POSITIVE AND NEGATIVE INFLUENCES OF RELIGIOUS COMFORT AND ANGER TOWARDS GOD ON EATING DISORDER SYMPTOMS

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Increased Prevalence

- 30 million people suffering within the US from an eating disorder
  - Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder (Wade, Keski-Rahkonen, & Hudson, 2011; Richards et al, 2013)
  - Affects both women and men, higher in women (Hudson, Hiripi, Pope, & Kessler, 2007)
  - Onset now as young as adolescence into young adulthood (Gordon, 2000; Richards et al, 2013)
ETIOLOGY/MAINTENANCE

- Etiology is multidimensional
  - Biological, genetic, psychological, and sociocultural factors (Fairburn, Cooper, Shafran, & Wilson, 2008; Klein & Walsh, 2004)

- Risk Factors/Maintenance (Stice, 2002)
  - Body dissatisfaction
  - Elevated body mass
  - Drive for thinness
  - Negative affect
THE RELIGION–SPIRITUALITY GAP

• Religion and spirituality are understudied in health-related research including psychology (Hill & Pargament, 2003)
• When studied they are often included as add-on variables
• Measures focus on brief single-items
  • Church attendance frequency, denominational affiliation, self-rated religiousness and spirituality
SPIRITUALITY VS. RELIGIOUSNESS

• Defining
  • Spirituality - “search for the sacred” (Pargament, 2013)
  • Religiousness - “a set of beliefs to which one ascribes in a community” (Emmons, 2003)

• Religious involvement can have both adaptive and maladaptive qualities (Exline et al., 2000)
  • Religious Comfort
  • Religious Strain

• Mechanisms that have been associated with positive health outcomes
RELIGION-HEALTH CONNECTION

- Hypothesized Moderator (Ellison & Levin, 1998)
  - A relationship between “stressors, religiosity, and health as contingent or interactive”
  - Tapping into the functional aspects (support, coping, meaning)
    - → improve patient’s health
    - → Reduce the harmful effects of stressors
  - Those with high encounters of stress will receive the greatest health benefits of religious support and coping
DUAL PATHWAY MODEL

• Homan & Boyatzis, 2010
  • Protective factors can prevent and reduce levels of risks factors
    • By interacting with risk factor to buffer its effects
    • Or disrupt mediational chain
  • They hypothesized that attachment to God could moderate and/or weaken pathways
DUAL PATHWAY MODEL

(HOMAN & BOYATZIS, 2010, P. 241)
HYPOTHESES

• Religious comfort would be positively associated with reduced eating disordered symptoms on admission and discharge.
• Anger toward God would be negatively associated with reduced eating disordered symptoms on admission and discharge.
SAMPLE

- $N = 275$ patients from surrounding LA treatment centers
  - Residential ($n = 130$)
  - Partial Outpatient ($n = 104$)
  - Intensive Outpatient ($n = 41$)
- Eating Disorder Diagnosis
  - Anorexia Nervosa ($n = 108$)
  - Eating Disorder NOS ($n = 55$)
  - Bulimia Nervosa ($n = 111$)
- Participants ranged in age from 10-65 ($M = 25.6$, $SD = 10.7$)
- 9.8% male | 90.2% female
- Participants were primarily Caucasian of 69.5%
  - African American (2.2%), Native American (0.7%), Hispanic (10.5%), Asian (4.0%), Other (6.9%)
METHOD

• Eating Disorder Inventory (EDI)
  • Eating Disorder Risk Scales
    • Drive for Thinness/Body Dissatisfaction
• Eating Disorder Examination – Questionnaire (EDE-Q)
  • Subscale
    • Eating Concern
• Religious Comfort and Strain Scale (RCS)
  • Two Subscales
    • Religious Comfort
      • Positive relationship with God
    • Religious Strain
      • Anger Towards God (includes 4 items from the Negative Emotions Towards God subscale)
ANALYSIS

- SPSS
  - Bivariate Correlations
  - Multiple Linear Regression
    - IV – Anger Toward God - admit
    - IV – Positive Relationship with God - admit
    - DV - EDI Drive for Thinness – admit
    - DV – EDI Body Dissatisfaction – admit
    - DV – EDE-Q Eating Disorder Risk - admit
    - DV – EDE-Q Eating Concern – discharge
  - Controlled for Gender
RESULTS

• At admission, as Positive Relationship with God increased,
  • Drive for Thinness, $r(266) = -0.14$, $p = 0.03$
  • Body Dissatisfaction, $r(266) = -0.13$, $p = 0.04$
  • Eating Disorder Risk, $r(266) = -0.13$, $p = 0.03$
  • decreased
ANGER TOWARD GOD

• At admission, Anger Towards God was associated with higher scores on Body Dissatisfaction, $r(266) = .13, p = .04$
• At discharge, Anger Towards God was associated with increased Eating Concerns, as assessed by the EDE-Q, $r(98) = .21, p = .04$
BODY DISSATISFACTION

• Linear regression
• After controlling for gender, at admission, Anger Toward God was significantly associated with Body Dissatisfaction, $\beta = .13$, $t(265) = 2.29$, $p = .02$
• After controlling for gender, at admission, Positive Relationship with God was inversely associated with Body Dissatisfaction, $\beta = -.15$, $t(265) = -2.58$, $p = .01$
• Linear regression
• After controlling for gender, at admission, Positive Relationship with God was inversely associated with Drive for Thinness, $\beta = -0.15$, $t(265) = -2.60$, $p = 0.01$
DISCUSSION

• Support for addressing spiritual concerns in the treatment of eating disorders
• Important to understand the interrelationships among feelings of anger towards God, a sense of a positive relationship with God, and eating disorder symptoms
  • Nuancing problematic or beneficial anger towards God
• Utilizing Exline’s Religious and Spiritual Struggles Scale to have more comprehensive view
  • Six types of struggle - divine, demonic, interpersonal, moral, doubt, and ultimate meaning (Exline et al., 2014)


