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pathology, including body dissatisfaction, low self-esteem, depression and disordered eating behaviours (Eisenberg, Neumark-Sztainer, & Story, 2003; Hill & Murphy, 2000; Jackson, Grilo, & Masheb, 2000; Myers & Rosen, 1999; Neumark-Sztainer, Falkner, Story, Perry, Hannan, & Mulert, 2002).

Given the interpersonal nature of bullying and teasing, it is likely that any link to the eating disorders will take the form of socially mediated cognitions and emotions, particularly as the trauma often takes place in full view of others (Craig & Pepler, 1997). Emotional states in general can be an antecedent to the eating disorders, and can trigger eating behaviours (e.g. Arnow, Kenardy, & Agras, 1995; Fairburn, 1997; McManus & Waller, 1995; Meyer, Waller, & Waters, 1998). However, given their social context, it is particularly likely that teasing and bullying will have their impact via socially mediated cognitions. Two candidate emotions are particularly likely to be relevant—social anxiety and shame. Social anxiety is a fear of social situations where individuals perceive themselves to be vulnerable to negative evaluation and exposure by others (Clark, 2005; Leary & Kowalski, 1995). Shame involves feelings of inferiority, powerlessness and self-consciousness, along with the desire to conceal deficiencies (Gilbert, 1998; Tangney, Miller, Flicker, & Barlow, 1996; Wicker, Payne, & Morgan, 1983). Each has the key element of concern about how one is perceived by others, and each has been shown to be relevant to eating pathology and to the eating disorders (e.g. Hinrichsen, Wright, Waller, & Meyer, 2003; Murray & Waller, 2002; Swan & Andrews, 2003).

This study will determine reported rates of childhood bullying and teasing among women with eating disorders, and will examine the potential role of socially mediated emotions in explaining the link between these phenomena. It is hypothesised that the link between those experiences and the severity of eating concerns will be mediated by shame and social anxiety.

METHOD

Participants

Following local ethical approval being granted, patients at a specialist eating disorders service were invited to take part in the research at their clinical assessment. The sample consisted of 92 female patients, with a mean age of 28.5 years (SD = 8.17, range = 18–58) and a mean body mass index (BMI = weight (kg)/height $(m)^2$) of 22.1 (SD = 7.71, range = 13–50). All participants were assessed by experienced clinicians, using a semi-structured interview. All received a diagnosis of an eating disorder, using strict DSM-IV criteria (American Psychiatric Association, 1994). They included: 12 patients with anorexia nervosa (restrictive subtype); 7 with anorexia nervosa (binging/purging subtype); 25 with bulimia nervosa (purging subtype); 7 with bulimia nervosa (non-purging subtype) and 41 with Eating Disorder Not Otherwise Specified (EDNOS). Of the EDNOS group: 6 had a diagnosis of binge eating disorder; 17 were atypical anorexics of the restrictive subtype; 2 were atypical anorexics of the binge/purge subtype; 9 were atypical bulimics (purging subtype); 3 used purging behaviours only and 4 could not be clearly categorised in this way.

Measures and Procedure

During their assessment for treatment, each woman completed three standardised self-report questionnaires, assessing eating pathology, shame and social anxiety. Questions about bullying and teasing were asked as part of the semi-structured assessment interview.

Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002). The ESS consists of 25 items, which measure: *characterological shame* (regarding personal habits, manner with others, the sort of person one is and personal ability); *behavioural shame* (regarding doing something wrong, saying something stupid and failure in competitive situations) and *bodily shame* (feeling ashamed of one's body or any part of it). Each element is assessed by items addressing its experiential, cognitive and behavioural components. Participants respond according to how they have felt in the past year. Each item is rated on a four-point scale. Higher scores (total range = 25–100) indicate greater levels of shame. The ESS has high internal consistency and good test–retest reliability (Andrews et al., 2002).

Brief Fear of Negative Evaluation questionnaire (Brief FNE; Leary, 1983). The original FNE (Watson & Friend, 1969) consists of 30 items, assessing the individual's social anxiety–concern about others' evaluations, distress over being negatively evaluated, avoidance of evaluative situations and the expectation that others would evaluate one negatively. It has been well-validated (Mattick & Clarke, 1998; Watson & Friend, 1969). For this study, the 12-item version of the FNE was used, as it is equally

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valid and takes less time to complete (Leary, 1983). This version uses a five-point Likert scale response format. Participants respond according to how they currently feel. Higher scores (range = 0–48) reflect a greater level of social anxiety.

Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983). The EDI consists of 64 items, which measure eating-disordered and related attitudes and behaviours. The scale consists of three eating attitude scales and five ego dysfunction scales. Only the three eating-related scales were used–*drive for thinness* (fear of weight gain and a preoccupation with dieting); *bulimia* (a tendency to think about and engage in bulimic behaviours such as binging and vomiting) and *body dissatisfaction* (extreme dissatisfaction with body shape). The EDI has been well validated (Garner, 1991). Higher scores indicate greater eating psychopathology.

Interview questions regarding bullying and teasing. There are few retrospective measures of bullying and teasing in childhood that are suitable for administering in adulthood. Most ask about experiences in the last six months (e.g. Olweus, 1993) or are designed for use with younger participants (e.g. Hoover, Oliver, & Hazler, 1992; Matsui, Tzuzuki, Kakuyama, & Onglatgo, 1996). Therefore, for the purposes of this study, the adult patients were asked whether they had any history of being bullied or teased by other children (up to the age of 18). Three specific experiences were addressed–*verbal bullying*, *physical bullying* and *teasing about appearance* (e.g. weight, height and body shape), using a yes/no response format. Participants were also asked to indicate: whether child perpetrators of bullying were peers (e.g. school friends) or family members (e.g. brothers or sisters); the youngest age that this bullying occurred; whether they disclosed the bullying to anyone and whether the reaction to disclosure was positive or negative. The rationale for these supplementary questions is that age of onset of trauma, disclosure of trauma and the reaction to that disclosure can have a moderating influence on psychological well being (Everill & Waller, 1995; Waller & Ruddock, 1993). All of these questions were asked as a part of the clinical assessment, in the context of questions about a range of potential antecedent factors in the patient's history.

Data Analysis

Independent sample *t*-tests were conducted to determine comparison levels of eating pathology, shame and social anxiety between those who did and who did not report childhood bullying and teasing. Pearson's correlation coefficients (*r*) were used to determine associations between social anxiety/shame and eating pathology. At each stage, variables that were not related were dropped from consideration for the subsequent mediational model. Multiple regression analyses were carried out to investigate the potential mediating role of socially mediated emotions (social anxiety and shame) in the relationship between bullying and eating psychopathology, using the method outlined by Baron & Kenny (1986).

RESULTS

Prevalence of Bullying and Teasing

Verbal bullying by one's family (mainly siblings) was reported by eight of the patients (8.7%), but verbal bullying by peers was more common, being reported by 43 patients (46.7%). In contrast, physical bullying was not common, whether perpetrated by family members (six cases—6.5%) or peers (11 cases—12.0%). Teasing by family members about appearance was reported by 13 patients (14.1%), and teasing by peers was reported by 39 patients (42.4%).

Association of Trauma with Eating Pathology (Independent Variable–Dependent Variable)

Table 1 shows that there were two reliable relationships between reported childhood experiences and later eating pathology. Being teased about appearance by peers and being verbally bullied by family members were both associated with a significantly greater level of body dissatisfaction in adulthood. As body dissatisfaction was the only aspect of eating pathology associated with the presence of bullying and teasing, only that EDI scale was used in subsequent analyses. Similarly, other forms of teasing and bullying were not used further, as they could not contribute to the mediational model (Baron & Kenny, 1986).

Associations between Social Affect and Body Dissatisfaction (Mediator-Dependent Variable)

Social anxiety (FNE scores) was reliably correlated with body dissatisfaction ($r = .497$, $p < .001$). All of the three shame subscales (ESS scores) were also

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Table 1. Association between bullying and eating pathology in the clinical sample

EDI subscale		Drive for thinness				Bulimia				Body dissatisfaction			
Trauma reported		Absent	Present	*t*-test		Absent	Present	*t*-test		Absent	Present	*t*-test	
Absent or present		Mean (SD)	Mean (SD)	*t*	*p*	Mean (SD)	Mean (SD)	*t*	*p*	Mean (SD)	Mean (SD)	*t*	*p*
Trauma	Perpetrator												
Verbal bullying	Family	14.8 (5.48)	16.4 (5.22)	0.74	NS	8.89 (6.43)	10.4 (5.26)	0.63	NS	18.7 (7.55)	23.1 (6.85)	1.58	.03
	Peers	14.5 (5.64)	15.3 (5.33)	0.59	NS	9.32 (6.43)	8.85 (6.27)	0.31	NS	19.3 (8.22)	19.1 (7.12)	0.10	NS
Physical bullying	Family	15.0 (5.50)	15.1 (5.23)	0.08	NS	8.74 (6.34)	12.5 (4.93)	1.41	NS	18.9 (7.60)	22.3 (7.00)	1.07	NS
	Peers	14.9 (5.28)	15.7 (6.63)	0.45	NS	9.00 (6.42)	9.36 (5.82)	0.18	NS	19.1 (7.63)	19.7 (7.50)	0.26	NS
Teasing	Family	14.9 (5.45)	15.4 (5.62)	0.30	NS	18.7 (7.71)	21.3 (6.71)	1.28	NS	18.7 (7.71)	21.3 (6.71)	1.12	NS
	Peers	15.4 (4.69)	14.6 (6.16)	0.63	NS	9.17 (6.62)	8.95 (6.10)	0.15	NS	17.3 (8.62)	21.0 (5.93)	2.14	.009

reliably associated with body dissatisfaction (behavioural—$r = .425$, $p < .001$; characterological—$r =\ .388$, $p < .001$and bodily—$r = .244$, $p < .02$). Therefore, given this similarity, the overall ESS shame score was used in subsequent analyses, as it was most strongly correlated with body dissatisfaction ($r = .463$, $p < .001$). Consequently, it can be concluded that both social anxiety and shame are potential mediators of the trauma-body dissatisfaction link, as they are associated with the dependent variable.

Association of Trauma with Affect (Independent Variable-Mediator)

Considering only those variables that have been shown to be relevant in the previous analyses, Table 2 shows the link between the two traumatic experiences (verbal bullying by family, teasing by peers) and the social emotions (social anxiety and shame). *T*-tests showed that reports of having been bullied by family members were associated with higher levels of social anxiety in adulthood, while reports of having been teased by peers were associated with higher current levels of shame. Therefore, both social anxiety and shame are potential mediators in the trauma-body dissatisfaction link, but each emotion is associated with a different form of trauma.

Mediational Analysis

In keeping with Baron and Kenny (1986), the previous analyses indicate that there are two mediational models to be tested—the potential role of shame as a mediator in the link between teasing by peers about appearance and body dissatisfaction, and the role of social anxiety in the link between verbal bullying by family and body dissatisfaction.

Shame as a mediator. To test this model, it was necessary to determine whether the association between teasing by peers and body dissatisfaction was reduced when shame was entered as a mediator. In the first analysis, teasing accounted for a small but significant percentage of the variance in body dissatisfaction ($F = 4.57$, $p < .04$, proportion of variance explained = 4.7%, $\beta = 0.246$). In the second analysis, the proportion of variance explained in the first step (by shame) was significant ($F = 11.4$, $p < .001$, proportion of variance explained = 23.2%, $\beta = 0.482$). However, in the second step, teasing no longer had a significant predictive effect on body dissatisfaction. The additional adjusted R^2 was 2.8% of the variance,

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Table 2. Levels of social anxiety (FNE score) and shame (ESS total score) among those reporting either of the two key traumatic experiences

Emotion	FNE				ESS			
Trauma reported absent/present	Absent	Present	t	p	Absent	Present	t	p
	Mean (SD)	Mean (SD)			Mean (SD)	Mean (SD)		
Type of bullying								
Verbal bullying by family	37.5 (8.12)	42.6 (4.90)	1.72	.045	73.4 (13.0)	74.1 (15.4)	0.15	NS
Teasing about appearance by peers	37.7 (8.31)	38.6 (7.70)	0.49	NS	70.1 (13.1)	76.9 (12.5)	2.25	.014

which was no longer significant (F change = 2.48, p = .12, β = 0.172). Using Baron & Kenny's (1986) criteria, these findings are compatible with a model where shame is a perfect mediator of the relationship between teasing about appearance by peers in childhood and body dissatisfaction in adult life.

Social anxiety as a mediator. To test this model, it was necessary to determine whether the association between verbal bullying by family members and body dissatisfaction was reduced when social anxiety was entered as a mediator. However, in the first analysis there was no reliable association between the independent variable (verbal bullying by family members) and the dependent variable (body dissatisfaction) (F = 2.50, p = .12, proportion of variance explained = 2.0%, β = 0.184). As there was no reliable association between the independent and dependent variables, it can be concluded that the data are not compatible with a model where social anxiety mediates the relationship between verbal bullying by family and body dissatisfaction.

DISCUSSION

This study of eating-disordered women has investigated the relationships of experiences of bullying and teasing with eating psychopathology, considering the potential mediating role of socially oriented affect (shame and social anxiety). The frequency of these experiences has been reported, although the use of a novel clinical measure means that these figures cannot be directly compared with previous research. There were specific links with social affect and with body dissatisfaction. First, being teased about appearance by peers and being verbally bullied by family members were each associated with a significantly greater level of body dissatisfaction in adulthood. Second, social anxiety and shame were associated with body dissatisfaction. Finally, the data were compatible with a model where shame acts as a perfect mediator between teasing about appearance by peers and the development of body dissatisfaction, but did not support social anxiety as a mediator of the relationship between verbal bullying by family and body dissatisfaction.

The association between teasing about appearance (in particular weight and shape) and body dissatisfaction is consistent with many empirical reports (Eisenberg et al., 2003; Hill & Murphy, 2000; Jackson et al., 2000; Myers & Rosen, 1999; Neumark-Sztainer et al., 2002). The associations between social affect and eating pathology in this clinical sample are also consistent with other clinical samples (Hinrichsen, Wright, Waller, & Meyer, 2003; Swan & Andrews, 2003), as are the findings of links between bullying/teasing and shame and social anxiety (Craig, 1998; Graham & Juvonen, 1998). A mediator model was supported–teasing by peers was associated with shame, and hence with body dissatisfaction. This mediator model supports our suggestion of a theoretical link between bullying and eating pathology, where having been teased about one's appearance by peers results in general levels of shame, focused specifically on pathological dissatisfaction with one's body.

These findings have implications for clinical practice. In the assessment process, it is important that clinicians should explore experiences of different types of childhood trauma (including bullying and teasing) and the impact that those experiences have had on the individual's emotions, cognitions and behaviours in adulthood. Treatment programmes might need to target bullying and teasing experiences, and the related social- emotional states. This could involve cognitive strategies (e.g. testing the utility of the cognitions that underpin the affect) and behavioural strategies (e.g. exploring more adaptive ways of coping with negative social affect).

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Further research is needed to show whether other emotions (e.g. depression) might act as mediators in the relationship between teasing/bullying and eating pathology, in order to determine whether the role of social affect is a specific one. Such research will also need to dismantle the construct of teasing, in order to understand its role in the development of an eating disorder. However, it will also be important to explore the potential role of moderators in the bullying/teasing-eating link (e.g. a supportive peer group vs. a hostile one), which might prove useful in determining factors that can be exploited to aid treatment. Those moderators are likely to include the role of children's coping styles in response to such experiences, and duration of the trauma. Longitudinal studies will be needed to determine these links comprehensively.

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