



Self-harm history predicts resistance to inpatient treatment of body shape aversion in women with eating disorders: The role of negative affect



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ABSTRACT

Although self-harm has been observed among patients with eating disorders, the effects of such tendencies on treatment outcomes are unclear. The current study employed structural equation modeling to (a) evaluate the relationship between self-harm and changes in body dissatisfaction and drive for thinness in a large sample of patients ($n = 2061$) who underwent inpatient treatment, and (b) to examine whether the relationship between self-harm and changes in body dissatisfaction and drive for thinness during inpatient treatment remains significant when controlling for change in negative affect during treatment. Results revealed that patients with a history of self-harm reported significantly less reduction in body dissatisfaction and drive for thinness following treatment. Patients experiencing less change in negative affect also reported significantly less reduction in body dissatisfaction and drive for thinness after discharge from treatment. However, the association between history of self-harm and reduction in body dissatisfaction and drive for thinness after treatment became non-significant when controlling for change in negative affect. This pattern of findings was also replicated among patients with a primary diagnosis of anorexia nervosa ($n = 845$), bulimia nervosa ($n = 565$), and eating disorder not otherwise specified ($n = 651$). The implications of these findings for delineating the specific role of self-harm in the nature and treatment of eating disorders are discussed.

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1. Introduction

Eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN) are characterized by disturbed patterns of eating behavior, extreme weight regulation, preoccupation with body weight and shape, and a distorted body image (American Psychiatric Association, 2013). Although eating disorders may not be highly prevalent in the general population (e.g., 0.5% and 1.0% for AN and BN, respectively; 0.9% and 1.5% among women; Hudson et al., 2007), reported rates may be due to current stringent criteria (e.g., frequency of binge episodes, Wilson and Sysko, 2009). In fact, most individuals with pathological eating behaviors fall in the eating disorder not otherwise specified (EDNOS) category

(Fairburn and Bohn, 2005), suggesting needed changes to the existing diagnostic criteria. Eating disorders are associated with severe health detriments including renal and gastrointestinal complications, electrolyte imbalance, and cardiovascular problems among other issues (Mehler et al., 2004). Further, approximately 4.0%, 3.9%, and 5.2% of cases associated with AN, BN, and EDNOS, respectively, result in death due to medical complication and suicide (Crow et al., 2009).

Eating disorders are also associated with self-harm which may reflect broader deficiencies in effective coping (e.g., Dingemans et al., 2007; Woodside et al., 2004). Self-harm is defined in various ways in the literature and various terms are used to label self-harm, including self-injurious behavior, intentional self-injury, nonsuicidal self-injury, and self-mutilation. Self-harm, broadly defined, is the intentional injuring of one's own body without apparent suicidal intent (Pattison and Kahan, 1983). Self-harm occurs in various forms, including cutting, branding or burning, picking at skin or reopening wounds, pulling hair, hitting or

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punching, and head banging (Nock, 2008; Skegg, 2005). Research has found high rates of self-harm among patients with eating disorders (Solano et al., 2005; Peebles et al., 2011; Claes et al., 2001), and recent research has emphasized the importance of targeting self-harm tendencies in the context of eating disorder treatment (Fischer and Peterson, 2015). Research has also shown that self-harm is even more common among patients with binge/purging symptoms (Peebles et al., 2011; Stein et al., 2004) who employ multiple purging methods (Stein et al., 2004).

Drive for thinness and body dissatisfaction represent significant risk factors for disordered eating (Dobmeyer and Stein, 2003; Stice et al., 2011). Drive for thinness consists of an excessive concern with dieting, preoccupation with weight, and fear of weight gain whereas body dissatisfaction involves not being satisfied with one's physical appearance (Garner, 1991). A growing body of research suggests that drive for thinness and body dissatisfaction may represent core endophenotypes of eating disorders (Keski-Rahkonen et al., 2005). Drive for thinness and body dissatisfaction have also been linked to self-harm (see Kostro et al., 2014 for review). For example, research has shown that body dissatisfaction is associated with higher rates of suicide attempts in adolescent boys and girls (Crow et al., 2008). A subsequent study also found that those who engage in self-harm display significantly more eating pathology than those who do not, including increased body dissatisfaction and bulimic tendencies. These findings suggest that body dissatisfaction and drive for thinness may also represent significant risk factors for engagement in self-harm.

Although a mechanism that may account for the link between self-harm and body dissatisfaction and drive for thinness has not been clearly delineated, the broader literature suggests that individuals that engage in self-harm may do so primarily to regulate emotions and communicate distress (Young et al., 2014). This is consistent with the view that self-harm among some eating disorder patients is maintained by social reinforcement (Nock, 2008). That is, self-harm may represent a high intensity social signal that is employed when less intense communication strategies fail (e.g., speaking, yelling, crying). Patients with eating disorders may also engage in self-harm in response to extreme and intolerable emotional reactivity and as a result of deficits in social problem-solving skills (Nock and Prinstein, 2005). Such deficits among patients with eating disorders may be partially mediated by difficulties with impulse control and goal directed behavior (Slee et al., 2008). Problems with impulse control and goal directed behavior among those with a history of self-harm may then manifest in other areas of functioning, including relationships with a partner and with other family members, employment, alcohol, and finances (Haw and Hawton, 2008). These perspectives appear to point to an emotion regulation function of self-harm in the eating disorders that may paradoxically evoke more negative emotion (Harrison et al., 2010).

Consistent with an emotion regulation function of self-harm, recent research has shown that patients with eating disorders report significantly higher levels of emotion intensity, lower acceptance of emotions, less emotional awareness and clarity, more self-reported emotion regulation problems, as well as decreased use of functional and increased use of dysfunctional emotion regulation strategies when compared to healthy controls (Svaldi et al., 2012). Self-harm may represent one of many dysfunctional strategies employed to regulate negative affect among eating disorder patients (Muehlenkamp et al., 2012). Although self-injury has been shown to quickly alleviate emotional distress in the short term among patients with eating disorders (Claes et al., 2010), research has also shown that those who engage in self-harm experience greater difficulties regulating their emotions (Ross et al., 2009) which may interfere with effective treatment.

Although the existing literature would suggest that self-harm may be associated with less favorable treatment outcome (Slee et al., 2008), this hypothesis has not been directly examined. In examining the unique association between self-harm and treatment outcome among patients with eating disorders, it is crucial to rule out the effects of negative affect. Indeed, self-harm may be associated with less favorable treatment outcomes among patients with eating disorders only due to its association with negative affect (Brown et al., 2007; Clarkin et al., 1983; Haw et al., 2001). For example, research has found that self-harm is associated with higher levels of depressive and anxiety symptoms (Muehlenkamp et al., 2012; Ross et al., 2009; Solano et al., 2005). Research has also shown that adolescent and adult self-harmers experience more negative emotions than those who do not self-harm (Fliege et al., 2009). Furthermore, negative affect has been linked to poor treatment outcome among patients with eating disorders (Keel and Mitchell, 1997; Rosenvinge and Moulund, 1990; Swift et al., 1985).

The present study examined the relationship between self-harm and change in body dissatisfaction and drive for thinness after inpatient treatment. It was predicted that patients with a history of self-harm would report significantly less eating disorder symptom and negative affect reduction after treatment. Given research showing that negative affect is a critical maintenance mechanism of eating disorder symptoms (Engel et al., 2013), the relationship between self-harm and change in eating disorder symptoms after treatment when controlling for changes in negative affect over the course of treatment was also examined. It was predicted that the relationship between self-harm and change in eating disorder symptoms would be (partially) accounted for by changes in negative affect.

2. Method

2.1. Participants

The present sample consisted of 2061 female inpatients from the Remuda Ranch Programs for Eating Disorders who met *DSM-IV TR* (APA, 2000) criteria for a principal eating disorder diagnosis (i.e., anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified). The total number of primary eating disorder diagnoses and comorbid diagnosis across all participants appears in Table 1.

The mean age of the sample was 23.08 years ($SD = 8.54$), with a range of 13–62 years. The ethnic composition of the sample was as follows: Caucasian ($n = 1895$; 91.9%), Hispanic ($n = 39$; 1.9%),

Table 1
Frequency of eating disorder diagnoses and comorbid conditions among study participants ($N = 2061$).

Diagnoses	<i>n</i>	%
<i>Primary Eating Disorder Diagnoses</i>		
Anorexia Nervosa	845	41.0
Bulimia Nervosa	565	27.5
Eating Disorder NOS	651	31.6
<i>Comorbid Diagnoses</i>		
Major depressive disorder	1122	54.4
Dysthymic disorder	163	7.9
Depressive disorder NOS	508	24.8
Post-traumatic stress disorder	289	14.0
Generalized anxiety disorder	815	39.5
Social phobia	242	11.7
Obsessive-compulsive disorder	438	21.3
Anxiety NOS	742	36.1
ADHD	240	11.6
Any Substance abuse/dependence	407	19.7

Note. ADHD = attention-deficit/hyperactivity disorder; NOS = not otherwise specified.

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