



# The influence of eating psychopathology on autobiographical memory specificity and social problem-solving



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## ABSTRACT

The primary aim was to examine the influence of subclinical disordered eating on autobiographical memory specificity (AMS) and social problem solving (SPS). A further aim was to establish if AMS mediated the relationship between eating psychopathology and SPS. A non-clinical sample of 52 females completed the autobiographical memory test (AMT), where they were asked to retrieve specific memories of events from their past in response to cue words, and the means-end problem-solving task (MEPS), where they were asked to generate means of solving a series of social problems. Participants also completed the Eating Disorders Inventory (EDI) and Hospital Anxiety and Depression Scale. After controlling for mood, high scores on the EDI subscales, particularly Drive-for-Thinness, were associated with the retrieval of fewer specific and a greater proportion of categorical memories on the AMT and with the generation of fewer and less effective means on the MEPS. Memory specificity fully mediated the relationship between eating psychopathology and SPS. These findings have implications for individuals exhibiting high levels of disordered eating, as poor AMS and SPS are likely to impact negatively on their psychological wellbeing and everyday social functioning and could represent a risk factor for the development of clinically significant eating disorders.

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## 1. Introduction

Autobiographical memory (AM) refers to the recollection of personally experienced events from the past. This aspect of memory is central to an individual's experience of the self and is vital for successful goal attainment (Conway and Pleydell-Pearce, 2000). There is convincing evidence that information in autobiographical memory is organised hierarchically, with general representations of events leading to more specific and detailed representations. This relates to an important element of goal pursuit, the ability to retrieve memories in sufficient detail for the task in hand. There is considerable evidence, using word cuing paradigms like the autobiographical memory test (AMT; Williams and Broadbent, 1986), that patients with depression and individuals who have experienced significant trauma exhibit impaired access to specific representations of personal events (see Williams et al. (2007) for a review). For example, if presented with the cue word "Party", these individuals would be more likely to respond with a

general memory "I used to enjoy parties when I was younger" rather than a specific event "I went to Emily's birthday party in February". In addition to the findings of impaired autobiographical memory specificity in patients with clinical depression there is a growing body of evidence (e.g. Dalgleish et al., 2007; Dickson and Bates, 2006; Goddard et al., 1997; Ramponi et al., 2004) demonstrating similar deficits in participants with subclinical depression (referred to as dysphoria). Some studies have also reported a negative relationship between AMS and measures of depression severity (e.g. Dalgleish et al., 2007; Drummond et al., 2006, Johannessen and Berntsen, 2009; Kaviani et al., 2011). Further evidence of the influence of mood on memory specificity comes from a study conducted by Yeung et al. (2006) that demonstrated impaired memory specificity in never-depressed participants following a negative mood induction. The decrease in AMS correlated with the reduction of self-rated happiness following the negative mood induction. Taken together there is clear evidence that mood, particularly depression, influences memory specificity. However, this tendency does not generalise to anxiety, as there is no evidence of AMS deficits in patients with generalised anxiety disorder (Burke and Mathews, 1992; Wessel et al., 2001) or in non-clinical participants with high trait anxiety (Richards and Whittaker,

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Although it is clear that not all psychiatric disorders are associated with deficits in autobiographical memory retrieval there is emerging evidence that individuals with eating disorders (ED) demonstrate reduced AMS. For example, [Dalgleish et al. \(2003\)](#) assessed a mixed sample of patients with anorexia nervosa (AN) and bulimia nervosa (BN) on the AMT and reported that, in comparison to a healthy control group, the patients with ED recalled fewer specific memories. This finding has subsequently been replicated in homogenous samples of patients with AN ([Bomba et al., 2014](#); [Nandrino, et al., 2006](#); [Kovacs et al., 2011](#)) and BN ([Laberg and Andersson, 2004](#)). It is important to note that these findings were independent of the influence of depression on memory specificity. [Laberg and Andersson \(2004\)](#) also reported that the AMS deficit was evident in patients that were in remission from their ED. This is consistent with the evidence that poor AMS persists in remitted depressed patients ([Mackinger et al., 2000a, 2000b](#); [Williams and Dritschel, 1988](#)). Reduced AMS has also been reported in non-clinical participants who might be considered 'at risk' of developing an eating disorder. For example, [Johannessen and Berntsen \(2009\)](#) demonstrated in two studies that participants who were currently dieting exhibited impaired memory specificity in comparison to non-dieters. Similarly, [Ball et al. \(2010\)](#) reported that individuals scoring high on the concern-with-dieting subscale of the restraint scale ([Herman et al., 1978](#)) exhibited impaired retrieval of specific memories on the AMT. However, in contrast to [Johannessen and Berntsen \(2009\)](#) they did not find a specificity difference between dieters and non-dieters. In line with [Ball et al. \(2010\)](#), it could be argued that this is because long-term restraint is the key factor and not short-term dieting status. Support for this proposal comes from studies reporting that, regardless of dieting status, overweight and obese participants report higher levels of restraint than do individuals with a normal weight ([Bohrer et al., 2015](#); [van Strien et al., 2007](#)). Another potential explanation concerns the influence of depression. AMS was negatively correlated with depression in study 1 of [Johannessen and Berntsen \(2009\)](#) and, although this relationship was not significant in study 2, the obese participants in that study did report significantly higher levels of depression than did the participants with normal weight, suggesting that the deficits in AMS might be a consequence of depression rather than dieting status. As [Ball et al. \(2010\)](#) did not assess depression in their sample it is not possible to confirm if this factor could explain their findings, but it is plausible, given that restraint is associated with body dissatisfaction ([van Strien et al., 2007](#)), which in turn, is associated with depression ([Espelage et al., 2003](#)). The current study aimed to establish if, after controlling for the effects of depression, participants reporting subclinical levels of eating psychopathology would exhibit deficits in autobiographical memory retrieval.

As noted by [Dalgleish et al. \(2007\)](#) impaired autobiographical memory specificity (AMS) is more than a mere cognitive curiosity; rather, it appears to be closely linked to processes relating directly to the onset, maintenance and recovery from a number of psychopathological conditions. For example, the overgeneral memory style is related to the persistence of symptoms in depressed patients ([Brittlebank et al., 1993](#); [Dalgleish et al., 2001](#); [Peeters et al., 2002](#); see [Sumner et al. \(2010\)](#) for a meta-analysis). Poor autobiographical memory specificity (AMS) also predicts negative mood in non-depressed participants in response to challenging life events ([Gibbs and Rude, 2004](#); [Mackinger et al. 2000a, 2000b](#); [van Minnen et al., 2005](#)) and has been shown to moderate the impact of daily hassles on depression, such that chronic life stress had a greater impact on the mood of individuals with poorer memory specificity ([Anderson et al., 2010](#)). Evidence has also demonstrated that AMS is negatively related to feelings of hopelessness ([Arie et al., 2008](#); [Kaviani et al., 2011](#)), which in turn is a significant

predictor of suicide and parasuicidal behaviour ([Victor and Klonsky, 2014](#)). With this in mind, evidence of reduced AMS in subclinical disordered eating would be important, as it might represent a risk factor for the development of clinical eating disorders. For example, overgeneral memory increases vulnerability for depression, which in turn is a risk factor for eating disorders ([Heron et al., 2014](#); [Hudson et al., 2007](#); [Stice, 2002](#)), possibly by mediating the relationship between body dissatisfaction and eating disorders ([Brechan and Kvalem, 2015](#); [Heywood and McCabe, 2006](#)).

In addition to the negative impact on mood, deficits in AMS are associated with impaired social problem solving ([Evans et al., 1992](#)). [Goddard et al. \(1996\)](#) assessed clinically depressed patients on the AMT and the means-end problem solving task (MEPS; [Platt and Spivack, 1975](#)). During the MEPS participants are presented with hypothetical social scenarios and asked to generate means of getting from the initial state (e.g. you realise you best friend is not talking to you) to an end goal state (you and your friend are talking again). The number of valid means generated and the effectiveness of these means (experimenter rated) are taken as an indication of the quality of social problem solving. [Goddard et al. \(1996\)](#) reported that depressed patients generated fewer, and less effective, means on the MEPS than did healthy controls. Importantly, this deficit was more evident in patients with reduced AMS on the AMT. The authors also highlighted that retrieval of categorical memories during the MEPS was particularly detrimental to social problem solving. These findings have been replicated in other samples of clinically depressed patients ([Raes et al., 2005](#)), bipolar patients ([Scott et al., 2000](#)) and participants with subclinical depression ([Goddard et al., 1997](#)). Importantly, it has been shown that autobiographical memory specificity mediates the relationship between negative mood and problem-solving performance ([Williams et al., 2005](#)). Further evidence of the link between autobiographical memory specificity and social problem solving comes from studies 4 and 5 of [Williams et al. \(2006\)](#), which demonstrated that directly manipulating participant's memory specificity impacted on their performance on the MEPS.

There is evidence that eating disorders are also associated with impaired social problem-solving. For example, [Grissett and Norvell \(1992\)](#) reported that patients with bulimia self-reported problems in social situations (on the Social Competence Scale; [Sarason et al., 1986](#)) and were rated, by independent observers (blind to their group membership), as less effective in a social context than were healthy controls. [Holt and Espelage \(2002\)](#) utilised a measure, the Anorexia and Bulimia Problem-solving Inventory (ABPI; [Espelage et al., 2000](#)), that was specifically designed to assess problem-solving in an eating disorders context and reported that participants indicating significant eating psychopathology on the EAT inventory exhibited less effective social problem solving than did healthy controls. This was particularly evident in scenarios relating to eating, weight, and interpersonal relationships. More recently, [Swanson et al. \(2010\)](#) reported that patients with AN exhibited maladaptive problem solving skills on the social problem solving inventory revised (SPSI-R; [D'Zurilla and Maydeu-Olivares, 1995](#)). Thus far, research into social problem solving in eating disorders has relied on self-report measures such as the SPSI-R. However, there is a need to examine social functioning in participants with disordered eating using objective measures of social problem solving, such as the MEPS. Therefore, this study represents the first attempt to conduct such an investigation. This has important implications because poor social functioning in participants with subclinical disordered eating could act as an indirect risk factor for the development of clinical eating disorders by undermining social support ([Ghaderi and Scott, 2001](#); [McClintock and Evans, 2001](#); [Sharpe et al. 2014](#); [Stice, 2002](#)).

To date, memory specificity and social problem solving have

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