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The mediating role of emotional invalidation between sexual-emotional abuse and depression symptoms of female Payame-Noor University Students in Tehran

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Introduction

Emotional invalidation is a transdiagnostic process that can be relevant across a variety of disorders. Emotional invalidation (the perception of others as indifferent to one's emotions) is associated with difficulty accepting emotions, maladaptive coping with emotions, perception of negative emotions as less controllable and comprehensible, and less psychological flexibility (Linehan, 1993; Leahy, Tirch, & Napolitano, 2011).

Childhood abuse (sexual and emotional abuse) may be considered prototypical experiences of invalidation of emotional experiences (Westpha, Leahy, Pala, & Wupperman, 2016; Leahy, 2015). Childhood abuse communicate that the child's internal experiences do not matter. Furthermore, abusive caregivers who routinely punish emotional or sexual displays convey that negative emotions are unacceptable and unimportant (Leahy, 2015). Also in cross-sectional studies, childhood abuse has been found to be a predictor of depressive symptoms directly (Infurna et al., 2016; Jascheka, Carter-Pokrasa, Hea, Leea, & Canino, 2016).

Emotional invalidation is linked to a host of internalizing such as depression, anxiety, and social avoidance (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011; Hong, & Lishner, 2016).The present study examined the predictive associations among childhood trauma (emotional and sexual), emotional invalidation and depressive symptoms in female college students with current major depressive disorder and with history of major depressive disorder. In summary, the following hypotheses are proposed:

Hypothesis 1. Sexual abuse would contribute to the depressive symptoms through emotional invalidation.

Hypothesis 2. Emotional abuse would contribute to the depressive symptoms through emotional invalidation.

Method

The present investigation is a descriptive-cross-sectional study. The population of this study was 21,000 female college students in six different branches of Payam-e-Noor University with Persian languages (Baharestan, Eslamshahr, Shahryar, Tehran Souht, Robatkarim and Varamin). Data were obtained from college women enrolled in a clinical research study of mood disorders and behavior from the 2015 to 2016 academic year. Of these, 394 were selected through available sampling, of whom 92 met the criteria for current major depressive disorder (MDD) and 347 who had history of MDD in the last 12 months.

Measures

Beck Depression Inventory: The BDI-II (Beck, Steer, & Brown, 2000) was used to assess depressive symptoms during the last two weeks. It measures the severity of depression and consists of 21 items. The reliability and validity of the BDI-II have been well demonstrated both in clinical and non-clinical samples (Beck et al., 2000).

Structured Clinical Interview for DSM-IV Axis I & II (SCID): SCID is a structured diagnostic measure designed to assess DSM–IV Axis I and II disorders. The SCID showed good reliability in previous studies (Maffei et al., 1997).

Childhood Trauma Questionnaire - Short Form: The CTQ (Bernstein et al., 2003) retrospectively assesses the severity of different types of trauma and provides five subscales: Sexual abuse, emotional abuse, physical abuse, physical neglect, and emotional neglect. Each item is scored on a five-point Likert scale from. The CTQ has demonstrated excellent reliability, convergent, divergent and predictive validity in both clinical and non-clinical populations (Bernstein et al., 2003).

Leahy Emotional Schemas Scale (LESS; Leahy, 2002): This scale is made up of 50 items that are used to assess how one thinks about his own emotions. The LESS is a six-point Likert scale for each question (very true of me = 6 to very untrue of me = 1), it includes items regarding how they have dealt with emotional experiences during the last month.

Results

The results showed that depressive symptoms were significantly correlated with emotional (r = 0.46), sexual (r = 0.29) abuse and emotional invalidation (r = 0.51). In the present study, the 95% confidence interval (CI) of the indirect effects was obtained with 5000 bootstrap samples. The final step was to determine if the 95% CI for the estimated indirect effect included zero. An indirect effect is significant at the .05 level if the 95%CI does not include zero.

There was significant indirect effect (path ab) of sexual abuse on depression symptoms through emotional invalidation (CI=0.20 to 0.75). In other words, consistent with that first hypothesis, emotional invalidation

significantly mediated the effect of sexual abuse on depression symptoms. In addition, the bootstrapping results indicated that the direct effect of sexual abuse on depression (path c' = 1.05, $p < 0.0001$) remained significant when controlling emotional invalidation, thus suggesting partial mediation.

In addition, according to the bootstrapping results, emotional invalidation significantly mediated the effect of emotional abuse on depression symptoms (CI = 0.33 to 0.65). The direct effect of emotional abuse on depression (path c' = 1.06, $p < 0.0001$) also remained significant when controlling emotional invalidation, thus suggesting partial mediation.

Discussion

The present study aimed to clarify whether emotional invalidation would explain the effect of childhood trauma (sexual and emotional abuse) on depressive symptoms. Consistent with our hypotheses, emotional invalidation partially mediated the effect of sexual and emotional abuse on depression. It is important to note, however, that this finding is consistent with previous studies (Leahy et al., 2011; Linehan, 1993; Infurna et al., 2016; Jascheka et al., 2016). Results from the current study suggested that one pathway by which sexual and emotional abuse may affect depressive symptoms is via emotional invalidation.

This finding can be explained by reffering to attachment theory. First, during the process of forming and maintaining attachment during early childhood, the rudiments of empathy, mirroring, and validation include the caregiver's responsiveness to the child's distress, which reinforces the child's mental representation—"My feelings make sense to others." Second, responsive soothing of the child's feelings by the caregiver encourages the child to believe, "My distressed feelings can be soothed." Initially, it is proposed that this "soothing" occurs through the caregiver's attention and reassurance but later is "internalized" by the child in self-calming and optimistic self-statements, similar to Bowlby's idea of internal working models, in this case the internal representation that one's feelings make sense and can be calmed. Third, the child's communication of feelings to the caregiver becomes an opportunity not only for expressing feelings but for the caregiver to link emotional states to external events that "cause" the feeling—"You're upset because your brother hit you." This attempt to comprehend the cause of feelings and to share them with the caregiver can also assist in differentiating these feelings—"It sounds like you are angry and hurt"—and in constructing a theory of mind that can be applied to both self and others. Indeed, without an adequate theory of mind, the child will be impaired in showing validation toward others and will be unable to soothe her own feelings and the feelings of others (Leahy et al., 2011).

Keywords: depression, emotional invalidation, emotional abuse, sexual abuse.