PERGAMON

Behaviour Research and Therapy 41 (2003) 887–894

BEHAVIOUR RESEARCH AND THERAPY

www.elsevier.com/locate/brat

The interpretation of symptoms of severe dietary restraint

R. Shafran [a,*], C.G. Fairburn [a], L. Nelson [a], P.H. Robinson [b]

[a] *Department of Psychiatry, Oxford University, Warneford Hospital, Oxford OX3 7JX, UK*
[b] *Department of Psychiatry, Royal Free Hampstead NHS Trust, London NW3 2QG, UK*

Accepted 29 June 2002

Abstract

A recent cognitive-behavioural theory of eating disorders proposes that people with eating disorders interpret symptoms of dietary restraint in terms of control. The primary aim of the present study was to test this hypothesis. A second aim was to test the hypothesis derived from clinical observation that people with eating disorders view these symptoms positively. Forty-four participants meeting DSM-IV criteria for a clinical eating disorder and 80 control participants with no history of an eating disorder completed an ambiguous scenario paradigm and self-report measures of eating disorder features and depression. Patients with eating disorders were significantly more likely to interpret symptoms of dietary control in terms of control, providing support for the cognitive-behavioural theory. There was only partial support for the second hypothesis. The implications for the new cognitive-behavioural theory and therapy are discussed.

Keywords: Eating disorders; Cognitive-behavioural; Empirical; Control; Starvation

1. Introduction

A cognitive-behavioural theory of anorexia nervosa has recently been proposed (Fairburn, Shafran, & Cooper, 1999). This theory suggests that an extreme need to control eating is a central feature of the disorder, and that three mechanisms operate to maintain the dietary restriction. One of these maintaining mechanisms concerns the person's interpretation of certain symptoms of starvation that result from significant weight loss. Such symptoms include abnormal attitudes and behaviour towards food and eating (e.g., preoccupation with food and eating, ritualistic eating), poor emotional and social functioning (e.g., mood liability), impaired cognitive performance (e.g., poor concentration), and physiological changes (e.g., heightened satiety) (Keys, Brozek, Henschel,

* Corresponding author. Fax: +44-1865-226-244.
E-mail address: roz.shafran@psych.ox.ac.uk (R. Shafran).

0005-7967/03/$ - see front matter © 2003 Elsevier Science Ltd. All rights reserved.
doi:10.1016/S0005-7967(02)00101-8

Mickelsen, & Taylor, 1950). Many such symptoms are not specific to starvation but are also features of dietary restraint. The theory suggests that certain of these symptoms promote further dietary restraint by undermining the person's sense of being in control of their eating, shape, weight or themselves in general, and that other aspects exaggerate these people's tendency to use control over eating as an index of self-control in general.

Some of the symptoms of dietary restraint are objectively unpleasant (e.g., dizziness, hunger). Nevertheless, it is apparent clinically that some patients positively value them. Such patients seem to interpret the symptoms as a sign of being in control and as evidence that they are striving towards or achieving their goal of controlling eating, shape or weight. Although not specified in the original theory of anorexia nervosa (Fairburn et al., 1999), interpreting such symptoms as a positive sign of being in control may contribute to the maintenance of the disorder.

These hypotheses and predictions derived from the cognitive-behavioural theory of anorexia nervosa are also likely to apply to patients with bulimia nervosa and many of those with atypical eating disorders. This is for two reasons. First, as mentioned previously, many of the symptoms described are not specific to starvation but are also characteristic of attempts to restrict eating (e.g., preoccupation with food). The great majority of patients with bulimia nervosa attempt to severely restrict their food intake (Fairburn, 1997; Russell, 1979) and the same is true of many patients with atypical eating disorders (Fairburn & Walsh, 2002) who are therefore, also likely to experience these symptoms. Second, such is the overlap between the different eating disorders in terms of their clinical features and their course over time (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000), it can be argued that many of the maintaining mechanisms implicated in the maintenance of bulimia nervosa (Fairburn, 1997) and anorexia nervosa (Fairburn et al., 1999) apply across the eating disorders (Fairburn, Cooper, & Shafran, in press).

The primary aim of the present study was to test the prediction that certain symptoms of dietary restraint are interpreted by patients with eating disorders in terms of control. A second aim was to test the clinically derived hypothesis that some patients with eating disorders value these symptoms and interpret them positively. The two hypotheses were tested using an adaptation of the ambiguous scenarios paradigm (Butler & Mathews, 1983; Cooper, 1997).

2. Method

2.1. Participants

Forty-four women (mean age = 28.4; SD = 9.8) meeting DSM-IV criteria (American Psychiatric Association, 1994) for a clinical eating disorder, participated in this study. All the patients were consecutive referrals receiving treatment for their eating disorder from eating disorder services at the Royal Free Hospital in London or the University Department of Psychiatry in Oxford who agreed to participate. Ten participants met diagnostic criteria for anorexia nervosa (mean BMI = 16.6; SD = 0.8), 12 met criteria for bulimia nervosa (mean BMI = 24.2; SD = 6.2) and 21 met criteria for an atypical eating disorder (AED; mean BMI = 23.0; SD = 7.3). The psychosocial functioning of the patients with atypical eating disorders was significantly impaired in every case and their subscale scores on the measure of eating disorder psychopathology (see later), were in the clinical range and at similar levels to the other clinical participants.