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Negative affective experiences in relation to stages of eating disorder recovery

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ABSTRACT

The purpose of this study was to examine a collection of negative affect symptoms in relation to stages of eating disorder recovery. Depressive symptoms, anxiety symptoms, loneliness, and perceived stress are known to be present in individuals with eating disorders; however, less is known about the presence of such constructs throughout the recovery process. Does this negative affect fog continue to linger in individuals who have recovered from an eating disorder? Female participants seen at some point for an eating disorder at a primary care clinic were categorized into one of three groups using a stringent definition of eating disorder recovery based on physical, behavioral, and psychological criteria: active eating disorder ($n = 53$), partially recovered ($n = 15$; psychological criteria not met), and fully recovered ($n = 20$; all recovery criteria met). Additionally, data were obtained from 67 female controls who had no history of an eating disorder. Self-report data indicated that controls and women fully recovered from an eating disorder scored significantly lower than partially recovered and active eating disorder groups in perceived stress, depression, and anxiety. Controls and the fully recovered group were statistically indistinguishable from each other in these domains, as were the partially recovered and active eating disorder groups, suggesting an interesting divide depending on whether psychological criteria (e.g., normative levels of weight/shape concern) were met. In contrast, controls and fully recovered and partially recovered groups all reported feeling significantly less lonely relative to those with an active eating disorder suggesting that improved perceptions of interpersonal functioning and social support may act as a stepping stone toward more comprehensive eating disorder recovery. Future research may want to longitudinally determine if an increase in actual or perceived social support facilitates the movement toward full recovery and whether this, in turn, has salutatory effects on depression, anxiety, and perceived stress.

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1. Introduction

Negative affect has strong connections with disordered eating. From a theoretical standpoint, Heatherton and Baumeister (1991) propose that binge eating provides temporary relief from negative emotional distress that accompanies ego threats. Empirically, experience sampling methodology has found that the highest rates of binge eating and purging appear to occur on days characterized by stable high negative affect or increasing negative affect across the day (Crosby et al., 2009). Other research has found that negative affect, defined as the experience of subjected distress, predicts higher levels of restrained eating (Paa & Larson, 1998).

Given the role that negative affect may play in the development and maintenance of disordered eating and considering the historically poor treatment prognosis and high relapse rates among individuals diagnosed with eating disorders (Grilo et al., 2007; Steinhausen, 2002), a priority for researchers is to better understand the role of negative affective experiences in the process of recovery from an eating disorder. For example, individuals with a history of anorexia nervosa (AN) that appear weight-restored and outwardly recovered may be on the precipice of relapse if experiencing psychological distress, as this distress may have the potential to hamper therapeutic progress, motivation to continue recovery, and positive interpersonal interactions. Similarly, for those with a history of bulimia nervosa (BN) abstinence from maladaptive eating behaviors may discontinue under affective distress as such behaviors often serve as a method of coping with uncomfortable affect. Given that psychological distress may contribute to where one lands on the eating disorder recovery continuum and may be a barrier to ongoing progress toward recovery, it is important to better understand the affective experiences of women across recovery groups. This paper explores the self-reported negative affective experiences of depression, anxiety, loneliness, and perceived stress in relation to stages of eating disorder recovery.

Depression has been an extensively studied correlate of disordered eating. Multiple studies have found major depressive disorder to be a

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common comorbid diagnosis in individuals with eating disorders such that 50–75% of those with a lifetime history of an eating disorder also have a lifetime history of depression (APA Workgroup on Eating Disorders, 2006; Fernandez-Aranda et al., 2007; Fichter & Quadflieg, 2004). Depressive symptoms are related to self-criticism of weight and shape as well as overvaluation of weight and shape, highlighting how the negative, generalized thinking associated with depression may manifest within a body dissatisfied population (Dunkley & Grilo, 2007). Depressive symptoms have been found to prospectively predict both the onset and increases in binge eating in female adolescents and young women (Skinner, Haines, Austin, & Field, 2012; Spoor et al., 2006; Stice, Presnell, & Spangler, 2002). Depressive symptoms also appear to increase as a result of disordered eating as elements of eating disorders may promote feelings of shame and isolation (Skinner et al., 2012; Stice & Bearman, 2001; Stice, Hayward, Cameron, Killen, & Taylor, 2000). Further, shared genetic factors may contribute to the development of both eating disorders and depression, implicating genes as predisposing an individual to both disorders and partly explaining the relation between the two (Slane, Burt, & Klump, 2011; Wade, Bulik, Neale, & Kendler, 2000).

Individuals with comorbid eating disorder and major depression diagnoses were found to have poorer eating disorder outcomes, suggesting that depression may hamper recovery from an eating disorder (Berkman, Lohr, & Bulik, 2007; Lowe et al., 2001). Interestingly, multiple studies have found that depressive symptoms may reemerge in individuals with AN as weight is restored, suggesting that the initial steps toward recovery from AN (i.e., weight regain) may indeed generate negative affect (Holtkamp, Müller, Heussen, Remschmidt, & Herpertz-Dahlmann, 2005; Mischoulon et al., 2011; Wagner et al., 2006). Thus, it may be important to identify and understand the role of depressive symptoms in the process of recovery as the reemergence of depression may stymie recovery efforts.

Studies investigating the comorbidity of anxiety disorders and eating disorders have found that approximately two-thirds of individuals with AN or bulimia nervosa (BN) have had one or more lifetime anxiety disorders, with obsessive–compulsive disorder and social phobia being the most common (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). In terms of temporal ordering, many individuals with eating disorders report experiencing anxiety prior to the onset of the eating disorder (Bulik, Sullivan, Fear, & Joyce, 1997; Kaye et al., 2004). Additional research corroborates the finding that anxiety may precede, and indeed be a risk factor for, an eating disorder (Bulik et al., 1997; Godart et al., 2007). Anxiety symptoms not only emerge prior to the onset of an eating disorder, but may also persist after recovery. For example, one study found that women in long-term recovery (10 years) from adolescent-onset AN had higher rates of anxious and obsessive–compulsive features compared to controls (Holtkamp et al., 2005). A similar pattern emerges for those with a history of BN such that anxiety symptoms are still present after recovery (Kaye et al., 1998; Stein et al., 2002; von Ranson, Kaye, Weltzin, Rao, & Matsunaga, 1999). Finally, in line with the finding that depressive symptoms and disordered eating may share common genetic factors, Silberg and Bulik (2005) found that anxiety also shares a genetic liability with eating disorders.

Loneliness refers to the subjective, distressing feeling that one's social needs are unmet and is accompanied by an inner desire to feel more closely connected to others (Hawkley & Cacioppo, 2010). Multiple studies have emphasized the connection between loneliness and eating pathology. For instance, feeling lonely is related to increased body dissatisfaction and weight/shape concerns in both adolescents and college women (Pritchard & Yalch, 2009; Sinton et al., 2012). Some studies have shown that feelings of loneliness are particularly related to bulimic symptomology such that loneliness is associated with increased food consumption and the desire to binge, particularly in individuals vulnerable to binge eating (i.e., restrained eaters) (Rotenberg & Flood, 1999; Tuschen-Caffier & Vogele, 1999; Zeeck, Steizer, Linster, Joos, & Hartmann, 2011). These feelings of loneliness may emerge prior to disordered eating as adult women with current or past AN binge–purge subtype were more likely to retrospectively report feeling lonely during adolescence compared to control groups with no eating disorder history, and reported feelings of loneliness emerging prior to the onset of their eating disorder (Troop & Bifulco, 2002). Interestingly, Stewart (2004) concluded that feelings of loneliness and isolation may contribute to eating disorder relapse and called for additional research directly investigating levels of loneliness and the recurrence of eating disordered symptoms.

Perceived stress, or the extent to which a situation in one's life is deemed distressing, may place some individuals at greater risk for developing disordered eating patterns. Unlike objective assessments of life stressors, reports of perceived stress incorporate an individual's cognitive and emotional response to her environment (i.e., the situation is demanding and she believes she has inadequate resources to cope with the situation) (Cohen, Kamarck, & Mermelstein, 1983). Elevated levels of perceived stress have been found to precede the onset of binge eating disorder in females, suggesting that perceived stress may indeed be a risk factor for the onset, or potentially the reemergence, of eating disorder symptoms (Striegel-Moore et al., 2007). Emotional eating, conceptualized as eating in response to negative affect, was elevated in an ethnically diverse sample of adolescents who reported higher rates of perceived stress than their peers (Nguyen-Rodriguez, Unger, & Spruijt-Metz, 2009). Interestingly, perceived stress appeared to influence emotional eating in female adolescents but not males, implying that young women may be more susceptible to overeating in the presence of stress. Focusing on restrictive eating, women with a history of AN reported stressful life events as a primary perceived cause of the development of their eating disorder (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Further, one experimental paradigm found that when faced with a public speaking task, women with AN reported higher levels of stress and negative arousal than healthy controls although both groups showed similar heart rate and cortisol responses. This finding suggests that increased stress reported by those with eating disorders may stem from psychological rather than physiological factors (Zonnevylle-Bender et al., 2005).

In general, perceived stress may stimulate disordered eating behaviors, particularly in individuals at risk for developing an eating disorder (e.g., females with low self-esteem or perfectionistic tendencies) (Beukes, Walker, & Esterhuyse, 2010; Sassaroli & Ruggiero, 2005). Further, stress may not only act as a risk factor for disordered eating but may also be amplified as a result of an eating disorder, thus exacerbating the cycle between perceived stress and eating pathology (Ball & Lee, 2002; Rosen, Compas, & Tacy, 1993). For those with a history of disordered eating, the heightened experience of stress may continue past the active stage of the eating disorder. One study found that psychological reports of stress from partially and fully weight-restored individuals with a history of AN were similar to those with acute AN (Miller, Erickson, Branom, & Steiner, 2009). In women with a history of BN, those who had not engaged in maladaptive eating patterns for over a year reported elevated levels of reactivity to stress compared to healthy controls (Stein et al., 2002). Given the complex relations between stress and disordered eating, it is important to better understand perceptions of life stress particularly in relation to recovery from an eating disorder.

In sum, previous research suggests that negative affective experiences such as depression, anxiety, loneliness, and perceived stress are related to disordered eating. However, less is known in terms of these experiences and recovery from eating disorders, and, to our knowledge, no work has taken the approach of defining recovery comprehensively, including a psychological recovery component, and examining negative affective experiences in a continuous fashion. Indeed, the prior findings related to recovery must be tempered by the lack of a comprehensive, consensus definition of recovery (Bardone-Cone et al., 2010; Bardone-Cone, Sturm, Lawson, Robinson, & Smith, 2010). Further, although research indicates that negative affective experiences may put individuals at risk for eating disorder

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