



# Feeling fat in eating disorders: Testing the unique relationships between feeling fat and measures of disordered eating in anorexia nervosa and bulimia nervosa



Jake Linardon<sup>a,\*</sup>, Andrea Phillipou<sup>b,c,d,e</sup>, David Castle<sup>c,d</sup>, Richard Newton<sup>e</sup>, Philippa Harrison<sup>d</sup>, Leonardo L. Cistullo<sup>d</sup>, Scott Griffiths<sup>f</sup>, Annemarie Hindle<sup>g</sup>, Leah Brennan<sup>g</sup>

<sup>a</sup> School of Psychology, Deakin University, 221 Burwood Highway, Burwood, VIC 3125, Australia

<sup>b</sup> Centre for Mental Health, Swinburne University of Technology, Australia

<sup>c</sup> Department of Psychiatry, The University of Melbourne, Australia

<sup>d</sup> Department of Psychiatry, St Vincent's Hospital, Australia

<sup>e</sup> Department of Mental Health, The Austin Hospital, Australia

<sup>f</sup> Melbourne School of Psychological Sciences, University of Melbourne, Australia

<sup>g</sup> School of Psychology, Australian Catholic University, 115 Victoria Parade/Locked Bag 4115, Melbourne, Victoria 3065, Australia

## ARTICLE INFO

### Article history:

Received 4 August 2017

Received in revised form 5 April 2018

Accepted 5 April 2018

### Keywords:

Feeling fat

Body image

Eating disorder

Anorexia nervosa

Bulimia nervosa

## ABSTRACT

Although widely discussed in theories of eating disorders, the experience of “feeling fat” in this population has received little research attention. This study tested the unique relationships between feeling fat and measures of problematic eating behaviours and attitudes. Data were analysed from individuals with anorexia nervosa (AN;  $n = 123$ ) and bulimia nervosa (BN;  $n = 51$ ). Correlations revealed considerable unshared variance between feeling fat and shape and weight over-evaluation and depressive symptoms. Moreover, when over-evaluation and depressive symptoms were controlled, feeling fat predicted unique variance in restraint and eating concerns. Findings offer some support for the idea that feeling fat is a distinct and important component of body image concerns in eating disorders. Further research that develops a standardized measure of feeling fat is required. Further research that examines whether feeling fat is an important treatment mechanism is also needed.

© 2018 Elsevier Ltd. All rights reserved.

## 1. Introduction

Body image concerns are central in eating disorders. There is growing evidence that distinct attitudinal components of body image exist (e.g., shape and weight over-evaluation, preoccupation, dissatisfaction, and fear of weight gain), and that these distinct components function differently in terms of their association to behavioural symptoms of eating disorders (Lydecker, White, & Grilo, 2017). These distinct components of body image have also been shown to be important risk and/or maintaining factors for eating disorder psychopathology. For example, early meta-analytic research of prospective studies has shown body dissatisfaction to be a strong predictor of eating pathology in non-clinical samples (Stice, 2002), and a recent meta-analysis of cross-sectional stud-

ies of clinical samples (binge-eating disorder and bulimia nervosa) reported robust links between shape and weight over-evaluation and disordered eating and psychological distress (Linardon, 2016). Recent research also suggests that preoccupation with shape and weight is a strong and independent predictor of problematic eating patterns even after controlling for other facets of body image (i.e., dissatisfaction and over-evaluation; Linardon et al., 2018; Lydecker et al., 2017; Mitchison et al., 2017). Findings on the significance of these distinct body image components have prompted calls for clinicians to screen, assess, and target these different facets during prevention and intervention programs (Lydecker et al., 2017)

Another purportedly distinct attitudinal component of body image is “feeling fat.” Despite receiving scant research attention, feeling fat is featured in prominent theoretical models of eating disorders (Fairburn, Cooper, & Shafran, 2003). For example, the transdiagnostic model of eating disorders proposes that feeling fat tends to be equated with “being fat,” that this experience may be a direct expression of the over-evaluation of weight and

\* Corresponding author.

E-mail address: [jake.linardon@deakin.edu.au](mailto:jake.linardon@deakin.edu.au) (J. Linardon).

shape, and that feeling fat serves to interact with or exacerbate other behavioural features of eating disorders (Fairburn, 2008). This model also proposes that experiences of feeling fat typically arises from the mislabelling of depressive symptoms (Fairburn, 2008). Consequently, feeling fat is an important treatment target in CBT for eating disorders. Although feeling fat is a common experience amongst women in the general population (Fairburn, 2008), differences in experiences of feeling fat in clinical and non-clinical populations is likely to be a matter of degree rather than kind. For example, Cooper and colleagues compared the experience of feeling fat in women with anorexia nervosa (AN;  $n=16$ ), women who were dieting ( $n=15$ ), and women who were not dieting ( $n=17$ ). The authors found that, while feeling fat was commonly experienced in all groups, this experience was more frequent and intense in women with AN, and that feeling fat's relationship with dysphoria and disordered eating was strongest in the AN group (Cooper, Deepak, Grocutt, & Bailey, 2007). This is the only study to have examined feeling fat in a clinical population. Thus, many questions still remain, including the significance of feeling fat in other eating disorder subtypes (e.g., bulimia nervosa; BN), and whether feeling fat can be seen as a distinct construct from related variables such as shape and weight over-evaluation and depressive symptoms.

This exploratory study aimed to build on this small literature by examining the associations of self-reported feelings of fatness with measures of problematic eating behaviours and attitudes in patients with AN and BN. A greater understanding of the potential significance of feeling fat may be important for understanding whether this experience is another distinct component of body image that warrants sufficient clinical attention during eating disorder treatment. Thus, we aimed to test whether feeling fat can contribute unique variance to measures of disordered eating (i.e., restraint, eating concerns, and compensatory behaviours) after taking into account the variance explained by over-evaluation and depressive symptoms. Moreover, we also aimed to explore whether any of the relationships observed between feeling fat and the selected dependant variables differed across diagnostic types.

## 2. Method

### 2.1. Participants and procedure

Participants were 178 females referred and assessed for outpatient treatment at the Body Image and Eating Disorder Treatment Recovery Service (BETRS) at St Vincent's Hospital, Melbourne. A detailed description of the service and treatment has been described elsewhere (Newton, Bosanac, Mancuso, & Castle, 2013). Data were collected upon initial presentation as part of a larger assessment protocol. The sample comprised participants who received a diagnosis of AN ( $n=124$ ; 70%) or BN ( $n=54$ ; 30%). Diagnoses were determined after comprehensive assessment by specialist clinicians under the guidance of a team of Consultant Psychiatrists. Table 1 presents the characteristics of the present sample. Participants with AN had a significantly lower BMI and significantly higher scores on depression and restraint than participants with BN. Participants were mostly Caucasian (72%); some identified as European (8.1%), Aboriginal and Torres Strait Islander (2.4%), East Asian (2.4%), and "other" (4%). Ethnicity was not provided by 11.1% of participants. Ethics approval was obtained, and informed consent was provided by all participants.

### 2.2. Measures

#### 2.2.1. Eating Disorder Examination Questionnaire (EDE-Q)

The EDE-Q is a 28-item self-report questionnaire that assesses core cognitive and behavioural symptoms of eating disorders that

have occurred over the past 28 days (Fairburn & Beglin, 1994). There are four subscales of the EDE-Q, including dietary restraint, shape concerns, weight concerns, and eating concerns. To assess feeling fat, we selected the single item "have you felt fat" from the shape concern subscale, which is rated along a 7-point scale, ranging from 0 (*no days*) to 6 (*every day*). For the assessment of over-evaluation, the average score of two over-evaluation items (i.e., has your weight [shape] influenced how you feel about yourself as a person) was used, which are both rated on 7-point scale, ranging from 0 (*not at all*) to 6 (*markedly*). Single items from the EDE-Q to assess different components of body image have been used in numerous studies (e.g., Lydecker et al., 2017). The dependent variables selected also came from the EDE-Q. We chose the three dependent variables: (1) the dietary restraint subscale; (2) the eating concerns subscale; (3) and the frequency of any compensatory behaviour (i.e., vomiting, compulsive exercise, and diuretic use). The *dietary restraint* (e.g., "have you been deliberately trying to limit the amount of food you eat in order to influence your weight or shape" and "have you tried to exclude from your diet any foods that you like in order to influence your weight or shape") and *eating concern* (e.g., "has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in" and "have you had a definite fear of losing control over your eating") 5 items, each rated on a 7-point scale. Higher scores indicate greater levels of eating restraint and concerns.

#### 2.2.2. Depression Anxiety Stress Scale (DASS)

The 14-item DASS depression subscale was used (Henry & Crawford, 2005). Participants are asked to indicate the extent to which each statement applies to them in the previous week. Items are rated along a 4-point scale, ranging from 0 (*never*) to 4 (*almost always*) and are summed. Higher scores indicate a greater severity of depressive symptoms.

## 3. Results

### 3.1. Preliminary analyses

No data were missing for feeling fat, over-evaluation, dietary restraint, and eating concerns. A small amount of missing data were observed for depressive symptoms and compensatory behaviours (4.5%). These data were missing completely at random, as indicated by a little's MCARs test  $\chi^2(45) = 33.33, p = .901$  and were imputed using expectation maximisation techniques. We also observed four multivariate outliers, based on the Mahalanobis values. Consequently, as per recommendations (Tabachnick & Fidell, 2007), we excluded these four cases (three had BN and one AN) from the main analyses, resulting in a sample of 123 participants with AN and 51 participants with BN.

### 3.2. Descriptive statistics

Descriptive statistics of study variables are presented in Tables 1 and 2. In Table 1, norms derived from previous studies of non-clinical samples are presented and compared with scores obtained from the current sample. As seen, the present sample reported markedly higher levels of depressive symptoms, body image concerns, eating concerns, and dietary restraint than the norms obtained from non-clinical samples. Correlation coefficients between study variables are in Table 2. For participants with AN, feeling fat and over-evaluation were significantly and positively related to each other, as well as to depressive symptoms, dietary restraint, eating concerns, and compensatory behaviours. For participants with BN, feeling fat and over-evaluation was significantly and positively related to each other, as well as to depressive symp-

Download English Version:

<https://daneshyari.com/en/article/7263043>

Download Persian Version:

<https://daneshyari.com/article/7263043>

[Daneshyari.com](https://daneshyari.com)