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Alexithymia and its relationships with body checking and body image in a non-clinical female sample

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Abstract

The aim of the present study was to evaluate in a non-clinical sample of undergraduate women, the relationships between alexithymia, body checking and body image, identifying predictive factors associated with the possible risk of developing an Eating Disorder (ED). The Toronto Alexithymia Scale (TAS-20), Body Checking Questionnaire (BCQ), Eating Attitudes Test (EAT-26), Body Shape Questionnaire (BSQ), Interaction Anxiousness Scale (IAS), Rosenberg Self-Esteem Scale (RSES) and the Beck Depression Inventory (BDI) were completed by 254 undergraduate females. We found that alexithymics had more consistent body checking behaviors and higher body dissatisfaction than nonalexithymics. In addition, alexithymics also reported a higher potential risk for ED (higher scores on EAT-26) when compared to nonalexithymics. Difficulty in identifying and describing feelings subscales of TAS-20, Overall appearance and Specific Body Parts subscales of BCQ as well as lower self-esteem was associated with higher ED risk in a linear regression analysis. Thus, a combination of alexithymia, low self-esteem, body checking behaviors and body dissatisfaction may be a risk factor for symptoms of ED at least in a non-clinical sample of university women.
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Keywords: Alexithymia; Body checking; Body image; Eating disorders; Emotions

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1. Introduction

It is widely recognized that the body dissatisfaction and an excessive concern about body weight and shape are core characteristic of Eating Disorders (ED) and are used to determine self-worth (Fairburn, Cooper, & Shafran, 2003; Garner, Olmstead, Polivy, & Garfinkel, 1984). Recently, there was an increased interest about the body image as a multidimensional issue that involves perceptual, attitudinal and behavioral characteristics (Cash & Henry, 1995; Ehrsson, Kito, Sadato, Passingham, & Naito, 2005; Williamson, 1990, 1996). Many researchers have focused their attention mainly to the perceptual and attitudinal aspects of body image whereas only few studies have investigated the behavioral consequences related to a negative body image (Reas, Whisenhunt, Netemeyer, & Williamson, 2002). Patients with or at risk of ED often have a negative perception of several body parts; in some cases, they avoid social situations that may point out their physical appearance and exert a ritualistic checking on their body weight and shape (Reas et al., 2002; Toro, Gila, Castro, Pombo, & Guete, 2005). The body checking could be considered somewhat similar to compulsive behaviors; through this checking patients are often able to avoid the anxiety that derives from negative concerns about their body weight and shape (Rosen, 1997; Williamson, 1990). Examples of body checking are the repetitive measure of body weight, the frequent exposures at mirror in order to verify possible body shape changes, the use of particular clothes that can "measure" the fatness or the thinness, the pinching of several body parts to verify their consistence, the comparison with other people about the own body weight and shape, the checking to see if thighs rub together and many more (Fairburn et al., 2003; Reas et al., 2002).

On the other hand, in ED patients, paradoxically, the body checking may reinforce the body dissatisfaction focusing further attention on concerns related to a negative body image (Fairburn, 1997). Fairburn, Shafran, and Cooper (1999) have pointed out the rule of the "body control" in the clinical evolution of anorexia. The body control and checking are used to monitor the body weight and shape changes, but increase the perceived imperfections and may lead to a higher body weight control. As consequence, a hypervigilant body control preserves the negative beliefs about presumed abnormal body shape. Moreover, they have hypothesized that the normal variations of body weight may be directly related to mood swings in ED patients. Since the body control and checking may play a role in the development and maintenance of an ED, the evaluation of the body checking behaviors may be useful in therapeutic programs aimed to help patients with ED (Bowers, 2000; Garner & Garfinkel, 1997). In fact, as clinical observations indicate that body checking increase both the patient's preoccupation with body shape and weight and the motivation to maintain dietary restraint, a therapeutic program aimed to reducing body checking may contribute to reduce body dissatisfaction and, consequently, ED symptoms (Shafran, Fairburn, Robinson, & Lask, 2004).

Furthermore, it is reasonable to think that individuals with anorexia nervosa and bulimia nervosa develop a highly organized cognitive schema concerning body- and weight-related information (Williamson, Muller, Reas, & Thaw, 1999). Body checking behaviors, like social scanning, may be both positively and negatively reinforced and strengthen the concerns about body size and shape as well as food and eating. Body checking rituals are used to regulate emotions through confirmation or attenuation of fears (and are therefore negatively reinforced), whereas in many circumstances the checking behaviors reinforce disordered patterns of behavior when the ritual results in an unfavourable or negative perception (Williamson, White, York-Crowe, & Stewart, 2004).

Coined by Sifneos (1973), the term "alexithymia" was introduced to designate a cluster of cognitive and affective characteristics that were observed among patients with psychosomatic diseases. The alexithymia construct, formulated from clinical investigations, is multifaceted and includes four distinct characteristics: (a) difficulty in identifying and describing feelings, (b) difficulty in distinguishing feelings from the bodily sensations, (c) diminution of fantasy, and (d) concrete and poorly introspective thinking (Taylor, Bagby, & Parker, 1991). Alexithymic individuals have affective dysregulation, the inability to self soothe and manage emotions because of a lack of awareness of emotions (Taylor, Bagby, & Parker, 1997). Thus, the adaptive informational value of emotions that is important for emotion regulation often eludes these individuals.

In non-clinical samples, the prevalence of alexithymia ranges from 0% to 28% (Guilbaud et al., 2002; Jimerson, Wolfe, Franko, Covino, & Sifneos, 1994). An increasing body of research indicates that alexithymia features exist not only in classic psychosomatic disorders but also in other severe and chronic somatic diseases and psychiatric disorders such as Somatoform Disorders, Major Depression and other Axis I disorders (Bankier, Aigner, & Back, 2001; De Berardis et al., 2005).

Concerning EDs, Bruch (1973) suggested that the difficulty to distinguish and describe feelings is one of the main problems in ED patients, related to a sense of general inadequacy and a lack of control over one's life. Moreover, Bruch

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