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Distress tolerance in the eating disorders

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Abstract

Objective: It is commonly noted that patients with eating disorders have difficulties in regulating emotional states. This construct is similar to the concept of distress tolerance, which has been identified as a problem in patients with impulsive disorders. However, the elements that make up distress tolerance are not clearly delineated, making it difficult to target treatment in relevant cases. This study aimed to develop a measure of distress tolerance, and to validate it clinically with the eating disorders.
Method: The sample consisted of 72 women with DSM-IV eating disorder diagnoses, and 62 women with no history of eating disorders. Each completed a newly developed measure of distress tolerance (the Distress Tolerance Scale; DTS) and the Eating Disorders Inventory.
Results: The DTS was made up of three scales, each with acceptable psychometric properties. Two of those scales differentiated the groups — the clinical women showed higher levels of 'Avoidance of affect', while the non-clinical women had higher scores in the 'Accept and manage' scale. Avoidance of affect was positively associated with unhealthy eating attitudes.
Conclusions: It is important to examine both maladaptive and adaptive means of coping with affect in the eating disorders. Treatment strategies for modification of distress tolerance should address both the reduction of avoidance and the development of emotional management skills. Further research is needed to determine whether these findings are relevant to the presence of other impulsive behaviours in the eating disorders.

Keywords: Eating disorder; Emotional regulation; Distress tolerance; Avoidance

Distress tolerance is the ability to endure and accept negative affect, so that problem-solving can take place (Linehan, 1993). Poor distress tolerance manifests as high emotional vulnerability and an inability to regulate emotion, and has been identified as a feature of individuals with borderline personality disorder and other impulsive features. Linehan (1993) has developed a form of cognitive-behaviour therapy (dialectical behaviour therapy; DBT) to address such cases, based on the recognition of their emotion regulation difficulties. DBT focuses on improving skills in areas such as mindfulness, as well as distress tolerance.

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Many clinical accounts conclude that eating disorder symptoms are associated with emotional dysfunction (e.g., Abraham & Beumont, 1982; Fairburn, 1997; Fairburn, Cooper, & Shafran, 2003; Lacey, 1986). There is now substantial empirical support for a direct and immediate link between emotional states and eating behaviour (e.g., Agras & Telch, 1998; Grilo, Shiffman, & Carter-Campbell, 1994; Meyer, Waller, & Waters, 1998; Rieger et al., 1998). Anger, anxiety, depression, loneliness and happiness are particularly important triggers and maintaining factors (e.g., Arnow, Kenardy, & Agras, 1992; Grace, Jacobson, & Fullager, 1985; Johnson & Larson, 1982; Katzman & Wolchik, 1984; Patton, 1992). Functional links have been proposed between emotional states and both bulimic and restrictive pathology. Bingeing has been linked with the blocking of negative affect (e.g., Heatherton & Baumeister, 1991; Lacey, 1986; McManus & Waller, 1995). In contrast, restrictive eating patterns have been linked with alexithymia (Christie, Watkins, & Lask, 2000; de Zwann, Biener, Bach, Wienagrotzki, & Stacher, 1996; Johnsson, Smith, & Amner, 2001; Nkam, Langlois-Thery, Dollfus, & Petit, 1997) — a construct that includes a narrowing of emotional functioning, flattening of affect, lack of outward display of emotion, and difficulties in the identification of emotions. Thus, there is substantial evidence that patients with eating disorders experience difficulties in coping with affect in an adaptive way, and one can hypothesize that the construct of distress tolerance (Linehan, 1993) is a potentially important one in the eating disorders.

The concept of distress tolerance suggests an additional therapeutic target in individuals who struggle to contain their emotions during treatment. Preliminary findings suggest promising results for DBT – including a distress tolerance module – in the treatment of both bulimia nervosa and binge eating disorder (Safer, Lively, Telch, & Agras, 2001, 2002). However, while there is substantial evidence regarding the behavioural outcomes of poor distress tolerance (e.g., binge eating, self-harm, restrictive eating, dissociation), it is also necessary to understand the nature of the distress tolerance difficulties in order to target treatment before the level of the behavioural responses. At present, there is little understanding of the maladaptive ways in which eating-disordered patients cope with affect, thus making it difficult to target therapy in a way that facilitates more adaptive coping with emotions (distress tolerance).

Therefore, this study has the aim of developing and validating a self-report measure of distress tolerance, in order to identify the nature of those difficulties in the eating disorders. It was hypothesized that those with eating disorders would be more likely to avoid emotional arousal (emotional avoidance), and that they would be less likely to face and resolve emotional states (emotional problem-solving).

1. Method

1.1. Participants

The participants consisted of both non-clinical and clinical (eating-disordered) women.

1.1.1. Non-clinical group

This group consisted of 62 female participants. They were recruited from undergraduate and graduate populations at a British university. The group was well matched to the clinical sample for age and body mass index (BMI = weight [kg]/height $[m]^2$). They were asked for self-reported height and weight, yielding a subjective BMI.

1.1.2. Eating-disordered group

The clinical group consisted of 72 women who met DSM-IV criteria (American Psychiatric Association, 1994) for a diagnosis of anorexia nervosa ($N=19$), bulimia nervosa ($N=25$) or Eating Disorder Not Otherwise Specified (EDNOS; $N=28$, including three who met criteria for binge eating disorder). One male anorexic patient who was recruited in the same period was excluded from the analysis. They were recruited from a specialist eating disorders service at assessment. All were diagnosed at assessment by trained clinicians, using a semi-structured clinical interview. The interview used is not a published one, but addresses DSM-IV criteria for diagnosis. It assesses: restrictive eating and weight loss patterns; current and past presence and frequency of objective bingeing episodes; purging behaviours (laxative abuse, diuretic abuse and vomiting); compensatory behaviours (restriction and exercise); menstrual function (including potential interfering