Regional update

A pilot study of body image perceptions, and attitudes toward obesity in hospitalized psychotic and non-psychotic patients

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ABSTRACT

Objective: Body image perceptions, and attitudes toward obesity were examined and compared between psychotic and non-psychotic patients with a mood disorder.

Methods: 80 psychotic patients and 36 non-psychotic patients with a mood disorder admitted to an acute inpatient psychiatric unit participated in the study. On admission, each patient completed a visual silhouettes scale of actual self and ideal self, as well as the Attitudes Toward Obese Persons (ATOP) scale.

Results: Analogous to the general population, psychotic and non-psychotic patients had similar body image perceptions, and experienced discrepancy between actual and ideal body image. Female patients with serious mental illness (SMI) picked a heavier actual self body image, and experienced greater discrepancy between actual and ideal body image compared to male patients with SMI. Psychotic and non-psychotic patients experienced similar modest neutral attitudes toward obese persons, however there was a trend for depressed patients to have more negative attitudes toward obese persons compared to non-depressed patients.

Discussion: The presence of an acute psychotic episode did not affect body perceptions, or obesity attitudes; however depressed patients had more negative obesity attitudes. Similar to the general population, females with SMI overassessed their body size, and experienced more body dissatisfaction compared to males with SMI.

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1. Introduction

Obesity is an epidemic in patients with serious mental illness (SMI), and affects up to 60% of patients with schizophrenia, 57.8% with major depressive disorder (MDD), and 68% with bipolar disorder (Hert et al., 2011). Obesity is thought to be secondary to the interaction of genetic and environmental factors, unhealthy lifestyles, mental illness, and psychotropic medications (Cash, 1994; Muth and Cash, 1997). Body image also plays an important role in the etiology and treatment of obesity but has been poorly studied in psychiatric populations (Cash, 1994; Muth and Cash, 1997). Body image is a multidimensional construct that encompasses perceptions about body size, emotions and cognitions about physical appearance as well as behaviors to control body shape and appearance (Cash, 1994; Muth and Cash, 1997). According to the self-discrepancy theory, larger discrepancies between actual and ideal body size perceptions results in greater body dissatisfaction, which is a both precursor for weight loss, as well as psychological distress and unhealthy eating habits (Garrusi et al., 2013). As a diverse construct, actual and ideal body perceptions are influenced by socioeconomic, cultural, demographic, and gender variables as well as psychological functioning.

Even though the research has been limited, observational studies have noted that patients with psychosis experience body disturbances (Chapman et al., 1978). Psychotic patients have reported experiencing body disintegration, disembodiment, and abnormal thoughts about bodily sensations secondary to multisensory processing dysfunction (Priebe and Rohrricht, 2001). Early studies estimated that between 15 and 31 percent of patients with schizophrenia spectrum disorders experience body image aberrations and configural processing deficits, which may affect the accurate perception of actual and ideal body size (Chapman et al., 2016).

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patients with psychosis commonly underestimate or overestimate various body parts (Cleveland 1960; Priebe and Rohricht, 2001). Additionally, the presence of a depressive episode may distort body perceptions, and furthermore depressed patients experience greater body dissatisfaction compared to psychotic patients (Priebe and Rohricht, 2001). A preliminary study reported that patients with schizophrenia, schizoaffective disorder, and depression had similar head and trunk size perceptions; however patients with schizophrenia and schizoaffective disorder underestimated the size of their legs (Priebe and Rohricht, 2001). To date, no studies have examined whole body perceptions in a hospitalized heterogeneous psychiatric population. Given the obesity epidemic, understanding body perceptions and discrepancies, which can influence weight related behaviors, is important especially during acute hospitalization, where medical complications of obesity are often addressed.

In addition, attitudinal biases toward obesity influence weight related behaviors. The Attitudes Toward Obese Persons (ATOP) scale is commonly administered in research and clinical settings to measure explicit obesity attitudes; a lower score reflects more negative attitudes toward obesity, and is strongly associated with a belief that weight is under the control of the individual (Feister, 2012). However, negative obesity attitudes do not consistently result in weight loss, and are instead associated with a lack of motivation to lose weight. Additionally, internalization of negative obesity attitudes may distort actual and ideal body perceptions, increase unhealthy eating behaviors, reduce physical activity, and exacerbate weight gain (Durso and Latner, 2008; Switaj et al., 2009; Puhl and Heuer, 2010). To our knowledge, no studies have examined explicit obesity attitudes in psychiatric populations. Accordingly, it is reasonable to infer that stigmatizing attitudes toward obesity maybe a barrier to weight management, and implementing interventions to reduce negative obesity attitudes in the inpatient psychiatric setting could be one promising strategy to address the obesity epidemic.

The aim of this pilot study is to examine and compare actual self and ideal self body image perceptions as well as explicit obesity attitudes in acutely psychotic patients and non-psychotic patients with a mood disorder on admission to an inpatient psychiatric unit. Using a factorial Analysis of Covariance (ANCOVA), we will examine the main and interaction effects of psychosis, and other variables that may influence body perceptions and obesity attitudes such as mood, race, and gender while controlling for the body mass index (BMI). The hypothesis is that psychotic patients will have distorted body image perceptions, not experience discrepancies between actual and ideal body image, and hold negative attitudes toward obesity compared to non-psychotic patients with a mood disorder, which may pose a barrier to weight management.

2. Methods

The Institutional Review Board (IRB) approved the protocol.

2.1. Participants

In 2011, consecutive consenting patients admitted to an acute inpatient psychiatric unit were recruited. The treating clinician diagnosed psychiatric disorders based on Diagnostic and Statistical Manual-IV Text Revision criteria.

2.2. Inclusion criteria

Psychotic disorder or mood disorder without psychosis; able and willing to consent.

2.3. Exclusion criteria

Intellectual disability; drug intoxication or withdrawal; eating disorders; any major medical disorder such as cancer, and endocrinopathies.

2.4. The figure rating scale

The Figure Rating Scale (FRS), developed by Stunkard and colleagues, consists of 2 rows of images (Stunkard et al., 1983). One row consists of male images and the other female images. Each row has nine silhouettes of increasing size from 1 (very thin) to 9 (very obese) (Stunkard et al., 1983). Studies have classified these silhouettes into underweight BMI (silhouette 1 and 2), normal BMI (silhouette 3 and 4), overweight BMI (silhouette 5 through 7), and obese BMI (silhouette 8 and 9) (Bhuiyan et al., 2003; Lynch et al., 2009). On admission, each patient selected a silhouette that represented actual self body image and ideal self body image. Actual self body image is the number of the figure selected by participants in response to the prompt: “choose the figure that reflects how you think you look.” Ideal self body image is the number of the figure chosen in response to the prompt: “choose your ideal figure.”

2.5. Attitudes toward obese persons scale

Explicit obesity attitudes were measured with the ATOP scale. The ATOP scale is a 20-item questionnaire, which measures attitudes toward obesity. Patients rate the degree of agreement or disagreement to a specific question, ranging from +3 (strongly agree) to –3 (strongly disagree), and scores range from 0 to 120. Higher scores represent more positive attitudes toward obesity; scores below 60 represent more negative obesity attitudes, and scores above 60 represent more neutral to positive obesity attitudes. The ATOP scale has internal reliability in adult populations, and has an alpha reliability of 0.80–0.84 (Allison et al., 1991; Puhl et al., 2010; Boss 2015).

2.6. Statistical analysis

All statistical analysis was calculated using IBM SPSS software. P was set at <0.05, two tailed.

A four- way ANCOVA was conducted to determine the influence of four independent variables, psychosis (psychotic, non-psychotic with a mood disorder), mood (depression, no depression), gender (female, male), and race (African American, Caucasian) on acutal self body image, ideal self body image, body image discrepancy (actual-ideal body image), and the ATOP scale while controlling for BMI.

3. Results

3.1. Sociodemographic and BMI data

Table 1 describes the BMI, and sociodemographic and psychiatric information for the entire sample. The index group consisted of 80 patients with a psychotic disorder and the comparison group consisted of 36 patients with a non-psychotic mood disorder (see Table 1). The psychotic group consisted of patients admitted for an acute exacerbation of psychotic symptoms, mostly positive symptoms in the context of non-adherence with psychotropic medications. The non-psychotic group consisted of patients admitted for worsening mood symptoms, primarily depression accompanied with suicidal ideations. Patients were prescribed various antipsychotics and anti-depressants but prior to admission were not compliant with these
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