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Examining the Role of Self-Discrepancy and Self-Directed Style in Bulimia Nervosa

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Abstract

Two of the primary components within Integrative Cognitive Affective Therapy (ICAT) are self-discrepancy and self-directed style. Self-discrepancy includes both actual:ideal (discrepancy between oneself and who one wishes they were) and actual:ought (discrepancy between oneself and who one believes they ought to be). Self-directed style in ICAT refers to a variety of behaviors emitted by a person toward the self including self-blaming and self-affirming. This study explored main effects and interactions between self-discrepancy and self-directed style in relation to global eating disorder (ED) psychopathology, depressive symptoms, and anxiety. Eighty treatment-seeking adults from the Midwest with BN or subthreshold BN completed interviews and self-report measures. Self-affirm and self-blame were associated with ED psychopathology, depressive symptoms, and anxiety. Actual:ideal discrepancy was related to anxiety and actual:ought discrepancy was related to anxiety and depression. Interactions were found between self-affirm and actual:ought discrepancy as well as self-blame and actual:ought discrepancy and depressive symptoms. High actual:ought was related to increased depressive symptoms regardless of levels of self-affirm and self-blame. Effect sizes for models were medium-to-large with anxiety models demonstrating the largest effects. This study provides further evidence supporting the ICAT model and treatment, which targets self-discrepancies, self-directed styles, and related emotional states.

Keywords

bulimia nervosa; self-discrepancy; self-directed style; integrative cognitive affective therapy

1. Introduction

Integrative Cognitive-Affective Therapy (ICAT) is a recently developed treatment for bulimia nervosa (BN; Wonderlich et al., 2015) that has been shown to be efficacious in treating BN (Wonderlich et al., 2014). Two of the primary components within the onset and momentary maintenance models of ICAT-BN are self-discrepancy (also referred to as self-evaluation) and self-directed style (also referred to as self-regulation) (Wonderlich et al., 2015). The onset and momentary maintenance models of ICAT-BN highlight the role of self-discrepancy and maladaptive self-directed styles in the development and maintenance of BN and associated psychopathology. Self-discrepancy refers to the extent to which a person believes there is a discrepancy between who they are and who they wish they were (i.e., actual:ideal discrepancy) or who they should be (i.e., actual:ought discrepancy) (Higgins, 1989). Self-directed style refers to how one thinks, feels, and behaves toward oneself (Benjamin, 1974). For example, self-blaming includes tendencies to act in a blaming and critical way toward oneself, whereas self-affirming includes tendencies to act in a compassionate way toward oneself. Guided by the ICAT-BN model, which specifies self-discrepancies and self-directed style as core processes, this study sought to clarify the role of these constructs in relation to eating disorder (ED) psychopathology and other co-occurring forms of psychopathology (i.e., depression and anxiety).

Existing evidence suggests that, compared to controls, individuals with BN display greater self-discrepancies, increased self-blame, and less affirming self-directed styles (Wonderlich et al., 2008). Further, self-discrepancies, including actual:ideal and actual:ought, are related to eating disorder (ED) psychopathology (Strauman et al., 1991) and depression and anxiety (Higgins et al., 1986; Wonderlich et al., 2008). Individuals with self-discrepancies related to body shape or weight may develop negative body-related cognitions, motivating behavioral efforts to achieve the ideal or ought attributes (e.g., by engaging in disordered and restrictive eating patterns). Similarly, maladaptive self-directed styles are associated with ED psychopathology (Pinksavage et al., 2015) and negative mood states (Martin and Dahlen, 2005; Wonderlich et al., 2008). In terms of self-directed styles, individuals high in self-blaming may assume personal responsibility for stress and negative events that occur (Janoff-Bulman, 1979), which may put them at risk for depression (Abramson and Sackheim, 1977) and shame (Watson et al., 2014). Conversely, self-affirming styles may promote better affect regulation and adaptive coping. For example, compassion toward oneself is related to improved psychological well-being, calmness in reaction to stress, and increased connectedness (Neff et al., 2007).

The onset and maintenance models of ICAT-BN hypothesize associations among self-discrepancy, maladaptive self-directed styles, and bulimic and other psychopathological symptoms. Of note, although not explicitly stated within the models, there may be interactions between self-discrepancy and self-directed style predicting mood and eating disorder (ED) psychopathology. For example, a blaming style may be more maladaptive for those with greater self-discrepancies (e.g., a tendency for self-blame following failures to meet extreme actual or ideal standards may result in greater ED psychopathology). Conversely, an affirming style may be protective for those higher in self-discrepancies (e.g.,

individuals who tend to be more self-affirming may be more compassionate about their inability to achieve extreme standards, resulting in lower ED psychopathology). Consistent with this type of interactional relationship, a number of studies have found that coping styles moderate the association between ED risk factors (i.e., social comparison, stress, and perfectionism) and ED psychopathology and negative affect (Hewitt et al., 1995; MacNeil et al., 2012; Pinksavage et al., 2015; Wichianson et al., 2009).

Based on the ICAT theoretical models, the current study explored (a) main effects of self-discrepancy and self-directed style in relation to global ED psychopathology, and (b) interactions between self-discrepancy and self-directed style in relation to global ED psychopathology. Global ED psychopathology was conceptualized as reflecting the broad range of ED symptoms, including both cognitive and behavioral. In addition, this study explored main effects of self-discrepancy and self-directed style and interactions between self-discrepancy and self-directed style in relation to co-occurring psychopathology relevant to the ICAT model, namely anxiety and depressive symptoms. Figure 1 depicts the empirical model examined in this study.

2. Method

2.1 Participants and procedure

Eighty treatment-seeking adults enrolled in a randomized clinical trial for treatment of BN (90% were women) at two sites in the Midwestern United States completed interviews and self-report measures. The mean age was 27.3 ± 9.6 years (range = 18 – 61 years) and the mean body mass index (BMI) was 23.9 ± 5.5 kg/m². Most participants were Caucasian (87.5%) and never married (68.8%). Participants were classified as either (a) full threshold BN ($n = 58$; 72.5%) according to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) or (b) subthreshold BN¹ ($n = 22$; 27.5%), defined as experiencing compensatory behaviors accompanying subjective binge eating episodes (i.e., self-reported overeating an amount of food that is not objectively large but in which a sense of loss of control is experience; Fairburn et al., 2008) at least weekly for 3 months before enrollment, or meeting BN criteria except for objective binge eating as defined by DSM-IV on average once per week). Exclusion criteria included: pregnancy/lactation, BMI <18 kg/m², lifetime bipolar or psychotic disorder diagnosis, current substance use disorder, medical or psychiatric instability, and current psychotherapy. All measures in the current analysis were administered at baseline before treatment commenced. Trained masters- and doctoral-level assessors conducted interviews, and diagnoses were ascertained based on the Eating Disorder Examination interview (see below). All assessors were trained initially by attending didactic and role playing sessions, observing experienced interviewers administer the measures, being observed by trainers in administering the measures, and having audiotaped assessment administrations reviewed by senior assessors. Ongoing assessment meetings and audiotape reviews among assessors were conducted to prevent drift. Relevant institutional review boards approved this protocol.

¹Given that subjective binge eating is associated with impairment, psychopathology, and outcomes consistent with objective binge eating, participants with subjective binge eating were included. Inclusion criteria were determined prior to the release of DSM-5 (i.e., using DSM-IV guidelines). It is possible that some of these participants would meet criteria for DSM-5 purging disorder.

2.2 Measures

2.2.1 Selves Interview (SELVES)—The SELVES interview (Higgins et al., 1986) measured self-discrepancy. Participants describe their actual, ideal, and ought self. The SELVES interviewer obtains an assessment of participants' beliefs regarding their current behaviors/attributes as well as self-guides, which may be conceptualized as personal standards. Participants were asked to generate lists of attributes that describe the kind of person they believe they actually are (i.e., actual self), the type of person they would ideally like to be (i.e., ideal self), and the kind of person they believe they must, or ought to be (i.e., ought self). Common responses to the ideal and ought questions were “successful,” “attractive,” “loving,” “conscientious,” “hard-working,” “kind,” or “independent.”

The scoring of the SELVES required several steps. First, for actual, ideal, and ought self-guides, any redundant and contradictory words that followed the original word in each particular list were removed. Second, the list of descriptors of the actual self were compared to the list of ideal and ought self-guides. Raters coded each pair of words as either a match, a mismatch of extent, a mismatch, and a non-match. A match was defined as pairs of words that were the same or similar and were given a score of −1. A mismatch was defined as pairs of words that were opposite and were given a score of +2. If the word pair were synonymous but negated by the presence of a qualifier that indicates a desire for more or less of the attribute (e.g., actual/own = happy; ideal/own = very happy), A mismatch of extent was defined as pairs of words that were the same or similar but included a qualifier (e.g., beautiful vs. very beautiful) and were given a score of +1. A non-match was defined as a pair of words that were neither similar nor opposing and were given a score of 0.

Each self-discrepancy score is a weighted difference score comparing the number of actual-self/self-guide “matches” (e.g., actual-self: “friendly,” ideal-self “friendly”) with the number of actual-self/self-guide “mismatches” (e.g., actual-self: “lazy”, ought-self “hard-working”). Non-matches were not included in the calculation of self-discrepancy scores. Actual:ideal discrepancy was a score comparing actual self and ideal self words and actual:ought discrepancy was a score comparing actual self and ought self words. The validity of this scoring procedure has been demonstrated in previous studies (Higgins et al., 2009). Scores range from negative to positive with higher positive scores reflecting greater self-discrepancy and lower negative scores meaning lower self-discrepancy. A score of −10 indicated complete match between self-guides and a score of +20 indicated complete discrepancy between self-guides.

2.2.2 Structural Analysis of Social Behavior Intrex Questionnaire (SASB)—The 32-item SASB introject questionnaire (Benjamin, 2000) measures one's self-directed style. We used the self-affirm (e.g., “I like and accept myself as is”) and self-blame (e.g., “I blame myself and put myself down”) subscales. Participants indicated the extent to which each item was characteristic of how they typically behave toward themselves. Cronbach's alphas were .78 and .79 for self-blame and self-affirm, respectively.

2.2.3 Eating Disorder Examination (EDE)—The EDE (Fairburn et al., 2008) interview assesses global ED psychopathology consisting of restraint, eating concerns, shape concerns,

and weight concerns. In the current study, inter-rater reliability ratings, conducted on a random sample of audiotaped interviews ($n = 16$; 20%), were all 0.91 .

2.2.4 State Trait Anxiety Inventory (STAI)—The STAI (Spielberger, 2010) is a 40-item measure of anxiety symptoms (e.g., feeling nervous or restless, feeling inadequate, and worrying). Only the trait version was used in this study. Cronbach's alpha was 0.96 in this sample.

2.2.5 Beck Depression Inventory (BDI)—The BDI (Beck et al., 1961) is a 21-item measure of depressive symptoms (e.g., sadness, loss of appetite, hopelessness). Cronbach's alpha was 0.89 in this sample.

2.3 Statistical Analysis

Descriptive statistics were calculated for study variables. Ordinary least squares (OLS) multiple regressions were used to independently examine main effects and four interactions (i.e., actual:ideal and self-affirm; actual:ideal and self-blame; actual:ought and self-affirm; and actual:ought and self-blame). There were thus four regressions for each dependent variable (i.e., ED psychopathology [EDE Global], depressive symptoms [BDI], and anxiety symptoms [STAI]). Self-blame and self-affirm were centered and used to create interaction terms. Analyses were calculated with the full sample as well as with the female participants only to examine potential gender differences. Given that the same pattern of findings emerged for the female sample, we elected to retain the full sample.

3. Results

Descriptive statistics and inter correlations among study measures are displayed in Table 1. Actual:ideal discrepancy was significantly and positively correlated with anxiety. Actual:ought discrepancy was significantly positively correlated with depressive symptoms, and anxiety. Self-blame was significantly positively correlated with ED psychopathology, depressive symptoms, and anxiety. Self-affirm was significantly and negatively correlated with ED psychopathology, depressive symptoms, and anxiety.

3.1 ED psychopathology

Results of the OLS multiple regressions are displayed in Table 2. Regarding main effects, less self-affirm and higher self-blame were associated with increased ED psychopathology. No significant interactions emerged. These models explained 8–14% of the variance in ED psychopathology.

3.2 Depressive symptoms

Although main effects for self-affirm and self-blame were found when actual:ideal discrepancy was included in the model, only actual:ought discrepancy was positively associated with depressive symptoms when actual:ought discrepancy was in the model. Interactions were also found between self-affirm and actual:ought discrepancy as well as between self-blame and actual:ought discrepancy. Higher levels of actual:ought discrepancy were related to increased depressive symptoms regardless of levels of self-affirm (see Figure

2A). When actual:ought discrepancy was low, higher self-affirm was associated with decreased depressive symptoms. Similarly, higher levels of actual:ought discrepancy were related to increased depressive symptoms regardless of levels of self-blame (see Figure 2B). When actual:ought discrepancy was low, higher self-blame was associated with increased depressive symptoms. These models explained 12–23% of the variance in depressive symptoms.

3.3 Anxiety symptoms

For main effects, self-blame, actual:ideal discrepancy and actual:ought discrepancy were positively associated with anxiety and self-affirm was negatively associated with anxiety. There were no significant interactions. These models explained 21–34% of the variance in anxiety.

4. Discussion

The goal of this study was to examine the role of core components of the ICAT-BN model by examining main effects and interactions of self-discrepancies and self-directed styles in relation to depression, anxiety, and ED psychopathology. For ED psychopathology, self-directed styles were significantly associated with increased ED psychopathology. Individuals engaging in more self-blaming and less self-affirming reported a higher level of ED psychopathology. This finding is consistent with previous research finding relationships between self-directed styles and ED psychopathology (e.g., Pinksavage et al., 2015). However, no significant interactions between self-discrepancies and self-directed styles were found for ED psychopathology.

In contrast, self-discrepancies and self-directed styles were found to interact in relation to depressive symptoms. Results showed that actual:ought discrepancy, but not actual:ideal, was strongly linked to depressive symptoms in individuals with BN. In fact, individuals who endorsed high discrepancies between their actual and ought selves were more likely to experience depressive symptoms, regardless of their self-directed style. However, self-directed style also played an important role in relation to increased depressive symptoms when actual:ought discrepancy was low. Relatedly, individuals low in actual:ought discrepancy who endorsed more adaptive self-directed styles reported fewer depressive symptoms. Thus, blaming and affirming self-directed styles may serve respectively as a depression risk and protective factors for some individuals. Additionally, although no significant interactions were observed for anxiety, it is important to note that self-discrepancies and self-directed styles were strongly associated with anxiety symptoms in this BN sample. Findings suggest that self-discrepancy and self-directed style each independently contribute to increased anxiety in adults with BN. Specifically, those who report engaging in more self-blaming and less self-affirming may have increased anxiety. Further, greater discrepancy between how one believes themselves to be and how one wishes they were or how they feel they should be may be associated with increased symptoms of anxiety.

Overall, the results support different inter-relationships between self-discrepancy and self-directed style in relation to various psychopathology symptoms. The pattern of findings in

the current study is notable considering previous results in non-ED samples suggesting that individuals with depression tend to show higher levels of actual:ideal discrepancies than non-depressed individuals, and anxious individuals tend to show higher levels of actual:ought discrepancies than non-anxious individuals (Higgins, 1987; Scott and O'Hara, 1993). In contrast the current study found that actual:ideal discrepancy was not associated with depressive symptoms and both actual:ideal and actual:ought discrepancy were related to anxiety. Associations between self-discrepancy and anxiety and depressive symptoms may differ among those with EDs versus those without EDs. Also, this difference may reflect greater symptom severity among our sample versus non-clinical samples.

4.1 Clinical implications

The study supports the salience of self-discrepancy and self-directed style in relation to psychopathology symptoms, consistent with the ICAT model of BN. Targeting self-discrepancy and self-directed styles in treatment may reduce a range of psychological symptoms including depressive symptoms, anxiety, and ED psychopathology. Specifically, results of the analyses predicting ED psychopathology suggest that either reducing a self-blaming style or increasing a self-affirming style may have benefits in reducing ED symptoms. Furthermore, results suggest that the effective treatment of depressive symptoms and anxiety in women with BN, both of which are commonly elevated in this population, may be facilitated by targeting both self-discrepancy and self-directed style.

4.2 Strengths and limitations

An important strength of this study was the use of interview assessments to measure many of the main constructs. In addition, our results further our knowledge of a difficult to recruit population – adults with full or subthreshold BN. Although the results of the current study offer a contribution to the existing literature, several limitations must be noted. Because this study was cross-sectional, all measures were collected at the same time. Therefore, this design limits our ability to make causal inferences from these data. For instance, while self-discrepancy and maladaptive self-directed styles may promote psychopathology, it is also plausible that ED psychopathology, anxiety, and depressive symptoms could lead to more self-discrepancy and maladaptive self-directed styles. In addition, the sample size of the study may have limited our ability to find significant effects, particularly interactions. Some effects were non-significant although they had a small-to-medium effect size. Finally, our findings may not be generalizable to all individuals with BN, as this was a treatment-seeking sample with symptom heterogeneity (e.g., some only reported subjective binge eating).

4.3 Conclusions and future directions

The current findings strengthen our understanding of the ICAT-BN model. In particular, these results demonstrate the potential of increased risk for ED psychopathology, anxiety, and depressive symptoms based on an individual's self-discrepancies, self-directed styles, and interactions between the two constructs. For example, a self-blaming style of coping was found to be more maladaptive for those with higher, but not lower, actual:ideal discrepancies, whereas a self-affirming style of coping was found to be more protective for those who had lower, but not higher, actual:ought discrepancies. These findings provide further evidence supporting the primary treatment targets in the ICAT-BN treatment protocol

(Wonderlich et al., 2015) including self-discrepancies, emotional states, and self-directed behavior.

Future research examining mechanisms by which self-discrepancies and self-directed styles are associated with psychopathology are needed. Also, our study elucidates potential between-person associations among self-discrepancies, self-directed styles, and psychopathology. Next steps in this area of research include identifying within-person associations between these study variables. Future studies should also compare results to other eating disorder and psychiatric groups to explore the extent to which the present findings are unique to BN. Finally, future research should examine associations between self-discrepancy and self-directed style in relation to specific ED behaviors.

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Figure 1.

Empirical model, derived from the ICAT-BN onset and momentary maintenance models, examining the main effects and interactions between self-discrepancy and self-directed style in relation to psychopathology. Solid lines represent paths theorized in the ICAT-BN model whereas the dashed line represents exploratory research questions.

Figure 2.

A) Interaction of self-affirm and actual:ought discrepancy on depressive symptoms; and B) Interaction of self-blame and actual:ought discrepancy on depressive symptoms.

Table 1

Descriptive Statistics among Study Variables

	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7
1. Actual:ideal discrepancy	-0.40	2.58	-	0.50***	-0.05	-0.04	.011	0.22	0.36***
2. Actual:ought discrepancy	-0.63	1.96		-	-0.22	0.14	0.21	0.36**	0.36***
3. Self-blame	7.54	2.80			-	-0.35**	0.23*	0.30**	0.47***
4. Self-affirm	3.10	1.65				-	-0.32**	-0.29*	-0.36**
5. ED psychopathology	3.27	1.10					-	0.42***	0.42***
6. Depressive symptoms	18.70	11.58						-	0.73***
7. Anxiety	51.63	12.44							-

Note. ED = eating disorder.

 $p < 0.001$, $p < 0.01$,

*

 $p < 0.05$

Interactions among Self-Discrepancy and Self-Directed Style Predicting Eating Disorder Psychopathology, Anxiety Symptoms, and Depressive Symptoms

Table 2

	<i>ED Psychopathology</i>				<i>Depressive Symptoms</i>				<i>Anxiety Symptoms</i>			
	β	<i>t</i>	R^2		β	<i>t</i>	R^2		β	<i>t</i>	R^2	
Affirm	-0.36	-3.18**	0.14		-0.28	-2.47*	0.12		-0.38	-3.58***	0.26	
Actual:Ideal	0.002	0.02			.019	1.59			0.29	2.70**		
Affirm X Actual:Ideal	-0.19	-1.58			-0.003	-0.02			-0.13	-1.19		
Blame	0.27	2.36*	0.10		0.28	2.49*	0.13		0.48	4.85***	0.34	
Actual:Ideal	0.12	1.01			0.18	1.61			0.36	3.65***		
Blame X Actual:Ideal	0.21	1.80			-0.06	-0.52			0.08	0.83		
Affirm	-.28	-2.22*	0.12		-0.12	-0.98	0.22		-0.25	-2.11*	0.21	
Actual:Ought	0.13	1.10			0.37	3.30**			0.31	2.77**		
Affirm X Actual:Ought	0.03	0.22			0.25	2.09*			0.10	0.87		
Blame	0.20	1.67	0.08		0.17	1.55	0.23		0.41	3.82***	0.27	
Actual:Ought	0.16	1.38			0.32	3.09**			0.28	2.83**		
Blame X Actual:Ought	-0.003	-0.02			-0.22	-2.00*			-0.05	-0.05		

Note: ED = eating disorder.

$p < 0.001$,

**

$p < .01$,

*

$p < .05$.