

Mood, eating attitudes, and anger in obese women with and without Binge Eating Disorder

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Abstract

Objective: The aim of this study was to evaluate the anger levels and their management in obese patients. **Methods:** A total of 103 obese women [51 with Binge Eating Disorder (BED) and 52 without BED] were included in the study and compared to 93 healthy controls. They were assessed with the State–Trait Anger Expression Inventory (STAXI), Beck Depression Inventory (BDI), and Eating Disorder Inventory-2 (EDI-2). **Results:** The BDI score is higher in obese subjects than in controls and obese binge eaters have higher levels of depression than obese patients without BED. Differences among the three groups can be found in almost all subscales of the EDI-2, even after controlling for the variable depression (BDI). For STAXI, the only difference among the three groups, which remains significant after controlling for

depression, is the tendency to express anger outside (AX-OUT), which is higher in obese binge eaters. The correlation study highlights the importance of impulsivity in the group of obese binge eaters, whereas in obese patients without BED, the tendency toward anger suppression (AX-IN) is seen. **Discussion:** Obese patients with BED might be considered a subgroup deserving greater psychiatric interest, both for the greater severity of the eating disorder and for the comorbidity with subthreshold depressive symptoms and with borderline personality traits. In obese patients without BED, eating behavior seems more correlated to the psychological functioning typical of psychosomatic disorders. Implications for treatment are discussed. © 2003 Elsevier Inc. All rights reserved.

Keywords: Anger; Obesity; BED; Psychosomatic disorders; Borderline personality

Introduction

Obesity is a chronic disorder, with a high prevalence in Western society [1] and a complex etiology, representing a serious risk for the health implications it entails (e.g., diabetes mellitus, hypertension, heart disease, etc.) and severely compromising the psychosocial functioning and quality of life of patients suffering from it [2].

Obesity is not included in the DSM-IV categorization of eating disorders (EDs) (American Psychiatric Association,

APA) [3]; therefore, the current diagnosis of obesity is made according to a single clinical criterion suggested by recent clinical guidelines developed by the National Heart, Lung and Blood Institute. A body mass index (BMI; kg/m²) between 25 and 29.9 defines “overweight,” and a BMI higher than 30 defines obesity [4]. Moreover, a BMI of 30–34.9 is classified as Class I obesity, 35–39.9 as Class II obesity, and 40 or higher as Class III or extreme obesity [4].

Even though obesity is not considered an ED per se, it is characterized by some psychological features common to EDs, including impulsivity and low self-esteem [5,6], body dissatisfaction [7], perfectionistic attitude [8], and disinhibition [5]. Other authors have highlighted an association between a higher body weight and symptoms of borderline personality [9].

With more detailed investigations in the last decade, the opinion that two distinct and specific subgroups of obese

Abbreviations: BED, Binge Eating Disorder; EDs, Eating disorders; EDI-2, Eating Disorder Inventory-2; STAXI, State–Trait Anger Expression Inventory; BDI, Beck Depression Inventory; BMI, body mass index

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patients exist has gathered proponents [10,11]: obese binge eaters (nonpurging) and nonbinge eaters. Binge-eating obese individuals exhibit significantly more eating and weight-related pathology, as well as more severe psychopathology than obese individuals who do not binge eat [12,13]. Particularly, binge eaters show higher levels of depression [14]. However, some authors consider it difficult to understand whether these psychopathologic correlates are a cause or a consequence of overeating [15]. Moreover, the psychopathology level does not seem related to weight [16].

In EDs, aggressiveness and anger are relevant psychopathologic core features [17] because they can influence course and treatment outcome [18–20]. Some authors have demonstrated that in EDs, correlations exist among severity of disturbed eating patterns, low degrees of self-assertiveness, high levels of self-directed hostility [21], and difficulty in expressing anger [22,23]. Moreover, in these disorders, impulsive actions can be correlated with difficulties in expressing anger [17,24,25].

Although some psychological and psychopathologic elements have been investigated in obesity, only a few studies have dealt with anger management in obese patients. The study of aggressiveness and anger in EDs has shown interesting results and has long been a peculiar research area of psychosomatic medicine [26]; anger proved to play an important role in severe medical conditions as hypertension [27,28], infarct [29], visceral fat tissue [30], and cardiovascular reactivity during interpersonal conflict [31]. The prevalence of such conditions is high in obesity [32].

In this study, anger has not been studied as a unitary construct, but in its multifaceted nature, according to the conceptualization of Spielberger [33]. This author has stressed the importance of considering anger both as an emotional state and as a trait. State–anger is a changeable emotional condition, including feelings ranging from tension to fury, which are usually accompanied by the activation of the autonomic nervous system. Trait–anger depends on the individual's predisposition toward anger experiences. Individuals with a high trait–anger experience state–anger more frequently and more intensely than those with a low trait–anger.

Moreover, Spielberger stresses the fact that individuals are very different in the way they express anger; anger can be directed and addressed to other people or things (outside), or it can be turned inside, where it is suppressed and restrained [33].

The aim of this study was to evaluate the mood, eating attitudes, and anger in obese subjects and in a nonclinical control group, thus testing the hypothesis that obese binge eaters and nonbinge eaters are two distinct subgroups.

Secondarily, a correlation study will be performed to determine whether an association exists among the aforesaid anger expression levels and modalities, mood state, and the eating-related psychopathology and overweight.

Methods

Subjects

The 103 obese patients were recruited from the 185 overweight patients who applied (spontaneously applied without advertisement or referred cases) to the Eating Disorder Pilot Center of the Psychiatric Clinic of the University of Turin from November 1999 to May 2001. Fifty-one (49.5%) of these patients matched the APA 1994 DSM-IV criteria for Binge Eating Disorder (BED group); the other 52 (50.5%) did not (non-BED group). None of the patients involved in the study had a history of vomiting. Ninety-three women were recruited for the control group (Con). All the patients included in the study were women, aged 20–60 years, with a BMI ≥ 30 .

A total of 82 patients applied to the center but were excluded for the following reasons: (a) age out of the established ranges ($n=15$); (b) BMI ranging from 27.3 to 30 ($n=10$); (c) overweight caused by pharmacologic treatments or secondary to already diagnosed or suspected metabolic or endocrine disorders (involving the systems responsible for the control of appetite and metabolism; $n=15$); (d) comorbidity of a full syndrome Axis I disorder ($n=40$), including mood ($n=18$), anxiety ($n=4$), and other ($n=2$) disorders; (e) comorbidity of another ED ($n=16$), specifically bulimia nervosa ($n=10$) and ED not otherwise specified ($n=6$).

Such an approach was chosen to avoid the excessive heterogeneity of the sample in a preliminary study and because anger levels can be influenced by Axis I disorders [33].

Diagnostic assessment for Axis I disorders was carried out with the support of the Structured Clinical Interview for DSM-IV (SCID-I/P) [34]. A psychiatrist and a dietitian performed a screening interview with each subject, lasting about an hour, to evaluate the possibility of inclusion in the study.

The control group ($n=93$) was recruited from a non-clinical population of subjects matching those of the clinical groups in age and educational and socioeconomic levels. Control subjects were randomly recruited by phone among the population living in Turin and surrounding districts, until their number was enough for the study aims. The age range was the same as that of the clinical group. The SCID-NP [34] was used for the exclusion of psychiatric disorders in this group.

The selected subjects were administered tests to assess eating habits [Eating Disorder Inventory-2 (EDI-2), Eating Disorder Inventory—Symptom Checklist (EDI-SC)] and anger [State–Trait Anger Expression Inventory (STAXI) and Beck Depression Inventory (BDI)]. None of the subjects participating in the study had ever taken these tests. None of the patients was treated with psychotropic drugs or with psychotherapy at baseline. None of the patients was following a controlled dietetic regimen at baseline. All

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