

**PSYCHOLOGICAL SENSE OF CONTROL
AND RECOVERY FROM ANOREXIA NERVOSA**

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Psychological Sense of Control and Recovery from Anorexia Nervosa

by

Summer W. Nipomnick

Abstract

A psychological sense of control has been implicated in the development and maintenance of anorexia nervosa. The paradoxical relationship the individual with anorexia has to psychological control mechanisms may lie at the heart of successful treatment and recovery from this complex syndrome. This study utilized Shapiro and Astin's (1998) unifying theory of human control as an integrative framework for understanding a sense of control as it relates to eating pathology. The foundation of the theory rests on the belief that the greatest human fear is losing control, while the strongest motivation is to have a sense of control. The purpose of the study was to investigate psychological components of control that may contribute to successful recovery from anorexia nervosa. Findings from this study revealed that overall sense of control, positive sense of control, and a positive assertive mode of gaining control were significant predictors of recovery status. Results confirmed that individuals who have recovered from anorexia endorse feeling more in control of their environment and of themselves. Recovered individuals displayed higher levels of self-efficacy, and a greater belief in their ability to set and attain meaningful goals. Additionally, this study supported the idea that higher levels of positive assertive modes of control (including such beliefs as one's ability to actively alter or change the environment, self, or others in a positive way) may contribute to recovery status. The findings from this study further our understanding of

psychological sense of control as it relates to recovery from anorexia and narrative accounts provided by participants further elucidate the internal and external battles for control experienced as part of this complex syndrome.

Keywords: anorexia nervosa; psychological sense of control; recovery; Shapiro Control Inventory; unifying theory of human control

PREVIEW

PREVIEW

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PREVIEW

CHAPTER ONE: INTRODUCTION

Anorexia nervosa is a serious psychological disorder that affects approximately .7% of the population and is most commonly diagnosed in adolescent females (Agras et al., 2004), although a growing number of men and adults of both genders are also susceptible. This syndrome of unknown etiology occurs on a continuum from mild to life threatening. It is frequently accompanied by predisposing genetic factors, comorbid psychopathology, and serious medical comorbidity. Primary prevention programs have been largely unsuccessful with 20% of individuals reporting chronic problems and an additional 24% experiencing residual symptoms (Agras et al., 2004; Fichter, Quadflieg, & Hedlund, 2006). Data indicate that approximately 50% of individuals diagnosed with anorexia are hospitalized, 50% receive medication, and almost 100% receive psychotherapy during the course of their illness (Agras et al., 2004). Anorexia has the highest mortality rate of any psychiatric diagnosis, approximately 10% per decade (Agras et al., 2004). The suicide risk is estimated to be 50 times that of the general population (Keel et al., 2003). It is the leading cause of death in young females 15 to 24 years of age (Agras et al., 2004) with death occurring due to suicide, infection, or succumbing to the effects of chronic starvation. In a 30-year longitudinal study comparing individuals with anorexia to the general population, those with a history of anorexia were six times more likely to have died during the 30-year followup than the general population (Papadopoulos, 2009). In their report, researchers indicated that they were “astonished” by the findings. Deaths were attributed not only to psychological factors but to a rise in medical risk factors as well.

The diagnosis of anorexia nervosa is based on the following diagnostic criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (DSM-IV-TR; American Psychiatric Association, 2000): (1) the inability to maintain body weight at or above 85% of normal for age and height, (2) even though underweight, an intense fear of becoming fat or gaining weight, (3) a distortion in body image, self-evaluation, and denial of seriousness of low body weight, and (4) amenorrhea, in post menorrheal females, or failure to meet developmental milestones in prepubertal females. The diagnosis is further divided into two subtypes, restricting and binge/purging. Most authorities have become flexible with regard to the body weight requirement and the duration of amenorrhea in the classification of anorexia as studies have found few differences in the clinical features between participants meeting full criteria for anorexia and those meeting all criteria except amenorrhea or weight below 85% for age and height (Garfinkel et al., 1996).

The etiology and treatment of anorexia is difficult to address due to the complexity of sociocultural, psychological, and biological underpinnings. Numerous sociocultural theories suggest that anorexia is the result of the objectification of women and portrayal of thinness and beauty in the media (Calogero, Davis, & Thompson, 2005; Orbach, 1978; Thompson & Heinberg, 1999). Psychological theorists propose that family dynamics, individuation, insecurity, and maladaptive coping mechanisms are the cause (Bruch, 1973, 1982; Lawrence, 1979; Minuchin, Rosman, & Baker, 2004). In addition, biological theorists claim there is mounting evidence that the neurotransmitter serotonin plays a key role in the development of anorexia (Collier et al., 1997; Hinney et al., 1997;

Huether, Zhou, & Ruther, 1997; Kaye, 1997). Despite numerous and conflicting etiological theories, the majority of researchers and clinicians suggest that the concept of psychological control plays a central role in anorexia. Various theorists have described anorexia as a lack of control over life and emotions (Thompson & Sherman, 1989), an internal struggle for self-control (Selvini Palazzoli, 1978), a battle for control within the family context, and a need for self-control (Lawrence, 1979). The theories of psychological control are heterogeneous in their explanations of control, how it functions, and its possible relationship to health and illness. These various understandings of control have not been fully applied to anorexia. We often hear people with anorexia say they initially feel in control until *it* (the anorexia) has control over the person. How does the individual regain a sense of control to move beyond his/her symptoms? How does the person “recover” when *it* has control? Does his/her relationship with control shift or change?

The purpose of this study was to investigate components of a psychological sense of control that may contribute to successful recovery from anorexia. A psychological sense of control is a multifaceted construct defined as the attainment of a desired outcome achieved through activities of self or other or a belief in an external force (Rodin, 1986). The National Institutes of Health refer to a sense of control as a person’s interrelated beliefs and expectancies about (a) an ability to perform behaviors leading to desired outcomes, and (b) the responsiveness of the environment to his/her behaviors (NIH, 1990). A sense of control is a salient construct in health psychology. It is believed to be a positive marker of health and well-being among patients with cancer, heart disease, and

terminal illness (Haugli, Steen, Finset, & Nygaard, 2000; Masters & Wallston, 2005; Park, Edmondson, Fenster, & Blank, 2008; Rabin & Pinto, 2005). It is associated with behavior change, positive outcome and adaptation, as well as prevention and health attitudes. Researchers also suggest that the way in which individuals cope with a loss of control typically results in maladaptive consequences and negative adaptation, and is often experienced by others as manipulative, coercive, and deceitful.

The majority of researchers and clinicians point to the centrality of a psychological sense of control in their explanations of anorexia despite numerous and conflicting etiological theories and clinical presentations. Garner, Garner, and Rosen (1993) refer to the individual's "steadfast unnatural control" in reference to restricting behavior of individuals with anorexia. In other areas of the literature individuals with anorexia have been noted to fear a loss of control (Crisp, 1995), experience coercive parental control (Haworth-Hoepfner, 2000), struggle for control in the formation of identity (Bruch, 1973), and use control to define the self through external expectations (Orbach, 1978). Empirical literature indicates that eating disorder patients perceive themselves as having less personal control than their counterparts and an increased sense that they are being controlled by others (Williams, Chamove, & Millar, 1990). Surprisingly, in areas unrelated to their eating disturbance, these individuals exhibit similar or greater control in contrast to comparison groups (Shapiro, Blinder, Hagman, & Pituck, 1993).

The paradoxical relationship an individual with anorexia has to psychological control mechanisms may lie at the heart of successful treatment and recovery from this

syndrome. This study examined whether individuals who have successfully recovered from anorexia displayed different means, mechanisms, and motives of control in comparison to their symptomatic counterparts. The findings from this study broaden our clinical understanding of psychological control as it relates to recovery from anorexia and further elucidate the internal and external battles for control that take place within the individual with anorexia.

Definition of Terms

The following definitions serve as a guide to clarify terms used throughout this paper:

Sense of control. The attainment of a desired outcome achieved through activities of self or other or a belief in an external force (Rodin, 1986). This includes a belief in the self as competent and efficacious and a belief that one's environment is structured and responsive (Bandura, 1989; Gurin & Brim, 1984; Weisz, 1986). The construct was objectively measured through the Shapiro Control Inventory (SCI).

Participant. A female between the ages of 18-45, who has a current or past history of anorexia nervosa, with initial onset between the ages of 13-25, as defined by the diagnostic criteria in the DSM-IV-TR.

Recovery. A process-oriented outcome that adults with anorexia nervosa experience as their psychological and physical health improves. To date, there is no universal definition of recovery in the eating disorder field. Consistent with recent research (Couturier & Lock, 2006), recovery was objectively defined as body mass index (BMI) >18.5 for at least one year duration and absence of symptoms meeting DSM IV-

TR criteria for anorexia nervosa. The construct was objectively measured using the Eating Disorder Diagnostic Scale (EDDS; Stice, Telch, & Rizvi, 2000) in conjunction with self-report data obtained from the Background Questionnaire.

Age of onset. The age at which the participant was first diagnosed with anorexia nervosa.

Body mass index. A statistical measure of body fat based on height and weight (World Health Organization, 2006). The body mass index is the weight in pounds divided by height in inches squared, multiplied by a conversion factor of 703.

- Underweight = <18.5
- Normal weight = 18.5-24.9
- Overweight = 25-29.9
- Obesity = BMI of 30 or greater

Conceptual Framework

The conceptual framework utilized in this study was Shapiro and Astin's (1998) unifying theory of human control. The goal of this investigation was twofold: (a) to create a psychological sense of control profile of women who have recovered from anorexia nervosa, and (b) to identify the components of a psychological sense of control that may contribute to successful recovery from anorexia. These goals are consistent with the conceptual framework reviewed below.

Unifying Theory of Human Control.

The unifying theory of human control is an integrative framework for understanding a sense of control as it relates to human motivation across the lifespan. The

application of this theory has been useful in the areas of depression, anxiety, and personality disorders (Shapiro, Potkin et al., 1993); eating disorders (Shapiro, Blinder et al., 1993); and with adult children of alcoholics (Shapiro, Weatherford, Kaufman, & Broenen, 1994). The foundation of the theory rests on the belief that the greatest human fear is losing control, while the strongest motivation is to have a sense of control (Shapiro & Astin, 1998). This desire for control is expressed across multiple domains on individual, interpersonal, and spiritual levels. Behavior and cognition are understood and explained as expressions of an individual's need to gain, maintain, or reestablish a sense of control. The sense of control construct subsumes both actual and perceived control and is formulated upon the belief that the individual has control or can gain control if desired (Shapiro & Astin, 1998). Shapiro and Astin's (1998) concept of control spans cognitive, developmental, and behavioral variables (i.e., having control, efforts to control, coping strategies) and motivational factors (i.e., desire for control and loss of control).

This study examined the components of a psychological sense of control that may contribute to successful recovery from anorexia nervosa. The Shapiro Control Inventory (SCI), which is based upon the unifying theory of human control, was utilized to assess domain-general (trait) and domain-specific (state) sense of control, positive and negative modes of control, motivation for control, and agency of control.

CHAPTER TWO: REVIEW OF THE LITERATURE

Anorexia nervosa has the highest mortality rate of any psychiatric diagnosis (Agras et al., 2004). While longitudinal studies indicate that approximately 46% of individuals with anorexia recover, 44 % continue to experience residual symptoms that interfere with work and life (Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Herpertz-Dahlmann et al., 2001; Ratnasuriya, Eisler, Szmukler, & Russell, 1991; Steinhausen, 2002; Strober, Freeman, & Morrell, 1997; Theander, 1996). As a clinician and researcher, I cannot help but wonder what we are failing to see, what part of anorexia have we yet to understand? If up to 20% of individuals diagnosed with this syndrome die (Theander, 1996; Ratnasuriya et al., 1991), then what are we missing? Control over food, over self, over the world, within self, and in ways unarticulated is an integral component of anorexia. Individuals with anorexia will often speak of the paradoxical need to control and their feelings of a lack of control as though anorexia has taken over their life. Despite theoretical diversity as to the etiology of anorexia, all have pointed to underlying themes of control. Treatments for anorexia also vary in their means and methods of control. Walsh and Kahn (1997), in an article on diagnostic criteria for eating disorders said, “we study what we define” (p. 369). If 44% of those seeking treatment for anorexia remain symptomatic, then we are failing those who are seeking our assistance.

The first section of this review will briefly evaluate prominent understandings and conceptualizations of the construct of control. The second section will review control as it is related to physical and mental health and well being. And, the third section will focus on the various ways a sense of control has been implicated in the etiology, treatment, and

outcome of anorexia. I will argue that a sense of control can serve as a useful overarching framework to understand recovery from anorexia.

The Concept of Control

This study utilized Shapiro and Astin's (1998) unifying theory of human control as an integrative framework for understanding and conceptualizing a sense of control. Central to this theory is the belief that a desire for control is expressed across multiple domains on individual, interpersonal, and spiritual levels. The development of the theory may account for earlier methodological biases in other measures of control. As a unifying theory, it attempts to incorporate related psychological constructs of control found within analytic (Adler, 1964; Farber, 1966; Freud, 1923; Klein, 1932; Mahler, 1968; Menninger, Mayman, & Pruyser, 1963; Rank, 1950), humanistic/ existential (Becker, 1973; Frankl, 1980; May, 1961; Rogers, 1951), cognitive/behavioral (Bandura, 1977; Beck, 1976; Lazarus, 1981; Rotter, 1966; Seligman, 1975), transpersonal (Astin & Shapiro, 1997), and social psychology (Averill, 1973; Burger, 1985; Glass, 1977; Lazarus, 1981; Lefcourt, 1973; Rodin, 1986) within its model.

Early conceptualizations of control and its related constructs largely centered on philosophical notions of free will, determinism, and freedom. In *The Republic*, Plato (2003) noted that appetites were guided and ruled by reason, while reason was dependent upon spirit. Later writers referred to the function of the spirit as "will" (Hamilton & Cairns, 1961). Along with the term *will*, Aristotle wrote about choice, desire, appetite, impulse, and purpose as motivating forces that turned thought into action (Barnes, 1984). Immanuel Kant (2004) noted that "the act of choice that can be determined by pure

reason constitutes the act of free will...The human act of choice...however...is in fact affected by such impulses or stimuli, but is not determined by them” (p. 13). According to these philosophers free will is volitional. Thomas Aquinas (1998) distinguished between acts of will that were determined by reason (desire and appetite) and those that are free and determined by God, thus introducing a spiritual component and a sense of control that existed outside the realm of the individual.

Opponents to the belief in volitional free will were philosophers such as Spinoza (1949) who believed that “the human mind cannot be the free cause of its own actions” (p. 119). Hume (1993) professed that there was no such thing as free will although he believed it to be a “matter of common experience...We suffer the illusion...because we are motivated by the fantastical desire of showing liberty” (pp. 44-63).

Among psychoanalytic schools of thought, theorists believe that nature and nurture shape personality, however there is great divergence as to the extent of the dominant influence. The early psychoanalysts focused on biological forces that involved instinctual desires and innate drives (Freud, 1961). Freud attached great significance to nature—instinctual drives—and believed that instinct explained relationships and environmental forces that in turn shaped personality. He conceptualized the controlling character trait as a complex defense (reaction formation) against impulses. He referred to a fierce internal battle where impulses pushed for expression and defenses were erected to defend against the impulse. It was the experience of these instinctual drives that served as the unconscious framework for motivation. There was an underlying belief in these formulations that the individual was relatively helpless to effect change.

Adler (2005) challenged this belief and suggested that the motivating force behind growth and goal-directed striving was the maintenance of control throughout life. Hendrick (1943) and Angyal (1941) referred to the innate desire to control and attributed to the individual a characteristic tendency toward self-determination, a tendency to resist external influences and to subordinate the external forces of the physical and social environment to their own sphere of influence. Wilhelm Reich (Mitchell & Black, 1995) suggested that control was the expression of a wish to gain and maintain power over others or, alternatively, an expression of efforts to defend against those very wishes through respect and flattery. Sullivan (Mitchell & Black) believed expressions of control to exist in an interpersonal framework where control is believed to be a defense against anticipated humiliation and profound anxiety. This line of thinking was further extended in studies done by Klein (1932) and Mahler (1968) who focused on emotional regulation and individual interaction, differentiation, and control of the environment.

Behaviorists contributed the belief that the environment was the critical variable that determined and controlled human behavior (Skinner, 1971; Watson, 1925/1958). They suggest that patterns of thought and systems of belief influence a person's sense of control. Bandura's (1977) concept of self-efficacy—the subjective assessment that one has the internal and external resources available to cope with a given situation—has been conceptualized as “the self-appraisal of competence and control” (Everly, 1989, p.122). A repeated experience of loss of control in which the individual believes him/herself to be helpless to effect outcome has been developed by Seligman (1991) and his work on learned helplessness.

While the psychodynamic position rests on the belief that behavior is largely a result of biological, instinctual, and developmental forces, the behaviorists ascribe control to environmental factors. Humanistic/existential theorists place an emphasis on personal choice, individual freedom and the responsibility of the individual to control his/her own life. May (1989), Sartre (1947, 1956), and Yalom (1980) suggest that personal control develops through exercising freedom and individual choice. They believe that existence is neither biologically or environmentally determined, rather they suggest that it develops and evolves through choices and actions across the lifespan.

Control and Psychological Functioning

The current understanding of psychological control can be divided into actual (objective) control, perceived (subjective) control, and the experience of control. Researchers have focused on how individuals gain and maintain a sense of control in their lives. We know that the ability to gain and maintain control is necessary for evolutionary survival (Migone & Liotti, 1998), that perceived control is an important variable in physical health and well being (Barez, Blasco, Fernandez-Castro, & Viladrich, 2008; Masters & Wallston, 2005; Park, Edmondson, Fenster, & Blank, 2008; Shapiro & Astin, 1998), and that control is a central element of psychotherapy and mental health (Backenstrass et al., 2006; Bandura, 1989; Beck, 1976; Cooper, Stockford, & Turner, 2007; Moulding, & Kyrios, 2007; Seligman, 1991).

Four decades of measurement have led to a shift in the conceptualization of control from a unitary construct to control as a multifaceted construct. Jullian Rotter's Internal External Locus of Control Scale (1966) was the first scale developed to measure