



Ego-syntonicity and ego-dystonicity of eating-related intrusive thoughts in patients with eating disorders



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ABSTRACT

The main objective of the present study was to analyse the role of the ego-dystonicity and ego-syntonicity of eating disorder intrusive thoughts (EDITs) in the genesis and maintenance of eating disorders (EDs). Participants were 98 female patients with EDs, 56 Spanish and 42 English (27.19 ± 9.59 years; body mass index (BMI): 18.72 ± 2.87). All of them completed the eating attitudes test, the Eating Attitudes Test, the Eating Intrusive Thoughts Inventory, the Ego-Dystonicity Questionnaire-Reduced version, and the Ego-Syntonicity Questionnaire. Patients indicated that their EDITs were rational and also undesirable and immoral, suggesting that EDITs are not fully ego-syntonic or ego-dystonic. Multivariate analysis of variance (MANOVA) indicated no differences in ego-syntonicity and ego-dystonicity across ED subtypes. Path analyses were performed to investigate the mediating role of the EDITs' ego-syntonicity and ego-dystonicity in their interference, dysfunctional appraisals and control strategies. They showed, first, that the more interference an EDIT caused, the more ego-syntonic and the less ego-dystonic it was and, second, that when the EDITs were assessed as ego-syntonic, patients tried to do what they indicated, whereas when they were assessed as ego-dystonic, patients made efforts to neutralise them. Clinical implications for the conceptualisation and treatment of ED are discussed.

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1. Introduction

One of the most intriguing characteristics of many individuals with eating disorders (EDs), especially those suffering from anorexia nervosa (AN), is the positive value they attach to their efforts to maintain symptoms such as their underweight and thinness under control (Vitousek et al., 1998). This is even true when they experience bothersome symptoms such as dizziness, hunger or concentration difficulties, since these symptoms are interpreted as a positive sign of control over their desired weight and thinness. This vicious cycle is considered a key point in the maintenance of EDs (Fairburn et al., 1999; Schmidt and Treasure, 2006) and it reveals a dysfunctional identification of patients with their disorder. For Bulik and Kendler (2000, p. 1757), a chronic ED patient's assertion that "a life without an eating disorder would be a life without an identity" exemplifies this dysfunctional identification. The ego-syntonicity of many ED patients with their symptoms makes them ambivalent and reluctant to undergo treatment (e.g., Vandereycken, 2006). In the context of self-determination theory, Mansour et al. (2012) demonstrate that,

in bulimic patients, lower post-treatment scores on measures of eating preoccupations (shape, weight and eating concerns) were predicted by high autonomous motivation at pre-treatment. These results indicate the importance of increasing efforts to enhance motivation for treatment (Treasure and Schmidt, 2001; Vitousek et al., 1998) and relapse prevention.

Nonetheless, some other ED symptoms are experienced as quite unpleasant and far from ego-syntonic, motivating the search for treatment (Garfinkel and Garner, 1982). The unwanted and repetitive intrusive thoughts, images and/or impulses about eating-related contents, or eating disorder intrusive thoughts (EDITs), frequently experienced by the vast majority of ED patients, are examples of symptoms that patients could value as negative. The intrusive nature and high frequency of the EDITs make them unpleasant, and patients can feel overwhelmed by their inability to keep them under control and by their interference in their daily activities (Fairburn, 2008; Woolrich et al., 2008). In addition, EDITs fit the characterisation of an ego-dystonic thought formulated by Purdon et al. (2007, p. 200) as "one that is perceived as having little or no context within one's own sense of self or personality. That is, the thought is perceived, at least initially, as occurring outside the context of one's morals, attitudes, beliefs, preferences, past behaviour and/or one's expectations about the kinds of thoughts one would or should experience."

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However, EDITs might also be ego-syntonic if ED patients interpret them as a motivating reminder of their valued goal, such as achieving a thin figure. Shafran et al. (2003) point out that the way patients interpret their symptoms determines how positively or negatively they value them. For example, feeling cold might be valued as positive because it can be interpreted as direct evidence of their control over their weight or thinness. The dual nature of some ED symptoms, ego-dystonic and also ego-syntonic, suggests that ego-dystonicity and ego-syntonicity are not the opposite ends of one unique dimension. Belloch et al. (2012), using a revised version of the Ego-Dystonicity Questionnaire from Purdon et al. (2007), found that, although related, ego-dystonicity and ego-syntonicity are best conceived as two separate dimensions in the case of both EDITs and unwanted intrusive thoughts with contents analogous to clinical obsessions.

In sum, ED symptoms may not always be considered ego-syntonic by ED patients. In the Yale–Brown–Cornell Eating Disorder Scale, Mazure et al. (1994) included two additional items that evaluated the ego-syntonicity/ego-dystonicity (consistency/inconsistency with their personality) of preoccupations and rituals. In a study of 40 women with an ED diagnosis, these authors found that more than half rated their eating-related preoccupations (28 women) and rituals (25 women) as ego-syntonic, whereas 10 women rated their preoccupations as ego-dystonic and 6 others rated their rituals in this way. Similar results were also found in recovered ED patients and restrained-eating control subjects (Sunday and Halmi, 2000).

The objective of this study is to examine in a group of women with ED to what extent the EDITs they experience are ego-dystonic or ego-syntonic, taking into account the subtype of the disorder. In addition, the mediating role of the ego-dystonicity and ego-syntonicity associated with the EDITs will be investigated with regard to the interference caused by the EDIT, the dysfunctional appraisals that this thought raises and the strategies used by the subjects to keep the thought under control.

2. Method

2.1. Participants

Ninety-eight women with an ED diagnosis (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR); *American Psychiatric Association*, 2000) participated in the study. Of them, 56 were recruited in the outpatient mental health clinic Dr. Peset Hospital (Valencia, Spain), which is included in the Spanish National Health System, while 42 were from the Eating Disorders Unit at Guy's Hospital in London (England). The total ED sample was distributed across ED subtypes as follows: 24 patients with anorexia nervosa restricting (ANR), 12 patients with anorexia nervosa purging (ANP), 16 patients with bulimia nervosa purging (BNP), 32 patients with eating disorder non-specified-restricting (EDNOS-R) and 14 patients with eating disorder non-specified-purging (EDNOS-P). Patients were diagnosed by means of the Structured Clinical Interview for DSM-IV (SCID-I).

The mean age was 27.19 years (S.D.=9.59, range=14–58) and the body mass index (BMI) was $M = 18.72$ (S.D.=2.87, range=12.58–27.43). The majority of the sample participants were single (75.5%), with a medium socioeconomic level (68.9%) and university studies (61.3%). All the patients had an ED as their main Axis I diagnosis, and up to 50% of the patients had a co-morbid diagnosis. Regarding Axis I co-morbidity, patients presented the following diagnoses: 14 major depression, 5 dysthymia, 4 adjustment disorder, 3 panic disorder, 1 generalised anxiety disorder, 3 anxiety disorder non-specified, 1 substance abuse and 1 posttraumatic stress disorder. Regarding Axis II co-morbidity, the personality disorder diagnoses were: 5 obsessive–compulsive, 4 histrionic, 3 borderline, 2 dependent, 2 avoidant, 1 antisocial and 4 non-specified. Co-morbidity was assessed with the SCID-I for Axis I disorders and the SCID-II for personality disorder co-morbidity. At the time of the assessment, patients were receiving Cognitive Behavioural Therapy (CBT) treatment in an outpatient resource.

2.2. Measures

Eating Attitudes Test (EAT-26; Garner and Garfinkel, 1979). This is a self-report instrument that assesses attitudes and behaviours related to ED across three

subscales: dieting, bulimia and oral control. The total score measures ED symptom severity. Each item is scored on a six-point Likert scale from 'always' to 'never'. The Spanish version (Castro et al., 1991) has shown good internal consistency in the present sample ($\alpha=0.82$).

Eating Intrusive Thoughts Inventory (Inventario de Pensamientos Intrusos Alimentarios, INPIAS; Perpiñá et al., 2011). This self-report questionnaire has two parts. Part 1 evaluates the frequency (from 0="I have never had this thought" to 6="I have this thought frequently during the day") with which 50 unwanted eating disorder-related intrusive thoughts, images and impulses (EDITs), related to dieting, body appearance and the need to do exercise, are experienced. The EDITs are grouped into three factors: appearance and dieting, exercising, and purging and disordered eating. In Part 2 participants were required to select from the previous list the single most upsetting EDIT they had experienced at least once (score=1) during the last 3 months. Then, the respondents evaluated this EDIT from 0='absolutely nothing' to 4='extremely' on the emotional consequences for having it (five items: unpleasantness, anxiety, sadness, guilt and shame), interference and control difficulties caused by the thought (three items: control difficulty, control ability and interference with concentration) and the appraisals the subject ascribes to the thought (eight items: thought over-importance, worry thought will come true, thought unacceptability, responsibility, overestimation of threat, over-importance of thought control, thought-action fusion likelihood and thought-action fusion morality). Next, participants were presented with a list of 22-thought control and/or neutralising strategies, and they were asked to rate (from 0=never to 4=always) to what extent they use each of these strategies to deal with the most upsetting EDIT chosen earlier. These control strategies are grouped into four factors (anxiety control strategies, thought suppression, obsessive–compulsive disorder (OCD) rituals and distraction) as well as two items ('do nothing' and 'do what the thought tells me'). In the current study, the internal consistency was as follows: Part 1 – total score $\alpha=0.96$; Part 2 (emotional consequences, interference, and appraisals) – $\alpha=0.75$; Part 2 (control strategies) – $\alpha=0.73$.

Ego-Dystonicity Questionnaire-Reduced Version (EDQ-r, Belloch et al., 2012). This self-report was originally designed by Purdon et al. (2007). After its adaptation to Spanish samples, it was reduced to 27 items, with a six-point Likert scale from 0=completely disagree to 5=completely agree. Items are grouped into three factors: undesirability of thought and rejection of it coming true, irrationality and incoherence with personality and immorality and/or inconsistency of thought with morals or ethics. Scores ≥ 2.5 indicate that the respondents 'agree somewhat' with the factor content. The internal consistency in the study was satisfactory for the total score ($\alpha=0.86$) and the three factors (undesirability: $\alpha=0.92$; irrationality: $\alpha=0.82$; immorality: $\alpha=0.70$).

Ego-Syntonicity Questionnaire-ESQ (Cuestionario de Egosintonía, CES; Belloch et al., 2012). This self-report includes 27 items with the opposite meanings and the same six-point Likert response scale as the EDQ-r. Again, items were grouped into three factors: desirability of thought, rationality and coherence with personality, and morality/consistency of thought with moral/ethics. For the study sample, the internal consistency was satisfactory for the total score ($\alpha=0.87$) and the three factors (desirability: $\alpha=0.93$; rationality: $\alpha=0.80$; morality: $\alpha=0.73$).

Both the EDQ-r and ESQ were completed focussing on the most unpleasant EDIT chosen from the INPIAS part one.

2.3. Procedure and statistical analyses

Participants were volunteers; before completing the questionnaires, they signed an informed consent form and data on their weight and height were collected. All the patients were interviewed by one of the authors (M.R.). To be included in the study, patients had to be able to read and understand written instructions. Statistical analyses were performed using Statistical Package for the Social Sciences (SPSS v.18; SPSS Inc., Chicago, IL, USA) and EQS (Structural Equation Modeling Software) v 6.1 (Bentler, 2006) for path analyses. A multivariate analysis of variance (MANOVA) was carried out to compare groups on ego-syntonicity/dystonicity factors and total scores. To analyse a hypothetical mediation of variables, path analyses were performed following the maximum likelihood method (Mardia's coefficient). The Bentler and Bonnet (1980) criteria were followed for the fit indices: comparative fit index (CFI), goodness-of-fit index (GFI), root mean-square error of approximation (RMSEA) and the Akaike Information Criterion (AIC) to compare models. Following the recommendations of several authors (Hu and Bentler, 1995; Kaplan, 2000; Marsh et al., 1996), the following criteria were used to indicate the fit of the models: CFI and GFI > 0.90 and RMSEA < 0.08 . Values for the CFI and GFI can range from zero to unity. The CFI expresses the fit of a model compared to the so-called null model. The null model establishes the absence of relationships among the manifest variables. The GFI measures the proportion of variance–covariance accounted for by the proposed model. The RMSEA penalises models that are not parsimonious, and it is sensitive to misspecified factor covariances. The AIC was used to compare models. Lower values indicate a better fit, and values closer to zero indicate that the model is more parsimonious.

The study received the approval of the Dr. Peset Hospital and King's College (PNM/09/10–13) ethics committees.

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