

Core beliefs in dieters and eating disordered women

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Abstract

Objective: The current study aimed to investigate the difference in the levels of core beliefs between eating disordered women and those who showed milder forms of symptomatology.

Methods: Thirty-five eating disordered women, 16 symptomatic dieters, 39 normal dieters and 34 non-clinical comparison women completed questionnaires measuring eating symptomatology (Eating Disorders Inventory [EDI]), core beliefs (Young Schema Questionnaire [YSQ]), depression (The Beck Depression Inventory-II [BDI-II]) and self-esteem (Rosenberg Self-Esteem Inventory [RSE]).

Results: With the exception of Entitlement beliefs, there were significant differences in the levels of core beliefs across all four groups. In particular, symptomatic dieters and eating disordered women differed on 8 YSQ subscales despite showing very similar level of eating symptomatology.

Discussion: The current findings lend support to the discontinuity model that suggests that there are fundamental differences between women with a clinical eating disorder and those with milder eating psychopathology. The clinical and research implications of the present results were discussed.

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The eating disorders continuum model (e.g., Nylander, 1971; Roden, Silberstein, & Striegel-Moore, 1985; Stice, Killen, Hayward, & Taylor, 1998) has been a subject of debate in recent years. The model suggests that whilst individuals with a clinical eating disorder and those with milder forms of eating difficulties may differ significantly in the severity of their eating symptomatology, there are no qualitative differences in terms of underlying psychological characteristics between these groups. Tylka and Subich (1999) found that both neuroticism and internal dieting locus of control increase in a linear fashion with the degree of eating disturbances, hence providing support for the continuum model. In another study, both psychological variables (e.g., negative affect, alexithymia) and sociocultural variables (e.g., perceived pressure for thinness, internalization of the thin-ideal stereotype) were found to significantly associate with eating symptomatology (Tylka, 2002). Similarly, Lowe et al. (1996) found a linear increase on both measures of

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general psychopathology (as measured using the Derogatis Symptom Inventory — DSI; Derogatis, 1988) and eating-disorder-specific psychopathology (e.g., restraint and weight concern) in bulimics, current dieters, restrained non-dieters, and unrestrained non-dieters.

One important implication of the eating disorders continuum model is that, as there are only quantitative differences between eating-disordered and non-eating-disordered groups, individuals can move along the continuum depending on the severity of their eating disturbances. In other words, a normal dieter may potentially develop an eating disorder if the dieting behaviours get out of control. Dieting is generally accepted to be linked to the development of both anorexia nervosa (e.g., Crisp, 1980; Vitousek & Ewald, 1993) and bulimia nervosa (e.g., Cooper, Todd, & Wells, 2000; Stice, Mazotti, Krebs, & Martin, 1998). Some authors even propose that it is an essential predisposing factor in the development of an eating disorder (Gendall, Joyce, Sullivan, & Bulik, 1998). For example, a prospective study of schoolgirls found that dieting brought an eight-fold increase to the risk of developing an eating disorder at a later date (Patton, Johnson-Sabine, Wood, Mann, & Wakeling, 1990). The spiral model proposed by Heatherton and Polivy (1992), although not entirely supporting the continuum perspective, suggests that clinical eating disorders may result from repeated failure to diet due to an decrease in self-esteem and increase in negative affect.

However, other authors support the idea that, whilst dieting may be an important contributory factor in its development, an eating disorder is unlikely to be caused by dieting alone (e.g., Schmidt, Tiller, Hodes, & Treasure, 1995). This lends support to the discontinuity model (e.g., Ruderman & Besbeas, 1992) which makes the assumption that there are important basic differences between women with eating disorders and women who diet. For example, Polivy and Herman (1987) argue that whilst focus on weight, shape and appearance may be observed in dieters and women with an eating disorder, these two groups can be distinguished by perceptual and body image disturbances, ineffectiveness, reduced self-esteem and interpersonal distrust. Similarly, Williamson et al. (2002) found that eating disordered individuals are fundamentally different from obese individuals and normal weight control on fear of fatness and drive for thinness.

It has been argued that eating disorders are essentially cognitive disorders in which the main cognitive disturbance is manifested in a characteristic set of attitudes and values concerning body weight and shape (e.g., Fairburn, 1997). More recently, research has focused more on the role of underlying beliefs about the self (as opposed to weight- or shape-related cognitions) in eating disorders (e.g., Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997; Cooper & Hunt, 1998; Cooper & Turner, 2000; Leung, Waller, & Thomas 1999; Leung, Waller, & Thomas 2000; Waller, Ohanion, Meyer, & Osman, 2000). In order to further investigate the validity of the continuum versus the discontinuity model, it seems sensible to compare underlying core beliefs of eating disordered individuals with those mild eating disturbances. There has been some preliminary evidence to suggest that anorexic women show higher levels of negative self-belief than female dieters (Cooper & Turner, 2000), which suggest some fundamental differences in the cognitive content in these two groups.

There are two main limitations in the study by Cooper and Turner (2000) — first, the measure used was the Eating Disorder Belief Questionnaire (Cooper et al., 1997), which considers negative self-belief as a unitary measure and fails to investigate the multi-faceted nature of unhealthy cognitions. Second, the study regarded dieters as a homogenous group, and did not consider the severity of the dieting behaviours. Cooper and Fairburn (1992) have identified two distinct types of dieters, namely, the symptomatic and normal dieters. Symptomatic dieters are those individuals who show some disordered eating behaviours that resemble behavioural features of anorexia nervosa or bulimia nervosa. In contrast, normal dieters are those people who follow “a standard reducing diet and/or the setting of predetermined and rigid rules such as a definite calorie limit, pre-set quantities of food or rules about what should be eaten” (Cooper & Fairburn, 1992, pp. 502).

The aim of the present study was to compare the core beliefs and eating symptomatology in eating disordered women, symptomatic dieters, normal dieters and comparison women. It was hypothesised that there would be significant differences in both eating psychopathology and core beliefs amongst the groups.

1. Methods

1.1. Participants

The eating disordered group consisted of 35 women with a DSM-IV diagnosis of either anorexia nervosa ($N=16$) or bulimia nervosa ($N=19$) recruited from two tertiary specialist eating disorders services and a university student counselling service. These women were combined into one ‘eating-disordered’ group as previous research (e.g., Leung et al., 1999) has suggested that there is little difference between levels of core beliefs amongst clinical groups. The symptomatic dieters group consisted of 16 women dieters who also showed some disordered eating behaviours that

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